PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
DECEMBER 13, 2024

Oregon
Tina Kotek, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM**
DATE: **December 13, 2024**
TIME: **8:00 a.m. – 11:30 a.m.**

Call to Order – Reza J. Sharifi, D.M.D., President **8:00 a.m.**

OPEN SESSION Via Zoom - Not in person
Join Zoom Meeting
https://us02web.zoom.us/j/85725433367?pwd=8aQDZthkkTpAuv8fxyhtphxzatjyJ8.1
Phone 253 215 8782 Meeting ID: 857 2543 3367 Passcode: 633360

Confirm Quorum & Review Agenda
1. Approval of October 25, 2024 Board Meeting Minutes

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

3. Committee and Liaison Reports
   - DAWSAC draft minutes from 11.13.2024 meeting – Chair Ginny Jorgensen
   - Set next DAWSAC meeting date. Staff suggestion - Friday, 2.14.2025 @ 12 pm
   - OGEC Advice for the Board
   - OBD Committee Assignments

4 Executive Director's Report
   - Staff Update
   - OBD Budget Status Report
   - Snapshot Reporting Requirements
   - Customer Service Survey
   - CDCA-WREB-CITA Letter
   - 2025 Calendars

5. Unfinished Business and Rules
   - Sec of State Filing – Rule changes effective on Jan 1, 2025
     - Note regarding OAR 818-042-0110
     - New Local Anesthesia Functions Certificate (LAFC)
       - DANB will have website info, application & instructions etc…available on 2/3/2024
       - Certificate fee $75
   - Update on request for Board to join CRDTS
   - Revisit the application and license renewal questions – was scheduled for Oct Board meeting, but ODA asked to discuss at Dec Board meeting
     - ODA & ODHA Request to update license and renewal questions
     - REVISED Initial application questions
     - REVISED license renewal questions

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 Stephen Prisby 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.

    - Current license questions
    - Oregon Medical Board (OMB) – adoption of mental health assessment model
    - OMB license application & renewal questions
    - ODA Email (117 pages) regarding removal of intrusive mental health and substance use disorder questions from initial licensing and relicensing applications
- ODHA Email – Scaling Assistant Training

6. Correspondence
    - ODAA Email raising concerns regarding implementation of HB 3223
    - ODHA Email and 4 documents regarding ADA Resolutions
    - Jenna Shanks, RDH Request for DHs to administer Botox in Oregon
    - Tina Clarke Request for Board approval of Local Anesthesia Dental Assistant Course
    - OAGD Request for Board approval of Local Anesthesia Dental Assistant course
    - OAGD Request for Board approval of Oregon Anesthesia Assistant AnA Certificate
    - Request for letter to the Board discussing DA phlebotomy training
    - Board staff Request for Board approval of updated lists of AnA and AnA-IV courses
    - Pacific University Request for approval of Local Anesthesia Dental Assistant Course
    - Dr. Donald Woods Request for approval of Local Anesthesia Dental Hygienist Course

7. Other
    - OHA - Evaluation of Oregon Health Plan Dental Provider Enrollment
    - Communication- Discussion of Division 42 implementation of 6-month window to obtain certification after training programs for Dental Assistants
        - Attachment Division 42 request
        - Attachment ORCR 6-month rule
    - CODA - State Board Participation in 2025 Accreditation Site Visits
    - Tribes
    - Other Public Comment

8. Articles & Newsletters (No Action Necessary)
    - CRDTS - Summer Report
    - KFF Health News - Dental Implant Article

PRESIDENT'S ANNOUNCEMENT FOR EXECUTIVE SESSION

EXECUTIVE SESSION **9:15 a.m.**
CONFIDENTIAL
The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f)(h)(L) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, and to consult with counsel.

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. Compliance Monitoring
14. Licensing and Examination Issues
15. Consult with Counsel

OPEN SESSION **11:00a.m.**

Join Zoom Meeting
https://us02web.zoom.us/j/85725433367?pwd=8aQDZthkkTpAuv8fxyhtphxzatjyJ8.1
Phone •1 253 215 8782 Meeting ID: 857 2543 3367 Passcode: 633360

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 Stephen Prisby 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.

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

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

ADJOURN **11:30 a.m.**

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

APPROVAL OF MINUTES

DRAFT

OREGON BOARD OF DENTISTRY
MINUTES
OCTOBER 25, 2024

MEMBERS PRESENT:	Reza Sharifi, D.M.D., President Sheena Kansal, D.D.S. Terrence Clark, D.M.D Michelle Aldrich, D.M.D. (portion of meeting) Olesya Salathe, D.M.D. Kristen Simmons, R.D.H., E.P.P. Sharity Ludwig, R.D.H., E.P.P. Ginny Jorgensen Chip Dunn
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/ Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Kathleen McNeal, Licensing Manager Shane Rubio, Investigator Gabriel Kubik, Investigator Dawn Dreasher, Office Specialist
ALSO PRESENT:	Joanna Tucker-Davis, Sr. Assistant Attorney General
VISITORS ALSO PRESENT: VIA TELECONFERENCE*:	Mary Harrison, Oregon Dental Assistants Association (ODAA); Barry Taylor, D.M.D., Oregon Dental Association (ODA); Brett Hamilton, (ODA); Lisa Rowley, Oregon Dental Hygienist Association (ODHA); Hannah Rich (ODHA)

*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.

President Reza Sharifi welcomed everyone to the meeting and then read the Mission Statement as follows:

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

Dr. Sharifi had the Board Members, Joanna Tucker Davis, and Stephen Prisby introduce themselves.

Mr. Prisby noted one excused absence for Board Member Dr. Aarati Kalluri.

NEW BUSINESS

Approval of August 23, 2024 Minutes

Ms. Simmons moved and Mr. Dunn seconded that the Board approve the minutes from the August 23, 2024 Board Meeting as presented. The motion passed with RS, SK, TC, OS, KS, SL, GJ, and CD voting Aye.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Barry Taylor, executive director of ODA, announced the ODA's 4th regional event at Brasada Ranch on November 1-2, 2024. Dr. Taylor announced that Dr. Caroline Zeller has been officially named President of the ODA. Dr. Taylor reported that he has had productive conversations with the OHA's new Dental Director, Dr. Farag, and that Dr. Farag attended the ODA's committee meeting on the previous evening. Dr. Taylor announced that the ODA House of Delegates has combined two components from the Eugene area to the Corvallis area into a new component called the Coastal Cascades Dentist Society.

Dr. Taylor reported that DOPAC and ADPAC have donated $15,000 to Healthy Teeth Hillsboro for the fluoride measure on the November 5, 2024 ballot.

Dr. Taylor reported that he recently attended the American Dental Association (ADA) House of Delegates. Dr. Taylor recounted that eight members of the ODA attended and participated in discussions concerning the workforce and CODA. Dr. Taylor also reported that there was a focus on promoting wellness and encouraging DEI at the ADA. Dr. Taylor announced that he will be speaking on the topic of CODA at the December ADA meeting and that he and Mr. Hamilton have meetings set up with ODHA and ODAA in preparation for the event. Dr. Taylor pointed out that the ODA does not necessarily pursue legislation in response to guidance received from the ADA.

Oregon Dental Hygienists' Association (ODHA)

Lisa Rowley, Advocacy Director of ODHA, announced that the 2024 Oregon Dental Hygiene Conference will be held Friday and Saturday, November 1-2, at the Salem Convention Center. This year's topics include Infection Control, Peri-Implant Disease, Dental Caries Management, Myofunctional Therapy, Dental Assisting Scope of Practice, Expanded Practice Dental Hygiene, Restorative Dental Hygiene, Dental Therapy, TMD & Sleep Apnea and the CSG D/DH Compact.

Ms. Rowley reported that the ODHA has also been very involved in the Healthy Teeth Hillsboro initiative. Ms. Rowley stated that ODHA has been sending emails to all their members who live in Hillsboro. She also acknowledged three senior year hygiene students at Pacific University who have been working on the initiative for their capstone project by creating graphics on the ODHA website and handing out leaflets in Hillsboro on Saturdays.

Oregon Dental Assistants Association (ODAA)

Mary Harrison, representative of ODAA, reported that ODAA has been busy meeting with team member associations. Ms. Harrison reported that this past week ODAA jointed the Oregon Association of Dental Labs for their conference and that ODAA were welcomed to participate and provide speakers, where both assistants and lab members could attend the excellent education available on both Friday and Saturday. Ms. Harrison expressed hope that this could become a

yearly event.

Ms. Harrison reported that the ODAA continues to communicate and meet with the ODA on most related topics. Ms. Harrison stated that transparency on issues is important to be able to work on related issues that effectively relate to members from all of Oregon's associations and dentistry as a whole. The ODAA continues to work on retention and recruitment issues, education, supporting all of Oregon's dental assistants, and helping anyone interested in becoming an assistant through all of the pathways available. Ms. Harrison announced that ODAA's speakers for the Oregon Dental Conference have been approved and expressed that the ODAA looks forward to great participation.

Ms. Harrison announced that the ODAA will join the ODHA for their annual meeting and will provide speakers and an information booth for the event.

ODAA encouraged the Board to pass Rule 818-042-0096 as presented, pointing out that the rule has been presented and passed by the Licensing and Standards and Rules committees. Ms. Harrison further noted that there have been months and months for input and that it was time to move forward with passing this rule to allow dental assistants, with proper training and exams, to perform local anesthesia procedures.

COMMITTEE AND LIAISON REPORTS

Dr. Sharifi reported that the OBD's committee and liaison assignments for May 2024 - April 2025 were available on the OBD website and noted that the assignments were attached for informational purposes.

Dr. Sharifi announced that the next DAWSAC meeting is scheduled for November 13, 2024 at 6:00 p.m. via Zoom.

EXECUTIVE DIRECTOR'S REPORT

Board & Staff Updates

The OBD welcomed Dawn Dreasher as the new Office Specialist on August 19, 2024. Dawn graduated from the University of Colorado with a BA in Philosophy. At law firms in Chicago and Denver, she served as a legal assistant in the areas of real estate and civil litigation. She also brings to the OBD her experience as an executive assistant in the reinsurance industry. She spent many years as a youth mentor in the BSA scouting program and continues to enjoy exploring the beautiful Pacific Northwest wilderness with her husband and two adult children.

Mr. Prisby announced that the Board will have openings in spring 2025. Mr. Prisby explained that Mr. Chip Dunn will have served two terms (8 years) and is due to complete his second term of service on March 31, 2025, having joined the Board on May 3, 2017. Mr. Prisby reported that the Board has begun soliciting interest for this Public Board Member Position.

Mr. Prisby further explained that Dr. Aarati Kalluri's term of service will end on March 31, 2025, and Dr. Sheena Kansal's term of service will end April 18, 2025. Mr. Prisby noted that both are eligible for another term of service and that both have indicated a willingness to serve another term. Mr. Prisby reported that he had conveyed that information to the Governor's Office.

Mr. Prisby pointed out that the attached document provides an overview of board service. Mr. Prisby offered to answer any questions about board service and the steps in the process of joining the OBD as a board member. Mr. Prisby noted that the attachment also includes descriptions of the two mandatory trainings all board members must complete annually. **Attachment #1**

Public Meetings Law Training for Board and Commission Members

(Wednesday, December 4th from 9:30 am to 12:00 pm) Mr. Prisby announced the online training session, which is designed for individual governing body members that are subject to Oregon Public Meetings Law and the public officials who help support the meeting and governing body members. This session satisfies the Public Meetings Law training requirement in ORS 192.700. Mr. Prisby clarified that the course content will cover the individual responsibilities of governing body members, how the statutes apply to convening a public meeting, a general overview of executive session provisions, and a look at the grievance process. Mr. Prisby noted that this session is two and a half hours. Mr. Prisby indicated that he will send the link to this meeting to all board members and that he plans to attend as well.

ORS 192.700 Annual training requirements.

(1)(a) The Oregon Government Ethics Commission shall annually prepare training on the requirements of ORS 192.610 to 192.705 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. [2023 c.417 §3]

OBD Budget Report

Mr. Prisby presented the attached budget report for the 2023 – 2025 Biennium. Mr. Prisby explained that this report, which is from July 1, 2023 through August 31, 2024 shows revenue of $2,394,793.41, and expenditures of $2,131,759.89.

Customer Service Survey

Mr. Prisby presented the attached legislatively mandated survey results from July 1, 2024 – September 30, 2024, which is the start of FY 2025. Mr. Prisby reported that the results of the survey show that the OBD received positive ratings from the majority of those that chose to submit a survey.

Staff Speaking Engagements

Mr. Prisby reported that he joined other health regulatory licensing board executive directors to give a brief overview of OBD licensing and other activities to the OHA's Health Care Workforce Committee Zoom Meeting on September 11, 2024.

Mr. Prisby reported that he was invited and presented to the House Interim Committee On Behavioral Health and Health Care during Legislative Days in Salem on September 23, 2024 with other health board executive directors. Mr. Prisby clarified that the executive directors were asked specific questions about licensing activities and also to share feedback on license compacts that are operating nationwide for many different types of healthcare practitioners.

Dr. Angela Smorra gave a "Record Keeping, Board Protocols, and OBD Update" presentation to the Marion Dental Research Group Study Club in Salem on October 16, 2024.

Mr. Prisby reported that he was contacted by KFF Health News/CBS regarding the Board's dental implant rules, dental implant CE, and patient protection for a news story they are planning later this year. Mr. Prisby stated that he was interviewed via Zoom on September 18, 2024. There should be a print article out later in the year on their investigation and reporting, and possibly a national news segment as well.

Mr. Prisby reported that he had separate meetings and conversations with Representative Nosse and Representative Ed Diehl about compacts. Mr. Prisby recounted that the representatives followed up with him regarding the six-page memo he had submitted presenting OBD concerns about the compacts. Mr. Prisby shared that there were good questions and dialogue about the issue. Mr. Prisby stated that the Board is neutral on the issue of compacts, but that he has been providing a lot of information to people.

Ms. Simmons reported that she is working with three dental hygiene students who are creating a letter to the Board request that dental hygienists be allowed to provide vaccinations. Mr. Prisby recounted a Zoom call with the students in which he clarified the process of presenting issues before the board. Mr. Prisby expressed appreciation for their leadership.

Mr. Prisby reported that he had a meeting with Dr. Ahmed Farag, the new OHA Dental Director, sharing that he appreciated Dr. Farag's outreach and enjoyed their discussion. Mr. Prisby stated that he invited Dr. Farag to a future Board meeting when his schedule will allow it.

Dental Hygiene & Dental Therapy License Renewal

Mr. Prisby reported the following results from the renewal period that started on August 1st and ended September 30th.

- Preliminary Dental Therapy license renewal shows 8 renewed (2 let their DT license expire)
- Preliminary Dental Hygiene license renewal shows 1918 Renewed for 2024.

Past Years:

- In 2023 1908
- In 2022 1884
- In 2021 1888
- In 2020 1948

- In 2019 1946
- In 2018 1954

FY 2024 Annual Performance Progress Report

Mr. Prisby presented the attached OBD FY 2024 Annual Performance Progress Report, which was submitted to DAS and the Legislative Fiscal Office before the due date. Mr. Prisby indicated that most state agencies are required to complete this report annually.

OBD Customer Service Policy

Mr. Prisby reported that DAS directed all agencies to develop an internal customer service policy which aligns with the Governor's expectations of all agencies to focus on our customers. Mr. Prisby stated that OBD Staff have reviewed the directive, and a draft policy will be available to the Board at the December board meeting and sent to DAS by the end of the year.

Dental Testing and Regulatory Summit

Mr. Prisby reported that the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB), ADEX, CDCA-WREB-CITA, and educators hosted a multi-day meeting fest, which was held in Louisville, Kentucky, September 24 - 29, 2024. Mr. Prisby noted that this was the first time all these organizations held all their meetings in concert, so that attendees could attend in the most economical way. Mr. Prisby pointed out that meeting programs and agendas from those organizations were attached. Mr. Prisby shared that it was well attended with participants from all over the US and that five past OBD Board Members also attended the summit. Mr. Prisby indicated that there will be more information on the event at the December Board meeting. Mr. Prisby stated that he received a follow-up report from CDCA, but that it arrived too late to be included in this Board packet. Mr. Prisby recounted that there were excellent speakers at the event discussing wellness, licensing compacts, and regulatory issues. Mr. Prisby mention that there were five former Board members in attendance as well.

2025 Board Meeting Dates

Mr. Prisby reported that the Board approved the updated meeting dates at the August Board Meeting. Mr. Prisby announced there will be five one-hour virtual meetings at 3:00 p.m. on the designated Fridays along with the six regular board meetings in 2025. Mr. Prisby explained that those extra meetings are intended to deal with overviews of budget issues that will be important to bring to the Board and must be discussed in public. Mr. Prisby indicated that any virtual meeting may be cancelled if there is no need to conduct it.

Governor's Expectations of Agency Leaders

Mr. Prisby reported that in January 2023, Governor Kotek sent a letter to state agencies outlining 11 specific expectations for operations in Oregon state government. Mr. Prisby explained that the purpose of this report is to update Governor Kotek on progress made in meeting expectations in the second quarter of 2024. Mr. Prisby pointed out that references to the OBD have been highlighted in the report on pages #17, 20, 22 & 24 and acknowledged that the OBD has been achieving the outcomes it has been directed to pursue.

UNFINISHED BUSINESS AND RULES

Dr. Sharifi offered a brief overview of the recent public rulemaking hearing and process. Dr. Sharifi recalled that at the August 23, 2024 Board Meeting, 19 rules were voted to go forward to a pubic rulemaking hearing. Dr. Sharifi noted that only one rule required guidance suggesting the issue of dental assistants who are being credentialed for local anesthesia be forwarded to the

Anesthesia Committee. Dr. Sharifi recommended the issue not be forwarded to the Anesthesia Committee because most Board members give excellent local anesthesia and are equipped to regulate it. The Anesthesia Committee, Dr. Sharifi pointed out, is required to regulate sedation practices, not local anesthesia.

Ms. Jorgensen spoke as a public member of the Board giving an overview of the issue. Ms. Jorgensen referred to the 2019 OBD survey of dentists soliciting information about dental assistants employed in their offices and asking what duties dentists would like added to the expanded functions list and pointing out that dental assistants performing local anesthesia procedures was first on the list. Ms. Jorgensen elaborated on the evolution of the issue and the credentialing requirements for dental assistants. The Board briefly discussed whether rule changes allowing dental assistants to provide local anesthesia should be forwarded to the Anesthesia Committee.

Mr. Prisby stated that, as the Rules Coordinator for the agency, he submitted those rule changes to the Secretary of State (SOS), and they were approved and placed in the SOS September Bulletin. Mr. Prisby noted that this is one requirement of state agencies in the rulemaking process. Mr. Prisby highlighted that the Public Comment period on the rule changes was open from Sept 1, 2024 through Oct 11, 2024. Mr. Prisby reported that the Public Rulemaking Hearing was conducted on Sept 24, 2024 via Zoom and that he was the Hearings Officer. A memo with attached public comments was in the board meeting packet for board members to review.

Dr. Clark moved and Ms. Ludwig seconded that the Board approve proposed OAR changes, presented in Tab 5, with the effective date of January 1, 2025. The motion passed with RS, SK, TC, OS, KS, SL, GJ, and CD voting Aye.

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 certification standard is the American Heart Association’s BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS course must be a hands-on course; online BLS courses will not be approved by the Board for initial BLS certification: After the initial BLS certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS certification card with an expiration date must be received from the BLS provider as documentation of BLS certification. The Board considers the BLS expiration date to be the last day of the month that the BLS instructor indicates that the certification expires.
(21) "Study model" means a replica of a patient's teeth and surrounding structures, typically made from either a physical impression or a scanned impression of the patient's mouth. It is used primarily for diagnostic and treatment planning purposes, allowing the dentist to study the patient's teeth and jaw alignment and plan procedures such as orthodontic treatment, restorative dentistry or prosthetic treatment. A study model is distinguished from a "working model," which is fabricated in a similar fashion as a study model and may be a more precise and accurate replica of the patient's teeth and jaw (where

applicable). A working model would be used for the fabrication of dental appliances, including without limitation orthodontic aligners, retainers, crowns and bridges or removable dentures.

818-012-0010
Unacceptable Patient Care
The Board finds, using the criteria set forth in ORS 679.140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:
(1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.
(2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.
(3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.
(4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.
(5) Fail to ensure radiographic and other imaging are of diagnostic quality.
(56) Render services which the licensee is not licensed to provide.
(67) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.
(78) Fail to maintain patient records in accordance with OAR 818-012-0070.
(89) Fail to provide goods or services in a reasonable period of time which are due to a patient pursuant to a contract with the patient or a third party.
(910) Attempt to perform procedures which the licensee is not capable of performing due to physical or mental disability.
(1011) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.
(1112) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.
(1213) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(1314) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.
(1415) Fail to advise a patient of any recognized treatment complications.

818-021-0018
Temporary Dental License for Active-Duty Members of the Uniformed Services and their Spouses or Domestic Partners of Active Duty Armed Forces of the United States Stationed in Oregon
(1) A temporary license to practice dentistry, dental hygiene, or dental therapy shall be issued to **Active-Duty Members of the Uniformed Services or their** the spouse or domestic partner of active duty armed forces personnel when the following requirements are met:

(a) A completed application and payment of fee is received by the Board; and
(b) Satisfactory evidence of having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(c) 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; and
(db) Submission of a copy of the military orders assigning the active-duty member to an assignment in Oregon; and
(ec) The spouse holds a current license in another state to practice dentistry, dental hygiene, or dental therapy at the level of application; and
(fd) The license is unencumbered **in good standing** and verified as active and current through processes defined by the Board; and
(g) Satisfactory evidence of successfully passing a clinical examination administered by any state, national testing agency or other Board-recognized testing agency.
(2) The temporary license shall expire on the following date, whichever occurs first: **remain active for the duration of the above-mentioned military orders.** (a) Oregon is no longer the duty station of the active armed forces member; or
(b) The license in the state used to obtain a temporary license expires; or
(c) Two years after the issuance of the temporary license.
(3) This temporary license is not renewable. If the dates in section two of this rule are exceeded and the spouse continues to practice in Oregon, the spouse must apply for an active Oregon license. This license must be obtained using the processes and fees established for permanent licensure. Continuing to work in Oregon when the temporary license has expired will be considered practicing without a valid license and is subject to Board action. **Each biennium, the licensee shall submit to the Board a Biennial Military Status Confirmation Form. The confirmation form shall include the following: (a) Licensee's full name;**
(b) Licensee's mailing address;
(c) Licensee's business address including street and number. If the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number. 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 continuing educational 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 any licensing board of any other jurisdiction or convicted of a crime.
(k) Confirmation of current active-duty status of service member.

818-021-0019
Temporary Dental Hygiene License for Spouses or Domestic Partners of Active Duty Armed Forces of the United States Stationed in Oregon
(1) A temporary license to practice dental hygiene shall be issued to the spouse or domestic partner of active duty armed forces personnel when the following requirements are met:

(a) A completed application and payment of fee is received by the Board; and
(b) Satisfactory evidence of having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(c) 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; and
(d) Submission of a copy of the military orders assigning the active duty member to an assignment in Oregon; and
(e) The spouse holds a current license in another state to practice dentistry at the level of application; and
(f) The license is unencumbered and verified as active and current through processes defined by the Board; and
(g) Satisfactory evidence of successfully passing a clinical examination administered by any state, national testing agency or other Board-recognized testing agency.
(2) The temporary license shall expire on the following date, whichever occurs first:
(a) Oregon is no longer the duty station of the active armed forces member; or
(b) The license in the state used to obtain a temporary license expires; or
(c) Two years after the issuance of the temporary license.
(3) This temporary license is not renewable. If the dates in section two of this rule are exceeded and the spouse continues to practice in Oregon, the spouse must apply for an active Oregon license. This license must be obtained using the processes and fees established for permanent licensure. Continuing to work in Oregon when the temporary license has expired will be considered practicing without a valid license and is subject to Board action.

818-026-0040
Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit
Nitrous Oxide Sedation.
(1) The Board shall issue a Nitrous Oxide Permit to an applicant who:
(a) Is either a licensed dentist or licensed hygienist in the State of Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Has completed a training course of at least 14 hours of instruction in the use of nitrous oxide from a dental school or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, or as a postgraduate.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow delivery of appropriate care in an emergency situation;
(b) An operating table or chair which permits the patient to be positioned so that the patient's airway can be maintained, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system; and
(g) Sphygmomanometer and stethoscope and/or automatic blood pressure cuff.
(3) Before inducing nitrous oxide sedation, a permit holder shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for nitrous oxide sedation;
(b) Give instruction to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for nitrous oxide sedation; and
(d) Obtain informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) If a patient chronically takes a medication which can have sedative side effects, including, but not limited to, a narcotic or benzodiazepine, the practitioner shall determine if the additive sedative effect of nitrous oxide would put the patient into a level of sedation deeper than nitrous oxide. If the practitioner determines it is possible that providing nitrous oxide to such a patient would result in minimal sedation, a minimal sedation permit would be required.
(5) A patient under nitrous oxide sedation shall be visually monitored by the permit holder or by an anesthesia monitor at all times. The patient shall be monitored as to response to verbal stimulation, oral mucosal color and preoperative and postoperative vital signs.
(6) The permit holder or anesthesia monitor shall record the patient's condition. The record must include documentation of preoperative and postoperative vital signs, and all medications administered with dosages, time intervals and route of administration.
(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The person administering the nitrous oxide sedation may leave the immediate area after initiating the administration of nitrous oxide sedation only if a qualified anesthesia monitor is continuously observing the patient.
(9) The permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(b) The patient can talk and respond coherently to verbal questioning;
(c) The patient can sit up unaided or without assistance;
(d) The patient can ambulate with minimal assistance; and
(e) The patient does not have nausea, vomiting or dizziness.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(11) Permit renewal. In order to renew a Nitrous Oxide Permit, the permit holder must provide proof of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Nitrous Oxide Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, nitrous oxide, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and

agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060 and 818-021-0070.

818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

818-026-0060
Moderate Sedation Permit

Moderate sedation, minimal sedation, and nitrous oxide sedation.
(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated; and
(c) Satisfies one of the following criteria:
(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced.
(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.
(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.
(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.
(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED); and
(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.
(5) Before inducing moderate sedation, a dentist permit holder who induces moderate sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for moderate sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;
(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.
(9) A dentist permit holder shall not release a patient who has undergone moderate sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(12) After adequate training, an assistant, when directed by a dentist permit holder, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents into an infusion line under the direct supervision of a dentist permit holder.
(13) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021- 0060.

818-026-0065
Deep Sedation Permit
Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.
(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:
(a) Is a licensed dentist in Oregon; and
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and

nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and
(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.
(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.
(5) Before inducing deep sedation, a dentist permit holder who induces deep sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for deep sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously monitored and the patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.
(9) A dentist permit holder shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may administer oral sedative agents calculated by a dentist permit holder or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.
(13) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

818-026-0070
General Anesthesia Permit
General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a General Anesthesia Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and
(c) Satisfies one of the following criteria:
(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.
(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.
(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and
(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.
(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist permit holder performing the dental procedures.
(5) Before inducing deep sedation or general anesthesia the dentist permit holder who induces deep sedation or general anesthesia shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient’s record.
(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist permit holder who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.
(7) Persons serving as anesthesia monitors for general anesthesia in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be assessed

every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.
(9) A dentist permit holder shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made in the patient's record by the dentist permit holder indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist permit holder.
(13) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

818-035-0072
Restorative Functions of Dental Hygienists
(1) The Board shall issue a Restorative Functions Endorsement (RFE) to a dental hygienist who holds an unrestricted Oregon license, and has successfully completed:
(a) 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, and successfully passed theWestern Regional Examining Board's **CDCA-WREB-CITA's Dental Hygiene** Restorative Examination or other equivalent examinations approved by the Board within the last five years; or
(b) If successful passage of the Western Regional Examining Board's **CDCA-WREB-CITA's Dental Hygiene** Restorative Examination or other equivalent examinations approved by the

Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.
(2) A dental hygienist may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):
(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration(s) by a Restorative Functions Endorsement dental hygienist;
(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

818-042-0010
Definitions
(1) "Dental Assistant" means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, dental therapist or another dental assistant or renders assistance under the supervision of a dental hygienist providing dental hygiene services.
(2) "Expanded Function Dental Assistant" means a dental assistant certified by the Board to perform expanded function duties.
(3) "Expanded Function Orthodontic Assistant" means a dental assistant certified by the Board to perform expanded orthodontic function duties.
(4) "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.
(5) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) "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.
(7) "Dental Assisting National Board (DANB)" is recognized by the Board as an acceptable testing agency for administering dental assistant examinations for certifications.

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), 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 **in**direct supervision.
(24) Place implant impression copings, except under **in**direct supervision.
(25) Any act in violation of Board statute or rules.

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.**

818-042-0095
Restorative Functions of Dental Assistants
(1) The Board shall issue a Restorative Functions Certificate (RFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed:
(a) 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, and successfully passed the Western Regional Examining Board's **CDCA-WREB-CITA's Dental Hygiene** Restorative Examination or other equivalent examinations approved by the Board within the last five years, or
(b) If successful passage of the Western Regional Examining Board's **CDCA-WREB-CITA's Dental Hygiene** Restorative Examination or other equivalent examinations approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.
(2) A dental assistant may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):
(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration by a Restorative Functions dental assistant.
(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

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.**

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.**

818-042-0116
Certification—Anesthesia Dental Assistant
The Board may certify a person as an Anesthesia Dental Assistant if the applicant submits a completed application, pays the certification fee and shows satisfactory evidence of:
(1) Successful completion of:
(a) The "Oral and Maxillofacial Surgery Anesthesia Assistants Program" or successor program, conducted by the American Association of Oral and Maxillofacial Surgeons; or
(b) The "Oral and Maxillofacial Surgery Assistants Course" or successor course, conducted by the California Association of Oral and Maxillofacial Surgeons (CALAOMS), or a successor entity; or
(c) The "Certified Oral and Maxillofacial Surgery Assistant" examination, or successor examination, conducted by the Dental Assisting National Board or other Board approved examination; or
(d) The Resuscitation Group – Anesthesia Dental Assistant course; or
(e) Other course approved by the Board; and
(2) Holding valid and current documentation showing successful completion of a Healthcare Provider BLS/CPR course, or its equivalent.

818-042-0130
Application for Certification by Credential
An applicant for certification by credential shall submit to the Board:

(1) An application form approved by the Board, with the appropriate fee;
(2) Proof of certification by another state and any other recognized certifications (such as CDA or COA certification) and a description of the examination and training required by the state in which the assistant is certified submitted from the state directly to the Board; or
(3) Certification that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant performing the functions for which certification is being sought. **and, if**
(4) If applying for certification by credential as an EFDA, EFODA or EFPDA, certification by a licensed dentist that the applicant is competent to perform the functions for which certification is sought; and.
(5**4**) If applying for certification by credential in Radiologic Proficiency, certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, or the Oregon Board of Dentistry, that the applicant has met that agency's training requirements for x- ray machine operators, or other comparable requirements approved by the Oregon Board of Dentistry.

818-042-0096
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.

Director Prisby discussed the Board request from ODHA and OIT Dental Hygiene educators to receive an update on OBD joining CRDTS-SRTA as a member state. The OBD and legal counsel requested additional information, and once that is received then will have more info to make a recommendation. Mr. Prisby mentioned that perhaps the information will be received and reviewed in time to make the December Board meeting agenda. The Board briefly discussed compact issues.

Dr. Sharifi noted that the OBD Bylaws, which were revised at the August 23, 2024 Board meeting, were in the meeting the packet and have been made available to the public on the OBD website.

CORRESPONDENCE

- August 29, 2024 Email from Director Prisby to Oregon Dental Hygiene Program Leaders. Mr. Prisby relayed an update from Amy Copeland from Pacific University regarding the development of a dental therapy program. Mr. Prisby also noted that Ms. Copeland shared that she was hearing positive remarks from graduates about the licensing process going very quickly. Mr. Prisby acknowledged Kathleen McNeal, OBD Licensing Manager, for her excellent work.
- September 9, 2024 Closing Report to OBD per ORS 680.210(2).
- October 10, 2024 Email from Stephanie Key, RDH requesting clarification regarding whether RDHs may adjust appliances outside the mouth and, if so, under what level of

supervision. The Board discussed the issue and asked Dr. Smorra to develop FAQs guidance for rule changes.

Dr. Sharifi moved and Dr. Kansal seconded that the Board forward the request for clarification of DPA guidance for RDHs to the Licensing, Standards and Competency Committee. The motion passed with RS, SK, TC, OS, KS, SL, GJ, and CD voting Aye.

- October 9, 2024 Email from Dianne Applegate, D.D.S. requesting an exemption for the radiographic proficiency certification requirement for Amanda Ghattas. The Board discussed the issue and concluded that adherence to the rule as currently written should stand, but that clarification is needed regarding how an applicant is to proceed toward certification after missing the six-month deadline to submit credentials to the Dental Assisting National Board (DANB). The Board suggested that, in the meantime, Ms. Ghattas reach out to DANB for guidance on how to reach certification.

Ms. Ludwig moved and Mr. Dunn seconded that the Board deny the request for an exemption for the radiographic proficiency certification requirement for Amanda Ghattas due to the way the rule is currently written and that the Board will request clarification moving forward from the Rules Oversight Committee and the Licensing, Standards and Competency Committee. The motion passed with RS, SK, TC, OS, KS, SL, GJ, and CD voting Aye.

OTHER

Items were in the Board meeting packet for informational purposes.

- August 28, 2024 CSG D/DH Inaugural Commission Meeting packet.
- August 28, 2024 Commission Meeting Minutes.
- CSG Lawsuit – Virginia Board of Dentistry. The Board briefly discussed the issue.
- Dr. Terrence Clark – Observations from CODA - OHSU School of Dentistry Site Visit.

ARTICLES AND NEWS

- American Association of Dental Boards (AADB) Townhall Announcement.

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.

Dr. Aldrich joined the meeting at 10:15 a.m.

OPEN SESSION: The Board returned to Open Session at 12:19 p.m.

Note the Board Members' votes are identified by their initials.

CONSENT AGENDA

2025-0041, 2025-0024, 2023-0121, 2025-0047, 2025-0042, 2025-0033, 2025-0040, 2025-0025, 2025-0031, 2025-0052, 2025-0023

Dr. Kansal moved and Mr. Dunn seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

COMPLETED CASES

2025-0019, 2024-0132, 2024-0071, 2025-0036, 2024-0056, 2024-0117, 2025-0013, 2025-0026, 2025-0004, 2024-0164, 2024-0094, 2025-0029, 2025-0014, 2025-0003, 2025-0006, 2024-0130, 2025-0008, 2024-0134, 2025-0030

Dr. Kansal moved and Mr. Dunn seconded that the Board close the matters with a finding of No Further Action or No Violation. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

SCOTT B. BODYFELT, D.M.D.; 2024-0153

Mr. Dunn moved and Ms. Ludwig seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and an $8,500 civil penalty to be paid within 120 days of the effective date of the order. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

MATTHEW PERRY BYRNE, D.D.S.; 2024-0104

Dr. Clark moved and Mr. Dunn seconded that the Board combine the matter with case 2024-0105, 2024-0106, 2024-0137 and 2024-0162 and issue a Notice of Proposed Disciplinary Action incorporating a reprimand, that Licensee unconditionally pass CPEP-PROBE: Ethics and Boundaries course within 90 days of the effective date of the Order and that Licensee be restricted to a group practice consisting of two or more Licensees of the Board for a five-year period from the effective date of the Order. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

2024-0055

Ms. Ludwig moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding the Licensee to assure that he always documents a description of treatment or services rendered. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

2025-0035

Ms. Jorgensen moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to ensure that a Healthcare Provider BLS is maintained while licensed. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

JOHN L. MCDONALD, D.M.D.; 2024-0172

Dr. Aldrich moved and Dr. Kansal seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, four hours of Board approved continuing education in the area of infection control within 90 days, quarterly submission of spores testing results for a period of one year from the effective date of the order, and a $9,500 civil penalty to be paid within 120 days of the effective date of the order. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

DALE LOUIS MCNUTT, D.M.D.; 2025-0011
Ms. Simmons moved and Mr. Dunn seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order to incorporate a reprimand, a $2,000.00 civil penalty to be paid within 30 days of the effective date of the Order, adhere to, participate in and complete all aspects of any and all alcohol or substance abuse treatment, enroll in a Board approved alcohol monitoring service for a minimum of 36 month from the effective date of the Order, notify the Board of any substance usage or positive test results within 48 hours of the usage or test results, agrees that upon a positive test result or substance usage, that Licensee will refrain from practice until the Licensee has completed a Board approved evaluation which has been reviewed by the Board and that Licensee should not use controlled substance, mood altering drugs or alcohol at any place or time unless prescribed by a licensed provider or for a bon a fide medical condition unless a true medical emergency exists. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

2025-0034
Dr. Salathe moved and Ms. Ludwig seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that a valid BLS for Healthcare Providers is maintained while licensed. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

2024-0178
Mr. Dunn moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure (1) she notifies the Board in writing of her intent to use a qualified anesthesia provider, and (2) her patient records contain a legible copy of all anesthesia records. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

PREVIOUS CASES REQUIRING BOARD ACTION

GABRIELA ARANDA, D.D.S.; 2024-0158
Dr. Clark moved and Mr. Dunn seconded that the Board affirm the Board's August 23, 2024 decision. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

THOMAS L. HAYMORE, D.M.D.; 2021-0109
Ms. Ludwig moved and Mr. Dunn seconded that in reference to case 2021-0109 and case 2021-0176 the Board accept Licensee's proposal and extend the $7,500.00 civil penalty payment to January 1, 2025, and the $75,000.00 hearing cost payment until June1, 2025. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

KHUYEN T. NGUYEN, D.M.D.; 2024-0023
Ms. Jorgensen moved and Dr. Aldrich seconded that the Board issue a settlement offer with a reprimand and a $1,000 civil penalty, payable within 60 days of the effective date of the Order for a violation of the Board's continuing education rule with language acknowledging the practice is now compliant with OAR 818-035-0020. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

THALIA-RAE PERRYMAN (CRIDDLE), D.M.D.; 2023-0191
Dr. Aldrich moved and Mr. Dunn seconded that the Board deny the Licensee's request and affirm the Board's August 23, 2024, decision. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

RATIFICATION OF LICENSES

Dr. Sharifi moved and Dr. Clark seconded that the Board ratify the licenses presented in tab 16. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

LICENSE PERMIT & CERTIFICATION

Ms. Simmons moved and Mr. Dunn seconded that the Board reinstate the expired license for Peter Ma, D.M.D. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

Dr. Salathe moved and Mr. Dunn seconded that the Board reinstate the expired license for Alisa Stephenson, R.D.H. The motion passed with RS, SK, TC, MA, OS, KS, SL, GJ, and CD voting Aye.

ADJOURNMENT

The meeting was adjourned at 12:31 p.m. Dr. Sharifi announced that the next Board Meeting would take place via Zoom on December 13, 2024.

_____

Reza J. Sharifi, D.M.D., President

ASSOCIATION REPORTS

Nothing to Report Under This Tab

COMMITTEE REPORTS

DRAFT

OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES (DAWSAC)
November 13, 2024

MEMBERS PRESENT:	Ginny Jorgensen, Co-Chair Amberena Fairlee, DMD - ODA Rep. Kari Hiatt - ODAA Rep. Lynn Murray Alexandria 'Alex' Case Jessica 'Jessie' Andrews Alyssa Kobylinsky joined the meeting at 6:20 pm Amanda Nash
STAFF PRESENT:	Dr. Angela Smorra, Dental Director/Chief Investigator Kathleen McNeal, Licensing Manager
VISITORS PRESENT: IN PERSON & VIA TELECONFERENCE*	Jen Hawley Price, DANB; Mary Harrison, ODAA; Joanna Tucker Davis, Senior Assistant Attorney General

Call to Order: The meeting was called to order by the Chair at 6:00 p.m. via Zoom.

Co-Chair Ginny Jorgensen welcomed everyone to the meeting and had the DAWSAC Members, OBD staff and Senior Assistant Attorney General introduce themselves.

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

Approval of July 17, 2024 Minutes
Co-Chair Ginny Jorgensen moved, and Alexandria Case seconded that the Committee approve the minutes from the July 17, 2024 DAWSAC Committee Meeting as presented. The motion passed unanimously.

DAWSAC Packet Introduced
HB 3223 goals for the DAWSAC were reviewed.

DAWSAC Request to Change Effective Date of HB 3223
Ms. Jorgensen announced that OBD Executive Director, Stephen Prisby reported at the August 23, 2024 Board Meeting, about the DAWSAC request was for the OBD to ask the Governor if she would intercede and ask the Legislative body if the effective date of HB 3223 could be extended one year from July 1, 2025 to July 1, 2026. Director Prisby reported that he had discussed it with one of the Governor's Policy Advisors, but that no new information was available at that time. Ms. Jorgensen reminded the committee that it is not the Board's decision to meet this request, as any changes to the bill must go through the legislature.

New Dental Assistants Local Anesthesia Rule
Ms. Jorgensen reported that at the October 25, 2024 Board Meeting, the Board approved 19 proposed rule changes, which included adopting a new rule to issue Local Anesthesia Functions Certificates to EFDAs, Rule 818-042-0096. Ms. Jorgensen announced the effective date is January 1, 2025. Ms. Jorgensen added that there are several items about the bill which must be put into place, such as having Board approved courses and decisions on the fees, certificates and wording structure of the bill.

Dr. Smorra reported that new course requests must be submitted to OBD staff by December 1, 2024 to be added to the agenda for the December 13, 2024 Board Meeting.

Ms. Jorgensen stated that the rule as written was clear and concise but suggested changing the name of the certificate to *Local Anesthesia Functions Dental Assistant* (LAFDA) in keeping with the certificate names of other functions Oregon dental assistants are allowed to perform.

Ms. Jorgensen stated that the Board must also decide on a certification fee that DANB will charge. Ms. Jorgensen offered that $50.00 is the fee for other DANB certificates. Ms. Jorgensen mentioned that on the LAFDA Certificate there will need to be an area for the applicant to indicate the approved OBD course name or number. Ms. Jorgensen added that a copy of a course completion certificate or an approved instructor's signature should be required.

CODA Talking Points on ADA Resolutions
A copy of the CODA Talking Points on Resolutions 401 and 411 were attached for informational purposes. The ODA will be addressing these in at the December 13 Board Meeting.

Amberena Fairlee, DMD reported as a delegate from the CODA meeting that Resolution 411 did not pass.

Local Anesthesia for Dental Assistant Course
Ms. Jorgensen provided for informational purposes an example of a 45-hour training program at the University of Minnesota School of Dentistry to train dental assistants to administer local anesthesia under the direct supervision of a dentist. Ms. Jorgensen stated that the Board must review and decide on courses that Oregon will approve.

Jen Hawley Price shared DANB updates. DANB is making progress on translating the dental assistant exams into Spanish and Vietnamese. DANB is introducing a Workforce Coalition in January 2025 and will publish a free, online resource toolkit in mid-January 2025.

Jessie Andrews presented an update about the services of the Willamette Career Academy's work with high school students. Ms. Andrews invited attendees to contact her for an opportunity to be a guest speaker at Willamette Career Academy. Dr. Smorra reported that the OBD staff provides lists of licensees upon request, in case that would be of help in her contacting dentists to help with the Willamette Career Academy's programs.

ADJOURNMENT
The meeting was adjourned at 6:47p.m. Chair Jorgensen stated that the next DAWSAC meeting via Zoom would be set in early 2025.

FOSTER Jessica * OGEC

From: oregon-gov-web-services@egov.com
Sent: Wednesday, November 6, 2024 1:03 PM
To: FENSTERMAKER Casey * OGEC
Cc: OGEC Mail * OGEC
Subject: Advice Request - From Website
Attachments: formsubmission.csv

First Name	Stephen
Last Name	Prisby
Email Address	stephen.prisby@obd.oregon.gov
Phone Number	9716733200
Ask for Advice	Greetings, I seek guidance on two scenarios, for compliance with PML. 1) The OBD has ten (10) Board Members. May two (2) Board Members discuss by email or phone call, policy issues that could be on the agenda for board discussions at a future board meeting? 2) We assigned two (2) Board Members to Co-Chair a standing committee that meets four times per year. May those two (2) Board Members communicate and discuss a future meeting agenda, for that particular committee that they Co-Chair? Sincerely, Stephen Prisby OBD Executive Director

Submission Date: 11/06/2024 03:03 PM CST

Submission ID: f7a259c5-5e52-4d3a-a905-feb5774c269a

Record ID:

Oregon
Tina Kotek, Governor

Government Ethics Commission
3218 Pringle Rd SE, Ste 220
Salem, OR 97302-1680
Telephone: 503-378-5105
Fax: 503-373-1456
E-mail: mail@ogec.oregon.gov
Website: www.oregon.gov/ogec

November 18, 2024

Sent via email:
stephen.prisby@obd.oregon.gov

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

Re: Advice No. 24-528I

Dear Stephen Prisby:

This letter of advice is provided in response to your request received on November 6, 2024, which presented a question regarding the application of Oregon Public Meetings law. This analysis and advice is being offered under the authority provided in ORS 244.284 as guidance on how the current provisions of Oregon Public Meetings law may apply to the specific circumstances you have presented.

In your request for advice, you state that the Oregon Board of Dentistry (OBD) has ten Board members and asked if two Board members can discuss policy issues that could be on the agenda for Board discussions at a future Board meeting. You also stated that two of the Board members have been assigned to Co-Chair a standing committee that meets four times per year. In a follow up phone call, you stated that the standing committee consists of 10-12 members, and they make recommendations to OBD based on a majority vote. You asked if those two Board members may communicate and discuss a future meeting agenda for the standing committee that they Co-Chair.

As you know, Oregon Public Meetings Law requires that decisions of a governing body must be arrived at openly. (ORS 192.620). A quorum of the members of a governing body may not meet in private to make a decision or to deliberate on any matter subject to the governing body's jurisdiction. This prohibition extends to private meetings and serial communications. (*See* ORS 192.630(2) and OAR 199-050-0020).

OAR 199-050-0020(1) prohibits a quorum of the members of a governing body from, "outside of a meeting conducted in compliance with the Public Meetings Law, us[ing] a series of communications of any kind, directly or through intermediaries, for the purpose of deliberating or deciding on any matter that is within the jurisdiction of the governing body." Subsection (2) clarifies that the prohibition in subsection (1) applies to "any one or a combination of the following methods of communication: (a) [i]n-person; (b)

[t]elephone calls; (c) [v]ideos, videoconferencing, or electronic video applications; (d)[w]ritten communications, including electronic written communications, such as email, texts, and other electronic applications; (e) [u]se of one or more intermediaries to convey information among members; and (f) [a]ny other means of conveying information."

In your first question, you ask if two members of the OBD may, by email or phone call, discuss policy issues that could be on the agenda in the future. Because six members of OBD are required to create a quorum, it would not violate the Public Meetings Law for two members to discuss Board business so long as they do not use serial communications to share those discussions to enough other Board members to create a quorum.

The standing committee was created by OBD for the purpose of making recommendations on policy or administration to OBD; thus the standing committee is considered an advisory committee and is a governing body subject to Oregon Public Meetings Law. In the instance where an advisory committee consists of either ten or twelve members, and a majority number of members constitute a quorum, two members communicating about committee business would not constitute a quorum and they could discuss the standing committee's business or agenda items without running afoul of Oregon Public Meetings Law. Once again, these two members would need to avoid engaging in any communications with a quorum of the standing committee outside of a public meeting.

If you have any additional questions regarding the application of Oregon Public Meetings Law, please feel free to contact me directly.

Sincerely,

Susan V. Myers
Executive Director

Oregon Board of Dentistry Committee and Liaison Assignments
May 2024 - April 2025
STANDING COMMITTEES

Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)

Purpose: To review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

Committee:

Terrence Clark, D.M.D., Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, D.M.D., ODA Rep
Laura Vanderwerf R.D.H., ODHA Rep
Kari Hiatt, ODAA Rep.
Kari Kuntzelman, DT, DT Rep
Alyssa Kobylinsky
Lynn Murray
Alexandria Case
Jessica Andrews
Amanda Nash
Carmen Mons
Cassie Gilbert
Megan Barron

Licensing, Standards and Competency

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

Committee:

Sheena Kansal, D.D.S., Chair
Terrence Clark, D.M.D.
Sharity Ludwig, R.D.H.
Chip Dunn
Julie Spaniel, D.D.S., ODA Rep.
Heidi Klobes, R.D.H., ODHA Rep.
Jill Lomax, ODAA Rep.
Kristen Moses, R.D.H., DT Rep.

Rules Oversight

Purpose: To review and refine OBD rules.

Committee:

Reza Sharifi, D.M.D., Chair
Aarati Kalluri, D.D.S.
Olesya Salathe, D.M.D.
Kristen Simmons, R.D.H.
Ginny Jorgensen
Philip Marucha, D.D.S., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Alexandria Jones, DT Rep.

Dental Therapy Rules Oversight

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

Committee:

Sheena Kansal, D.D.S., Chair
Kristen Simmons, R.D.H.
Ginny Jorgensen
Sarah Kowalski, R.D.H., OHA Rep.
Brandon Schwindt, D.M.D., ODA Rep.
Amy Coplen, R.D.H., ODHA Rep.
Bonnie Marshall, ODAA Rep.

Wilbur Rodriguez, 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
Aarati Kalluri, D.D.S.
Olesya Salathe, D.M.D.
Alayna Schoblaske, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Linda Kihs, ODAA Rep.
Jason Mecum, DT Rep.

Dental Hygiene

Purpose: To review issues related to Dental Hygiene.

Committee:
Sharity Ludwig, R.D.H, Chair
Kristen Simmons, R.D.H.
Sheena Kansal, D.D.S.
David J. Dowsett, D.M.D., ODA Rep.
Daniel Tovar, R.D.H., ODHA Rep.
Bonnie Marshall, ODAA Rep.
Mark Kobylinsky, R.D.H., DT Rep.

Enforcement and Discipline

Purpose: To improve the discipline process.

Committee:
Terrence Clark, D.M.D., Chair
Kristen Simmons, R.D.H.
Chip Dunn
Jason Bajuscak, D.M.D., ODA Rep
Jill Mason R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Yadira Martinez, R.D.H., 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.
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
Jeffrey Kobernik, D.M.D.

LIAISONS

Stephen Prisby, Executive Director and current OBD Board Members choose assignments and interest in other entities as they arise.
American Assoc. of Dental Administrators (AADA)
American Assoc. of Dental Boards (AADB)
American Board of Dental Examiners (ADEX)
CDCA WREB CITA
CRDTS-SRTA
CSG

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
December 13, 2024

Staff Updates

The OBD will be closed for the holidays on Wednesday, Dec. 25 and Wednesday, Jan. 1. Most OBD Staff will be taking time off throughout December, but emails and calls will still be responded to promptly when the OBD is open during regular business hours.

I was scheduled to attend a Dec 10 Open House event for the Legislature.
Attachment #1

OBD Budget Status Report

Attached is the latest budget report for the 2023 - 2025 Biennium. This report, which is from July 1, 2023 through, October 31, 2024 shows revenue of $2,824,165.14 and expenditures of $2,480,539.86. **Attachment #2**

Snapshot of reporting requirements

The Governor and DAS have required a number of reports to hold agency leaders accountable for its work. The OBD has done an acceptable job meeting the deadlines and requirements for 2024.

	Complete	In Progress	Not Applicable	notes
Executive Director Performance 360 Review	X			March 2024
Strategic Planning	X			2022-2025 plan
Managing IT Processes			X	For agencies over 50 FTE
Performance Feedback for Employees	X			Quarterly Check Ins
Measuring Employee Satisfaction	X			October 2024
Diversity, Equity and Inclusion Plan	X			
Agency Emergency Preparedness	X			
Agency Hiring Practices	X			
Audit Accountability			X	No Audits to address
New Employee Orientation Updates		X		DAS
Uplift Oregon Benefits Workshop	X			
Intro Manager Training			X	No new managers
Customer Service Training		X		DAS
Data Governance Plan	X			
Succession Planning Update	X			
Tribal Relations Report	X			
Rules Report	X			
Customer Service Policy		X		Due March 2025

Customer Service Survey
The customer service surveys received from July 1, 2024 – November 30, 2024 are attached and a majority rate their experience with us positively. **Attachment #3**

CDCA-WREB-CITA Letter
A recap of the annual meeting was submitted to the OBD on 10/22 memorializing important work and actions from that September meeting. **Attachment #4**

2025 Calendars
The OBD calendar is attached and note the first board meeting in 2025 will be on Friday, Feb 7, and it will be held virtually for about one hour, to review the upcoming legislative session and other timely updates. The 2025 Legislative session calendar is also attached.**Attachment #5**

OREGON'S
SMALL AGENCIES, BOARDS
AND COMMISSIONS

OPEN HOUSE
MEET 'N TREATS

Meet Multiple Directors and Board Members

Tuesday DEC. 10 2024

NOON - 1 P.M.
HOUSE 2ND FLOOR
CONFERENCE ROOM 278

Attachment #1

Group	Committee(s) Focus	AGENCY	Legislative Group Meetings (NAME)	Legislative Group Meetings (AGENCY ROLE)	Legislative Open House (NAME)	Legislative Open House (AGENCY ROLE)
1	**Sen. Health Care**; Patterson, Hayden, Bonham **Hum Serv SUB**; SGB, Reynolds **House BH & Health Care**; Nosse, Nelson, Bowman, Javadi	Board of Dentistry	Stephen Prisby	Executive Director	Stephen Prisby	Executive Director
		Oregon Board of Nursing	**Rachel Prusak**	Executive Director	Rachel Prusak	Executive Director
			Kimberly Goddard	Deputy Director	Kimberly Goddard	Deputy Director
		Oregon Board of Massage Therapists	Ekaette Udosenata-Harruna	Legislative Coordinator	Ekaette Udosenata-Harruna	Legislative Coordinator
		Oregon Board of Naturopathic Medicine	Mary-Beth Baptista	Executive Director		
		Oregon Medical Board	Nicole Krishnaswami	Executive Director	Nicole Krishnaswami	Executive Director
2	**Sen. Health Care**; Patterson, Hayden, Bonham **House BH & Health Care**; Nosse, Nelson, Bowman, Javadi **Pub Sub**; Sollman, Evans, Gorsek, DBS, Grayber	Board of Pharmacy	**Rosa Klein**	Interim Executive Director	Gary Runyon Pharm. D., R.Ph.	Pharmacist Consultant
		Mental Health Regulatory Agency	Todd Younkin	Executive Director		
		Oregon Patient Safety Commission	Valerie Harmon	Executive Director	Valerie Harmon	Executive Director
			TJ Sheehy	Director of Programs	TJ Sheehy	Director of Programs
		Psychiatric Security Review Board	Alison Bort	Executive Director		
3	**Sen Housing and Dev**; Jama, Patterson, Sollman **Sen L&Biz;** Taylor, Bonham, **House Housing**; Helm, VBI, **Gen Gov SUB;** Patterson, Smith, Bonham, Gomberg, Reschke, Walters	Appraiser Certification & Licensure Board	Chad Koch	Executive Director		
		Construction Contractors Board	**Chris Huntington**	Executive Director		
		Landscape Contractors Board	Annie von Domitz	Administrator	Annie von Domitz	Administrator
		Real Estate Agency	Steve Strode	Commissioner	Steve Strode	Commissioner
			Anna Higley	Deputy Commissioner	Anna Higley	Deputy Commissioner
4	**Sen Human Serv**; SGB, Manning, Proz, Weber **Sen. Health Care**; Patterson, Hayden, Bonham House BH & **Health Care;** Nosse, Nelson, Bowman, Javadi	Board of Licensed Social Workers	Raymond Miller	Executive Director	Raymond Miller	Executive Director
		Board of Examiners for Speech-Language Pathology & Audiology	Erin Haag	Executive Director	Erin Haag	Executive Director
		Commission for the Blind	Dacia Johnson	Executive Director		
		Oregon Board of Physical Therapy	**Michelle Sigmund-Gaines**	Executive Director	Michelle Sigmund-Gaines	Executive Director
5	**Sen NR & Wfire**; Golden, Girod, Proz, DBS, Taylor **House NR & Water;** Helm, Owens, Hartman, Marsh, McLain, Scharf **NR SUB;** Frederick, VBI, Levy	Department of Geologist and Mineral Industries	Christina Appleby	Legislative Coordinator	Christina Appleby	Legislative Coordinator
		Oregon Veterinary Medical Examining Board	Pete Burns	Executive Director	Pete Burns	Executive Director
		Oregon Racing Commission	**Connie Winn**/Chair Doherty	Executive Director, ORC	Chris Montecino	Chief Investigator
		Oregon Watershed Enhancement Board	Sara O'Brien	Executive Director, OWEB	Stephanie Page	Deputy Director, OWEB
					Eric Hartstein	Senior Policy Coordinator
6	**Gen Gov SUB**; Patterson, Smith, Bonham, Gomberg, Reschke, Walters **House Econ Dev+**; Nguyen, Lively, Javadi Walters **House Em Mgmt, Gen Gov, Vets;** Grayber, Evans, Tran	Enterprise Information Services	Shirlene Gonzalez	Legislative Director	Shirlene Gonzalez	Legislative Director
		Oregon Government Ethics Commission	Susan Myers	Executive Director		
		State Library	**Wendy Cornelisen**	State Librarian	Wendy Cornelisen	State Librarian
		Travel Oregon	Kate Baumgartner	External & Public Affairs Strategist	Kate Baumgartner	External & Public Affairs Strategist
7	**Gen Gov SUB**; Patterson, Smith, Bonham, Gomberg, Reschke, Walters **Sen Fin & Rev;** Meek, Golden, Jama **House Em Mgmt, Gen Gov, Vets**; Grayber, Evans, Tran	Oregon Board of Accountancy	Martin Pittioni	Executive Director	Martin Pittioni	Executive Director
		Board of Tax Practitioners	**Laura Kardokus**	Executive Director	Laura Kardokus	Executive Director
					Corina Drake-Minor	Board Chair
					Rachel Bradley	Board Vice-Chair
8	**Sen Ed**; Weber,Frederick, SGB **House Ed;** Neron, McIntire, Valderrama **Ed SUB;** Frederick, Weber, McLain	Teacher Standards and Practices	**Melissa Goff**	Interim Executive Director	Melissa Goff	Interim Executive Director
			Elizabeth Keller	Director of Licensure	Tom Wrosch	Leg Director
			Cristina Edgar	Director of Professional Practices		
			Bill Rhoades	Director of Educator Preparation and Programs		

Names in bold assigned as group leads

Oregon Board of Dentistry

Date run: 11/17/2024

For the Month of **OCTOBER 2024** AY 2025 FY 2025

3400 BOARD OF DENTISTRY *REVENUE*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan
0205	OTHER BUSINESS LICENSES	92,742.00	2,520,847.00	3,495,149.00
0210	OTHER NONBUSINESS LICENSES AND FEES	3,050.00	13,300.00	14,900.00
0410	CHARGES FOR SERVICES	707.00	21,191.00	148,355.00
0505	FINES AND FORFEITS	8,000.00	181,741.00	240,000.00
0605	INTEREST AND INVESTMENTS	6,440.49	83,840.16	60,000.00
0975	OTHER REVENUE	20.00	3,245.98	14,001.00
Grand Total		**110,959.49**	**2,824,165.14**	**3,972,405.00**

3400 BOARD OF DENTISTRY *TRANSFER OUT*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	101,051.75	267,000.00
Grand Total		**0.00**	**101,051.75**	**267,000.00**

3400 BOARD OF DENTISTRY *PERSONAL SERVICES*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan
3110	CLASS/UNCLASS SALARY & PER DIEM	57,928.01	917,344.02	1,548,096.00
3115	BOARD MEMBER STIPENDS	3,548.00	38,447.00	46,900.00
3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,585.00
3170	OVERTIME PAYMENTS	(1,432.40)	1,144.41	6,669.00
3180	SHIFT DIFFERENTIAL	0.00	1.00	0.00
3190	ALL OTHER DIFFERENTIAL	660.74	10,157.51	41,510.00
3210	ERB ASSESSMENT	15.33	214.62	404.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	9,937.11	170,314.59	288,767.00
3221	PENSION BOND CONTRIBUTION	2,545.64	44,957.25	72,030.00
3230	SOCIAL SECURITY TAX	4,598.62	73,315.56	130,994.00
3241	PAID FAMILY MEDICAL LEAVE INSURANCE	240.41	3,630.90	5,391.00
3250	WORKERS' COMPENSATION ASSESSMENT	10.59	164.97	351.00
3260	MASS TRANSIT	351.97	5,580.59	10,681.00
3270	FLEXIBLE BENEFITS	13,651.82	175,574.23	301,948.00
Grand Total		**92,055.84**	**1,440,846.65**	**2,458,326.00**

3400 BOARD OF DENTISTRY *SERVICES AND SUPPLIES*

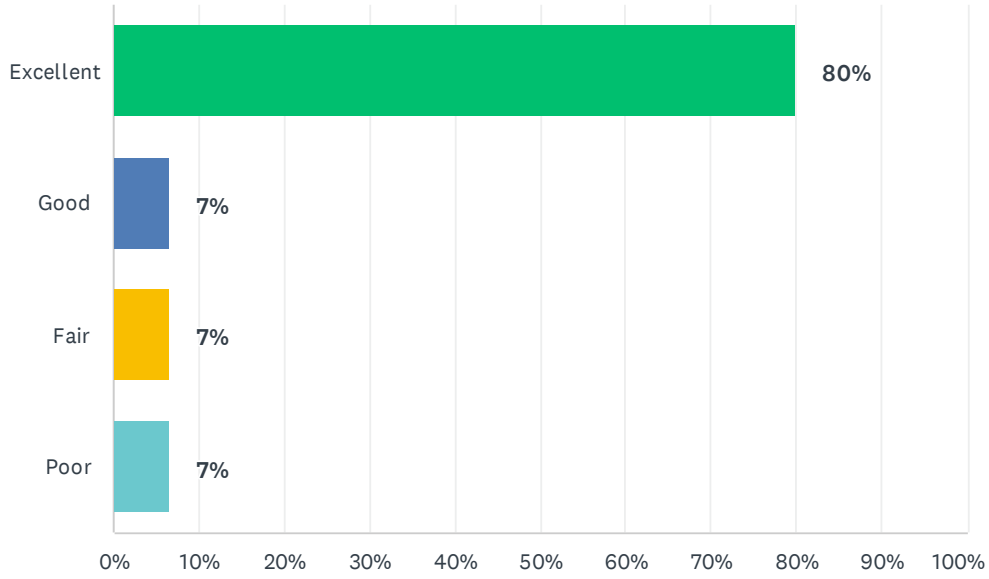
D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan
4100	INSTATE TRAVEL	1,236.73	9,174.97	55,194.00
4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,220.00
4150	EMPLOYEE TRAINING	1,113.92	15,737.58	58,929.00
4175	OFFICE EXPENSES	725.04	15,502.83	99,149.00
4200	TELECOMM/TECH SVC AND SUPPLIES	901.74	12,442.24	27,088.00
4225	STATE GOVERNMENT SERVICE CHARGES	41,420.91	91,465.56	94,114.00
4250	DATA PROCESSING	(15,453.50)	95,704.61	163,405.00
4275	PUBLICITY & PUBLICATIONS	0.00	1,726.44	16,145.00
4300	PROFESSIONAL SERVICES	20,091.50	260,146.33	458,367.00
4315	IT PROFESSIONAL SERVICES	884.00	1,997.00	161,038.00
4325	ATTORNEY GENERAL LEGAL FEES	11,687.50	156,245.33	338,907.00
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	120.00	766.00

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan
4400	DUES AND SUBSCRIPTIONS	0.00	1,546.80	11,331.00
4425	LEASE PAYMENTS & TAXES	9,104.14	132,410.70	206,576.00
4475	FACILITIES MAINTENANCE	0.00	0.00	634.00
4575	AGENCY PROGRAM RELATED SVCS & SUPP	2,799.00	29,978.51	142,660.00
4650	OTHER SERVICES AND SUPPLIES	6,970.69	86,186.33	94,383.00
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	6,343.00
4715	IT EXPENDABLE PROPERTY	0.00	28,256.23	25,521.00
Grand Total		**81,481.67**	**938,641.46**	**1,968,770.00**

				Current Month	Bien_To_Date	Rpt Mm Bal Ytd Avg
3400	**BOARD OF DENTISTRY**	Revenue	***REVENUE***	110,959.49	2,824,165.14	1,214,612.81
		Revenue Total		**110,959.49**	**2,824,165.14**	**1,214,612.81**
		Expenditures	***PERSONAL SERVICES***	92,055.84	1,440,846.65	707,497.23
			SERVICES AND SUPPLIES	81,481.67	938,641.46	546,021.74
			TRANSFER OUT	0.00	101,051.75	69,607.50
		Expenditures Total		**173,537.51**	**2,480,539.86**	**1,323,126.47**

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

Answered: 15 Skipped: 0

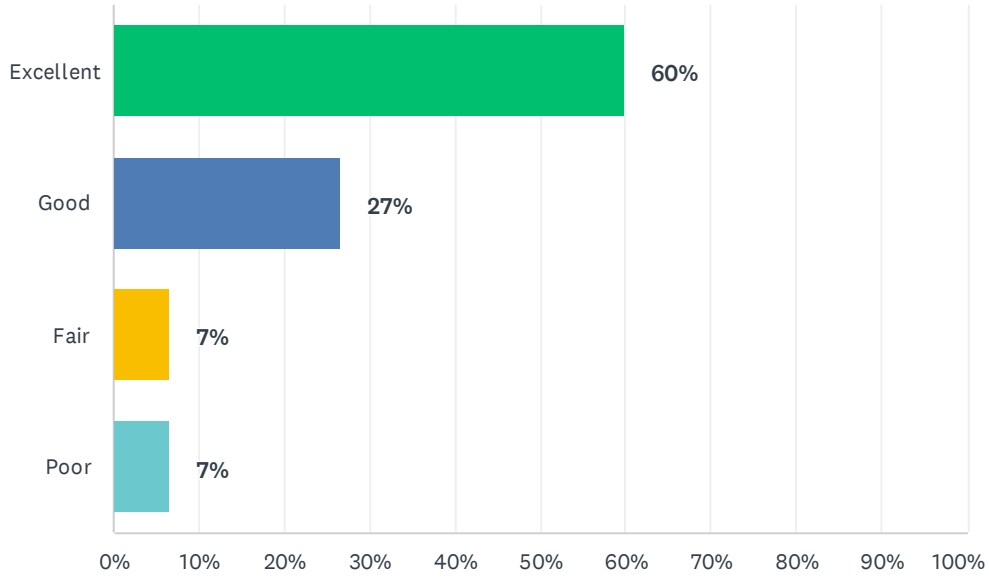


ANSWER CHOICES	RESPONSES	
Excellent	80%	12
Good	7%	1
Fair	7%	1
Poor	7%	1
TOTAL		15

Attachment #3

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

Answered: 15 Skipped: 0

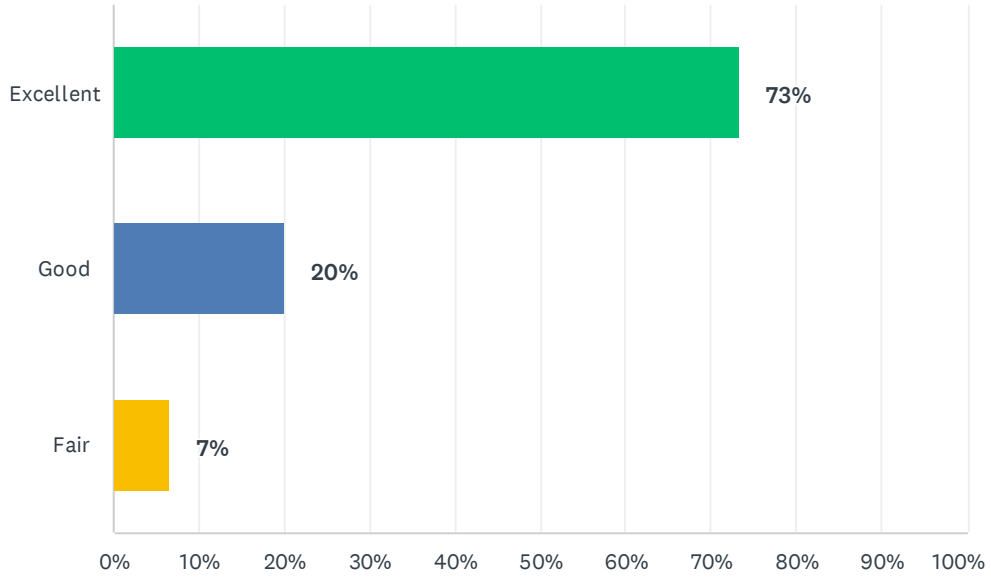


ANSWER CHOICES	RESPONSES	
Excellent	60%	9
Good	27%	4
Fair	7%	1
Poor	7%	1
TOTAL		15

Attachment #3

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

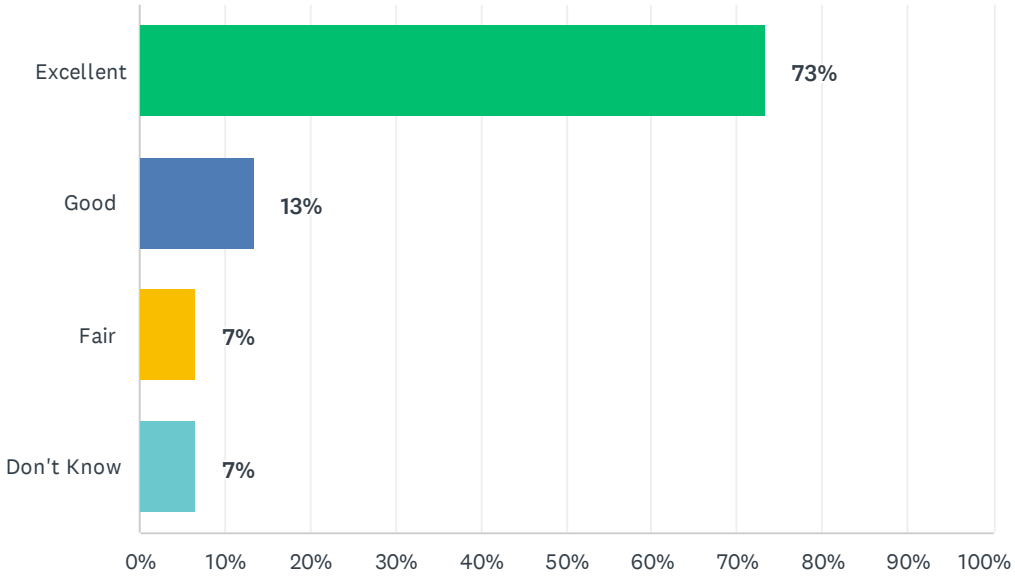
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	73%	11
Good	20%	3
Fair	7%	1
TOTAL		15

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

Answered: 15 Skipped: 0

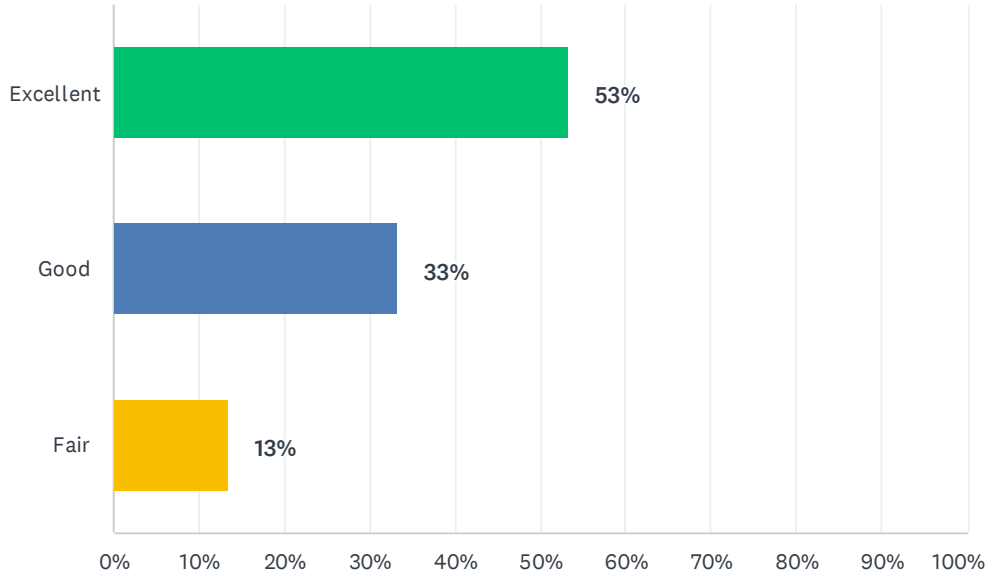


ANSWER CHOICES	RESPONSES	
Excellent	73%	11
Good	13%	2
Fair	7%	1
Don't Know	7%	1
TOTAL		15

Attachment #3

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

Answered: 15 Skipped: 0

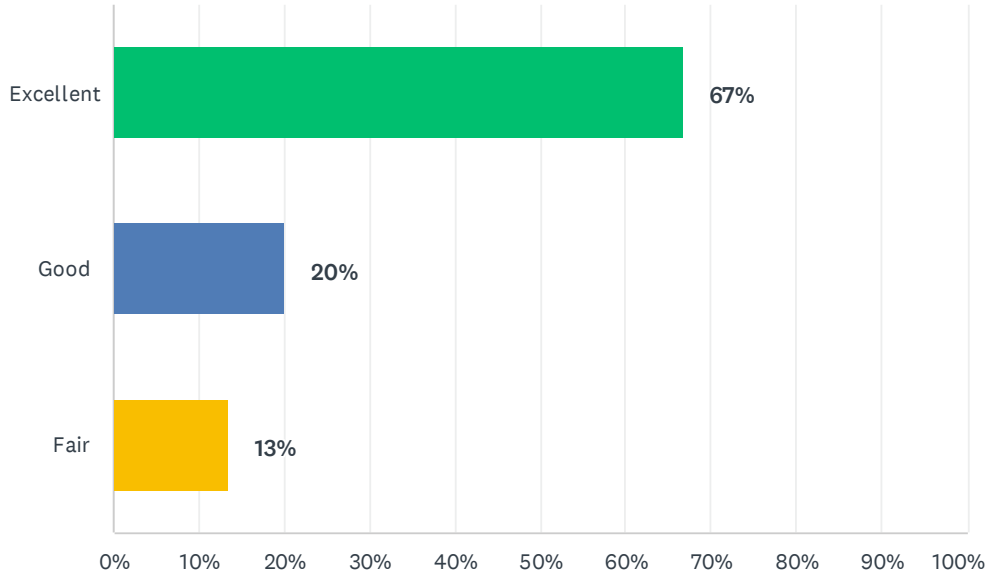


ANSWER CHOICES	RESPONSES	
Excellent	53%	8
Good	33%	5
Fair	13%	2
TOTAL		15

Attachment #3

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

Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	67%	10
Good	20%	3
Fair	13%	2
TOTAL		15

Attachment #3

CDCA WREB CITA

The National Exam Standard

October 22, 2024

To Mr. Stephen Prisby and the members of the Oregon Board of Dentistry,

Despite Hurricane Helene making travel impossible for many, the CDCA-WREB-CITA held its 55th Annual Meeting in conjunction with the Dental Testing and Regulatory Summit September 26-28, 2024, at the Galt House in Louisville, Kentucky. With an undercurrent of concern for the protection of the public, the collaborative spirit created palpable energy. We are grateful to have spent time with so many of you and offer these highlights from the event for those who could not attend.

State Board Presidents, Vice Presidents & Executive Directors Forum

Kicking off the session, Chairman Dr. Mark Armstrong (OH) announced that California joined 53 other jurisdictions to become the newest member of CDCA-WREB-CITA. Representatives from 32 states participated in this engaging two-hour session, driven by input from State Boards. This round-robin event allowed attendees to share activities and perspectives on issues ranging from dental licensure compacts to licensure pathways for internationally trained professionals and the importance of state sovereignty throughout the regulatory process. Here were the top issues dental board leaders reported to us:

- Dental/DH licensure compact
- Challenges to boards' authority/legislative oversight/potential to be absorbed into an umbrella board/consolidation/audit review
- Mobile dentistry/tele-dentistry/spa dentistry/botox
- Universal licensing legislation/licensure question reform "have you ever?"
- Workforce shortages/development/DH shortages
- Expanded scope of practice for Auxiliaries/Clinical Local Anesthesia for DH/Scope of Practice
- Dental Therapy/DT Testing
- Internationally trained dental professionals"/foreign licensure
- Radiation safety

In the past year, thirty-four new dental board members have become new CWC voting members, many as first-time examiners nationwide, gaining first-hand experience and awareness of licensure examinations. CWC invites all board members to actively participate in ADEX examinations.

General Assembly

In 2024, CDCA-WREB-CITA offered the ADEX examination at EVERY dental school in the United States and additional sites in Puerto Rico, Canada, Mexico, and Jamaica. In Dental Hygiene, we offered over 350 examinations from Maine to Hawaii and Florida to Alaska, serving more than 80% of licensure exam candidates nationwide. Speaking to an audience of more than 500 exam licensure and regulatory leaders, CWC Chairman Dr. Armstrong emphasized that the ADEX exam is now the clear standard in clinical licensure testing, a distinction mirrored in the ADEX tagline, "The National Exam Standard."

Dr. Armstrong acknowledged several key examiners involved in grass-roots efforts to protect the current high competency standards provided by the ADEX examination. Unfortunately, the ADA-supported CSG Dental and Dental Hygiene Licensure Compact lowers that standard by not requiring a hands skills competency examination.

Chief Executive Officer Mr. Alexander Vandiver illustrated how investments in examination administration technology have enhanced operations and capabilities. Proprietary tools now permit cloud-based management of CWC's suite of examination applications, from exam assignment staffing to candidate results delivery within the state board score portal, better-serving examiners, educators, and state boards alike.

Immediate past Chair Dr. Harvey Weingarten (IN) invited leadership from each organization at the Dental Testing & Regulatory Summit to participate in a panel discussion, sharing areas of activity and common interests. Organizations at the summit included the American Association of Dental Administrators (AADA), the American Board of Dental Examiners (ADEX), and the American Association of Dental Boards (AADB). They were also joined by an educator representing the CWC's Educators Conference. Together they discussed mission-critical initiatives and topical dental regulatory challenges each expects to be facing. Topics of interest once again included licensure compacts, scope of practice, representation, and more.

Director of Examinations, Dr. Benjamin Wall, highlighted candidate performance and examiner performance. In 2024, CWC continued to enhance the validity and quality in exam administration by investing in means and methods that enhance our collective examiner capabilities. A reflection of increased fidelity in simulated testing, no patient-based ADEX examinations are scheduled for 2025.

All incumbent members of the Board of Directors were reelected. For a complete list with bios, visit our website.

State Caucuses

Individual state caucuses provided a platform for discussion regarding issues of importance in each state. Attendees also shared significant concerns regarding the future of licensure as potentially impacted by dental licensure compacts. Caucuses selected Steering Committee representatives. For Oregon, the following persons were selected to serve: Kristen Simmons RDH, Dr. Darren Huddleston, and Dr. Jonna Hongo with Jill Mason RDH serving as an alternate. The next Steering Committee meeting will take place on April 1, 2025.

Educators Conference

Also impacted by Hurricane Helene, CWC hosted educators from more than 160 programs for our annual Educators Conference on Saturday, September 28th. In addition to preparatory sessions for the 2025 ADEX examinations, educators got a first glimpse of the candidate and educator's portal's next-generation capabilities. CDCA-WREB-CITA is committed to providing programs with top-notch service from scheduling through results delivery.

The Annual Meeting will return to Texas in 2025, scheduled for October 16-18, at the Gaylord Texan.

As always, we appreciate any pertinent updates you can share regarding licensure, board roster changes, or meeting schedules. As a reminder, CDCA-WREB-CITA supports the Interstate Dentist and Dental Hygienist Licensure Compact and can also be a resource to connect you with its originator, the AADB. If you or your board would like additional information or have questions, please email me at sbeeler@adextesting.org.

OBD 2025 Calendar

JANUARY

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

APRIL

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JUNE

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JULY

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Office Closed

1 Hour – Zoom Board Meeting

Board Meeting

Attachment #5

2025 Session Calendar

JANUARY						
S	M	T	W	T	F	S
			1 New Year's Day	2	3	4
5	6	7	8	9 New Member Academy	10 New Member Academy	11
12	13 Org Days; Swearing In	14 Trainings	15 Trainings	16 Trainings	17 LC Draft Request Deadline	18
19	20 MLK Day	21 Session Begins	22	23	24	25
26	27	28	29	30	31	

FEBRUARY						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17 President's Day	18	19	20	21 LC returns drafts	22
23	24	25 Measure Intro Deadline	26 Revenue Forecast	27	28	

MARCH						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10 Begin Daily Floor	11	12	13	14	15
16	17	18	19	20	21 Post Work Session	22
23/30	24/31	25	26	27	28	29

APRIL						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9 First chamber deadline	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9 Post Work Session	10
11	12	13	14 Revenue Forecast	15	16	17
18	19	20	21	22	23 Second Chamber Deadline	24
25	26 Memorial Day	27	28	29	30	31

JUNE						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18 Target Sine Die	19 Juneteenth	20	21
22	23	24	25	26	27	28
29 Constitutional Sine Die	30					

Dates subject to the adoption of CR (2025 Regular Session)

Organizational Day	Member swearing in; organization; and first reading of pre-session filed bills.
Training Days	Member and staff training.
Leg. Counsel Deadlines	Deadlines for bills to be requested, returned by LC, and introduced (after these deadlines, subsequent drafts and intros count against per legislator limits. See SR 13.15(2); HR 12.35.
State Holiday	Holiday.
Important Session Dates	Deadlines for bills to be posted for work sessions, then voted out of policy committees in the first and second chambers. Joint policy committees adhere to the second chamber deadline only. Does not apply to Conduct, Rules, Revenue, or JWM.
Floor Sessions	Senate and House floor sessions will be announced by the Senate President or House Speaker. Daily floor sessions begin on Monday, March 10, 2025.
Revenue Forecast	Revenue forecast.

Attachment #5

UNFINISHED BUSINESS & RULES

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

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

PERMANENT ADMINISTRATIVE ORDER

FILED
10/28/2024 11:20 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

OBD 2-2024
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board is amending 17 rules, adopting 1 rule and repealing 1 rule.

EFFECTIVE DATE: 01/01/2025

AGENCY APPROVED DATE: 10/25/2024

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

1500 SW 1st Ave
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

RULES:
818-001-0002, 818-012-0010, 818-021-0018, 818-021-0019, 818-026-0040, 818-026-0050, 818-026-0060, 818-026-0065, 818-026-0070, 818-035-0072, 818-042-0010, 818-042-0040, 818-042-0080, 818-042-0095, 818-042-0096, 818-042-0110, 818-042-0113, 818-042-0116, 818-042-0130

AMEND: 818-001-0002

RULE TITLE: Definitions

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to include definition of "Study Model".

RULE TEXT:
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 certification standard is the American Heart Association’s BLS Healthcare Providers Course or its equivalent, as determined by the Board.This initial BLS course must be a hands-on course; online BLS courses
will not be approved by the Board for initial BLS certification. After the initial BLS certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS certification card with an expiration date must be received from the BLS provider as documentation of BLS certification.The Board considers the BLS expiration date to be the last day of the month that the BLS instructor indicates that the certification expires.
(21) "Study Model" means a replica of a patient's teeth and surrounding structures, typically made from either a physical impression or a scanned impression of the patient's mouth. It is used primarily for diagnostic and treatment planning purposes, allowing the dentist to study the patient's teeth and jaw alignment and plan procedures such as orthodontic treatment, restorative dentistry or prosthetic treatment. A study model is distinguished from a "working model," which is fabricated in a similar fashion as a study model and may be a more precise and accurate replica of the patient's teeth and jaw (where applicable). A working model would be used for the fabrication of dental appliances, including without limitation orthodontic aligners, retainers, crowns and bridges or removable dentures.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.010, 680.010

AMEND: 818-012-0010

RULE TITLE: Unacceptable Patient Care

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to add #6, that it is unacceptable patient care to fail to ensure images are of diagnostic quality.

RULE TEXT:

The Board finds, using the criteria set forth in ORS 679.140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:

(1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.

(2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.

(3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.

(4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.

(5) Fail to ensure radiographic and other imaging are of diagnostic quality.

(6) Render services which the licensee is not licensed to provide.

(7) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.

(8) Fail to maintain patient records in accordance with OAR 818-012-0070.

(9) Fail to provide goods or services in a reasonable period of time which are due to a patient pursuant to a contract with the patient or a third party.

(10) Attempt to perform procedures which the licensee is not capable of performing due to physical or mental disability.

(11) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.

(12) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.

(13) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.

(14) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.

(15) Fail to advise a patient of any recognized treatment complications.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.140(1)(e), 679.140(4), 680.100

AMEND: 818-021-0018

RULE TITLE: License for Active-Duty Members of the Uniformed Services and their Spouses or Domestic Partners Stationed in Oregon

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to comply with Federal Law.

RULE TEXT:
(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 or domestic partner when the following requirements are met:
(a) A completed application and payment of fee is received by the Board; and
(b) Submission of a copy of the military orders assigning the active-duty member to an assignment in Oregon; and
(c) The spouse holds a current license in another state to practice dentistry, dental hygiene, or dental therapy at the level of application; and
(d) The license is in good standing and verified as active and current through processes defined by the Board; and
The license shall remain active for the duration of the above-mentioned military orders.
(2) Each biennium, the licensee shall submit to the Board a Biennial Military Status Confirmation Form. The confirmation form shall include the following:
(a) Licensee's full name:
(b) Licensee's mailing address;
(c) Licensee's business address including street and number. If the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number. 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 continuing educational 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;
(j) A statement that the licensee has not been disciplined by any licensing board of any other jurisdiction or convicted of a crime; and
(k) Confirmation of current active-duty status of service member.

STATUTORY/OTHER AUTHORITY: Oregon Laws 2019, Chapter142, Section 1, ORS 679.600

STATUTES/OTHER IMPLEMENTED: ORS 679.600

REPEAL: 818-021-0019

RULE TITLE: Temporary Dental Hygiene License for Spouses or Domestic Partners of Active Duty Armed Forces of the United States Stationed in Oregon

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The Board is repealing this rule as it is out of compliance and OAR 818-021-0018 meets Federal requirements for the military.

RULE TEXT:
(1) A temporary license to practice dental hygiene shall be issued to the spouse or domestic partner of active duty armed forces personnel when the following requirements are met:
(a) A completed application and payment of fee is received by the Board; and
(b) Satisfactory evidence of having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(c) 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; and
(d) Submission of a copy of the military orders assigning the active duty member to an assignment in Oregon; and
(e) The spouse holds a current license in another state to practice dentistry at the level of application; and
(f) The license is unencumbered and verified as active and current through processes defined by the Board; and
(g) Satisfactory evidence of successfully passing a clinical examination administered by any state, national testing agency or other Board-recognized testing agency.
(2) The temporary license shall expire on the following date, whichever occurs first:
(a) Oregon is no longer the duty station of the active armed forces member; or
(b) The license in the state used to obtain a temporary license expires; or
(c) Two years after the issuance of the temporary license.
(3) This temporary license is not renewable. If the dates in section two of this rule are exceeded and the spouse continues to practice in Oregon, the spouse must apply for an active Oregon license. This license must be obtained using the processes and fees established for permanent licensure. Continuing to work in Oregon when the temporary license has expired will be considered practicing without a valid license and is subject to Board action.

STATUTORY/OTHER AUTHORITY: Oregon Laws 2019, Chapter 142, Section 1

STATUTES/OTHER IMPLEMENTED:

AMEND: 818-026-0040

RULE TITLE: Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to update reference to BLS and delete CPR verbiage from rule.

RULE TEXT:
Nitrous Oxide Sedation.
(1) The Board shall issue a Nitrous Oxide Permit to an applicant who:
(a) Is either a licensed dentist or licensed hygienist in the State of Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Has completed a training course of at least 14 hours of instruction in the use of nitrous oxide from a dental school or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, or as a postgraduate.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow delivery of appropriate care in an emergency situation;
(b) An operating table or chair which permits the patient to be positioned so that the patient's airway can be maintained, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system; and
(g) Sphygmomanometer and stethoscope and/or automatic blood pressure cuff.
(3) Before inducing nitrous oxide sedation, a permit holder shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for nitrous oxide sedation;
(b) Give instruction to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for nitrous oxide sedation; and
(d) Obtain informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) If a patient chronically takes a medication which can have sedative side effects, including, but not limited to, a narcotic or benzodiazepine, the practitioner shall determine if the additive sedative effect of nitrous oxide would put the patient into a level of sedation deeper than nitrous oxide. If the practitioner determines it is possible that providing nitrous oxide to such a patient would result in minimal sedation, a minimal sedation permit would be required.
(5) A patient under nitrous oxide sedation shall be visually monitored by the permit holder or by an anesthesia monitor at all times. The patient shall be monitored as to response to verbal stimulation, oral mucosal color and preoperative and postoperative vital signs.
(6) The permit holder or anesthesia monitor shall record the patient's condition. The record must include documentation of preoperative and postoperative vital signs, and all medications administered with dosages, time

intervals and route of administration.
(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS), or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The person administering the nitrous oxide sedation may leave the immediate area after initiating the administration of nitrous oxide sedation only if a qualified anesthesia monitor is continuously observing the patient.
(9) The permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(b) The patient can talk and respond coherently to verbal questioning;
(c) The patient can sit up unaided or without assistance;
(d) The patient can ambulate with minimal assistance; and
(e) The patient does not have nausea, vomiting or dizziness.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(11) Permit renewal. In order to renew a Nitrous Oxide Permit, the permit holder must provide proof of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Nitrous Oxide Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, nitrous oxide, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060 and 818-021-0070.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

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

AMEND: 818-026-0050

RULE TITLE: Minimal Sedation Permit

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to update reference to BLS and delete CPR verbiage from rule.

RULE TEXT:

Minimal sedation and nitrous oxide sedation.

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

(a) Is a licensed dentist in Oregon;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated

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

STATUTORY/OTHER AUTHORITY: ORS 679

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

AMEND: 818-026-0060

RULE TITLE: Moderate Sedation Permit

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to update reference to BLS and delete CPR verbiage from rule.

RULE TEXT:

Moderate sedation, minimal sedation, and nitrous oxide sedation.

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

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated; and

(c) Satisfies one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.
(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.
(5) Before inducing moderate sedation, a dentist permit holder who induces moderate sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for moderate sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS), or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;
(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.
(9) A dentist permit holder shall not release a patient who has undergone moderate sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(12) After adequate training, an assistant, when directed by a dentist permit holder, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents into an infusion line under the direct supervision of a dentist permit holder.
(13) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a

current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021- 0060.

STATUTORY/OTHER AUTHORITY: ORS 679

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

AMEND: 818-026-0065

RULE TITLE: Deep Sedation Permit

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to update reference to BLS and delete CPR verbiage from rule.

RULE TEXT:

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:

(a) Is a licensed dentist in Oregon; and

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

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

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

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

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

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

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

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

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

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

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

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

(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing deep sedation, a dentist permit holder who induces deep sedation shall:

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

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

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

(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist

permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for deep sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS), or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously monitored and the patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.
(9) A dentist permit holder shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may administer oral sedative agents calculated by a dentist permit holder or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.
(13) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

STATUTORY/OTHER AUTHORITY: ORS 679

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

AMEND: 818-026-0070

RULE TITLE: General Anesthesia Permit

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to update reference to BLS and delete CPR verbiage from rule.

RULE TEXT:

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a General Anesthesia Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and

(c) Satisfies one of the following criteria:

(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.

(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.

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

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

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

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

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

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

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

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

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

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

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.

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

(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep

sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist permit holder performing the dental procedures.
(5) Before inducing deep sedation or general anesthesia the dentist permit holder who induces deep sedation or general anesthesia shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist permit holder who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.
(7) Persons serving as anesthesia monitors for general anesthesia in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS), or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be assessed every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.
(9) A dentist permit holder shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.
(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have nausea or vomiting and has minimal dizziness.
(11) A discharge entry shall be made in the patient's record by the dentist permit holder indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist permit

holder.

(13) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

STATUTORY/OTHER AUTHORITY: ORS 679

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

AMEND: 818-035-0072

RULE TITLE: Restorative Functions of Dental Hygienists

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The Board is amending the rule to clarify the name of the exam required for the restorative function.

RULE TEXT:

(1) The Board shall issue a Restorative Functions Endorsement (RFE) to a dental hygienist who holds an unrestricted Oregon license, and has successfully completed:

(a) 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, and successfully passed the CDCA-WREB-CITA's Dental Hygiene Restorative Examination or other equivalent examinations approved by the Board within the last five years; or

(b) If successful passage of the CDCA-WREB-CITA's Dental Hygiene Restorative Examination or other equivalent examinations approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.

(2) A dental hygienist may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):

(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration(s) by a Restorative Functions Endorsement dental hygienist;

(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.010(3), 679.250(7)

AMEND: 818-042-0010

RULE TITLE: Definitions

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The Board is amending the rule by defining DANB as a recognized testing agency for administering dental assistant exams for certifications.

RULE TEXT:

(1) “Dental Assistant” means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, dental therapist or another dental assistant or renders assistance under the supervision of a dental hygienist providing dental hygiene services.

(2) “Expanded Function Dental Assistant” means a dental assistant certified by the Board to perform expanded function duties.

(3) “Expanded Function Orthodontic Assistant” means a dental assistant certified by the Board to perform expanded orthodontic function duties.

(4) “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.

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

(6) “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.

(7) “Dental Assisting National Board (DANB)” is recognized by the Board as an acceptable testing agency for administering dental assistant examinations for certifications.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

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

AMEND: 818-042-0040

RULE TITLE: Prohibited Acts

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to change level of supervision required in #23 and #24 of rule.

RULE TEXT:

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), 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 indirect supervision.

(24) Place implant impression copings, except under indirect 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

AMEND: 818-042-0080

RULE TITLE: Certification — Expanded Function Dental Assistant (EFDA)

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to clarify the timing in which documentation is required to meet criteria to receive the certification.

RULE TEXT:

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 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.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(7)

AMEND: 818-042-0095

RULE TITLE: Restorative Functions of Dental Assistants

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to clarify the name of the exam required for the restorative function.

RULE TEXT:

(1) The Board shall issue a Restorative Functions Certificate (RFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed:

(a) 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, and successfully passed the CDCA-WREB-CITA's Dental Hygiene Restorative Examination or other equivalent examinations approved by the Board within the last five years, or

(b) If successful passage of the CDCA-WREB-CITA's Dental Hygiene Restorative Examination or other equivalent examinations approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.

(2) A dental assistant may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):

(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration by a Restorative Functions dental assistant.

(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.010, 679.250(7)

ADOPT: 818-042-0096

RULE TITLE: Local Anesthesia Functions of Dental Assistants

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The Board is adopting a new rule to allow dental assistants to administer local anesthesia when certified and rule criteria have been met.

RULE TEXT:
(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.

STATUTORY/OTHER AUTHORITY: ORS 679, ORS 679.600

STATUTES/OTHER IMPLEMENTED: ORS 679.600

AMEND: 818-042-0110

RULE TITLE: Certification — Expanded Function Orthodontic Dental Assistant (EFODA)

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to clarify the timing in which documentation is required to meet criteria to receive the certification.

RULE TEXT:

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.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(7)

AMEND: 818-042-0113

RULE TITLE: Certification — Expanded Function Preventive Dental Assistants (EFPDA)

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to clarify the timing in which documentation is required to meet criteria to receive the certification.

RULE TEXT:

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.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679

AMEND: 818-042-0116

RULE TITLE: Certification — Anesthesia Dental Assistant

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to remove reference to CPR.

RULE TEXT:

The Board may certify a person as an Anesthesia Dental Assistant if the applicant submits a completed application, pays the certification fee and shows satisfactory evidence of:

(1) Successful completion of:

(a) The "Oral and Maxillofacial Surgery Anesthesia Assistants Program" or successor program, conducted by the American Association of Oral and Maxillofacial Surgeons; or

(b) The "Oral and Maxillofacial Surgery Assistants Course" or successor course, conducted by the California Association of Oral and Maxillofacial Surgeons (CALAOMS), or a successor entity; or

(c) The "Certified Oral and Maxillofacial Surgery Assistant" examination, or successor examination, conducted by the Dental Assisting National Board or other Board approved examination; or

(d) The Resuscitation Group – Anesthesia Dental Assistant course; or

(e) Other course approved by the Board; and

(2) Holding valid and current documentation showing successful completion of a Healthcare Provider BLS course, or its equivalent.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(7)

AMEND: 818-042-0130

RULE TITLE: Application for Certification by Credential

NOTICE FILED DATE: 08/26/2024

RULE SUMMARY: The rule is being amended to remove the requirement that a state needs to submit information directly to the Board.

RULE TEXT:
An applicant for certification by credential shall submit to the Board:
(1) An application form approved by the Board, with the appropriate fee;
(2) Proof of certification by another state and any other recognized certifications (such as CDA or COA certification) and a description of the examination and training required by the state in which the assistant is certified; or
(3) Certification that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant performing the functions for which certification is being sought. If applying for certification by credential as an EFDA, EFODA or EFPDA certification by a licensed dentist that the applicant is competent to perform the functions for which certification is sought.
(4) If applying for certification by credential in Radiologic Proficiency, certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, or the Oregon Board of Dentistry, that the applicant has met that agency's training requirements for x-ray machine operators, or other comparable requirements approved by the Oregon Board of Dentistry.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.020, 679.025, 679.250

Note – The highlighted part of the rule language change was inadvertently left off the Secretary of State filing.

The rule will move on the next time the Board makes rule changes to correct that omission.

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.**

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.

Oregon Board of Dentistry
Initial Application Personal History Questions

Revised 08/2024

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 submit additional information on a separate 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 Dental 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 dental, dental hygiene, or dental therapy license (CDCA-WREB-CITA, ADEX, etc.) 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 dental, dental hygiene, or dental therapy 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 dental, dental hygiene, or dental therapy 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 dentistry, dental hygiene, or dental therapy related entity; or have you been notified that such action or request is pending or proposed?

Category II

The Oregon Board of Dentistry 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 referring to the Oregon Health Professionals' Service Program (www.hpspmonitoring.com) by contacting the Board office by emailing information@obd.oregon.gov or calling 971-673-3200.

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 Board of Dentistry 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 Board of Dentistry
Renewal Application Personal History Questions

Revised 08/2024

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 submit additional information on a separate 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 Dental 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 Board of Dentistry 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 referring to the Oregon Health Professionals' Service Program (www.hpspmonitoring.com) by contacting the Board office by emailing information@obd.oregon.gov or calling 971-673-3200.

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 Board of Dentistry 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. You 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 Type	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 (With 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 CURRENTLY LICENSE OR HAVE HELD LICENSURE IN ANOTHER STATE, COUNTRY OR JURISDICTION:

License Verification 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 Tab. 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 Valid 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 APPLICATION 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 TO 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 To	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 To	Degree Earned	Actions
Marquette University School of Dentistry	Milwaukee	WI	08/2015	05/2019	Doctor of Dental Surgery DDS	

Specialty Training 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 To	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 Type	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 :.

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.

December 13, 2024

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

Re: *Removal of Intrusive Mental Health & Substance Use Disorder Questions from Initial Licensing and Relicensing applications*

Dear President Sharifi and Members of the Board,

On behalf of the coalition represented herein, who collectively represent the majority of licensed dentists in Oregon, we jointly request that the Oregon Board of Dentistry ("OBD") support:

1. **Removal** of intrusive mental health and substance abuse questions from the OBD's initial licensing and relicensing application for OBD licensees.
2. **Replacement** by adopting language that would align OBD with Oregon Medical Board (OMB) and be consistent with recommendations from the Federation of State Medical Boards, The Joint Commission, Federation of State Physician Health Programs, American Medical Association, American Dental Association and many others.

The objective of this memo is to demonstrate with supporting evidence that adopting these changes not only fulfills the OBD's responsibility to protect the public it has precedent of ensuring legal compliance. Accompanying this memo is compilation of supporting documentation collated to Reference List.

We appreciate the OBD's interest and thoughtful deliberations on this important request. We share the same commitment as the OBD that patient safety and protecting the public's health is essential, and therein believe providers' total health, including physical and mental health, must be safeguarded to ensure patient safety. When health care providers can receive compassionate care instead of stigma, it's better for them and better for their patients.

To level set, this matter was first considered at the Board's August 2023 meeting and over the ensuing 15 months has been discussed at length at the OBD's Licensing, Standards and Competence Committee and in front of the full Board. To date, despite the robust discussion and strong evidence-based precedent, no motion has been made on modifying the OBD's recredentialing practices. On behalf of our dentist licensees, we are hopeful that such a motion will be made at the December 2024 meeting.

The basis of, impetus behind, and justification for our position and request is summated into three domains: effectively protecting the public, encourages seeking care, and ensures OBD is following state and federal laws.

Effectively Protects the Public

State medical and dental boards have obligations both to protect the public from providers who may be impaired by illness and to protect the rights of the practitioner applying for licensure. Historically, these mental health diagnosis and substance use disorder questions were often added to licensing and credentialing applications emanating from misplaced desire to protect the public from health workers who might not be fit to give care. Importantly, there is no evidence such questions serve that function. To the contrary, ample existing evidence underscores the OBD's practice causes more harm than good and does not meet its stated goal of promoting disclosure and public safety. Physician surveys conclude most professionals will avoid disclosure and treatment out of fear for their license or professional reputation. The potential for stigma and reputational/professional harm are simply too great. As a result, treatment is often delayed or simply doesn't occur. Significant research shows that intrusive mental health questions in fact lead to licensees' non-disclosure of information, and avoidance of treatment, due to fear of recrimination, which puts the public at greater risk. In one survey, nearly 40% of physicians reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure.[i] A similar number were afraid or knew another physician fearful of seeking mental health care because of questions asked in medical licensure, credentialing or insurance applications.

Encourages Seeking Care

Stigmatizing and antiquated questions have created fear-based culture of silence, so those suffering the most would continue to isolate themselves instead of feeling supported. One study showed that only 6% of female physicians with a formal diagnosis or treatment for mental illness had disclosed it to their state.[ii] In another study of medical residents, 61% of those responding to a survey reported that they felt they would benefit from psychiatric services. However, only 24% of those who felt they needed care sought treatment. The most commonly reported barriers to seeking care were lack of time (77%), concerns about confidentiality (67%), concerns about what others would think (58%), cost (56%), and concern for the effect on one's ability to obtain licensure (50%).[iii] These studies make clear that professional stigma and embarrassment are the primary barriers to disclosure and treatment.

Recognition of this intent-actuality disconnect prompted and has, since at least 2020, led to a substantial and growing evidence-based movement by state health licensing boards to remove or limit invasive questions around mental health and substance abuse diagnosis and treatment. A purposeful refocus on reducing stigma surrounding mental health conditions will encourage licensees to seek mental health care, should they need it, without fear of punitive action. The emerging – and we believe more-humane – approach is to provide licensees an advisory statement with supportive language, and then ask for an attestation from the licensee that they have read the statement and understand. Notably, in April of 2023 the OMB became one of 26 state medical licensing agencies to adopt the attestation approach as replacement to invasive questions. The Oregon State Board of Nursing may follow suit with vote scheduled to adopt OMB-modelled attestation language.

Ensures Legal Compliance

We believe the status quo violates Title II of the Americans with Disabilities Act ("ADA Title II") which broadly prevents discrimination by public entities against persons with disabilities, including persons with mental health diagnoses and substance abuse disorders.

Since at least the early 1990s, numerous state licensing agencies' practices around mental health and substance abuse inquiries have been challenged on ADA Title II grounds. In New Jersey, the state medical society challenged the State Board of Medical Examiners' use of intrusive mental health and substance abuse questions and the US Department of Justice ("DOJ") submitted an amicus brief which provided a comprehensive summary of the law and urged the Court to conclude that the Board's re-licensure program violated ADA Title II.

More recently and locally, Senator Ron Wyden sent a February 23, 2023 letter encouraging the DOJ to extend its investigations of ADA Title II offenses to include the practices of state medical license boards around mental health and substance abuse questions. Oregon's Medical Board discarded the practice less than two months later, on April 6, 2023. The DOJ responded to Sen. Wyden on June 26, 2023, stating "[i]t is clear that intrusive inquiries regarding an applicant's mental health history run afoul of the ADA to the extent that state medical boards use them as eligibility criteria to screen out applicants with disabilities and such inquiries are not necessary to determine whether an applicant is fit to practice medicine." The DOJ then cited back to its own amicus brief (linked above), as well as its 2014 Letter of Findings in the State of Louisiana Attorney Licensure System matter.

For all of these reasons, we respectfully ask the Oregon Board of Dentistry to direct the Licensing, Standards & Competency Committee to adopt the resolution we drafted to align with OMB's approach. We urge the OBD at December 13th Board meeting to take action by making motion for "removal of intrusive mental health and substance use disorder questions on initial credentialing and recredentialing applications and align the dentist licensure applications with the Oregon Medical Board's language."

Thank you for your consideration.

Maun Chaudhry, MS, DDS
President
Capitol Dental/ Gentle Dental

Teri Barichello, DMD
Vice President and Chief Dental Office
Delta Dental of Oregon

Caroline Zeller,
President,
Oregon Dental Association

Lisa J. Rowley, MS, RDH, CDA, FADHA
Advocacy Director 2024-2026
Oregon Dental Hygienists' Association

Cyrus Lee, DMD, FACD
Chief Executive Officer
Executive Dental Director
Permanente Dentistry

[i] Dyrbye, L. (2017). *Medical licensure questions and physician reluctance to seek care for mental health conditions*. Mayo Clinic Proceedings, 92(10): 1486 – 1493. DOI: 10.1016/j.mayocp.2017.06.020.
[ii] Gold, K, et al. (2016), *"I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment and reporting*. General Hospital Psychiatry, Volume 43, Nov-Dec 2016, pp. 51-57 https://www.sciencedirect.com/science/article/abs/pii/S0163834316301281 (visited June 7, 2024).
[iii] Aaronson, A, et al. *Mental Health During Residency Training: Assessing the Barriers to Seeking Care*. Academic Psychiatry, Volume 42, February 2018, pp. 469-472 https://link.springer.com/article/10.1007/s40596-017-0881-3 (visited June 7, 2024).

Proposed questions to be adopted by OBD

XXI. Attestation Questions – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.** NOTE: Answering "yes" to Question L does not require any further details.

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES	NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES	NO
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES	NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?	YES	NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
G.	Have you **ever** voluntarily or involuntarily left or been discharged from any education or training programs related to your current licensure or certification?	YES	NO
H.	Have you **ever** had board certification revoked?	YES	NO
I.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES	NO
J.	Have you ever been charged with a criminal violation (*felony or misdemeanor*)?	YES	NO
K.	Do you presently use any illegal drugs?	YES	NO
L.	We recognize that providers encounter health conditions, including those involving physical and mental health and substance use disorders, just as their patients do. It is imperative that providers address their health concerns for their own well-being, as well as for patient safety. Do you attest to no current physical, mental health, or chemical dependency conditions (alcohol or other substances) that currently affect your ability to practice, with or without reasonable accommodation? Please disclose any current conditions that require employer-provided accommodations on a separate sheet.	YES	NO
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/ hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES	NO
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES	NO
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES	NO

e.g. *hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: **Date:**

ADA American Dental Association®
America's leading advocate for oral health

211 East Chicago Avenue
Chicago, Illinois 60611

T 312.440.2700
F 312.440.7488
www.ada.org

Brett H. Kessler, D.D.S.
President

November 22, 2024

President Reza J. Sharifi, D.M.D.
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

Dear President Sharifi and Members of the Board:

The American Dental Association (ADA) is committed to supporting the health and wellness of dentists who have dedicated their lives to improving the health and well-being of their patients and their communities. As such, we respectfully urge you to adopt the recommendation made by the Oregon Dental Association (ODA) to remove potentially stigmatizing questions contained within the applications for initial dental licensure and licensure renewal in Oregon.

No dentist should fear disciplinary action for seeking treatment or assistance for their own physical, behavioral or mental health conditions, including substance use disorders. The ADA strongly supports the removal or revision of questions on applications for dental licensure or credentialing that could potentially discriminate against dentists who have ever received counseling, therapy or treatment for mental health issues, including substance misuse. While the stigmatizing impact of these questions is unintentional, they nevertheless impose an unjust and unnecessary toll on dentists who have sought treatment for past mental health issues, as well as dentists who are currently receiving or are planning to seek treatment. We believe that dentists who are dealing with mental health issues or battling substance use disorders should be encouraged to seek treatment without fear of adverse impacts to their dental licenses or professional reputations.

We support the ODA's recommendation, which is in line with revisions made recently by the Oregon Medical Board to its licensure applications, that the invasive questions on the dental licensure applications be replaced with the attestation model approach, which requires applicants to read a statement related to their current fitness and ability to practice and then attest that they've read and understand that statement. Attestation models serve to protect the public while also allowing the individual licensee to seek care for mental health conditions, including substance use disorders, without fear of punitive action. The Oregon Medical Board followed the Federation of State Physician Health Programs (FSPHP) statement and the American Medical Association's (AMA) recommendations when they made the changes to their licensure applications. At this year's American Association of Dental Boards' (AADB) Annual Meeting, there was a focus on well-being, including the importance of removing barriers dentists may encounter to seek help for mental health, including substance use disorders. ADA's President, Dr. Brett Kessler presented on one of the AADB panels as well as other ADA Members. Dr. Kessler, has served as the ADA representative on the National Academy of Medicine's (NAM) Action Collaborative on Clinician Well-Being and Resilience.

The ADA has long been committed to improving and safeguarding the health and well-being of dentists. In 2023, the ADA House of Delegates passed Resolution 517 Preventing Unfair Discrimination to address these important public safety and dentist health issues. This October, the ADA's Council on Dental Practice and Council on Government Affairs created a resource toolkit highlighting the states where state boards of dentistry have reformed their licensure questions in an effort to assist and encourage other states to do the same.

Healthy patients require healthy dentists. Now more than ever, we must prioritize the health and well-being of the dentists who tirelessly care for us and promote and foster an environment where every dentist who wants and needs necessary treatment is able to seek that treatment without the fear of loss of licensure or reputational harm. As such, we respectfully urge the Oregon Board of Dentistry to join the growing number of state licensure boards, hospitals, and health systems that have revised their licensing and credentialing applications to eliminate questions that contribute to the stigma associated with seeking care for mental health or substance use disorders.

Sincerely,

Brett Kessler, D.D.S.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

cc: Richard Rosato, D.M.D., ADA President Elect
Barry Taylor, D.M.D., Executive Director, Oregon Dental Association
Julie Spaniel, D.D.S., Oregon Dental Association Board of Trustees

United States Senate

WASHINGTON, DC 20510

February 23, 2023

Dear Attorney General Merrick Garland, Assistant Attorney General Kristen Clark, and Disability Rights Section Chief Rebecca Bond:

I write to encourage the Department of Justice (DOJ) to extend its investigations of offenses under the American Disabilities Act (ADA) to include the practices of state medical license boards. Many of these boards ask physicians about their mental health and substance use or addiction history, beyond what is necessary to fulfill the purpose of screening physicians for current, debilitating cases of mental illness and substance use or abuse. These questions both discourage many applicants and licensed physicians from receiving care that they need, and they violate Title II of the ADA, which forbids public entities from discriminating against qualified individuals on the basis of disabilities, including mental health conditions. I know that you share my goals of protecting health privacy, encouraging a robust medical workforce, promoting mental health care, and enforcing the ADA, and so I write to ask you to prioritize this concern by issuing DOJ guidance and holding state medical boards accountable.

States oversee the qualifications of their physicians as part of the power to protect the health, safety, and welfare of its citizenry, but some of the questions that many state medical boards ask of physicians on their initial licensure exams and renewals are, according to the American Psychiatric Association, the American Medical Association, and the Federation of State Medical Boards, irrelevant to assessing current ability to practice. In fact, several peer-reviewed journal articles estimate that two-thirds of state medical boards violate Title II of the ADA with personal, taxing, and unnecessarily broad questions about doctors' psychiatric history.[1, 2, 3] The repercussions are not just a matter of law, but they also inform the practices of hospitals, health plans, and malpractice insurance companies, and impact the medical well-being of physicians.

A 2019 study[4] looked at initial medical licensing processes in all states to determine if qualified applicants who report mental illness experience discrimination and to identify the most physician-friendly states for mental health.

The authors ranked Alaska as the worst of all states when it came to invasiveness of mental health questions on initial licensing applications with 25 yes-or-no questions including:

---

1 Schroeder,et al., Do State Medical Board Applications Violate the Americans With Disabilities Act?. Academic Medicine 84(6):p 776-781, June 2009. | DOI: 10.1097/ACM.0b013e3181a43bb2.

2 Dyrbye et al., Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. Mayo Clinic Proceedings 92(10):p 1486-1493, October 1, 2017. | DOI: 10.1016/j.mayocp.2017.06.020.

3 Jones et al., Medical Licensure Questions About Mental Illness and Compliance with the Americans With Disabilities Act. Journal of the American Academy of Psychiatry and the Law Online 46(4):p 458-471, December 2018. | DOI: 10.29158/JAAPL.003789-18.

4 Wible, Pamela, and Arianna Palermini, Physician-Friendly States for Mental Health: A Comparison of Medical Licensing Boards. Qualitative Research in Medicine and Healthcare 3(3):p 107-119, December 22, 2019. | DOI: 10.4081/qrmh.2019.8649.

> "Have you ever been diagnosed with, treated for, or do you currently have: followed by a list of 14 mental health conditions including depression, seasonal affective disorder, and "any condition requiring chronic medical or behavioral treatment."

The District of Columbia asks two questions, both unrestricted in time and the second "broad and subjective given that one anonymous and unsubstantiated complaint can lead to a physician [Physician Health Program] referral and undermine a doctor's career":

> "Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?"
>
> "Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?"

Georgia's application does not directly ask impairment or mental health questions, but requires three separate peer references to answer whether the physician has or had in the past any mental or physical illnesses or personal problems that interfere with their medical practice. "Personal" problems are open to interpretation and there's no indication that any assertions contained in these references must be substantiated by evidence.

These kinds of questions go far beyond conditions that could impair qualified individuals and may require comprehensive disclosure of one's medical and professional history.

Even though physicians face an inordinate amount of stress—their burnout rate is 50%, twice the general working population's level[5]—many avoid seeking mental health support due in part to these questions. In one survey of women physicians experiencing mental health difficulties, 44% of respondents who did not seek treatment cited licensure questions as a reason why.[6] In another survey of surgeons who experienced suicidal thoughts over the previous year, 60% said the questions would make them more reluctant to seek help.[7] Physicians have had one of the highest suicide rates of any profession, and the pandemic has exacerbated suicide risk factors.[8] Troublingly, there have also been reports of unwanted mental health support or assessments as physicians have reported retaliatory inquiries into physical, mental, or emotional health and referrals to impaired practitioner programs.

---

5 Yates et al., Physician Stress and Burnout. The American Journal of Medicine 133(2):p 160-164, September 11, 2019. | DOI: 10.1016/j.amjmed.2019.08.034.

6 Gold et al., "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. General Hospital Psychiatry 43: p 51-57, November-December 2016. | DOI: 10.1016/j.genhosppsych.2016.09.004.

7 Shanafelt et al., Special Report: Suicidal Ideation Among American Surgeons. Archives of Surgery 146(1)p. 54–62, January 17, 2021. | DOI: 10.1001/archsurg.2010.292.

8 Kakarala, Sophie E. and Prigerson, Holly G., Covid-19 and Increased Risk of Physician Suicide: A Call to Detoxify the U.S. Medical System. Front Psychiatry 13: February 9, 2022. | DOI: 10.3389/fpsyt.2022.791752. PMID: 35222114; PMCID: PMC8864162.

The DOJ oversees professional licensing bodies and has previously intervened when those bodies violated Title II of the ADA. For example, in 2014, the DOJ advised the Vermont Human Rights Commission about the unlawful nature of questions by state law boards about mental health history. Later that year, the DOJ investigated the Louisiana state law board for questions that violated Title II of the ADA. The DOJ also staked out a similar position in the case of state medical boards, writing in a 1993 *amicus curiae* brief before the U.S. District Court for the District of New Jersey that the New Jersey Boards of Medical Examiners' "focus on past diagnoses and treatment of disabilities rather than conduct cannot be deemed justified." Nevertheless, to our knowledge, the DOJ has yet to open an investigation into a state medical board for violating Title II.

I urge the DOJ to investigate state medical boards' compliance with the ADA. The DOJ should also issue guidance on 28 C.F.R. § 35.130 to clearly state that state medical boards cannot ask inappropriate medical licensing and application questions, especially questions related to mental health history. In the interim, I ask that you provide me with complete answers to the following questions by March 16th, 2023:

- Does the DOJ have additional information, beyond the scholarship mentioned above, about the extent and different ways state medical boards may be violating Title II of the ADA? If so, please explain what it has learned.
- Has the DOJ's Civil Rights Division been engaged on this issue during the last several years? If so, please explain what work they are doing.
- Does the DOJ stand behind its 1993 *amicus curiae* brief in Medical Society of New Jersey v. Jacobs? If so, can it commit to publishing a version of it in the form of subregulatory guidance?
- How will the DOJ ensure that all state medical boards comply with the law and affected applicants or physicians have recourse?
- Has the DOJ examined similar issues when it comes to residency programs and hospital privileges?

I also ask that you brief my personal office staff members Jenni Katzman and Kevin Wu on these questions.

Thank you for your attention to this important matter.

Sincerely,

Ron Wyden
United States Senator

Jeffrey A. Merkley
United States Senator

Cory A. Booker
United States Senator

National Network
Information, Guidance and Training on the Americans with Disabilities Act

Call us toll-free
1-800-949-4232 V/TTY
Find your regional center at
www.adata.org

For the most current and accessible version, please visit
https://adainfo.us/addiction

The ADA, Addiction and Recovery

The Americans with Disabilities Act (ADA) ensures that people with disabilities have the same rights and opportunities as everyone else. This includes people with addiction to alcohol and people in recovery from opioid and substance use disorders. This is a very complex subject due to developing court cases.

Structure of the ADA

Below are the first three titles of the ADA. This is the structure under which people's rights are protected and responsibilities are defined.

Employment (Title I): This title focuses on reasonable accommodations, which can include a change in the way work is performed.

State and local governments (Title II): This title focuses on access to services, programs, and activities in public education, corrections and the courts etc.

Places of public accommodation (Title III): This title focuses on access to goods and services in such places as sober homes, health care facilities and other private businesses that serve the public.

The ADA applies to addiction to alcohol and to the illegal use of drugs differently. This fact sheet explains these differences through scenarios.

Definition of Disability

A person has a disability under the ADA if the person:

1. Has a physical or mental impairment that substantially limits one or more **major life activities**, e.g. someone with bi-polar disorder, diabetes or addiction to alcohol; or
2. has a **history** of an impairment that substantially limited one or more major life activities, e.g. someone who has a history of cancer; or someone in recovery from illegal use of drugs; or
3. Is **regarded** as having such an impairment, e.g. someone who has a family member who has HIV, so is assumed to have HIV as well and face discrimination as a result, or someone who is perceived to have a disability and is treated negatively based on the assumption of disability.

Major life activities include, but are not limited to: walking, seeing, caring for oneself, learning, working, thinking, communicating and also the operation of bodily functions, such as neurological and brain functions.

Addiction to Alcohol

Regardless of whether the addiction to alcohol is current or in the past, it is generally considered a disability because it is an impairment that affects brain and neurological functions.

Scenario: Michael is often late for work. His supervisor warns him about his tardiness. The third time Michael is late, his supervisor gives him a written warning, stating that one more late arrival will result in termination. Michael tells his supervisor that he is addicted to alcohol. He says his late arrivals are due to his drinking and that he needs immediate time off for treatment.

Is Michael protected under Title I of the ADA? Yes, he is a person with a disability (addiction to alcohol), but it is complicated. The employer does not have to withdraw the written warning nor grant an accommodation that supports Michael's drinking, like allowing him to arrive late in the morning. The employer can require an employee with addiction to alcohol to meet the same standards of performance and behavior as other employees. The employer must grant Michael's request to take leave to enter a rehab program, unless the employer can prove that Michael's absence would cause a great difficulty or expense (undue hardship).

Scenario: Isabella's manager hears a rumor that she is addicted to alcohol, and reassigns her to a less stressful job with lower pay because of concerns that work stress contributes to her drinking, despite the fact that she has not had any work-related problems.

Is Isabella protected under the ADA? Yes, she is being **regarded** as having a disability, and has been negatively affected. Isabella's manager violated the ADA when he reassigned Isabella to a lower paying job.

Illegal Use of Drugs

The ADA protects a person in recovery who is no longer currently engaging in the illegal use of drugs, and who can show that they meet one of the three definitions of disability (see above definition of disability).

Illegal use of drugs means:

- Use of illegal drugs such as heroin or cocaine.
- Use of prescription medications such as OxyContin or Morphine

  BUT the person has no prescription;
  OR is using more than is prescribed;
  OR has a fraudulent prescription.

In recovery means:

1. Is in recovery from a substance use disorder;
2. Has ceased engaging in the illegal use of drugs;
3. Is either participating in a supervised rehabilitation program; or
4. Has been successfully rehabilitated.

What does "current" mean?

1. "Illegal use occurred recently enough to justify a reasonable belief that a person's drug use is a real and ongoing problem."
2. Under the ADA, whether someone is currently using drugs illegally is decided on a case-by-case basis.

Scenario: Marianna has been **cocaine-free** for eight years. She applies for a job that she is qualified to do. The employer refuses to hire her because he knows about her past addiction.

Is Marianna protected under Title I of the ADA? Yes, she is protected under the ADA because she has a *history* of an impairment (addiction to cocaine), and has refrained from the use of illegal drugs for eight years which is a good indication that there is not an ongoing problem. The potential employer violated the ADA when he refused to hire Marianna because of her recovery status.

Medication To Treat Substance Use Disorders

When medication is used to treat substance use disorders, a person is legally prescribed medication such as Suboxone, Methadone, or Vivitrol etc. to treat their addiction.

Scenario: Tom is receiving medication to treat his substance use disorder. He appeared in family court and requested that he begin to see his children on the weekend. The judge responded to his request saying, "You'll see your children when you get off Suboxone".

Is Tom protected under Title II of the ADA? Yes, he has a **history** of addiction. Those who receive medication to treat opioid use disorders usually have a history of addiction to controlled substances. Family court is regarding the use of Suboxone as though it is an illegal drug. Suboxone is a legally prescribed medication to help Tom function just like insulin is prescribed for the health and function of a person with diabetes. Tom's use of Suboxone cannot, by itself, justify a refusal to let Tom see his children on the weekend.

What if the court found out that he recently used cocaine while receiving medication to treat opioid use disorder? Would he have protections under the ADA? No, Title II does not protect individuals who are "currently engaging in the illegal use of drugs."

Scenario: Alex had a double hip replacement and needs to go into a private rehabilitation facility for physical therapy for a month. When the rehabilitation facility finds out he is being prescribed methadone, they refuse to accept him as a patient.

Is Alex protected under Title III of the ADA? Yes, methadone is a legally prescribed drug used to treat addiction. The rehab facility violated Title III of the ADA when it denied Alex admission based upon his medical assisted treatment.

Addiction and Legal Use of Drugs

Scenario: Jennifer became addicted to Percocet while taking the medication in a prescribed manner and in prescribed amounts.

Is Jennifer protected under the ADA? Yes, she is protected under the ADA because she is legally using a drug as prescribed for an underlying condition. However, if she takes more than prescribed, she may not be covered under the ADA.

Need more information?

If you have questions about your rights or obligations under the ADA, contact your local ADA Center. Each center has ADA specialists who provide information and guidance to anyone requesting ADA information. You can call toll-free at 1-800-949-4232. You can also email your local center by clicking the following link and completing the form: adata.org/email. All calls and emails are treated anonymously and confidentially.

New England ADA Center

Institute for Human Centered Design

1-800-949-4232

ADAinfo@NewEnglandADA.org

www.NewEnglandADA.org

Content was developed by the New England ADA Center, and is based on professional consensus of ADA experts and the ADA National Network.

The contents of this factsheet were developed under grants from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant numbers 90DP0087 and 90DP0086). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this factsheet do not necessarily represent the policy of NIDILRR, ACL, HHS, and you should not assume endorsement by the Federal Government.

The Joint Commission

Joint Commission Reiterates Importance of Removing Barriers to Mental Health Care for Staff

March 31, 2021

We have passed the one-year mark of the COVID-19 public health emergency, and health care staff continue to deal with the serious toll this pandemic has taken on their mental health.

The Joint Commission believes it is critical to remind health care organizations to take steps to remove barriers preventing clinicians from seeking mental health care services. It was well-documented prior to the pandemic that clinicians fear seeking mental health treatment because of concerns related to professional repercussions, specifically because questions about their mental health history may be asked during the credentialing and licensing process. Recent polls taken during the pandemic reiterate that the concerns still exist.

The Joint Commission reaffirms its May 2020 statement that we do not require organizations to ask about a clinician's history of mental health conditions or treatment. The Joint Commission strongly encourages organizations to not ask about past history of mental health conditions or treatment and supports recommendations to limit questions to conditions that *currently* impair the clinician's ability to perform his or her job. Organizations should review questions and ensure these questions do not hinder clinicians from seeking mental health services. This is one small step we can take to support health care workers.

Over the last year, The Joint Commission has issued a Quick Safety on promoting psychosocial well-being of health care staff and a Sentinel Event Alert, along with many other publications addressing health care staff well-being. It is vital that health care workers feel supported in accessing needed mental health resources.

ADANews

My View: How are you doing, really?

by **Robert G. McNeill, D.D.S., M.D.**

November 21, 2024

One question. One question was all it took to eliminate a stigma.

Up until 2023, Texas dentists looking to renew their licenses had to check yes or no on a series of “have you ever” questions dealing with treatment for depression and substance abuse disorder. Check the “yes” box, and the stigma was there.


Dr. McNeill

As chair of licensing for the Texas State Board of Dental Examiners, I can proudly report that this is no longer the case. Applications now include the following question, which is consistent with recommended language from the Federation of State Medical Boards that addresses current impairment: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical and professional manner?”

Shortly after our change, one of my friends told me that he was finally able to get help for alcohol use disorder and suicidal ideations because he would no longer need to check the yes box on the renewal form.

The Texas State Board of Dental Examiners was the first state board of dentistry to be recognized by the Dr. Lorna Breen Heroes' Foundation as a Wellbeing First Champion. The foundation, which was started by the family of an emergency room doctor who died by suicide in 2020 during the COVID-19 pandemic, champions licensure and credentialing reform for physicians and other health care providers.

As a Texan and as a dentist, I’m proud of the change we implemented. But nationwide, we need to do better.

According to the ADA Well-Being Index, 56% of dentists report feeling distressed or struggling. This year, we have a unique opportunity with ADA President Brett Kessler,

D.D.S., who has been in recovery for substance use disorder for 26 years. Let's make change happen, together.

I encourage my fellow state board members nationwide to evaluate their approach to mental health. Collaboration between organized dentistry, regulators, educators and clinicians is essential to addressing this issue. I am thankful that an ADA House of Delegates resolution put forth efforts to help promote change.

Dr. Kessler recently spoke to the American Association of Dental Boards, urging board members to be part of the solution. He highlighted how vague, stigmatizing "have you ever" mental health questions prevent providers from seeking care. "I was afforded the opportunity to get help with dignity," he said. We must ensure others have the same opportunity. Data shows that removing these questions, as we've done in Texas, supports providers without compromising safety. This is an opportunity for regulators to be proactive and work with stakeholders toward a positive change.

The stress on dentists has only increased since the pandemic, with new challenges in patient care, financial stability, and navigating new safety protocols. It is essential that we prioritize self-care — whether it's by taking vacations, focusing on our health, or simply taking time for ourselves. Without this balance, the risk to our mental and physical well-being rises.

Past ADA President George Shepley, D.D.S., stated on my podcast *Between Two Teeth*, "We need to put the oxygen on ourselves so we can care for our patients." As a regulator, I witness the consequences when self-care is neglected. Now is the time to prioritize both public and licensee safety by being proactive, not reactive.

We've been aware of provider stress and mental health challenges for decades — it's time to act. Dental associations must move beyond lip service, and regulators need to re-evaluate how we approach mental health. Data from the Well Being Index shows that well-being issues often correlate with an increase in dental errors, underscoring the need to protect both the public and our providers. Four states, including Texas, have achieved reform, and efforts are underway in four other states. A resource toolkit is available for interested state dental associations, state boards, credentialing organizations and individual dental providers to remove stigmatizing questions from licensing and credentialing applications.

To my colleagues, I encourage you to take the Well-Being Index and check in on your peers. When was the last time you asked a colleague how they're truly doing? Rebuilding trust, communicating openly, and working together is the path to solving this complex problem. Many lives depend on it.

Dr. McNeill is an oral and maxillofacial surgeon in private practice in Garland, Texas. He is the chair of licensing for the Texas State Board of Dental Examiners and a member of the ADA Dental Team Wellness Advisory Committee.

Most Read

View More >

Judge orders EPA to address impacts of fluoride in drinking water

New ADA policies empower states to alleviate dental workforce shortage

Corporate Transparency Act filing deadline approaches

What to know about section 179 deduction when filing your taxes

Dentech Expo winners announced

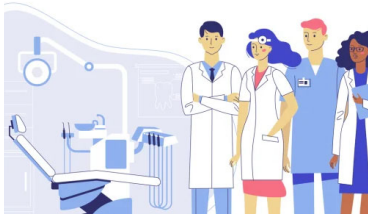
Tags

Wellness

Recommended Content

AROUND THE ADA

Professor, retired colonel recipient of ADA Distinguished Service Award

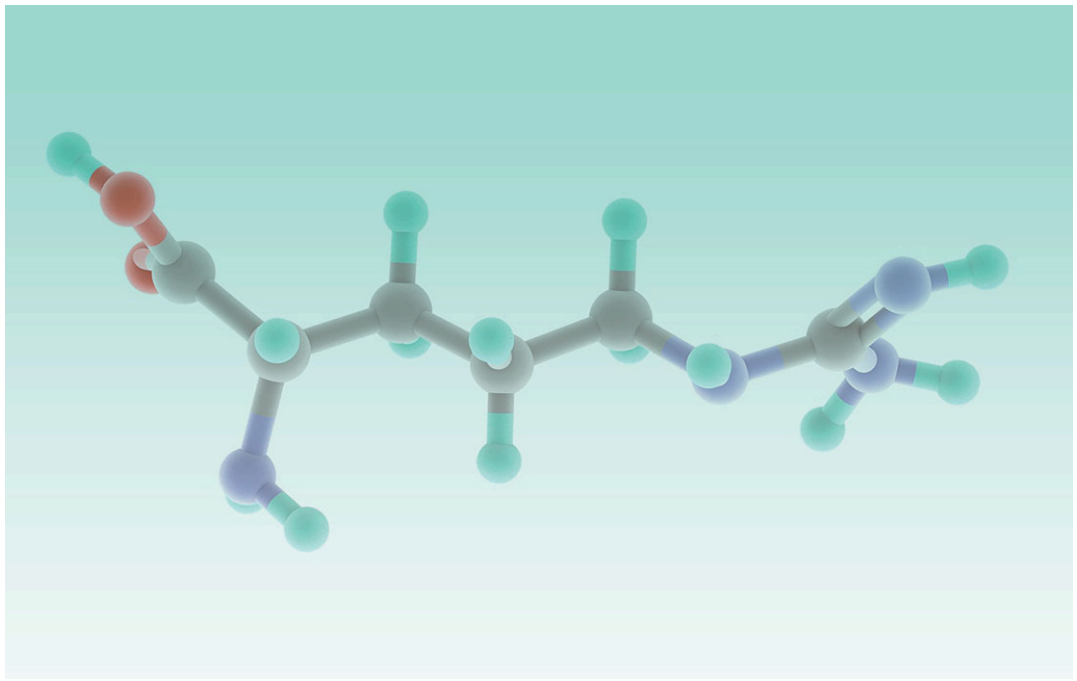


PRACTICE

Should we fear corporate dentistry? Why I changed my mind

Educating patients is always in season

Reinforce your messages with help from ADA.



Sponsored

Arginine and the Healthy Oral Microbiome

Learn More

Overview

The American Dental Association has a long-standing commitment to supporting the health and well-being of dental professionals.

The Council on Dental Practice (CDP) supports advocacy and policy efforts that improve mental and physical health and wellness for dental professionals. In 2022, CDP determined the need to elevate the conversation around these efforts through convening a strategic meeting (Summit) that fostered dialogue between stakeholders in dentistry and established a coalition of partners. CDP's Dental Team Wellness Advisory Committee (DWAC) planned the first ADA Health and Well-Being Summit with the following goals in mind:

- Provide a national platform for state and local dental professionals and their respective organizations to convene, connect and share;
- Highlight existing ADA and external resources that support provider health and wellness;
- Collaborate with the physician model which continues to raise awareness that stigmatizing language on initial and renewal licensing applications, and credentialing applications may negatively impact whether a provider asks for help for a mental, physical or behavioral health challenge;

Summit attendees included representatives from the inaugural group of ADA Wellness Ambassadors, as well as a second group that were onboarded into the program in 2023. The Council created the ADA Wellness Ambassador Program in 2022 to assist the ADA in:

1. Expanding the awareness of physical and mental health wellness and well-being challenges faced in the dental profession.
2. Prioritizing the need to provide resources at state and local levels to those who may wish to seek help.
3. Connecting those who need support to available resources.

The first group of ambassadors completed over 40 projects during their onboarding year (2022-2023). An introductory video about the ADA Wellness Ambassador Program can be viewed at https://www.youtube.com/watch?v=hSQ5daYK0wo.

Summit attendees represented 34 states and 17 ADA Trustee Districts, and included CDP and DWAC volunteers, state and local dental societies and organizations, physician health programs, dental specialty societies such as the American Association of Oral and Maxillofacial Surgeons (AAOMS), the American Student Dental Association (ASDA) and the American Dental Education Association (ADEA).

This summary provides information shared by the panelists. The agenda with its respective information on the panelists can be found in Appendix 1 and the handout shared with ADA wellness related resources in Appendix 2.

First Panel Presentation Highlights

PROMOTING A HEALTHY WORKFORCE

Dr. Kessler:

The ADA is at the table to support a national plan for health workforce well-being, alongside other organizations all under the prioritized engagement of U.S. Surgeon General Dr. Vivek Murthy. The work of the National Academy of Medicine (NAM) Action Collaborative can be found on their website at https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/, including the publication of the recent (October 2022) National Plan for Health Workforce Well-Being. The ADA aligned its provider health and wellness efforts, such as the Summit, use of the Mayo Clinic's Well-being Index, the Wellness Ambassador Program, collaboration with Federation of State Physician Health Programs (FSPHP), and the ADA Dentist Well-Being Program Directory to the seven key priority areas NAM outlined in the National Plan, which are:

- Create and sustain positive work and learning environments and culture
- Invest in measurement, assessment, strategies and research
- Support mental health and reduce stigma
- Address compliance, regulatory and policy barriers for daily work
- Engage effective technology tools
- Institutionalize well-being as a long-term value and
- Recruit and retain a diverse and inclusive health workforce

Dr. Kessler believes that stigma is the biggest barrier to a provider seeking help for a mental, physical or behavioral health condition. He was featured in a recent NAM video: Health Leader Operationalizes NAM National Plan for Health Worker Well-Being.

STAKEHOLDERS WORKING TOGETHER

Dr. McNeill:

As an example of a case that can be seen at the state board level, a story was shared involving a struggling dentist: the dentist was a male in his late 40's and suffered from relationship and financial pressures of running a practice. He had a history of alcohol use in the past. He became more anxious, depressed, and isolated. A complaint was filed with the state dental board as he was observed taking medication from the office. Subsequently, he ended up taking his life.

A practitioner safety issue is a direct patient safety issue, and all stakeholders can work together to help with challenges of mental health issues. State Dental Board Examiners can learn from the Federation of State Medical Boards (FSMB), American Medical Association (AMA), ADA, and the Dr. Lorna Breen Heroes' Foundation (Dr. Lorna Breen Heroes' Foundation).

Each stakeholder has a unique role in the solving the problem. Traditional approaches like webinars help with knowledge transfer, but effectiveness might be increased with unique partnerships such as working with influencers and wellness ambassadors.

What are the barriers: Individually and collectively not seeing it as a problem, insurability issues, state board stigmatization, working together, messaging.

OPTIONS TO HELP DENTAL PROFESSIONALS EXPERIENCING A SUBSTANCE USE, MENTAL HEALTH OR BEHAVIORAL HEALTH CONDITION

Dr. Budd:

Guiding principles of healthcare professional assistance programs, such as dentist health programs (DHP), physician health programs (PHP), and other professional assistance programs (PAP):

- Dual Mission: public protection and professional assistance
- Health care professionals with substance use or mental health issues deserve help with dignity (as with any other condition)
- Early intervention; otherwise, illness progresses to impairment
- Confidentiality provides incentive to get help and prevents possible legal and HIPAA issues

What support looks like:

- Connect: let them know they aren't unique, they aren't alone, and help is available. Provide compassion and understanding
- Case management: help navigate recovery from entry to maintenance through referrals to peer support and vetted assessment and treatment experts in health care professional recovery
- Accountability: monitoring with documentation
- Advocacy with boards, insurers, other regulatory agencies when appropriate
- Practice coverage
- Financial aid

What prevents a dental professional from signing up for these programs:

- Not aware of a problem
- Not aware of a solution (2021 ADA Dentist Well-Being Survey Report) (figure below)
- Health care professional's personality: "*I've got this*."
- Shame
- Fear loss of reputation and/or license
- Distrust of program's competency and/or confidentiality
- The health care professional chooses an alternative pathway to recovery

Stigma

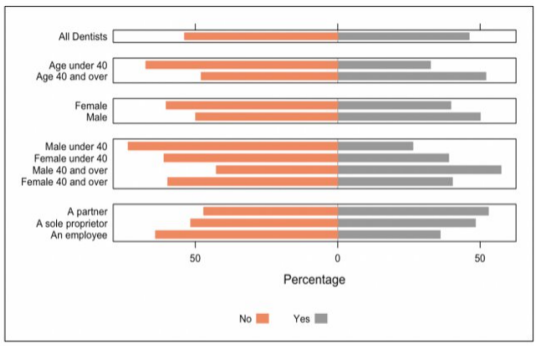
Types of Stigma

	Public	Self	Institutional
Stereotypes & Prejudices	People with mental illness are dangerous, incompetent, to blame for their disorder, unpredictable	I am dangerous, incompetent, to blame	Stereotypes are embodied in laws and other institutions

Source: https://www.psychiatry.org/patients-families/stigma-and-discrimination

Unawares

>54% NO



<46% YES

Source: 2021 ADA Dentist Well-being Survey Report

Opportunities to raising awareness, reducing stigma, decreasing barriers:

- Put forward the best programs possible
  - Adopt well-being best practices in collaboration with FSPHP
  - Make funding and resources available for staff training
- Preventive education
  - Expand Wellness Ambassadors Program
  - Continue to integrate well-being in dental school curricula
  - Require well-being continuing education for initial and renewal licensure
- Collaborate with regulatory agencies
  - Eliminate license application questions that may violate HIPAA
    Promote alternative-to-discipline through use of Memorandum of Understanding (MOUs) that assure boards of assistance program accountability and transparency

- The National Council of Dentist Health Programs is an organization that helps to raise awareness, share resources and reduce stigma and barriers.

Second Panel Presentation Highlights

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS (FSPHP) AND OPPORTUNITY FOR DENTAL PROFESSIONALS, A CLOSER LOOK AT WASHINGTON STATE

Dr. Bundy:

MISSION: To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

VISION: A society of highly effective PHPs advancing the health of the medical community and the patients they serve.

GUIDING VALUES OF FSPHP: Mission, Vision And Values (fsphp.org)

- **Empowering Membership**
- **Advocacy**
- **Collaboration**
- **Equity**
- **Education and Research**
- **Leadership**

- Direct Service: 28 state PHPs provide direct assistance to dentists (listed in graphic below); are there more states that would like dentists included in the state PHP/PAP?
- Collaboration
- State Dental Associations with their state PHP/PAP
- Non-PHP dental assistance programs with state PHP/PAP
- Policies and procedures, best practices; FSPHP 2019 Guidelines
- PHP/PAP educational outreach on topics such as addiction, mental illness, burnout, etc., among health professionals (state and local dental associations, journal clubs, dental schools)
- Dental assistance program staff membership in Federation of State Programs: Annual Meetings, Regional Meetings, e-list, and more
- Advocacy/policymaking: A unified voice in support of confidentiality protections, licensing/credentialing question reform and more

Washington Highlights

- Successfully reformed licensure questions for physicians and physician assistants, strengthened confidentiality protections for PHP participants, updated destigmatizing outdated statutory language, and extended immunity protections in working with students and trainees.

- Teleservice and virtual office support all PHP operations. A home-based toxicology collection system resulted in improved participant satisfaction and decreased monitoring burden.

- A focus on financial impact by addressing participant financial aid program, deferred payment plans, and legislation related to surcharge increases. Future advocacy to focus on funding

strategies to reduce or eliminate all fees associated with PHP services, eliminate out-of-pocket expense for specialized evaluation and treatment for PHP-involved health professionals, and mitigate the adverse impact of time out of practice.

Model Physician Health Program

- Voluntary
- Confidential
- Therapeutic
- Accountable
- Trusted
- Peer-based
- Expert
- Objective
- Comprehensive (not just SUD)*

*May be aspirational for some programs…

Physician Health Programs Serving Dentists

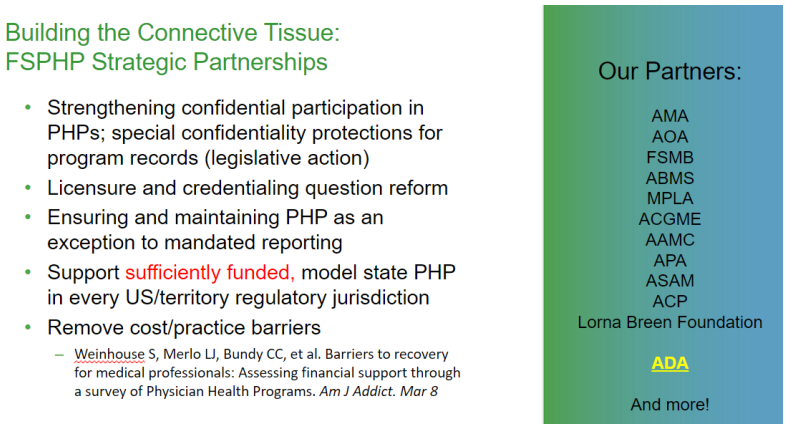
1. Arizona (2)
2. Arkansas
3. Connecticut
4. California
5. Delaware
6. Florida
7. Hawaii
8. Idaho
9. Illinois
10. Louisiana
11. Michigan
12. Minnesota
13. Missouri
14. Montana
15. Nevada
16. New Hampshire
17. New Jersey
18. New Mexico
19. Ohio
20. Oklahoma
21. Oregon
22. Pennsylvania
23. Rhode Island
24. South Carolina
25. Utah
26. Virginia
27. Washington
28. Wyoming

Federation of State Physician Health Programs

- 316 Members
- 50 State Physician (Professional) Health Program Voting Members
  - In development:
  - - Nebraska, Wisconsin
  - Non-Member PHP: Maine
- 168 Associate PHP Members
- 17 Canadian Members
- 81 Members of various member types

FSPHP Mission

To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.



ALIGNMENT OF EFFORTS WITH THE NAM NATIONAL PLAN FOR HEALTH WORKFORCE WELL-BEING AND LESSONS LEARNED

Dr. Hengerer:

1. Encourage leadership to foster a culture of well-being that is integrated into program operations, HR management, services and curricula.

- Instill approaches to decrease stress and burnout in the above listed areas.
- Build programs for coping and resilience skills.
- Set reasonable productivity expectations and provide resources to support those expectations.
- Transparency and honest communication are essential.
- Establish wellness as a priority and lead culture change.

2. Measure the stress levels in the environment.

- Carry out surveys and repeat as institute culture change.
- Listen to the stakeholders and communicate intentions.
- Support mental health services and reduce stigma.
- Confidential mental health services with insured coverage.
- Dental professionals need to recognize their own stress, burnout and mental health issues and feel safe to seek care without stigma or risk to their livelihood. This requires assessing and altering barriers by regulators and leadership organizations.

3. Recruit and retain diverse and inclusive workforce.
- Develop pathways and pipeline programs and partnerships.
- Provide debt relief opportunities.
- Create job sharing and flexibility and childcare options.
- Create incentives and continuing education opportunities for advancement and improved patient care.

AMERICAN MEDICAL ASSOCIATION'S KEY LESSONS LEARNED TO REDUCE STIGMA AND PHYSICIANS' BARRIERS TO RECEIVING CARE

Mr. Blaney-Koen:

- Words do matter; having a hard target such as auditing the language on licensure (initial and renewal) applications, credentialing forms and peer review reference forms is important.

  - Collaboration between organized medicine and medical boards is vital.
  - Information collection is a first step for organized dentistry to know what questions dentists are asked on their initial and renewal licensure applications, credentialing forms, and peer review reference forms.
  - Physicians should be able to confide in each other if they need mental, physical or behavioral health help.

- Through their work with the FSMB and the Dr. Lorna Breen Heroes' Foundation, the AMA has helped normalize conversations around provider health and well-being, focusing only on current impairment versus a past diagnosis or treatment. The AMA has been relentless in their advocacy and communications so that clear messages are delivered frequently and consistently and that any myths about what is required on a licensing or credentialing application is addressed. Asking a provider if they have ever had a mental health issue or substance use disorder is inappropriate.

THE JOINT COMMISSION'S RELATIONSHIP WITH DENTAL PROFESSIONALS

Ms. Spates:

- The Joint Commission was jointly founded in 1951 by the American College of Surgeons, American College of Physicians, American Medical Association, American Dental Association, and the American Hospital Association.

- In 2020 and 2021, The Joint Commission released statements debunking myths related to credentialing requirements and asking health care professionals about any past history of mental illness or substance use disorder. The 2021 statement can be found at 03312021-removing-barriers-to-mental-health-treatment-statement.pdf (jointcommission.org).

- The Joint Commission also has important programs that support clinician well-being. Resources related to clinician well-being can be found at https://www.jointcommission.org/resources/patient-safety-topics/healthcare-workforce-safety-and-well-being/. Resources on workplace violence prevention can be found at https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/.

THE HISTORY AND PROGRESS OF THE FEDERATION OF STATE MEDICAL BOARDS' (FSMB) WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT, A TIERED APPROACH TO LICENSURE QUESTIONS, AND THE IMPORTANCE OF EFFECTIVE COMMUNICATIONS

Mr. Staz:

- FSMB has been inclusive from the beginning of their work that led to a policy adopted in 2018. They developed a new model of committee deliberation to achieve the goal of inclusivity by inviting different stakeholders, experts and partner organizations that have a nexus to the issue of physician well-being or burnout and asked them two questions: 1) what are you doing in this space that we could learn from? and 2) what would you recommend that FSMB do?

- FSMB's journey since 2018 has been a long one and progress has been slow at times. They consistently provide information to state medical boards about the value of physician well-being and how it relates to their missions to protect the public. They created educational sessions online and at their Annual Meetings and have sent reminders of their policy recommendations to state medical boards. Many state medical boards approached FSMB requesting information, presentations at board meetings about how to achieve meaningful licensing application reform.

- When FSMB had Mr. Corey Feist, the Dr. Lorna Breen Heroes' Foundation's Board President and Co-Founder as a speaker at their 2022 Annual Meeting, the pace of change began to accelerate rapidly because of the Corey's perspective and the Foundation named in memory of his sister in-law.

- FSMB learned that a one-size-fits-all solution would not be possible for all 70 of their member state medical boards. Boards have varying degrees of autonomy and different legislative structures and may also have members who are reluctant to adopt one approach at the expense of another that they feel holds promise.

- FSMB suggests a tiered approach which includes three different approaches, each with its own benefits in terms of removal of barriers to treatment seeking:

    - The first tier is to use the FSMB's model language: *"Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"*

    - The second tier would be to remove the questions altogether.

    - The third tier would be to use an "attestation" model, such as the one implemented by the North Carolina Medical Board (see below).

Attestation - North Carolina Medical Board

"Important: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other 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 medical practice, and anonymously self-referring to the NC Physicians Health Program (www.ncphp.org), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. ***The failure to adequately address a health condition, where the licensee is unable to practice medicine within reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine."***

- FSMB shares language from licensing applications that they find holds promise for encouraging treatment and reducing stigma. FSMB feels the attestation model is a great example of this in that it does not require licensees to divulge any information about health conditions or previous treatment, but still raises the issue of safeguarding one's health as a professional expectation, thereby initiating (or continuing) the conversation and reducing stigma.

Third Panel Presentation Highlights

STATE DENTAL ORGANIZATION SUCCESS STORIES: MINNESOTA, NORTH CAROLINA AND SOUTH DAKOTA

Ms. Anderson:

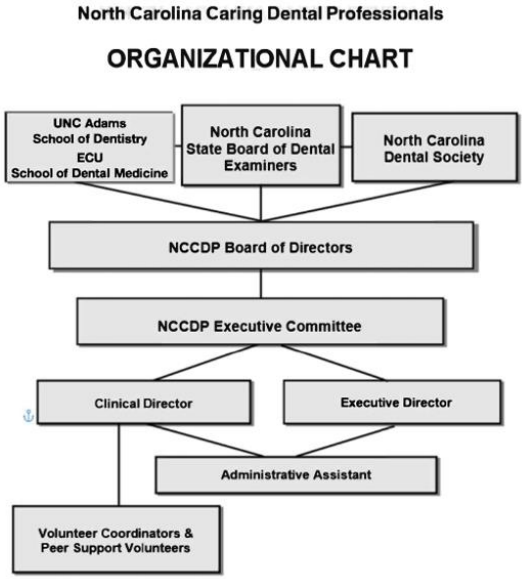
- The Minnesota Board of Dentistry has changed disclosure language related to substance use and mental health on dentist licensure applications and renewals. The questions reflect mandatory reporting requirements in statute. Diversion reporting and referral can come through the Board of Dentistry and are also accepted as confidential self-referrals, but not accepted as anonymous ones.

- The Board of Dentistry works collaboratively with other Minnesota dental and health care organizations including the state dental association and the Minnesota Health Professional Services Program (which provides confidential services to dentists) to address stigma, identify illness earlier, promote health and wellness, offer a non-punitive form of accountability that is confidential, and protects the health and safety of the public.

- Between July 2018 and June 2023, HPSP program participants from the Minnesota Board of Dentistry had a 65% success rate compared to 54% for other health care professionals during that same time frame.

Dr. Claytor:

This organization chart summarizes the North Carolina Caring Dental Professionals (NCCDP):



- Funding is supported by state statute which authorizes licensure fee collection. The State Auditor can conduct a performance audit to ensure that “due process rights are protected” under the law and are followed by the NCCDP. The anonymity of those who self-refer is protected, and those who are referred by the state board preserve their relationship with the board.

- The tripartite format maintains an important separation of powers, with biannual NCCDP Board of Directors Meetings. NCCDP Executive Committee manages daily operations.

- Ability to provide no-interest loans to NCCDP participants stems from state and dental community fundraising, such as the notable Jake Thorpe Fund and the NC Community Foundation.

- The most crucial relationships are with volunteers, in particular the peer support volunteers (PSVs). Both the quarterly regional meeting and the Annual Fall NCCDP Jake Thorpe Conference bring a sense of community as participants (including vendors, PSVs, spouses) build

relationships and maintain contact. NCCDP starts educating future colleagues and team members by connecting at dental schools and dental hygiene schools. Education is offered from area health education centers and study clubs to the annual NC Dental Society meetings.

Ms. Wolf:

- After the suicide of a South Dakota dentist, the South Dakota Dental Association (SDDA) realized the need for mental health support for dentists and invested in the Be Well Program. This led to a three-way partnership to sponsor the program, organized through SDDA and sponsored by the SDDA, The South Dakota Board of Dentistry, and the South Dakota Dental Foundation.

Components of the SDDA Be Well Program:

- 3 Free Counseling/Coaching Sessions
- ALL Dentists and their Team Members
- Utilized for personal or professional issues
- On-site Well-being Workshops, Webinars
    - Survey data to create topics/programs
- Be Well Program Committee
- Awareness Campaign: Newsletters, Facebook
- Be Well Track at Annual Conference

Wellness Ambassador Presentations

The following ADA Wellness Ambassadors presented the projects they accomplished during their onboarding year (2022-2023):

Dr. Karen Foster (CO) served as a panelist on an ADHA/ADA webinar in 2022 titled “Mental Health in Dental Professionals: The Pandemic & Beyond”. She introduced the ADA and her fellow ambassadors to the American Foundation for Suicide Prevention (AFSP) and their “Talk Saves Lives” presentation, and led the ADA and AFSP in a collaborative effort to develop a new resource titled *After a Suicide Postvention Toolkit,* which is available to all dental professionals at https://www.ada.org/resources/practice/wellness/mental-health. Additionally, Doctor Foster published an article in the *Journal of the American Dental Association* titled “The Ethics of the unexpected loss of a practitioner”, available at https://jada.ada.org/article/S0002-8177(23)00106-X/fulltext.

Dr. Julie Spaniel (OR) developed and successfully appealed for funding for the Oregon Wellness Program, including the origination of peer-to-peer Wellness Ambassadors. She assisted neighboring states by modeling the Oregon program for them. She has worked to remove intrusive mental health and substance use related questions from licensure and credentialing applications in her state and is dedicated to creating awareness by normalizing the conversation around mental health.

Dr. Joel Collins (GA) spoke about the importance of small groups and discussed his projects helping dental students become more aware of their health and wellness.

Dr. David Lesansky (NC) shared a video with Summit attendees highlighting why he agreed to serve as an ADA Wellness Ambassador and how important it is for dental professionals to support and help each other with honest conversations about health and well-being, including mental health.

Anne Morrison (NE), president of the Alliance of the ADA, focused on mental health and wellness related education for Alliance members, and on connecting and sharing resources with dentist members from the states in ADA Trustee District 10 and their state Executive Directors.

Dr. Cathy Hung (NJ) encouraged the second group of ambassadors to focus on their “why” when determining their projects and to identify efforts that align with their strengths. Her projects allowed her to

interview dental leaders and publish those articles in ADA channels, including the New Dentist Now blog, as well as in the New Jersey Dental Association (NJDA) e-newsletter, the AAOMS Today publication with a two-part article on burnout and stress, the ADA Sound Bites podcast, and her local component society (Mercer Dental Society) newsletter. NJDA's wellness resources are available at https://www.njda.org/member-resources/wellness-resources.

Dr. William Hammel's III (IL) whose work centered on delivering presentations to the three dental schools in Illinois about substance use disorder awareness and prevention. He shared his story of recovery and also wrote articles that were published in the Illinois State Dental Society magazine. Additionally, Dr. Hammel is the co-chair of the ISDS Dentists Support Program and a leader on the National Council of Dentist Health Programs.

Doctor Amisha Singh (CO) used a video to highlight her projects which centered on her "why" to serve as an ambassador to support dental students as a full-time faculty member. Her projects included a presentation to the Virginia Dental Association on Health and Wellness on the fourth leg of the Quadruple Aim, as well as two articles in the Metro Denver Dental Society magazine, one of which has also been published in other channels. Doctor Singh incorporated wellness into the 2023 orientation University of Colorado Anschutz School of Dental Medicine for D1s. Doctor Singh and colleagues just published a manuscript in the *Journal of Dental Education* titled "Are we well? A post-pandemic snapshot of dental educator wellness, well-being, and fulfillment" which can be found at https://onlinelibrary.wiley.com/doi/10.1002/jdd.13346.

Summit attendees were also able to watch two mental health videos developed by the Michigan Dental Association in 2023 for Mental Health Awareness Month (May), which can be found at:

https://youtu.be/81GxTXZ3jRc?si=EnytJ9TTVLgaOfPF and
https://youtu.be/_EtHDor0YWA?si=GYxZ1wJ3tg51gra9.

Participant Table Discussion Results

Of the 108 Summit attendees, 97 provided the following responses to a survey developed by DWAC.

100% of attendees believe that there are dentists who are currently struggling with physical and/or mental health challenges who are not getting help.

79% of attendees believe that the majority of these dentists **do not** know how or where to seek help, or that they are hesitant or afraid to ask for help.

100% believe that dentists should be looking to their associations for assistance in finding help.

97% believe that all levels of the tripartite (ADA, State, Local) have a role to play in helping dentists address physical and mental health challenges and in maintaining wellness.

49% feel that State and Local association leaders and staff are receptive to developing new wellness programs or enhancing existing programs to address the concerns of dentists at various ages and stages of their career.

90% know of someone who has struggled or is currently struggling with a physical and/or mental health challenge.

63% know of a dental professional who has died by suicide.

Appendix 1 – ADA Health and Well-Being Summit Agenda

AGENDA

8 a.m.	**Breakfast**	
8:30 – 8:45 a.m.	**Welcome and Introductory Remarks and Recognition**	*Dr. Linda Edgar, president-elect, ADA* *Dr. Manny Chopra, chair, Council on Dental Practice (CDP)*
8:45 – 8:50 a.m.	**Wellness Ambassador Video**	*Wellness Ambassadors Group 1*
8:50 – 8:55 a.m.	**Overview of Summit Attendees**	*Dr. Kami Dornfeld, chair, Dental Team Wellness Advisory Committee (DWAC)*
9 – 9:55 a.m.	**First Panel Presentation**	*Dr. Brett Kessler, Trustee 14th District, ADA Representative on the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience* *Dr. Robert McNeill, Wellness Key Opinion Leader* *Dr. Alan Budd, Director, Dentists Concerned for Dentists of MA and National Council of Dentist Health Programs*
10 – 11 a.m.	**Second Panel Presentation – Highlights from the Physician Model**	*Dr. Chris Bundy, Executive Medical Director of the Washington Physicians Health Program (WPHP) and Past President of the Federation of State Physician Health Programs (FSPHP)* *Dr. Art Hengerer, Former Chair of the Board, Federation of State Medical Boards (FSMB), FSMB Representative on the NAM Action Collaborative on Clinician Well-Being and Resilience, Board Member, FSPHP* *Daniel Blaney-Koen, JD, Senior Attorney, American Medical Association* *Kathryn E. Spates, JD, ACNP-BC, Executive Vice President, Public Policy and Government Relations, The Joint Commission* *Mark Staz, MA, Vice President, Education, Federation of State Medical Boards*
11 – 11:15 a.m.	**Break**	
11:15 – 11:45 a.m.	**Wellness Ambassador Presentations**	*Four ADA Wellness Ambassadors (Group 1) share 5-minute overviews of their projects* *Michigan Dental Association mental health videos (7 minutes)*
11:45 a.m. – 12:15 p.m.	**ADA Wellness Strategy & Coalition Building – Facilitated Discussion with All Attendees**	*Dr. Kami Dornfeld, chair, DWAC*
12:15 – 12:45 p.m.	**Lunch/Networking**	
12:45 – 1:15 p.m.	**Wellness Ambassador Presentations**	*Four ADA Wellness Ambassadors (Group 1) share 5-minute overviews of their projects*
1:15 – 2 p.m.	**Third Panel Presentation – Spotlight on State Well-Being Priorities/Success Stories**	*Bridgett Anderson, LDA, MBA, Executive Director, Minnesota Board of Dentistry* *Dr. Bill Claytor, Executive Director, North Carolina Caring Dental Professionals* *Mary Wolf, MS, LPC-MH, BCC, President, Veritee Partners, LLC, on behalf of the South Dakota Dental Association's Be Well Program*
2 – 2:30 p.m.	**Facilitated Discussion with All Attendees**	*Goal: Protecting Health – Saving Lives*
2:30 – 3 p.m.	**Closing Remarks and Recognition**	*Dr. Kami Dornfeld, chair, DWAC*

Appendix 2 – Wellness Resources Flyer (September 2023)

ADA

WELLNESS RESOURCES FROM THE COUNCIL ON DENTAL PRACTICE

Explore **ADA.org/Wellness** for articles, courses, videos and other resources across these health and well-being areas: mental health, physical health, opioid prescribing, and pregnancy.

Managing the Big Three: Burnout, Anxiety, Depression

ADA.org/WellnessPanel

Friday, October 6, 2023 • SmileCon Orlando, Dental Central, Wellness Hub

In this session, moderated by Dr. Jarod Johnson, the New Dentist Committee District 10 representative and mental health advocate, a panel of dentists will share experiences with depression, anxiety and other mental health challenges as well as ways to support one another during tough times.

ADA Dentist Well-Being Program Directory *(updated in 2023)*

ADA.org/WellnessDirectory

This Well-Being Program Directory provides a list of healthcare professionals in each state who will serve as a point of contact and offer support during a time of need. This is part of the ADA mission to enhance the personal and professional lives of our members for the betterment of the dental team and the patients they serve.

After a Suicide Postvention Toolkit

ADA.org/Postvention

September is national suicide prevention awareness month. *After a Suicide: A Guide for Dental Workplaces* was developed in 2023 by the American Foundation for Suicide Prevention (AFSP) and the American Dental Association (ADA). This resource reflects learnings in responding to a suicide death for professional dental settings.

ADA Ergonomic Stretches

ADA.org/Stretch

Better ergonomics can improve your practice — daily stretching and exercise, can help dental practitioners and their team enjoy long, healthy careers. Download the ADA Ergonomics Stretches infographic today, including 25 quick stretches, to keep you and your dental team healthy.

ADA Wellness Videos

ADA.org/WellnessVideos

Visit ADA's Wellness Playlist on our YouTube channel to watch new, short promotional videos on:

- ADA Dentist Well-Being Program Directory
- 2-part Resilience Webinar courses in ADA CE Online
- ADA Opioid Prescribing Resources

ADA Practice Institute • Center for Dental Practice | dentalpractice@ada.org

MAYO CLINIC

Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions

Liselotte N. Dyrbye, MD, MHPE; Colin P. West, MD, PhD; Christine A. Sinsky, MD; Lindsey E. Goeders, MBA; Daniel V. Satele, BS; and Tait D. Shanafelt, MD

Abstract

Objective: To determine whether state medical licensure application questions (MLAQs) about mental health are related to physicians' reluctance to seek help for a mental health condition because of concerns about repercussions to their medical licensure.

Methods: In 2016, we collected initial and renewal medical licensure application forms from 50 states and the District of Columbia. We coded MLAQs related to physicians' mental health as "consistent" if they inquired *only* about current impairment from a mental health condition or did not ask about mental health conditions. We obtained data on care-seeking attitudes for a mental health problem from a nationally representative convenience sample of 5829 physicians who completed a survey between August 28, 2014, and October 6, 2014. Analyses explored relationships between state of employment, MLAQs, and physicians' reluctance to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure.

Results: We obtained initial licensure applications from 51 of 51 (100%) and renewal applications from 48 of 51 (94.1%) medical licensing boards. Only one-third of states currently have MLAQs about mental health on their initial and renewal application forms that are considered consistent. Nearly 40% of physicians (2325 of 5829) reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Physicians working in a state in which neither the initial nor the renewal application was consistent were more likely to be reluctant to seek help (odds ratio, 1.21; 95% CI, 1.07-1.37; P=.002 vs both applications consistent).

Conclusion: Our findings support that MLAQs regarding mental health conditions present a barrier to physicians seeking help.

 ■ Mayo Clin Proc. 2017;92(10):1486-1493

From the Mayo Clinic Program on Physician Well-Being, Department of Medicine (L.N.D., C.P.W., T.D.S.) and Department of Health Sciences Research (D.V.S.), Mayo Clinic, Rochester, MN; and American Medical Association, Chicago, IL (C.A.S., L.E.G.). T.D.S. is currently affiliated with Department of Medicine, Division of Hematology, Stanford University, Stanford, CA.

The prevalence of psychological distress among physicians is high.[1,2] Unfortunately, their mood disorders often go untreated,[1,3,4] contributing to a higher prevalence of suicide among physicians in comparison to other US workers.[1,5] A third to half of physicians do not have a personal physician or regular source of health care,[6-8] and physicians are less likely to have seen their personal physician in the past year than other US adults.[9] Information regarding physicians' use of mental health services is limited, although data suggest that physicians frequently self-treat for depression and avoid seeking care for mental health conditions because of concerns that a mental health condition may affect their license to practice.[1,3,4] For example, in a 2008 national study of 7905 US surgeons, 6.3% reported suicidal ideation during the previous 12 months.[4] Among those with recent suicidal ideation, 26% had sought care, 16% had self-prescribed their antidepressant, and 60% reported that they were reluctant to seek care because of concerns that doing so could affect their licensure to practice.[4]

Many state licensing boards ask questions about mental health diagnoses or treatment. The fact that licensing boards inquire about these dimensions is believed to be a major deterrent to help seeking among troubled physicians, many of whom have treatable

Mayo Clin Proc. ■ October 2017;92(10):1486-1493 ■ http://dx.doi.org/10.1016/j.mayocp.2017.06.020
www.mayoclinicproceedings.org ■

disorders.[1,3,10-12] Such a concern is reasonable because a study published in 2007 found that greater than one-third of state licensure board executive directors reported that a diagnosis of mental illness was itself sufficient to sanction physicians.[13] In addition, there are reports of disclosure of mental health conditions resulting in overt and covert discrimination (eg, restrictions on clinical practice, mandatory clinical proctoring, and mandatory psychiatric evaluation for the purpose of determining competence).[1,3,10,13-15] There is also a real possibility of public disclosure of physicians' personal health information.[1,14,16]

State medical licensure boards serve to protect the public through licensure, surveillance, misconduct investigations, and disciplinary actions.[17] The Federation of State Medical Boards advises that medical licensure boards not ask physicians about history of mental illness[18] and indicates that doing so could violate the Americans with Disabilities Act of 1990.[19,20] The American Psychiatric Association has also specifically stated that impairment and potential risk of harm to patients cannot be inferred from a diagnosis or treatment alone.[10,21] Indeed, many have called for medical licensure applications to include only questions about current functional impairment of professional performance[1,19,21-25] and for decisions regarding licensure to be based solely on professional performance.[22,26] In response, some state licensing boards have modified their questions in regard to mental health[14]; however, many may remain in violation of the Americans with Disabilities Act,[19,21] and the prevalence of licensure questions about physicians' history of mental illness appears to be increasing.[20]

It remains unknown whether physicians who are licensed by medical boards that inquire about current or past diagnosis or treatment of a mental health condition are more reluctant to seek care for a mental health concern than those who are licensed by medical boards that inquire only about current impairment. In this study, we evaluated the relationship between state medical licensure application questions about mental health and whether physicians endorse reluctance to seek help for a mental health condition because of concerns about repercussions to their medical licensure.

METHODS

In 2016, we requested the initial and renewal medical licensure application forms from all 50 states and the District of Columbia (referred to henceforth as "states"). Application questions related to physicians' mental health, physical health, and substance abuse were extracted, reviewed, and independently coded by 2 of the authors (L.N.D. and T.D.S.) using an evidence-based approach informed by the American Medical Association,[25] American Psychiatric Association,[21] and Federation of State Medical Boards[18] polices and recommendations and the Americans with Disabilities Act of 1990.[19,20] Applications were classified as "consistent" if they inquired *only* about current (within a time period of 12 months or less) impairment from a medical condition or mental health condition (eg, "Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?") or did not ask about mental health conditions.[1,19,21-24] Applications that asked about history (ever) of impairment or whether the applicant had a mental health condition that *could* affect competency, *could* possibly impair ability to practice medicine, or *could* lead to impairment if left untreated were not considered consistent. Similarly, applications that asked about current or past diagnosis or treatment of a mental health condition (rather than impairment from such a condition) were not considered consistent. If both the initial licensure and renewal applications were designated as consistent from a given state, the medical licensure board for that state was coded as "both applications consistent." If the initial but not the renewal application was classified as consistent, the medical licensure board for that state was coded as "initial application consistent." If the renewal application but not the initial application for a given state was classified as consistent, the medical licensure board for that state was coded as "renewal application consistent." If neither the initial nor the renewal application from a given state was considered

consistent, the medical licensure board for that state was coded as "neither application consistent."

Convenience Sample of US Physicians

We obtained data on care-seeking attitudes for a mental health problem from a nationally representative convenience sample of 5829 nonretired US physicians who participated in a previously reported national survey from August 28, 2014, to October 6, 2014.[2] The survey included questions about personal (sex, age, relationship status) and professional (degree [allopathic or osteopathic], work hours, specialty, practice setting, currently practicing) characteristics as well as the physician's state of employment. In addition, physicians were asked, "If you were to need medical help for treatment of depression, alcohol/substance use, or other mental health problem would concerns about the repercussions on your medical licensure make you reluctant to seek formal medical care?" (response options "yes" or "no"). Those who indicated "yes" were considered to be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Respondents were included in this analysis if they were (1) allopathic physicians who answered the question about reluctance to seek care or (2) osteopathic physicians who worked in one of the 36 states that have a conjoined medical board (ie, one medical board licensured both allopathic and osteopathic physicians) and who answered the question about reluctance to seek care.

Statistical Analyses

Standard descriptive summary statistics were calculated. Using the physician's reported state of employment, along with our independently obtained data on state licensure questionnaire, each physician was classified as practicing in a "both application consistent," "initial application consistent," "renewal application consistent," or "neither application consistent" state. We explored the relationship between medical licensure application categories of the state in which physicians practiced and whether physicians reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure using χ^2 tests. Multivariate logistic regression analysis was performed to identify personal (age, sex, relationship status) and professional (practice setting, state licensure category, specialty) characteristics associated with reluctance to seek formal medical care because of concerns about repercussions to their medical licensure. All tests were 2-sided with type I error rates of 0.05. All analyses were performed using SAS statistical software, version 9 (SAS Institute).

RESULTS

We obtained 51 of 51 (100%) initial and 48 of 51 (94.1%) renewal medical licensure application forms, resulting in a final sample of 48 medical licensing boards with complete information on both initial and renewal licensure applications. Twenty-one initial and 21 renewal applications were considered consistent. These applications included 11 initial and 8 renewal applications that asked *only* about current impairment from a mental health condition as well as 10 initial and 13 renewal applications that included no questions related to mental health. Overall, 16 of 48 medical licensing boards (33.3%) were classified as both applications consistent, 3 (6.2%) as initial applications consistent, 5 (10.4%) as renewal applications consistent, and the remaining 24 (50.0%) as neither applications consistent. Classification by state is presented in the Figure.

Demographic characteristics of the 5829 physicians in the convenience sample are presented in Table 1. Overall, 3867 physicians (66.3%) were male, the mean (SD) age was 54.5 (12) years, 5087 (87.3%) were married or partnered (single, 627 [10.8%]; widowed, 87 [1.5%]), and 3089 (53.0%) were in private practice (academic medical center, 1451 [24.9%]; veterans hospital, 89 [1.5%]; active military practice, 42 [0.7%]; other, 1158 [19.9%]).[2] Of the 5829 physicians, 1387 (23.8%) worked in the primary care setting, 1100 (18.9%) in a surgical specialty, 948 in a medical specialty (16.3%), 1786 (30.6%) in another direct patient care discipline (eg, emergency medicine, neurology, dermatology), 371 (6.4%) in a non–direct patient care discipline (eg, radiology, pathology), and 192 (3.3%) in other disciplines (data on

Mayo Clin Proc. ■ October 2017;92(10):1486-1493 ■ http://dx.doi.org/10.1016/j.mayocp.2017.06.020
www.mayoclinicproceedings.org

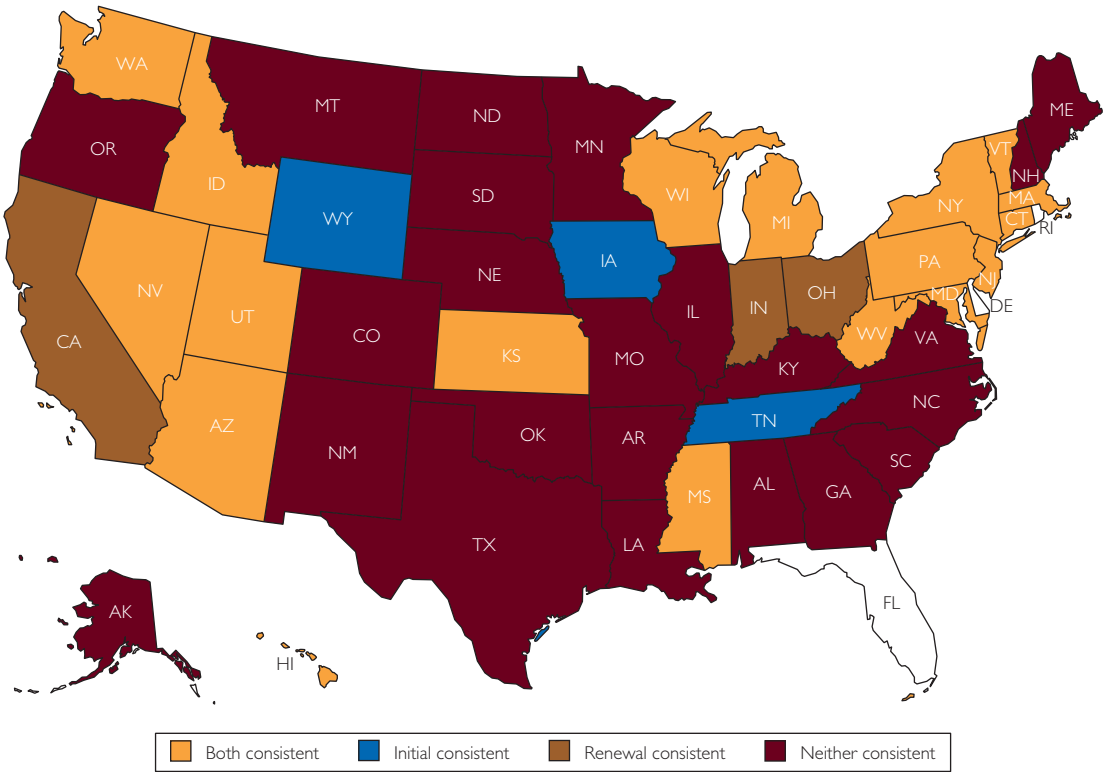


FIGURE. Medical license applications by state. Applications were classified as "consistent" if they inquired only about current impairment from a medical condition (globally) or mental health condition. Data were not available for Florida, Rhode Island, and Delaware (indicated in white).

specialty were missing in 45 physicians [0.8%]). Demographic characteristics of responders were relatively similar to those of all US physicians and to those of previous national samples of US physicians.[2,27]

Overall, nearly 40% of physicians (2325 of 5829 [39.9%]) reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Reluctance to seek care was least prevalent among physicians practicing in states in which both applications were designated consistent (775 of 2117 [36.6%]) compared with those practicing in states classified as initial application consistent (89 of 206 [43.2%]; $P=.06$), renewal application consistent (443 of 1080, [41.0%]; $P=.02$), and neither application consistent (1018 of 2426 [42.0%], $P<.001$) (overall, $P=.002$ across categories). These data suggest that classification of state licensing board applications was related to physicians' reported reluctance to seek help for a mental health condition because of its potential effect on their license to practice.

In multivariate analysis to explore factors independently associated with whether physicians reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure, physicians who were younger, male, and worked in private practice were more reluctant to seek help (Table 2). Physicians working in a state in which neither application was consistent were more likely to be reluctant to seek help (odds ratio, 1.21 [95% CI, 1.07-1.37]; $P=.002$ vs both applications consistent), as were those who worked in states in which only the renewal application was consistent (odds ratio, 1.22 [95% CI, 1.05-1.43];

TABLE 1. Demographic Characteristics of 5829 Physicians

Characteristic	No. (%) of physicians[a]
Sex	
Male	3867 (66.3)
Female	1927 (33.1)
Missing	35 (0.6)
Age (y), mean (SD) (N=5787)	54.5 (12.0)
Relationship status	
Single	627 (10.8)
Married	4854 (83.3)
Partnered	233 (4.0)
Widowed	87 (1.5)
Missing	28 (0.5)
Degree	
Allopathic physician (MD)	5634 (96.7)
Osteopathic physician (DO)	195 (3.3)
Practice setting	
Private practice	3089 (53.0)
Academic medical center	1451 (24.9)
Veterans hospital	89 (1.5)
Active military practice	42 (0.7)
Other	1158 (19.9)
Years in practice, mean (SD)	22.2 (12.6)
Specialty	
Primary care	1387 (23.8)
Surgical specialty	1100 (18.9)
Medical specialty	948 (16.3)
Other direct patient care discipline[b]	1786 (30.6)
Other non–direct patient care discipline[c]	371 (6.4)
Other	192 (3.3)
Missing	45 (0.8)

[a]Percentages may not total 100 because of rounding.
[b]For example, emergency medicine, neurology, dermatology.
[c]For example, radiology, pathology.

P=.011 vs both applications consistent). These findings persisted when specialty was included in the model (data not shown).

DISCUSSION

In this national study of nearly all (94.1%) medical licensure board applications, only one-third of states (16 of 48 [33.3%]) had questions on their initial and renewal application forms that were congruent with the American Medical Association,[25] American Psychiatric Association,[21] and Federation of State Medical Boards[18] polices and recommendations or in clear compliance with the Americans with Disabilities Act of 1990.[19,20] Nearly 40% of physicians reported they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure, and physicians working in a state in which neither the initial nor the renewal application was consistent were more likely to be reluctant to seek help.

Large population studies have found attitudes toward mental health help-seeking are associated with actual mental health care service use.[28,29] If, as observed in large previous national studies,[4] 6% of the more than 800,000 US physicians have experienced suicidal thoughts in the past 12 months and 40% of those with such suicidal ideation do not seek care because of concerns that it may have repercussions for their medical licensure, this would imply that licensure concerns may be a factor in 20,000 US physicians not receiving the professional help they need for mental health concerns.

Because the lack of seeking professional help is thought to contribute to the elevated risk of suicide among physicians in comparison to the general US population,[1] barriers to help-seeking should be removed when identified. In this regard, it is notable that physicians who worked in states with medical licensure questions consistent with national recommendations[18,19,21,25] were less likely to report that they would be reluctant to seek formal medical care for treatment of a mental health conditions because of concerns about repercussions to their medical licensure than physicians who worked in states not classified as consistent. This relationship between the way state medical licensure boards inquired about mental health conditions was independently related to whether the physicians in that state reported a reluctance to seek mental health care after adjusting for sex, age, relationship status, practice settings, and specialty. Physicians working in states in which neither the initial nor the renewal application was consistent had a 21% increase in the odds of reluctance to seek help for a mental health concern. Even physicians working in states/territories in which only the initial licensure application was not consistent had a 22% increase in the odds of reluctance to seek help for a mental health concern independent of age. This observation suggests that the questions on the initial licensure application may leave a lasting impression on physicians.

The finding that male and younger physicians were more reluctant to seek help is

Mayo Clin Proc. ■ October 2017;92(10):1486-1493 ■ http://dx.doi.org/10.1016/j.mayocp.2017.06.020
www.mayoclinicproceedings.org

consistent with findings from studies of the general US population reporting that younger individuals and men are disproportionately deterred by stigma about mental illness, which is associated with reduced help-seeking.[28] The observation that physicians in private practice had 25% to 50% greater odds of being reluctant to seek help for a mental health concern on multi-variate analysis warrants further study but may be due to greater concern over public disclosure resulting in current or future patients judging them negatively[28] and choosing to go elsewhere for care.

Our study has several limitations. First, some medical licensure applications may have asked different questions about mental health in 2014 (the year the cohort of physicians were surveyed) than at the time we collected licensure questions in 2016. Second, although analysis of early responders vs later responders (a standard approach to response bias) suggests that the sample was representative with respect to age, sex, and specialty, it is possible that the sample may not be representative with respect to attitudes about seeking care for mental health conditions. The rate of reluctance to seek formal medical care because of concerns about repercussions to medical licensure in our study, however, was similar to what has been previously reported in the literature.[4,30]

Our study has several important strengths. First, we were able to obtain the initial and renewal licensure application forms from all but 3 states. Second, the designation of medical licensure application question category (both consistent, initial consistent, renewal consistent, or neither consistent) was determined independent of the data on physicians' self-reported attitudes about whether concerns for licensure impacted whether they would seek help for mental health conditions. Third, 2 investigators independently coded each medical licensure application question pertaining to mental health using an evidence-based approach.[18,19,21,25]

The results of this study suggest that the way in which medical licensure questions regarding mental health conditions are asked may impact whether physicians are reluctant to seek help for a mental health condition. Physicians working in states in which medical licensure application questions inquire broadly about current or past diagnosis or treatment of a mental health condition, past impairment from a mental health condition, or presence of a mental health condition that *could* affect competency were 21% to 22% more likely to be reluctant to seek help. In contrast, physicians who worked in states in which questions on medical licensure applications asked only about current impairment from a mental health condition or included no question pertaining to mental health were less likely to endorse such reluctance and thus may be more likely to seek and receive care if the need arose.[28,29] These findings support continued efforts to develop regulations and policies that encourage physicians to seek help, as suggested by others.[1,19] They also support universal use of consistent licensure questions across the US states. In this regard, the American Psychiatric Association has already developed and recommended the following language for state licensing boards to use on licensure applications: "Are you

TABLE 2. Multivariate Analysis of Factors Associated With Reluctance to Seek Formal Medical Care Because of Concerns About Repercussions to Medical Licensure[a,b]

Independent variable	OR (95% CI)[c]	*P* value	Overall *P* value
Age (for each 1 year older)	0.97 (0.97-0.98)	<.001	<.001
Female (reference, male)	0.74 (0.66-0.84)	<.001	<.001
Relationship status (reference, married)			.22
Partnered	0.98 (0.74-1.29)	0.88	
Single	1.17 (0.98-1.39)	0.08	
Widowed	0.77 (0.47-1.27)	0.3	
Practice location (reference, private practice)			<.001
Academic medical center	0.74 (0.64-0.84)	<.001	
Veterans hospital	0.51 (0.31-0.81)	.005	
Other practice setting	0.82 (0.71-0.95)	.007	
Medical licensure application questions (reference, both applications consistent)			.007
Neither application consistent	1.21 (1.07-1.37)	.002	
Renewal application consistent	1.22 (1.05-1.43)	.011	
Initial application consistent	1.29 (0.96-1.74)	.09	

[a]OR = odds ratio.

[b]Factors in the multivariate analysis included sex, age, relationship status, practice setting, state medical licensure application questions category (both optimal [reference], initial consistent, renewal consistent, neither consistent). Physicians considered reluctant to seek help if they answered "yes" to the question, "If you were to need medical help for treatment of depression, alcohol/substance use, or other mental health problem, would concerns about the repercussions on your medical license make you reluctant to seek formal medical care?"

[c]OR >1 indicates greater reluctance to seek care for mental health condition because of its potential effect on physicians' license to practice; OR <1 indicates less reluctance.

currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."[21] Such a question encourages physicians to consider any physical or mental health issue that could impair their performance and helps to destigmatize mental illness. In addition, it also enables state medical boards and their members to protect the public while being consistent with the Americans with Disabilities Act of 1990. Although there are concerns that the very nature of some illnesses could impede physicians' abilities to recognize their own limitations, a history of a medical or psychiatric disorder has little predictive value for present impairment of functioning, and there is no evidence that the risk to patients is sufficiently great to require disclosure of private medical records for public scrutiny.[10,21]

CONCLUSION

Changing medical licensure application questions, as well as similar items asked by hospitals and group practices in the credentialing process, so that they inquire about *current* functional impairment appears to be a simple but potentially meaningful step to reduce barriers to physicians seeking help for mental health conditions. Such a change, although potentially cumbersome because state medical boards may need to work with their legislators for changes to the state medical practice acts, could be implemented at minimal cost.

Grant Support: Funding for this work was provided by the Mayo Clinic Department of Medicine Program on Physician Well-Being.

Correspondence: Address to Liselotte N. Dyrbye, MD, MHPE, Mayo Clinic Program on Physician Well-Being, Department of Medicine, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (Dyrbye.liselotte@mayo.edu).

REFERENCES

1. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA*. 2003; 289(23):3161-3166.
2. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014 [published correction appears in *Mayo Clin Proc*. 2016;91(2):276]. *Mayo Clin Proc*. 2015;90(12):1600-1613.
3. Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": a survey of female physicians on mental health diagnosis, treatment, and reporting. *Gen Hosp Psychiatry*. 2016;43:51-57.
4. Shanafelt TD, Balch CM, Dyrbye L, et al. Special report: suicidal ideation among American surgeons. *Arch Surg*. 2011;146(1):54-62.
5. Schernhammer E. Taking their own lives—the high rate of physician suicide. *N Engl J Med*. 2005;352(24):2473-2476.
6. Cedfeldt AS, Bower EA, Grady-Weliky TA, Flores C, Girard DE, Choi D. A comparison between physicians and demographically similar peers in accessing personal health care. *Acad Med*. 2012;87(3):327-331.
7. Gross CP, Mead LA, Ford DE, Klag MJ. Physician, heal thyself? regular source of care and use of preventive health services among physicians. *Arch Intern Med*. 2000;160(21):3209-3214.
8. Shanafelt TD, Oreskovich MR, Dyrbye LN, et al. Avoiding burnout: the personal health habits and wellness practices of US surgeons. *Ann Surg*. 2012;255(4):625-633.
9. Centers for Disease Control and Prevention. BRFSS prevalence & trends data. https://www.cdc.gov/brfss/brfssprevalence/. Updated January 23, 2017. Accessed November 17, 2016.
10. American Psychiatric Association. Position statement on confidentiality of medical records: does the physician have a right to privacy concerning his or her own medical records? *Am J Psychiatry*. 1984;141(2):331-332.
11. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. *Lancet*. 2009;374(9702):1714-1721.
12. Altchuler SI. Commentary: granting medical licensure, honoring the Americans with Disabilities Act, and protecting the public; can we do all three? *Acad Med*. 2009;84(6):689-691.
13. Hendin H, Reynolds C, Fox D, et al. Licensing and physician mental health: problems and possibilities. *J Med Licensure Discipline*. 2007;93(2):6-11.
14. Sansone RA, Wiederman MW, Sansone LA. Physician mental health and substance abuse: what are state medical licensure applications asking? *Arch Fam Med*. 1999;8(5):448-451.
15. Miles SH. A challenge to licensing boards: the stigma of mental illness. *JAMA*. 1998;280(10):865.
16. Worley LL. Our fallen peers: a mandate for change. *Acad Psychiatry*. 2008;32(1):8-12.
17. Scutchfield FD, Benjamin R. The role of the medical profession in physician discipline [editorial]. *JAMA*. 1998;279(23): 1915-1916.
18. Federation of State Medical Boards. *Americans With Disabilities Act of 1990: Licensure Application Questions; A Handbook for Medical Boards*. Dallas, TX: Federation of State Medical Baords of the United States, Inc; 2006.
19. Schroeder R, Brazeau CM, Zackin F, et al. Do state medical board applications violate the Americans with Disabilities Act? *Acad Med*. 2009;84(6):776-781.
20. Polfliet SJ. A national analysis of medical licensure applications. *J Am Acad Psychiatry Law*. 2008;36(3):369-374.
21. American Psychiatric Association. Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing. https://www.psychiatry.org/home/policy-finder?k=understanding%20icd. Published 2015. Accessed December 12, 2016.
22. American Psychiatric Association Work Group on Disclosure. *Recommended Guidelines Concerning Disclosure and Confidentiality*. Washington, DC: American Psychiatric Association; 1997.
23. Council on Psychiatry and the Law. *Discrimination Against Persons With Previous Psychiatric Treatment: Postion Statement*. Washington, DC: American Psychiatric Association; March, 1997. APA Document Reference No. 970002.
24. Hansen TE, Goetz RR, Bloom JD, Fenn DS. Changes in questions about psychiatric illness asked on medical licensure applications between 1993 and 1996. *Psychiatr Serv*. 1998;49(2): 202-206.
25. Council on Medical Education. *Access to Confidential Health Services for Medical Students and Physicians (Recommendation B)*:

American Medical Association website. https://assets.ama-assn.org/sub/meeting/documents/i16-refcomm-c.pdf. Accessed December 12, 2016.
26. Hampton T. Experts address risk of physician suicide. *JAMA*. 2005;294(10):1189-1191.
27. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377-1385.
28. Clement S, Schauman O, Graham T, et al. What is the impact of mental health-related stigma on help-seeking? a systematic review of quantitative and qualitative studies. *Psychol Med*. 2015;45(1):11-27.
29. ten Have M, de Graaf R, Ormel J, Vilagut G, Kovess V, Alonso J; ESEMeD/MHEDEA 2000 Investigators. Are attitudes towards mental health help-seeking associated with service use? results from the European Study of Epidemiology of Mental Disorders. *Soc Psychiatry Psychiatr Epidemiol*. 2010;45(2):153-163.
30. Rath KS, Huffman LB, Phillips GS, Carpenter KM, Fowler JM. Burnout and associated factors among members of the Society of Gynecologic Oncology. *Am J Obstet Gynecol*. 2015;213(6):824.e1-9.

Brooklyn Law Review

Volume 80 | Issue 3 Article 2

2015

Have You Ever...? How State Bar Association Inquiries into Mental Health Violate the Americans with Disabilities Act

Alyssa Dragnich

Have You Ever . . . ?

HOW STATE BAR ASSOCIATION INQUIRIES INTO MENTAL HEALTH VIOLATE THE AMERICANS WITH DISABILITIES ACT

Alyssa Dragnich[†]

> *"In the 1950's and early 1960's bar examiners looked for communists and fornicators. In the late 1960's and early 1970's they looked for hippies and pot smokers. Then came the era of cocaine, homosexuals, bankrupts and unpaid student loans."*[1]

INTRODUCTION

Today, bar examiners are singling out bar applicants with any history of mental health treatment. In 2014, 26 states required any person applying for a license to practice law to answer questions about her[2] past mental health diagnoses and treatment as part of the "character and fitness" investigation all bar applicants undergo. Some of those amended their applications following a Department of Justice settlement with the Louisiana Supreme Court in August 2014,[3] but 14 states[4] continue to ask impermissible questions about an applicant's mental health.

The specific questions vary in scope and intrusiveness, depending on the state in which the applicant is applying. If an applicant refuses to answer the questions, she will not be admitted to the bar. If she answers any question affirmatively, she is then subjected to a host of additional requirements, which can include production of all past medical records from

---

[†] Professor of Legal Writing and Lecturer in Law at the University of Miami School of Law. Many thanks to the law librarians at the University of Miami for their research help and to Peter Nemerovski, Rachel H. Smith, Rachel Stabler, and Susan Stefan for their helpful comments. Brian Goldenberg and Caroline McGee provided outstanding research assistance.

[1] Richard C. McFarlain, *Character & Fitness Process Before the Florida Board of Bar Examiners*, FLA. B.J., Jan. 1989, at 29, 34.

[2] For the sake of consistency, this Article uses the feminine pronoun throughout.

[3] *See infra* Part II.B.

[4] The survey information taken from state bar applications is current as of April 2015.

doctors, hospitals, and therapists; an appearance before a hearing of bar examiners; and consent to additional psychological examinations. Even after all of that, she may be only "conditionally" admitted, allowing the board of bar examiners indefinite jurisdiction over her right to practice.[5]

Despite the passage of the Americans with Disabilities Act (ADA) in 1990 and the firm position of the Department of Justice (DOJ) that these bar application questions violate the ADA, states persist in making these inquiries. Under the ADA, mental health inquiries are suspect because they screen out applicants with disabilities. The Code of Federal Regulations requires that any such screening be "necessary" to achieve its stated purpose.[6] Here, bar examiners' stated purpose is to protect the public from "unfit" attorneys.

This Article argues that bar examiners fail to prove the screening is necessary because they cannot show that the screening is effective at reducing the rate of unfit attorneys, as measured by the per capita rates of attorney discipline in each state. The data shows that there is no connection between asking about mental health on a bar application and future rates of attorney misconduct. These results mirror what psychologists and psychiatrists have said for years: that there is no connection between a diagnosis of mental illness and future misconduct as an attorney. Thus, because bar examiners cannot show that their questions about mental health are necessary to protect the public, these questions violate the ADA.

Part I of the Article outlines the statutory framework of the ADA and its implementing regulations. It discusses the arguments proffered by bar examiners in support of mental health inquiries and then the responses made by disability rights advocates as to why those arguments are unpersuasive.

Part II reviews the case law on this issue to date, as well as the landmark settlement reached between the DOJ and the Louisiana Supreme Court in August 2014. In this settlement, Louisiana agreed to eliminate mental health questions from its bar application, radically change its system of conditional licensing for attorneys with mental health issues, and pay $200,000 to compensate past victims of its discrimination.[7] Almost immediately, the National Conference of Bar Examiners (NCBE) moved to revise its standard character and fitness questions to eliminate queries about mental health.

---

[5] *See infra* Part IV.A.3.

[6] 28 C.F.R. § 35.130(b)(8) (2014).

[7] *See infra* Part II.B.

Part III reviews specific questions used by various states across the country, analyzing which comply with the ADA and which do not.

Part IV delves into the "necessary" query. It argues that bar examiners are not capable of making accurate predictions of future fitness based on an applicant's mental health history. It then compares the rates of attorney discipline from states that do not ask about mental health as part of the character and fitness investigation with states that do ask, showing that there is no connection between asking about mental health on a bar application and future rates of attorney discipline in that state. Part IV then reveals that very few applicants are actually denied admission on mental health grounds and argues that these inquiries persist only because of fear and stereotypes surrounding mental illness.

The article concludes with recommendations for state bar associations and law schools.

I. BACKGROUND

In 1996, one author called the question of bar association inquiries into mental health "one of the most disputed issues to face boards of bar examiners in recent years."[8] Almost 20 years later, the issue has not become any less contentious.

A. Statutory Framework

Before the passage of the ADA, several bar applicants challenged bar association questions about an applicant's mental health on the grounds that these questions violated their right to privacy, but courts rejected these arguments, holding that the states' need to protect the public and the profession outweighed the applicants' privacy interests.[9] In 1990, Congress enacted the ADA, a broad civil rights act that prohibits discrimination against people with physical and mental disabilities. Under the ADA, a person is considered disabled if she (a) has "a physical or mental impairment that substantially limits one or more major life activities," (b) has "a

---

[8] Kelly R. Becton, Comment, *Attorneys: The Americans with Disabilities Act Should Not Impair the Regulation of the Legal Profession Where Mental Health is an Issue*, 49 OKLA. L. REV. 353, 353 (1996).

[9] *See, e.g.*, Fla. Bd. of Bar Exam'rs Re: Applicant, 443 So. 2d 71 (Fla. 1983) (upholding Board of Examiners' refusal to process application on basis of applicants' refusal to answer question inquiring about mental health treatment).

record of such an impairment," or (c) is "regarded as having such an impairment."[10]

Title II[11] of the ADA, which applies to state and local government agencies, states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any entity."[12] Federal courts have consistently held that 1) Title II applies to state bar associations; and 2) bar applicants with a history of mental health diagnosis or treatment are "qualified individuals with a disability."[13]

Congress required the DOJ to write the implementing regulations for the ADA.[14] Under those regulations, a public entity is prohibited from administering "a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability."[15] Furthermore, "[a] public entity shall not impose or apply any eligibility criteria that screen out or tend to screen out an individual with a disability . . . unless such criteria can be shown to be *necessary* for the provision of the service, program, or activity being offered."[16]

Courts have already determined that bar application questions about mental health "screen out or tend to screen out" applicants with mental disabilities.[17] The definition of "disability" includes a history of alcohol or drug addiction, but not current drug use.[18] Although many commentators discuss the questions surrounding mental health and addiction together, this Article addresses only mental health questions.

There is a public safety exception to Title II. The law "does not require a public entity to permit an individual to participate in or benefit from the services, programs, or activities of that public entity when that individual poses a

---

[10] 42 U.S.C. § 12102(1) (2012).

[11] *Id.* § 12131(1)(B).

[12] *Id.* § 12132.

[13] *See, e.g.*, ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *5-6 (S.D. Ind. Sept. 20, 2011); Ellen S. v. Fla. Bd. of Bar Exam'rs, 859 F. Supp. 1489, 1492-93 (S.D. Fla. 1994); *see also* Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans With Disabilities Act*, 49 U.C.L.A. L. REV. 93, 128 (2001).

[14] 42 U.S.C. § 12134(a).

[15] 28 C.F.R. § 35.130(b)(6) (2014).

[16] *Id.* § 35.130(b)(8) (emphasis added).

[17] *See, e.g.*, Med. Soc'y of N.J. v. Jacobs, No. 93-3670 (WGB), 1993 WL 413016, at *7 (D.N.J. Oct. 5, 1993); *In re* Application of Underwood, 1993 WL 649283, at *2 (Me. Dec. 7, 1993).

[18] 42 U.S.C. § 12114(a). The ADA does apply to a person who is participating in a drug rehabilitation program and not currently using illegal drugs. *Id.* § 12114(b)(2).

direct threat to the health or safety of others,"[19] unless the threat can be eliminated by reasonable accommodation.[20] Bar examiners have used this "direct threat" language to justify the necessity of their inquiries into applicants' mental health.[21]

Bar examiners, not applicants, bear the burden of showing that these questions are indeed necessary.[22] Several federal courts have held that "[e]ligibility criteria that 'screen out' or 'tend to screen out' disabled individuals violate the ADA unless the proponent of the eligibility criteria can show that the eligibility requirements are necessary."[23] Furthermore, a court is not permitted to merely accept the bar examiners' statement that the screening questions are necessary but "must make an independent inquiry into the soundness of [the] policy."[24]

An affirmative answer to any of the mental health questions triggers an onslaught of additional inquiries and disclosures.[25] Applicants are required to execute medical record release forms and produce records, treating notes, prescription history, and more from all previous psychologists, psychiatrists, and therapists.[26] In some states, these forms require the production of treatment history and notes from all mental health providers the applicant has ever seen.[27] In some cases, a committee of the board of bar examiners will review the records and process the application. In other cases, the applicant may be required to attend a hearing before the bar examiners. These requests pose an additional burden not borne by non-disabled applicants.[28]

---

[19] 28 C.F.R. § 35.139(a).

[20] 42 U.S.C. § 12111(3).

[21] *See, e.g.*, ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *1 (S.D. Ind. Sept. 20, 2011).

[22] Colo. Cross Disability Coal. v. Hermanson Family Ltd., 264 F.3d 999, 1003 (10th Cir. 2001) ("Several district courts have placed the burden of showing that the eligibility criteria are necessary on the proponent of such criteria." (citations omitted)); *In re* Petition & Questionnaire for Admission to the R.I. Bar (*Rhode Island*), 683 A.2d 1333, 1336 (R.I. 1996) ("[T]he burden is on those who propose to ask the questions to show an actual relationship . . . .").

[23] Hahn v. Linn Cnty., 130 F. Supp. 2d 1036, 1055 (N.D. Iowa 2001); *see also* Bowers v. NCAA, 118 F. Supp. 2d 494, 518 (D.N.J. 2000).

[24] Stillwell v. Kan. City Bd. of Police Comm'rs, 872 F. Supp. 682, 687 (W.D. Mo. 1995).

[25] *See, e.g.*, FLA. BD. OF BAR EXAM'RS, ONLINE BAR APPLICATION (on file with author) ("Please direct each such professional and hospital and/or other facility to furnish to the Board any information the Board may request with respect to any such hospitalization, consultation, treatment or diagnosis.").

[26] *Id.*

[27] *See, e.g.*, *id.*

[28] Med. Soc'y of N.J. v. Jacobs, No. 93-3670 (WGB), 1993 WL 413016, at *7 (D.N.J. Oct. 5, 1993).

B. Bar Examiner Arguments

Each state sets its own criteria for licensing attorneys, and states have broad latitude in administering this process.[29] All states typically require applicants to pass a written exam on substantive law, as well as undergo what is effectively a background investigation, known as the "character and fitness" process.[30] During this investigation, bar examiners probe into all aspects of an applicant's life, including her academic record, former residences, marital status, employment record, credit and financial history, military service, criminal acts, legal proceedings, and more.[31]

The stated purpose of the character and fitness investigation is to protect the public from unfit or unscrupulous attorneys and safeguard the system of justice, which some commentators interpret as protecting the image of the profession.[32] The United States Supreme Court has held that "any qualification [required by bar examiners] must have a rational connection with the applicant's fitness or capacity to practice law."[33] However, many scholars have criticized the tenuous connection between a character and fitness investigation and a person's future conduct as an attorney.[34]

As part of the character and fitness inquiry, bar examiners historically have insisted on investigating the mental health of bar applicants.[35] Examiners argue that this investigation is needed because "mental illness in a practicing attorney can lead to extremely adverse consequences for the unsuspecting public."[36] A prior General Counsel to the Florida Board of Bar Examiners has argued that "it is *necessary* for the protection of the public to

---

[29] Schware v. Bd. of Bar Exam'rs of N.M., 353 U.S. 232, 239 (1957); Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 443 (E.D. Va. 1995).

[30] *Bar Admissions Basic Overview*, AM. B. ASS'N, http://www.americanbar.org/groups/legal_education/resources/bar_admissions/basic_overview.html (last visited Apr. 20, 2015).

[31] Donald H. Stone, *The Bar Admission Process, Gatekeeper or Big Brother: An Empirical Study*, 15 N. ILL. U. L. REV. 331, 353 (1995).

[32] John D. McKenna, Note, *Is the Mental Health History of an Applicant a Legitimate Concern of State Professional Licensing Boards? The Americans with Disabilities Act vs. State Professional Licensing Boards*, 12 HOFSTRA LAB. L.J. 335, 344 (1995) ("[B]ar associations[,] . . . like other [professional] associations, are interested in protecting their image and economic well being.").

[33] *Schware*, 353 U.S. at 239.

[34] *See infra* note 349.

[35] Thomas A. Pobjecky, *Everything You Wanted to Know About Bar Admissions and Psychiatric Problems But Were Too Paranoid to Ask*, B. EXAM'R, Feb. 1989, at 14, 21 ("To fulfill their obligation to the public, bar examiners must be equipped to identify bar applicants with serious mental problems.").

[36] Thomas A. Pobjecky, *Mental Health Inquiries: To Ask, or Not to Ask—That Is the Question*, B. EXAM'R, Aug. 1992, at 31, 31.

screen out would-be lawyers who are not mentally fit or emotionally stable . . . ."[37] He further stated that "a mentally unfit bar applicant will go on to become a mentally unfit attorney unless prevented by the bar admitting authority."[38]

Erica Moeser, the current president of the NCBE,[39] has stated, "If the scenario were shifted from the licensing of lawyers to some other line of work, such as first-grade teachers, it is difficult to imagine that anyone seriously would argue that the current mental health of applicants should be placed out of bounds."[40] Moeser made this statement when she was the chairperson-elect of the American Bar Association Section of Legal Education and Admissions to the Bar in 1994—four years after the ADA passed.[41] She went on to write that "the insistence by some that the Americans with Disabilities Act bars any inquiry at all into an applicant's mental health . . . is a misuse of a watershed of civil rights legislation."[42]

C. Responses from Disability Rights Advocates

Disability rights advocates argue that inquiry into mental health on a bar application is ill-advised for a number of reasons. The inquiry could deter law students from seeking beneficial counseling, embarrass applicants and delay approval of their applications, provide an incentive for applicants to lie on their applications, force mental health professionals to violate their own ethical codes by breaching confidentiality, and discriminate against mental disabilities but not physical disabilities.

1. Deterrent Effect

Perhaps the biggest risk of requiring applicants to disclose their past mental health treatment is that it deters some people who would benefit from treatment from seeking

---

[37] *Id.* at 33.

[38] Pobjecky, *supra* note 35, at 16. There are two problems with this statement. The first is the implicit assumption that an applicant diagnosed with a mental illness is unfit. The second is the belief that an applicant who is unfit at one time will be unfit in the future. Mental illnesses tend to wax and wane throughout a person's lifetime. If an applicant is truly mentally unfit at the time of application, then her application should be denied. But a determination of fitness rests on the applicant's actual capabilities at the time of application, not the mere existence of a diagnosis.

[39] *See* discussion of the NCBE actions on this issue, *infra* Part II.C.

[40] Erica Moeser, *Yes: The Public Has a Right to Know About Instability*, A.B.A. J., Oct. 1994, at 36, 36.

[41] *Id.*

[42] *Id.*

it.[43] It is impossible to measure precisely how many students forego treatment in fear of the bar application, but no one doubts that the effect is real.[44]

Many states now include a disclaimer on their applications, urging applicants not to avoid seeking treatment if they need it. But the efficacy of these disclaimers is questionable because many applicants may not believe them and will continue to avoid treatment.[45]

2. Embarrassment, Invasion of Privacy, and Processing Delays

Many applicants are ashamed and humiliated by being forced to provide details of their very difficult and personal circumstances to strangers.[46] Applicants must execute broad medical record release forms, and they often must attend a hearing before a committee of bar examiners, where they are required to answer additional questions about their treatment history.

These additional investigations can substantially delay the processing of the application,[47] further embarrassing the applicant and in many cases, affecting her employment prospects. The delay in processing these applications is a "great source of inconvenience, distress, economic loss and even physical harm."[48] There is also some risk that bar examiners will, perhaps unconsciously, make harsher judgments about other aspects of an applicant's file—such as credit issues—once the examiners have knowledge of the applicant's mental disability.[49]

Some commentators believe that the lengthy and intrusive process may be a deliberate action by bar examiners to discourage applicants with disabilities from even applying for bar admission.[50] Other bar examiners may view the delays

---

[43] Stephen T. Maher & Lori Blum, *A Strategy for Increasing the Mental and Emotional Fitness of Bar Applicants*, 23 IND. L. REV. 821, 830-33 (1990); *see also* Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 445 (E.D. Va. 1995) (detailing bar applicant's argument that a question asking about mental health "ha[d] the adverse effect of deterring mental health treatment and stigmatizing those who do seek treatment").

[44] Bauer, *supra* note 13, at 150. Some authors argue that the applicants that the bar examiners should be most worried about are those applicants who are in need of treatment but have not sought it. *See, e.g.*, Maher & Blum, *supra* note 43, at 829. The reasoning is that applicants who are currently in treatment are likely to be more stable.

[45] Becton, *supra* note 8, at 370; Maher & Blum, *supra* note 43, at 833.

[46] *See, e.g.*, Bauer, *supra* note 13, at 113-25.

[47] *Id.* at 95-96; Phyllis Coleman & Ronald A. Shellow, *Fitness to Practice Law: A Question of Conduct, Not Mental Illness*, FLA. B.J., May 1994, at 71, 72.

[48] Stanley S. Herr, *Questioning the Questionnaires: Bar Admissions and Candidates with Disabilities*, 42 VILL. L. REV. 635, 678 (1997).

[49] Bauer, *supra* note 13, at 207.

[50] Herr, *supra* note 48, at 678.

as beneficial because they keep the candidate's file pending for a longer period of time, in essence serving as an illegal form of probation while providing more time for the board to monitor the applicant.[51] The NCBE Bar Examiners' Handbook notes that it is "easier to refuse admittance to an immoral applicant than it is to disbar him after he is admitted."[52]

3. Incentive for Applicants to Lie

The current system provides a perverse incentive for applicants to lie on their applications.[53] If an applicant answers "no" to all of the mental health questions, the inquiry ends there, assuming nothing else in the applicant's file is problematic. However, if the same applicant honestly answers "yes" on her application, she is subjected to a barrage of additional scrutiny. She must produce her medical records, might be required to attend a hearing where she will be asked deeply personal questions, and will experience a delay in processing her application. "It is an irony of the current system that the most candid and cooperative applicant often faces the longest ordeal, while other applicants with similar backgrounds who tick the box 'no' sail into the bar with no ripple of attention."[54] Surely honesty is a more important characteristic for an attorney than the presence or absence of a particular mental health diagnosis.

Several commentators have questioned the low rate of affirmative answers to bar application mental health questions, wondering if applicants are in fact omitting information. The *Clark* decision[55] noted that although evidence suggested that approximately 20% of the United States population suffers from some form of mental illness at any given time, the rate of affirmative answers regarding mental health on the Virginia bar application was less than 1%.[56] The court stated that this discrepancy "indicates that [the question] is ineffective in identifying applicants suffering from mental illness."[57] Law students likely experience mental illness at a lower rate than the general population, but such a wide variance is highly questionable.

---

[51] *Id.*
[52] NAT'L CONF. OF BAR EXAM'RS, BAR EXAM'RS' HANDBOOK, 73:4 (3d ed. 1991).
[53] Herr, *supra* note 48, at 658.
[54] *Id.*
[55] *See infra* Part II.A.5.
[56] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 437 (E.D. Va. 1995).
[57] *Id.*

Similarly, during a five-year span, only 2.5% of applicants to the Connecticut bar disclosed mental health treatment on their applications.[58] In *Texas Applicants*,[59] the court found that from August 1987 until the decision in 1994, only 30 applications raised mental health issues.[60] One bar examiner interprets these results to mean that "[if] a bar examining authority is not seeing any applicants with these problems, then it is suggested that such authority is not looking very hard."[61]

Another author believes the lower than expected rate of affirmative answers may be because applicants view the questions as an illegitimate intrusion and are simply refusing to answer the questions truthfully.[62] Regardless of the cause, the low number of affirmative answers "calls the utility—and fairness—of the whole enterprise into question."[63]

4. Mental Health Providers' Duty of Confidentiality

Psychologists, psychiatrists, and other mental health providers are bound by professional ethical rules that require doctor-patient confidentiality.[64] Asking a psychologist to disclose privileged provider-patient information is asking her to violate her own ethical code.[65] For bar examiners to make this request is particularly hypocritical, given that lawyers are bound by their own confidentiality rules.[66]

Mandatory disclosures about mental health on bar applications may make the course of treatment less effective. Knowing that they will have to disclose their treatment, applicants may be less forthcoming with their therapists and doctors.[67] Successful psychotherapy generally requires openness and truthfulness from the patient,[68] and if the patient is worried about what her therapist could reveal to others, it may cause the patient to withhold information, hindering her

---

[58] Bauer, *supra* note 13, at 105.

[59] *See infra* Part II.A.4.

[60] Applicants v. Tex. State Bd. of Law Exam'rs, No. A 93 CA 740 SS, 1994 WL 923404, at *4 (W.D. Tex. Oct. 11, 1994). The opinion did not state the number of total applications received.

[61] Pobjecky, *supra* note 35, at 16.

[62] Bauer, *supra* note 13, at 105.

[63] Herr, *supra* note 48, at 674.

[64] Maher & Blum, *supra* note 43, at 834.

[65] Frederick A. Elliston, *Character and Fitness Tests: An Ethical Perspective*, B. EXAM'R, Aug. 1982, at 8, 13.

[66] *Id.* ("It is wrong for lawyers to ask other professionals to disclose information when they are forbidden to do so themselves.").

[67] Maher & Blum, *supra* note 43, at 829-30.

[68] *Id.* at 834.

treatment and prognosis.[69] In addition, the therapist herself may alter the treatment plan based on the knowledge that she must disclose that treatment, rather than choosing the best therapeutic option for the patient.[70]

5. No Equivalent Inquiry into Physical Disabilities

The vast majority of bar applications do not ask applicants about any physical disabilities that may impair their ability to practice law. The Code of Recommended Standards for Bar Examiners, adopted in 1987—thus predating the ADA—expressly provides that "the physical disability of the applicant is not relevant to character and fitness for law practice and should not be considered."[71] But many physical disabilities run the risk of being even more incapacitating than mental disabilities. For example, a diabetic[72] who is having difficulty controlling her blood sugar or who takes an incorrect dose of insulin may experience erratic and extreme behavior even worse than that commonly seen in some psychotic patients.[73] Hypothyroidism, a fairly common physical disorder and one that is generally regarded as mild, can cause hallucinations and psychosis in some cases.[74] Yet, no bar examiner inquires into the thyroid status of bar applicants. Many other physical conditions could render an attorney unfit to practice.[75] But states do not ask about physical disabilities in the same way that they pry into mental disabilities.

II. LEGAL PROCEEDINGS TO DATE

A. Court Decisions

The first courts to confront the issue of mental health questions on licensing applications held that asking "have you

---

[69] *Id.*

[70] *Id.*

[71] Bauer, *supra* note 13, at 153.

[72] Diabetes is a physical disability under the ADA. *Questions & Answers about Diabetes in the Workplace and the Americans with Disabilities Act (ADA)*, U.S. EQUAL OPP. EMP. COMM'N, *available at* http://www.eeoc.gov/laws/types/diabetes.cfm#fn9 (last visited Apr. 20, 2015).

[73] Ira Burnim, Legal Dir. of the Bazelon Ctr. for Mental Health Law, Remarks at *Suffering in Silence: The Tension Between Self-Disclosure And a Law School's Obligation to Report Conference Panel* (2009), *in* 18 AM. U. J. GENDER SOC. POL'Y & L. 121, 122 [hereinafter *Suffering in Silence*].

[74] Thomas W. Heinrich & Garth Grahm, *Hypothyroidism Presenting as Psychosis: Myxedema Madness Revisited*, 5 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 260, 260 (2003).

[75] Herr, *supra* note 48, at 642.

ever had any mental health treatment" or "any mental disorder" were overbroad and violated the ADA. As the questions became narrower over time, the courts' holdings did too. This section describes the progression of cases over time, from 1993 until the present.

1. *Medical Society of New Jersey v. Jacobs*

The first case to confront the issue of mandatory inquiries into mental health involved physicians, not attorneys. In 1993, an association representing physicians in New Jersey sought a preliminary injunction against the New Jersey Board of Medical Examiners, the state agency that licensed physicians.[76] The physicians protested questions that appeared on forms required of those seeking an initial medical license or renewal of an existing license. The questions were "Have you ever suffered or been treated for any mental illness or psychiatric problems?" and "Are you presently or have you previously suffered from or been in treatment for any psychiatric illness?"[77]

The District Court of New Jersey held that these questions clearly singled out qualified individuals with disabilities.[78] If an applicant answered affirmatively, she was subjected to further investigation, and the questions were therefore an impermissible screening device under the ADA because they imposed additional burdens on qualified individuals with disabilities.[79] The court further held that "these additional burdens are unnecessary" and that "[t]he Court is confident that the Board can formulate a set of effective questions that screen out applicants based only on their behavior and capabilities."[80] The court was clear that the mental health questions "substitute[d] an impermissible inquiry into the status of disabled applicants for the proper, indeed necessary, inquiry into the applicants' behavior."[81]

---

[76] Med. Soc'y of N.J. v. Jacobs, No. 93-3670 (WGB), 1993 WL 413016, at *1 (D.N.J. Oct. 5, 1993).

[77] *Id.* at *1.

[78] *Id.* at *5.

[79] *Id.* at *7.

[80] *Id.* The court suggested that appropriate inquiries could be "based on [applicants'] employment histories; based on whether applicants can perform certain tasks or deal with certain emotionally or physically demanding situations; or based on whether applicants have been unreliable, neglected work, or failed to live up responsibilities." *Id.*

[81] *Id.* The court then concluded that although the plaintiff physicians had a high probability of succeeding on the merits, they had not shown immediate irreparable injury because they had not provided any evidence that the Board actually subjected

Interestingly, the court was careful to state that it was not the questions themselves that were discriminatory, but rather the extra investigation that an affirmative answer to the questions triggered.[82] In other words, if the Board asked the questions but then did not act upon the answers, the questions themselves would be permissible.[83]

2. *In re Underwood*

Only a few months later, the Supreme Court of Maine ruled on the same question, this time in the context of attorney licensing.[84] In *Underwood*, two bar applicants refused to answer the following questions on the Maine state bar application: "Have you ever received diagnosis of an emotional, nervous or mental disorder?" and "Within the ten (10) year period prior to the date of this application, have you ever received treatment of emotional, nervous or mental disorder?"[85]

In a short opinion, the court held that both asking the questions and requiring applicants to sign broad medical record authorizations violated the ADA because it discriminated on the basis of disability and imposed eligibility criteria that screened out individuals with disabilities.[86] The court noted that "it is certainly permissible for the Board . . . to fashion other questions more directly related to *behavior* that can affect the practice of law without violating the ADA."[87]

3. *Ellen S. v. Florida Board of Bar Examiners*

In 1994, a bar applicant and several law students sued the Florida Board of Bar Examiners, alleging that four aspects of the Board's bar application violated the ADA: 1) broad questions about mental health treatment and diagnosis, 2) broad medical records release authorizations, 3) a letter of inquiry sent from the Board to all treating professionals, and 4) follow-up investigations and hearings conducted by the Board.[88] The application asked the following questions:

---

applicants who answered affirmatively to additional investigations. *Id.* at *11. Therefore, the court denied the application for a preliminary injunction, even though the opinion was quite clear that the Board's scheme violated Title II of the ADA. *Id.*

[82] *Id.* at *8.

[83] *Id.*

[84] *In re* Application of Underwood, 1993 WL 649283 (Me. Dec. 7, 1993).

[85] *Id.* at *1 n.1.

[86] *Id.* at *2.

[87] *Id.*

[88] Ellen S. v. Fla. Bd. of Bar Exam'rs, 859 F. Supp. 1489, 1490-91 (S.D. Fla. 1994).

> Consultation with Psychiatrist, Psychologist, Mental Health Counselor, or Medical Practitioner.
>
> _____ Yes _____ No Have you ever consulted a psychiatrist, psychologist, mental health counselor or medical practitioner for any mental, nervous or emotional condition, drug or alcohol use? If yes, state the name and complete address of each individual you consulted and the beginning and ending dates of each consultation.
>
> a. _____ Yes _____ No Have you ever been diagnosed as having a nervous, mental or emotional condition, drug or alcohol problem? If yes, state the name and complete address of each individual who made each diagnosis.
>
> b. _____ Yes _____ No Have you ever been prescribed psychotropic medication? If yes, state the name and complete address of each prescribing physician. Psychotropic medication shall mean any prescription drug or compound effecting the mind, behavior, intellectual functions, perceptions, moods, or emotions, and includes anti-psychotic, anti-depressant, anti-manic and anti-anxiety medications.[89]

The Southern District of Florida held that Title II of the ADA applied to the licensing of attorneys,[90] and that the Board's actions of placing additional burdens on qualified applicants with disabilities discriminated against those applicants.[91] Technically, the *Ellen S.* decision ruled only on the Board's Motion to Dismiss and held that the court had jurisdiction to hear the case.[92] After this decision, the plaintiffs and the Board entered a consent decree where the Board voluntarily changed the disputed questions.[93]

4. *Applicants v. Texas State Board of Law Examiners*

Only two months later, a district court in Texas reached the opposite conclusion of the *Ellen S.* court and upheld several mental health questions on the Texas bar application.[94] Surprisingly, the Texas decision did not even mention *Ellen S.* The Texas application asked the following questions:

> a. Within the last ten years, have you been diagnosed with or have you been treated by [sic] bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?

---

[89] *Id.* at 1491 n.1.
[90] *Id.* at 1493.
[91] *Id.* at 1494.
[92] *Id.* at 1495-96.
[93] *See* Doe v. Jud. Nominating Comm'n, 906 F. Supp. 1534, 1543 (S.D. Fla. 1995).
[94] Applicants v. Tex. State Bd. of Law Exam'rs, No. A 93 CA 740 SS, 1994 WL 923404, at *1 (W.D. Tex. Oct. 11, 1994).

> b. Have you, since the age of attaining eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?[95]

Answering affirmatively required the applicant to provide additional information, authorize the release of medical records, and subject herself to an additional investigation by the Board.[96] The Texas questions were limited in temporal scope, while the challenged questions in *Medical Society of New Jersey* and *Ellen S.* were open-ended, "have you ever" been treated questions. Because of this temporal limitation, the court held that the Texas questions were more narrowly tailored.[97]

However, the *Texas Applicants* questions included a list of specific diagnoses that appeared to frighten the court, which wrote "[b]ipolar disorder, schizophrenia, paranoia, and psychotic disorders are serious mental illnesses that may affect a person's ability to practice law."[98] The court reasoned that even though a person may go for long periods of time without a problem, the risk of any future "episode" was sufficient to trigger a further investigation by the Board.[99]

The court stated that the Board's "individualized, case-by-case investigation"—which plaintiffs characterized as "screening out" and "additional burdens"—was actually "efforts to avoid improper generalization or stereotyping of mentally disabled individuals."[100] The court went on to commend the Board, saying "the Board discharges its duty in a responsible

---

[95] *Id.* at *2 n.5.

[96] *Id.* at *2.

[97] *Id.* at *9.

[98] *Id.* at *3.

[99] The opinion read as follows:

> Bipolar disorder, schizophrenia, paranoia, and psychotic disorders are serious mental illnesses that may affect a person's ability to practice law. People suffering from these illnesses may suffer debilitating symptoms that inhibit their ability to function normally. The fact that a person may have experienced an episode of one of these mental illnesses in the past but is not currently experiencing symptoms does not mean that the person will not experience another episode in the future or that the person is currently fit to practice law. Indeed, a person suffering from one of these illnesses may have extended periods between episodes, possibly as much as ten years for bipolar disorder or schizophrenia. Although a past diagnosis of the mental illness will not necessarily predict the applicant's future behavior, the mental health history is important to provide the Board with information regarding the applicant's insight into his or her illness and degree of cooperation in controlling it through counseling and medication. In summary, inquiry into past diagnosis and treatment of the severe mental illnesses is necessary to provide the Board with the best information available with which to assess the functional capacity of the individual.

Id.

[100] *Id.* at *7.

manner while making every effort not to discriminate against those who have suffered a mental illness but have the present fitness to practice law."[101]

The opinion further stated that the Board was charged with an "awesome responsibility":[102]

> The Board has a duty not to just the applicants, but also to the Bar and the citizens of Texas to make every effort to ensure that those individuals licensed to practice in Texas have the good moral character and present fitness to practice law and will not present a potential danger to the individuals they will represent. The Board has a limited opportunity to accomplish this task—the time of the filing of the declaration and application. The Board, therefore, must make every effort to investigate each applicant as thoroughly as possible and as efficiently as possible during this limited time.[103]

The reference to a "limited" time period for investigation is somewhat misleading, given that these applicants filed as first-year law students, more than two years before they were scheduled to sit for the bar examination. But the court concluded that the Board's "rigorous application procedure, including investigating whether an applicant has been diagnosed or treated for certain serious mental illnesses, is indeed necessary to ensure that Texas' lawyers are capable, morally and mentally, to provide these important services."[104] The court went so far as to say that the Board "would be derelict in its duty if it did not investigate the mental health of prospective lawyers."[105]

The Texas suit was perhaps complicated by the fact that the Texas Board of Law Examiners had revised its mental health questions several times in recent years: it used one question prior to April 1992, another from April 1992 to July 1993, and then a third after July 1993.[106] The plaintiffs did not file their complaint until October 22, 1993.

Other courts and commentators have criticized the *Texas Applicants* decision.[107] This includes the DOJ, which has long maintained that the questions upheld in this

---

[101] *Id.*
[102] *Id.* at *8.
[103] *Id.*
[104] *Id.*
[105] *Id.* at *9.
[106] *Id.* at *2 & nn.3-5.
[107] *See, e.g.*, Herr, *supra* note 48, at 667.

decision are impermissible because of their focus on status rather than behavior.[108]

5. *McCready v. Illinois Board of Admissions to the Bar*

In *McCready*, the applicant challenged questions on a bar application form to be completed by a person serving as a reference for the applicant.[109] The Illinois bar application did not ask about mental health, but the third-party reference forms required by the bar asked if the reference knew of any "drug or alcohol dependency or abuse," as well as "any emotional, mental, behavioral or nervous affliction" on the part of the applicant.[110]

The Northern District of Illinois found that the questions struck down in *Ellen S.* were broader than the questions at issue and followed the lead of *Texas Applicants* in finding that Illinois's inquiry was narrowly tailored.[111] The court held that it was "ludicrous . . . to propose that [the purpose of the ADA] can only be accomplished by prohibiting a state from directly investigating and assessing an applicant's emotional and mental fitness . . . ."[112] It went on to replicate the language of *Texas Applicants* and say that the Board "would be derelict in its duty if it did not investigate the mental health of prospective lawyers to the extent allowed by law[,]" and concluded that the ADA "does not prohibit reasonable inquiry concerning the mental disabilities or addictions of applicants for admission to the bar."[113] The court held that because the application did not ask *the applicant*, only her references, and imposed no additional burden on the applicant, the inquiry did not violate the ADA.[114]

6. *Clark v. Virginia Board of Bar Examiners*

One month after *McCready*, the Eastern District of Virginia struck down a mental health question on the Virginia

---

[108] Letter from Jocelyn Samuels to C.J. Bernette J. Johnson et al. 2 (Feb. 5, 2014) [hereinafter DOJ Letter], *available at* http://www.ada.gov/louisiana-bar-lof.pdf; Herr, *supra* note 48, at 667.

[109] McCready v. Ill. Bd. of Admissions to the Bar, No. 94 C 3582, 1995 WL 29609, at *6 (N.D. Ill. Jan. 24, 1995).

[110] *Id.* at *6. The plaintiff's issues appeared to be related to drug and alcohol dependency, not mental health.

[111] *Id.*

[112] *Id.* at *7.

[113] *Id.*

[114] *Id.* at *6.

bar application.[115] At the time of the suit, Virginia's application asked "Have you within the past five (5) years, been treated or counselled for a mental, emotional, or nervous disorder?"[116] An affirmative answer required the applicant to furnish details about her diagnosis, treatment, and prognosis.[117]

The opinion carefully evaluated testimony from two competing expert witnesses, both psychiatrists. The plaintiff's expert, Dr. Howard V. Zonana, testified that the question asked for information that "is unrelated to applicants' present ability to practice law and has little or no predictive value."[118] Dr. Zonana first stated that "there is little evidence to support the ability of bar examiners, or even mental health professionals, to predict inappropriate or irresponsible future behavior based on a person's history of mental health treatment."[119] The court noted that the American Psychiatric Association supported the position that "psychiatric history should not be the subject of applicant inquiry because it is not an accurate predictor of fitness."[120]

The defendant's expert was Dr. Charles B. Mutter, a psychiatrist and former member of the Florida Board of Bar Examiners.[121] Dr. Mutter testified that broad mental health questions were "essential" and narrower questions were "inadequate because they allow[ed] applicants to filter their responses and provide self-promoting answers."[122] The court rejected Dr. Mutter's position as "immoderate" and "somewhat extreme," finding that it was "unsupported by objective evidence and discordant with a contemporary understanding of mental health questions under the ADA."[123] The court noted that Dr. Mutter "was unable [to] point to any evidence proving a correlation between mental health questions and an inability to practice law."[124] The court was also concerned that the inquiry would deter

---

[115] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 431 (E.D. Va. 1995). When the complaint was first filed, the court concluded that it did not have jurisdiction over the matter, although it oddly then proceeded to discuss the ADA instead of stopping at the jurisdictional question. Clark v. Va. Bd. of Bar Exam'rs, 861 F. Supp. 512, 516 (E.D. Va. 1994). The court then determined that the plaintiff Clark was not disabled and granted summary judgment in favor of the board of bar examiners. *Id.* at 517. However, after Clark filed a motion to alter judgment, the court determined that the previous decision was in error and that 1) the court did have jurisdiction and 2) the court's determination that Clark was not disabled was "premature." *Id.* at 517-19. The court reversed the grant of summary judgment. *Id.*

[116] *Clark*, 880 F. Supp. at 433.

[117] *Id.*

[118] *Id.* at 435.

[119] *Id.*

[120] *Id.*

[121] *Id.* at 436.

[122] *Id.*

[123] *Id.*

[124] *Id.*

law students from seeking counseling[125] and could negatively affect the treatment of those who did seek counseling.[126]

The court stated it was "not clear" that the disputed question screened out potential applicants, but that the question clearly did "impose[] an additional burden on applicants with disabilities . . . ."[127] Because this additional burden existed, the Board had to show that the question was "necessary" to the licensing function.[128] The court found that "the Board presented no evidence of correlation between obtaining mental counseling and employment dysfunction,"[129] and, therefore, the question was not "necessary" under the ADA.[130] In addition, the court found that Virginia's question was broader than those asked in *Texas Applicants*, which were "addressed only to specific behavioral disorders relevant to the practice of law."[131]

The court emphasized the narrow scope of its ruling by stating that "some form of mental health inquiry is appropriate,"[132] and declined to rule on whether all mental health questions should be eliminated from bar applications.[133] The court also specifically declined to craft a question that would comply with the ADA: "As the Court's job in this case is to decide whether [Question] 20(b) complies with the ADA, not to draft a question that would comply with the ADA, the Court will refrain from offering any *dictum* guidance."[134]

7. *Doe v. Judicial Nominating Commission*

In *Doe*, the Southern District of Florida applied the same analytical framework to a judicial nomination application.[135] In Florida, when a state judicial vacancy occurs between elections, a judicial nominating commission (JNC) solicits and reviews applications before submitting nominees to the governor.[136] An attorney who sought a judicial nomination filed suit on the grounds that the questions in the application violated the ADA. The questions asked for general information about the applicant's physical health and asked if applicants

---

125 *Id.* at 437-38.
126 *Id.* at 438.
127 *Id.* at 442.
128 *Id.* at 442-43.
129 *Id.* at 446.
130 *Id.*
131 *Id.* at 444.
132 *Id.* at 436.
133 *Id.* n.10.
134 *Id.* at 446.
135 Doe v. Jud. Nominating Comm'n, 906 F. Supp. 1534 (S.D. Fla. 1995).
136 *Id.* at 1536.

have ever been treated for "any form of mental illness" or "any form of emotional disorder or disturbance or otherwise [had] been treated by psychologists, psychiatrists, or other mental health care professionals in the last five years."[137]

The court focused its inquiry on the "necessary" exception, finding that the "forced disclosure of information relating to disabilities without a necessary basis for the information is a form of discrimination because it screens out, or tends to screen out, the disabled by imposing disproportionate burdens on them."[138] The court concluded that the JNC's questions were overbroad because they inquired about "any form of mental illness" and "any hospital confinement."[139] The court found that such inquiries were over-inclusive because they would "force the disclosure of intimate, personal matters that have nothing to do with job performance."[140] The court also noted that "at minimum, the inquiry must be subject to reasonable time limitations . . . ."[141]

The court enjoined the JNC from asking the disputed questions and requiring medical records releases.[142] However, the court explicitly rejected the plaintiff's argument that the ADA prohibited the asking of *any* questions about mental and physical fitness and held that "the ADA does not prevent inquiry into an applicant's status, i.e., diagnosis or treatment for severe mental illness."[143]

8. *In re Petition and Questionnaire for Admission to the Rhode Island Bar (Rhode Island)*

In 1996, the Supreme Court of Rhode Island issued perhaps the most thoroughly researched opinion on this issue.[144] The case began when the ACLU of Rhode Island challenged four questions on the Rhode Island bar application on the grounds that they violated the ADA.[145] The board of bar examiners then revised two of the questions, and its Committee on Character and Fitness then petitioned the Supreme Court of

---

[137] *Id.* at 1537.
[138] *Id.* at 1544.
[139] *Id.*
[140] *Id.*
[141] *Id.* at 1545.
[142] *Id.*
[143] *Id.* at 1541-42.
[144] *In re* Petition & Questionnaire for Admission to the R.I. Bar (*Rhode Island*), 683 A.2d 1333 (R.I. 1996).
[145] *Id.* at 1333.

Rhode Island for instructions on how to proceed with the remaining two questions.[146]

The challenged questions asked "Have you ever been hospitalized, institutionalized or admitted to any medical or mental health facility (either voluntarily or involuntarily) for treatment or evaluation for any emotional disturbance, nervous or mental disorder?" and "Are you now or have you within the last five (5) years been diagnosed as having or received treatment for an emotional disturbance, nervous or mental disorder, which condition would impair your ability to practice law?"[147] An affirmative answer to either question triggered the need to produce medical records and a further investigation.

As part of the case, the court invited written comments from the public and held a public hearing.[148] It also appointed a special master, who was both a lawyer and a medical doctor, to investigate the matter.[149] The court placed great weight on the report of the special master, which concluded that there was no link between previous psychiatric treatment and a person's ability to function effectively in the workplace.[150] The special master also found that there was no empirical evidence showing that lawyers with a history of psychiatric treatment had a higher incidence of disciplinary actions later.[151] The special master's conclusions essentially mirrored those of the plaintiff's expert, Dr. Zonana, in *Clark*.[152]

Ultimately, the court adopted the question recommended by the special master: "Are you currently suffering from any disorder that impairs your judgment or that would otherwise adversely affect your ability to practice law?"[153] The other questions were removed from the application.[154]

9. *O'Brien v. Virginia Board of Bar Examiners*

In 1998, Virginia's bar application question was challenged once again.[155] After *Clark*, the Virginia Board of Bar Examiners had revised the question to read as follows:

---

[146] *Id.* & n.1.

[147] *Id.* at 1334.

[148] *Id.* at 1333-34.

[149] *Id.* at 1333.

[150] *Id.* at 1336; *see also* discussion *infra* Part IV.A.1.

[151] *Rhode Island*, 683 A.2d at 1336.

[152] *See supra* Part II.A.6.

[153] *Rhode Island*, 683 A.2d at 1337. There was also a second question about the current use of drugs and alcohol.

[154] *See id.* at 1333 n.1.

[155] O'Brien v. Va. Bd. of Bar Exam'rs, No. 98-0009-A, 1998 WL 391019 (E.D. Va. Jan. 23, 1998).

> Within the past five years, have you been diagnosed with or have you been treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, antisocial personality disorder, or any other condition which significantly impaired your behavior, judgment, understanding, capacity to recognize reality, or ability to function in school, work or other important life activities?[156]

The new question also included a preamble stating that the Board did not seek information related to situational counseling.[157] The *O'Brien* opinion held that the revised question addressed "many" of the concerns raised in *Clark* and that the question was "carefully tailored to respect the privacy rights of the individual applicant."[158] The court therefore denied the plaintiff's motion for a preliminary injunction and upheld the question under the ADA.

10. *Brewer v. Wisconsin Board of Bar Examiners*

In *Brewer*, the applicant did not challenge the questions on the bar application but rather the Wisconsin Board of Bar Examiners' requirement that she undergo a psychological examination at her own expense.[159] The cost of this evaluation was estimated between $1500 and $2000.[160]

The Eastern District of Wisconsin held that even if the Board ultimately licensed the plaintiff, "requiring [her to] undergo [the examination] at her own expense and submit the results to the Board amount[ed] to a burden to which the vast majority of her classmates and other applicants were not subjected."[161] The court reasoned that even without a current psychological evaluation, the Board would be able to look at the plaintiff's past conduct and behavior to evaluate her fitness to practice law, just as it did for applicants without disabilities.[162]

---

[156] *Id.* at *3.

[157] *Id.* "Situational counseling" is generally regarded as counseling to help a person handle a particular situation. Common examples include the death of a loved one, relationship difficulties, or exam stress.

[158] *Id.* at *3-4.

[159] Brewer v. Wis. Bd. of Bar Exam'rs, No. 04-C-0694, 2006 WL 3469598, at *1 (E.D. Wis. Nov. 28, 2006).

[160] *Id.* at *2.

[161] *Id.* at *10.

[162] *Id.* at *12.

11. *ACLU of Indiana v. Indiana State Board of Law Examiners*

In *ACLU of Indiana v. Indiana State Board of Law Examiners*, the Southern District of Indiana struck down one question on the Indiana bar application but upheld three others.[163] The court held that questions asking about "any mental, emotional or nervous disorders," beginning from the age of 16, were overly broad.[164] However, the court upheld a question asking about specific diagnoses, noting its similarity to questions upheld by *Texas Applicants* and *O'Brien*.[165] Even though the Indiana question was unlimited in temporal scope, while the *Texas Applicants* and *O'Brien* questions were not, the court held that "the Board had a sound basis" for the unlimited time period "given the undisputed evidence that mental illnesses tend to recur throughout a person's lifetime."[166]

The court also upheld a question asking "Do you have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice law in a competent and professional manner?"[167] In upholding this question, the court stated, "[u]ndoubtedly, these related questions are narrowly focused on the *current* time period."[168] The court held specifically that these questions were "permissible under the ADA . . . because [they] appropriately bear on the applicant's *current* ability to practice law."[169]

B. Department of Justice Actions in 2014

The DOJ Civil Rights Division has long been involved in this issue, including filing amicus briefs in many of the cases discussed above. In early 2014, the DOJ took its strongest action to date to bring state bar associations into compliance. First, it responded to a request from the Vermont Human Rights Commission asking whether Vermont's bar application questions violated the ADA. On January 21, 2014, the DOJ

---

163 ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *1 (S.D. Ind. Sept. 20, 2011).

164 *Id.* at *9.

165 *Id.* at *8.

166 *Id.* at *9.

167 *Id.* at *10.

168 *Id.*

169 *Id.*

sent a written response concluding that Vermont's questions did violate the ADA.[170]

The following month, the DOJ sent a more stern letter, using similar language and reasoning, to the Louisiana Supreme Court.[171] The Louisiana case began when the Bazelon Center for Mental Health Law filed an administrative complaint with the DOJ on behalf of an applicant who was granted conditional admission to the Louisiana bar because of her mental health diagnosis.[172] This led to the DOJ's investigation of Louisiana's bar admission procedures, including its application questions as well as its conditional admission program. The DOJ's letter to Louisiana explained that Louisiana's system of evaluating applicants for the Louisiana bar, as well as its conditional admission program, violated the ADA.[173] The DOJ letter set forth a number of remedial measures for the Louisiana Supreme Court to implement and warned that the Attorney General might initiate a lawsuit if Louisiana did not comply.[174]

Although Louisiana disputed that its policies violated the ADA,[175] it ultimately agreed to a settlement with the DOJ on August 14, 2014.[176] Before this settlement, Louisiana used old NCBE Questions 25, 26, and 27[177] to solicit information about

---

[170] *See* DOJ Letter, *supra* note 108, Attachment 1.

[171] *Id.*

[172] *See Louisiana Bar Conditional Admissions*, BAZELON CENTER FOR MENTAL HEALTH L., http://www.bazelon.org/In-Court/Current-Litigation/Louisiana-Bar-Conditional-Admissions.aspx (last visited Mar. 14, 2015).

[173] DOJ Letter, *supra* note 108.

[174] *Id.* at 31-34.

[175] SETTLEMENT AGREEMENT BETWEEN U.S. AND LA. SUP. CT. UNDER THE AMERICANS WITH DISABILITIES ACT ¶¶ 7, 10 (Aug. 14, 2014) [hereinafter LA. SETTLEMENT AGREEMENT], *available at* http://www.ada.gov/louisiana-supreme-court_sa.htm.

[176] *Id.* at ¶¶ 1-3.

[177] The previous versions of the NCBE questions were as follows:

> 25. Within the past five years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?
>
> 26A. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice law in a competent and professional manner?
>
> 26B. If your answer to Question 26(A) is yes, are the limitations caused by your mental health condition . . . reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?
>
> 27. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation;

applicants' mental health. Under the settlement agreement, Louisiana deleted those questions and now uses the new NCBE Questions 25 and 26, as well as a third question of its own.[178]

The new NCBE questions are as follows:

> 25. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice law in a competent, ethical, and professional manner?
>
> 26. A. Do you currently have any condition or impairment (including, but not limited to, substance abuse, or a mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice law in a competent, ethical, and professional manner?
>
> B. If your answer to Question 26(A) is yes, are the limitations caused by your condition or impairment reduced or ameliorated because you receive ongoing treatment or because you participate in a monitoring or support program?

Additionally, Louisiana agreed to refrain from inquiring about an applicant's mental health diagnosis or treatment at all, unless the applicant raised mental health as a defense to explain conduct or behavior that might otherwise warrant a denial of admission or the bar examiners learned that such a mental health defense had been raised elsewhere.[179] If such a defense is raised, the bar examiners will first request statements from the applicant and possibly from the applicant's treating professional, whose statement "shall be accorded considerable weight."[180]

> any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization, or licensing authority?

See DOJ Letter, *supra* note 108, at 5.

[178] LA. SETTLEMENT AGREEMENT, *supra* note 175, ¶ 14. Louisiana also added a new Question 28, which reads:

> Within the past five years, have you engaged in any conduct that:
>
> (1) resulted in an arrest, discipline, sanction or warning;
>
> (2) resulted in termination or suspension from school of employment;
>
> (3) resulted in loss or suspension of any license;
>
> (4) resulted in any inquiry, any investigation, or any administrative or judicial proceeding by an employer, educational institution, government agency, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure; or
>
> (5) endangered the safety of others, breached fiduciary obligations, or constituted a violation of workplace or academic conduct rules?

Id.

[179] *Id.* ¶ 13(c).

[180] *Id.*

The settlement provides that Louisiana bar examiners will no longer request medical records as a matter of course but instead only when their reasonable concerns cannot be resolved by further dialogue with the treating professional.[181] Louisiana also agreed not to use conditional admission solely on the basis of mental health.[182] All applicants who are currently admitted on a conditional basis will be granted full admission, unless the applicant has engaged in concerning conduct or her condition currently impairs her ability to practice law.[183]

This settlement applies to all pending applications and to any applicants who previously answered the mental health questions affirmatively and were denied admission.[184] Those files must be reevaluated under the new standards. In addition, Louisiana agreed to pay $200,000 to compensate seven applicants identified by the DOJ as having been harmed by the past discrimination.[185]

This settlement is a watershed moment. It represents a clear statement that the DOJ will insist on scrupulous adherence to the letter and spirit of the ADA. States whose current applications do not conform with the ADA[186] should take immediate action to bring their application processes into compliance.

C. Response of the National Conference of Bar Examiners

The NCBE, the organization that administers many bar exams, including the Multistate Bar Examination (MBE), Multistate Professional Responsibility Examination (MPRE), and Multistate Performance Test (MPT), also offers character and fitness processing services for states.[187] The NCBE offers a standard application form, which states may adopt in full or in part, or states may hire the NCBE to process their applicants' files using an application form written by the state.[188] Other states do not use the NCBE forms but use the language of the NCBE questions on their own applications.[189] In the past,

---

[181] *Id.*

[182] *Id.* ¶ 13(d).

[183] *Id.* ¶ 21(b)(i).

[184] *Id.* ¶ 21.

[185] *Id.* ¶ 22.

[186] *See infra* Part III.A.

[187] *See Character and Fitness*, NAT'L CONF. OF B. EXAMINERS, http://www.ncbex.org/character-and-fitness/ (last visited Apr. 20, 2015).

[188] *Id.*

[189] Herr, *supra* note 48, at 644.

revision of the NCBE questions has been an "indicator of future trends in state bar applications."[190]

While the DOJ and Louisiana were negotiating the settlement, the DOJ was also in negotiations with the NCBE. On February 24, 2014, the NCBE notified state bar associations that it had revised the mental health questions on its standard application form—Questions 25, 26, and 27, as well as the preamble to those questions.[191]

In its letter, the NCBE was careful not to concede that the DOJ's interpretation about the illegality of these questions was correct. The NCBE insisted that it was not a covered entity under Title II of the ADA, but that it was "mindful of the pressure that the DOJ has brought to bear upon jurisdictions that use [its] questions."[192] The NCBE stated that "it would be incorrect to conclude that we agree with [the DOJ's] positions" and that new Question 25 "should not be read to signify the NCBE's agreement with the DOJ's position."[193] But actions speak louder than words, and the new questions represent a major departure from the previous questions.

The new NCBE questions are as follows:

> 25. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice law in a competent, ethical, and professional manner?
>
> 26. A. Do you currently have any condition or impairment (including, but not limited to, substance abuse, or a mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice law in a competent, ethical, and professional manner?
>
> B. If your answer to Question 26(A) is yes, are the limitations caused by your condition or impairment reduced or ameliorated because you receive ongoing treatment or because you participate in a monitoring or support program?
>
> 27. Within the past five years, have you asserted any condition or impairment as a defense, in mitigation, or as an explanation for your conduct in the course of any inquiry, any investigation, or any administrative or judicial proceeding by an educational institution,

---

[190] *Id.* at 644-45; Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 441 (E.D. Va. 1995) ("[The NCBE] questions formed the basis for many states' mental health questions, including Virginia . . . . While the actions of the NCBE and ABA are not binding on the states, they signify the substantial impact the ADA is having on the formulation of mental health inquiries.").

[191] Memorandum from Erica Moeser, President, Nat'l Conf. of Bar Exam'rs to Bar Admission Adm'rs (Feb. 24, 2014) (on file with author).

[192] *Id.* at 1.

[193] *Id.* at 1-2.

> government agency, professional organization, or licensing authority; or in connection with an employment disciplinary or termination procedure?[194]

The question about specific mental health diagnoses is completely gone. The new Question 26 is very similar to the question upheld in *ACLU of Indiana*, with the crucial deletion of the "if untreated" language.[195] The inquiry is properly limited to current impairment and the focus is on ability, not diagnosis. Therefore, these questions do not screen out or tend to screen out applicants with disabilities and thus comply with the ADA.

The Louisiana settlement and the NCBE revisions should send a very clear message to states. The DOJ has proven its willingness to take action and strike a hard line with bar associations to bring them into compliance. But as of this writing, 14 states continue to ask questions on their bar applications that violate the ADA, and only one year ago, that number was 26.

III. WHAT IS PERMITTED UNDER THE ADA?

The nature and breadth of questions asked varies dramatically from state to state. Nine states ask no questions about mental health at all.[196]

A. States That Ask About Mental Health

As of April 2015, 24 states were using the revised NCBE questions.[197] Seven states ask their own questions about mental health, and three of those violate the ADA.[198] Seven states continue to ask questions about specific mental health diagnoses,[199] down from 18 states in 2014.[200] Ten states[201]

---

194 *See id.* at 5.

195 *See* discussion *infra* Part III.A.2.

196 Alaska, Arizona, California, Illinois, Maine, Massachusetts, New Mexico, Pennsylvania, and Tennessee. *See* Alyssa Dragnich, Bar Admission Survey (2015) [hereinafter Bar Survey] (unpublished survey) (on file with author). This survey reviewed the character and fitness questions on the bar applications of all 50 states and the District of Columbia as of April 2015.

197 Alabama, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Indiana, Kansas, Louisiana, Maryland, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Oklahoma, South Dakota, Vermont, Washington, and Wyoming. *Id.* Georgia also asks additional questions of its own.

198 Arkansas, Georgia, Hawaii, Iowa, Michigan, Minnesota, and South Carolina. *Id.*

199 Florida, Kentucky, Nevada, Ohio, Texas, Utah, and Virginia. *Id.*

200 Colorado, Connecticut, Delaware, Florida, Idaho, Indiana, Kansas, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Texas, Utah, and Virginia. *Id.*

201 Arkansas, Florida, Kentucky, New Hampshire, Ohio, Oregon, Rhode Island, Virginia, West Virginia, and Wisconsin. *Id.*

continue to ask the "if untreated" question, also down from 18 in the previous year. In total, 14 states still ask application questions that violate the ADA.[202]

1. Questions about Specific Diagnoses

Seven[203] state applications currently ask about specific mental health diagnoses, which is the question upheld in *Texas Applicants*,[204] but deleted from the new NCBE questions.[205] The applicable time period for this inquiry varies, with most states inquiring about the previous five or 10 years. The most common form of the specific diagnosis question asks: "In the past [5 or 10] years, have you been diagnosed with, been treated or sought counseling for bi-polar disorder, schizophrenia, paranoia, or any other psychiatric disorder, or have you ever been committed to any institution for the treatment of any such condition?"[206]

In *Rhode Island*, the special master specifically considered and rejected a question about specific diagnoses, such as bipolar disorder and schizophrenia, on the grounds that it likely violated the ADA by inquiring into diagnosis and status rather than behavior and function.[207] Some commentators who object to questions about mental health generally would still permit inquiry into specific diagnoses such as bipolar disorder or schizophrenia.[208] But this approach continues to reflect a biased vision of mental illness because it effectively concludes certain types of mental illness are permissible, but other types are not.

This is the wrong lens through which to view the issue. Twenty years ago, some bar examiners insisted they needed to know details of an applicant's counseling sessions for temporary stresses, such as exam anxiety or bereavement.[209] Today, the opposite is true: most state applications specifically state that this type of situational counseling does not need to

---

[202] Arkansas, Florida, Georgia, Kentucky, Minnesota, Nevada, New Hampshire, Ohio, Oregon, Texas, Utah, Virginia, West Virginia, and Wisconsin. *Id.*

[203] Florida, Kentucky, Nevada, Ohio, Texas, Utah, and Virginia. *Id.*

[204] *See* Applicants v. Tex. State Bd. of Law Exam'rs, No. A 93 CA 740 SS, 1994 WL 923404, at *2 (W.D. Tex. Oct. 11, 1994).

[205] *See* discussion *supra* Part II.C.

[206] *See, e.g.*, KY. OFFICE OF BAR ADMISSIONS, *Admission by Examination SCR 2.022 Attorney Applicants Summer 2015* (on file with author).

[207] Bauer, *supra* note 13, at 139 n.144.

[208] *See, e.g.*, *id.* at 213 (suggesting that bipolar disorder and schizophrenia may be appropriate subjects of inquiry under the ADA); *see also* Becton, *supra* note 8, at 383-84.

[209] *See infra* Part IV.B.2.

be disclosed.[210] Just as the states slowly recognized that there was no need for information on situational counseling, so too should they recognize that there is no need for information on specific diagnoses, absent any conduct irregularities.

Any inquiry into physical disabilities that asked about only "serious" disabilities would be immediately recognized as a violation of the ADA. What would qualify as "serious?" Blindness? A missing limb? Those certainly sound "serious" but in no way preclude a person from being an outstanding attorney. Drawing a parallel to physical disabilities (and bearing in mind that the inquiry for physical and mental disabilities is the same under the ADA) shows the futility of attempting to separate out "serious" mental illness from other types.

General classifications by diagnosis are wholly ineffective at predicting if someone might be an unfit attorney in the future.[211] The "mere presence of a medical condition is not an accurate predictor of fitness," and people diagnosed with the same condition can react very differently and have very different levels of functionality.[212]

For example, many people diagnosed with the "serious" conditions of bipolar disorder or schizophrenia are capable of succeeding in high-level and stressful jobs.[213] Some people diagnosed with bipolar disorder manage their condition extremely well, and their coworkers and clients would never know about their diagnosis.[214] The same is true for many people diagnosed with schizophrenia.[215]

Applicants with bipolar disorder probably comprise a majority of the hearings, conditional admissions, and denials that result from mental health disclosures.[216] This is perhaps the disorder that laypeople most frequently misunderstand and fear.

---

[210] *See, e.g.*, MINN. BD. OF BAR EXAM'RS, *Application for Admission*, *available at* http://www.ble.state.mn.us/file/Bar%20Application%202014%20-%20fill%20in(6).pdf.

[211] Allison Wielobob, *Bar Application Mental Health Inquiries: Unwise and Unlawful*, 24 HUM. RTS. 12, 14 (1997).

[212] Coleman & Shellow, *supra* note 47, at 72.

[213] James T.R. Jones, *Walking the Tightrope of Bipolar Disorder: The Secret Life of a Law Professor*, 57 J. LEGAL EDUC. 349, 351 (2007) (citing Marsha Langer Ellison & Zlatka Russinova, *A National Survey of Professionals and Managers with Psychiatric Conditions: A Portrait of Achievement and Challenges*, BOSTON U. CTR. FOR PSYCHIATRIC REHABILITATION (1999), *available at* http://cpr.bu.edu/wp-content/uploads/2013/05/National-Survey-of-Professionals-and-Managers-with-Psychiatric-Conditions.pdf.

[214] *See* Herr, *supra* note 48, at 674 n.175.

[215] Jennifer Jolly-Ryan, *The Last Taboo: Breaking Law Students With Mental Illnesses and Disabilities Out of the Stigma Straightjacket*, 79 U.M.K.C. L. REV. 123, 137 (2010) (citing Michael E. Waterstone & Michael Ashley Stein, *Disabling Prejudice*, 102 NW. U. L. REV. 1351, 1370 (2008)).

[216] Bauer, *supra* note 13, at 165.

In fact, "bipolar" has even become a pejorative term,[217] much as "gay" has been used not to refer to sexual orientation but as a slur.

But most people diagnosed with bipolar disorder, even those with severe forms, can stabilize their mood swings and related symptoms with proper treatment. People diagnosed with bipolar disorder can be—and are—successful lawyers and judges.[218] Two medical researchers who have treated many lawyers with bipolar disorder write that "most individuals with this condition function quite well in their occupation."[219]

No state application differentiates between Bipolar I and Bipolar II disorders. A medical doctor who served on the Georgia Board to Determine Fitness of Bar Applicants has noted that many people—one can assume this includes bar examiners—"do not understand the difference between Bipolar I and Bipolar II disorders."[220] A diagnosis of Bipolar II is generally appropriate when the person has not experienced a full-blown manic episode.[221] There has been a significant increase in the number of adolescents diagnosed with Bipolar II in the last decade,[222] a large number of whom have never had a manic episode and have never been hospitalized.[223] Bar examiners appear to be most concerned with manic episodes[224] (rightly or wrongly), so failing to differentiate between Bipolar I and II is not logical and suggests that bar examiners do not understand the difference.

As one successful law professor who suffers from bipolar disorder has stated: "I want to demonstrate that those with mental illness can have full and satisfying professional and personal lives, and they need not and should not endure stigma or doubt as to their ability to perform their personal or employment duties."[225] This same professor—who graduated Order of the Coif from Duke University School of Law, worked at Davis Polk & Wardwell in New York City, clerked for a

---

[217] Jon Kelly & Denise Winterman, *OCD, Bipolar, Schizophrenic and the Misuse of Mental Health Terms*, BBC NEWS MAG. ONLINE, (Oct. 10, 2011), http://www.bbc.com/news/magazine-15213824.

[218] Jolly-Ryan, *supra* note 215, at 136; Jones, *supra* note 213, at 354 n.27; Michael E. Waterstone & Michael Ashley Stein, *Disabling Prejudice*, 102 NW. U. L. REV. 1351, 1371 (2008).

[219] Bauer, *supra* note 13, at 167-68 (quoting David L. Dunner & G. Andrew H. Benjamin, *Bipolar Affective Disorder (Manic Depressive Illness)*, B. EXAM'R, Nov. 1994, at 25, 28).

[220] Peter Ash, *Predicting the Future Behavior of Bar Applicants*, B. EXAM'R, Dec. 2013, at 6, 12.

[221] *Id.* at 13.

[222] *Id.* at 12.

[223] *Id.* at 13.

[224] *See, e.g.*, Pobjecky, *supra* note 35, at 20.

[225] Jones, *supra* note 213, at 357 n.36, 373.

judge on the Fifth Circuit Court of Appeals, taught at the University of Chicago Law School, and earned tenure at the Louis D. Brandeis School of Law at the University of Louisville—never applied for bar admission in Kentucky in part because that would have required him to disclose his bipolar diagnosis.[226]

Several highly successful law professors have been open about their struggles with mental illness. Perhaps the best known is Elyn Saks, the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law.[227] Others include Marjorie Silver of Touro Law School;[228] Sol Watchler, a former judge on the New York Court of Appeals and adjunct professor at Touro;[229] James T.R. Jones at the Louis D. Brandeis School of Law at the University of Louisville;[230] and Lisa T. McElroy at Drexel University School of Law.[231]

Critics would say that these professors are outliers and that just because a few attorneys diagnosed with mental illnesses have been successful does not mean that all such attorneys will be. But attorneys with mental illnesses who commit egregious misconduct are also outliers and not representative of the general attorney population. The thesis of this Article is that the presence or absence of a mental health diagnosis cannot predict a person's future fitness as an attorney.

Furthermore, the disorders that bar examiners choose to single out in their applications reveal the examiners' limited knowledge of mental health and mental illness. As recently as 2014, some states' lists of diagnoses appeared oddly under-inclusive. For example, most of the applications did not ask about obsessive compulsive disorder or post-traumatic stress disorder. Severe cases of either could render a person incapable of practicing law. An attorney with narcissistic personality disorder or borderline personality disorder is arguably at a higher risk of committing misconduct. But only four states asked about personality disorders in their lists of diagnoses.

---

[226] *Id.* at 357 & 357 n.36.

[227] *See* ELYN R. SAKS, THE CENTER CANNOT HOLD: MY JOURNEY INTO MADNESS (2007).

[228] Anita Bernstein, *Lawyers with Disabilities:* L'Handicapé C'est Nous, 69 U. PITT. L. REV. 389, 403 (2008) (citing Michael L. Perlin, *"You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 715 n.182 (2003)).

[229] *Id.* (citing SOL WATCHLER, AFTER THE MADNESS: A JUDGE'S OWN PRISON MEMOIR (1997)).

[230] Jones, *supra* note 213, at, 349-50.

[231] Lisa T. McElroy, *Worrying Enormously about Small Things*, SLATE (July 18, 2013 8:16 AM), http://www.slate.com/articles/health_and_science/medical_examiner/2013/07/living_with_anxiety_and_panic_attacks_academia_needs_to_accommodate_mental.html.

This is not to suggest, of course, that these disorders should be added to the list of named diagnoses on application questions. If a person suffering from any of these disorders seeks admission to the bar, the inquiry ought to be the same as for all other applicants: the focus should be the record of conduct, not the diagnosis. If a person has successfully completed three years of law school, a time of great stress,[232] and successfully passed the written bar examination, then there is every reason to believe that she will go on to be a fit and capable attorney. If the person had conduct problems during law school—for example, she was found to have fabricated parts of a resume, or she verbally assaulted a classmate—those incidents would be revealed through the other parts of the character and fitness investigation. Asking about specific diagnoses only screens out applicants with certain disabilities and does not yield more accurate predictions of future fitness.

2. The "If Untreated" Question

Ten states ask if applicants have "any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which in any way currently affects, or *if untreated could affect*, your ability to practice law in a competent and professional manner?"[233] This question was specifically upheld in *ACLU of Indiana*.[234]

But as worded, the question is senseless. If the candidate *is* treating her condition and experiencing no impairment, a hypothetical inquiry about what might happen if she discontinued treatment is pointless. It is rather like asking "If

---

[232] An estimated 44% of law students meet the criteria for clinically significant levels of psychological distress. Todd David Peterson & Elizabeth Waters Peterson, *Stemming the Tide of Law Student Depression: What Law Schools Need to Learn from the Science of Positive Psychology*, 9 YALE J. HEALTH POL'Y L. & ETHICS 357, 359 (2009). Students begin law school with normal levels of stress, but their stress continues to increase throughout their three years in school (not decreasing after the first year). *Id.* Their levels of depression and anxiety remain significantly elevated even two years after graduation. *Id.* This stress is not unique to American law students but is seen in law schools around the world. *See, e.g.*, Wendy Larcombe et al., *Does an Improved Experience of Law School Protect Students against Depression, Anxiety and Stress? An Empirical Study of Wellbeing and the Law School Experience of LLB and JD Students*, 35 SYDNEY L. REV. 407 (2013) (discussing stress among Australian law students).

[233] IND. SUP. CT. BD. OF LAW EXAM'RS, *Character & Fitness Questionnaire*, *available at* https://myble.courts.in.gov/browseform.action?sid=46405001&ssid=46705001&applicationId=9 (emphasis added).

[234] ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *10 (S.D. Ind. Sept. 20, 2011).

you stop studying, are you at risk of failing any of your classes?" The answer would depend on a myriad of factors, including the point in the semester one stops studying, the course one is taking, one's innate intelligence, one's previous knowledge of the subject area, and more. It is both impossible to accurately predict and pointless to speculate—because the candidate has no intention of ceasing to study, there is no reason to ask the hypothetical. The same comparison could also be drawn to a physical disability, such as diabetes. If an applicant with diabetes controls her condition with diet and medication, would the bar examiners ask her whether she could be impaired should she stop her treatment? The answer is surely no.

The "if untreated" question requires only a modest amendment to bring it into compliance with the ADA, and in fact, this is essentially one of the revised NCBE questions.[235] If the "if untreated could affect" language were deleted, the question would read "Do you have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which in any way currently affects your ability to practice law in a competent and professional manner?" With this amendment, the question is limited to "currently affects" and thus the question is permissible.

The *ACLU of Indiana* court upheld this question by stating that it was "narrowly focused on the *current* time period."[236] The court held specifically that these questions were "permissible under the ADA" "because [they] appropriately bear on the applicant's *current* ability to practice law."[237]

But the court critically misread the question. The clause "if untreated could affect" relates to the *future*, not the present. If this clause were omitted, the court's interpretation of the question as focusing only on current fitness would be correct, and the question would be permissible. Questions about current fitness are appropriate and permitted. However, the "if untreated" clause necessarily requires applicants and bar examiners to speculate about an event that may never occur. Therefore, this clause must be deleted.

---

[235] New NCBE Question 26(a) asks "Do you currently have any condition or impairment (including, but not limited to, substance abuse, or a mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice law in a competent, ethical, and professional manner?" *See supra* Part II.C.

[236] *ACLU of Ind.*, 2011 WL 4387470, at *10.

[237] *Id.*

3. Preambles

Over time, many states have added a preamble to their mental health questions. Some current preambles urge applicants who need mental health treatment to obtain it and not be deterred by the application questions.[238] Some preambles define terms such as "ability to practice law" and "currently" (in the context of "any condition that *currently* impairs . . . ").[239] Most disclaimers state that mental health treatment will not necessarily result in the denial of bar admission. The efficacy of these disclaimers is questionable.[240] Many bar applicants may not believe the disclaimers and fear that disclosure of treatment will result in delays or denials of their applications. Whether bar examiners truly abide by these sentiments is also questionable.

The Texas application's preamble is perhaps more threatening than comforting:

> If you have received mental health counseling or have been hospitalized for mental health reasons and do not know the diagnosis which was made, you should contact the health care provider responsible for your care and inquire as to whether you were diagnosed with bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder. In answering the following questions, you are entitled to rely on the diagnosis of your treating health care provider. You do not need to report any counseling, treatment, or hospitalization, which was for a diagnosis other than those included in the following questions.

---

[238] *See, e.g.*, Preamble of Arkansas discussed *infra* Part III.A.3.

[239] Emphasis added. For example, California's preamble includes the following definitions:

> "Ability to practice law" includes performing services in a court of justice, in any manner, throughout its various stages and in conformity with adopted rules of procedure. In a larger sense it includes providing legal advice and counsel and preparation of legal instruments and contracts by which legal rights are protected. Law practice may also include the resolution of legal questions for consumers by advice and action if difficult or doubtful legal questions are involved, which, to safeguard the public, reasonably demand the application of a trained legal mind.
>
> "Good moral character" includes qualities of honesty, fairness, candor, trustworthiness, observance of fiduciary responsibility, respect for and obedience to the laws to the state and the nation, and respect for the rights of others and for the judicial process.
>
> "Currently" does not mean on the day of, or even in the weeks or months preceding the completion of the application. Rather, it means recently enough so that you believe that there is something that may have an ongoing impact on your ability to be an attorney.

COMM. OF BAR EXAM'RS, STATE BAR OF CAL., APPLICATION FOR EXTENSION OF DETERMINATION OF MORAL CHARACTER 12, *available at* http://www.calbar.ca.gov/Portals/0/documents/exmcwebform.pdf (last visited Mar. 15, 2015).

[240] Maher & Blum, *supra* note 43, at 833.

> A "yes" response to either of the following questions does not mean necessarily that you will be found to lack the fitness required for admission to the Bar. The Board is sensitive to confidentiality concerns. Please refer to Rule I(d) of the Rules Governing Admission to the Bar of Texas concerning confidentiality.[241]

Saying that a "yes response . . . does not necessarily mean you will be found to lack the fitness required for admission to the Bar" could be interpreted as saying an affirmative answer creates a rebuttable presumption of unfitness.

Arkansas's application has the following preamble and questions:

> According to Rule XIII of the Rules Governing Admission to the Bar of Arkansas—"every applicant for admission to practice by examination and every applicant for reinstatement of license to practice must be of good moral character and mentally and emotionally stable. The determination of the eligibility of every such applicant shall be made by the Board and the burden of establishing eligibility shall be on the applicant."
>
> The following questions 10(e) through 10(g) are designed to elicit information in light of the standards set forth above. Your responses to the following questions are treated in absolute confidence by the Arkansas State Board of Law Examiners. However, in the event your responses to the inquiries below establish serious concerns about your current ability to represent the citizens of Arkansas as a licensed lawyer, further inquiry may result. Such additional inquiries will be as limited in scope as possible, and will likewise remain confidential to the extent possible.
>
> Applicants with a history of mental or emotional infirmity or history of substance or alcohol abuse have been admitted to the Bar of Arkansas in the past. The mere revelation of treatment for mental or emotional infirmities, or substance or alcohol abuse, is not, in itself, a basis upon which an applicant is ordinarily denied admission. The questions below have been narrowly drawn to acquire information on the most serious instances of mental or emotional infirmity, or substance or alcohol abuse. The Arkansas State Board of Law Examiners does not seek information that is fairly characterized as "situational counseling." Examples of such counseling include stress counseling, domestic counseling, grief counseling, and counseling for eating or sleeping disorders.
>
> (e) Have you ever been declared, or are you presently, a ward of any court of competent jurisdiction; or have you ever been adjudicated, or are you presently, an incompetent or insane person as determined by any court of competent jurisdiction?

---

[241] TEX. BD. OF LAW EXAM'RS, GEN. APPLICATION FOR ADMISSION TO THE BAR OF TEX. 9 [hereinafter TEX. APP.], *available at* http://www.ble.state.tx.us/pdfs/Applications/Gen_App.pdf (last visited Mar. 16, 2015).

> (f) Do you currently have any condition or impairment including, but not limited to, mental or emotional infirmity, alcoholism, substance abuse, or nervous disorder or condition which in any way currently affects, or if untreated could affect, your ability to practice law in a competent and professional manner in this jurisdiction?
>
> If yes, briefly describe the condition or impairment.
>
> (g) Are you currently utilizing or being treated with prescription drugs or other substances in order to manage a mental or emotional infirmity, alcoholism, substance abuse, or nervous disorder or condition?
>
> If yes, briefly describe the prescription drugs or other substances, and the purpose for which prescribed.[242]

The Arkansas Preamble is somewhat amusing because it describes the questions as "narrowly drawn," yet the question about "prescription drugs or other substances" is perhaps the broadest in the country. One can imagine a laundry list of prescription or holistic medications a law student may be taking for "mental or emotional infirmity," none of which has any bearing on her ability to practice law. For example, insomnia can be described as a mental or emotional condition and is one that commonly afflicts law students. An applicant taking prescription Ambien or over-the-counter melatonin would technically need to list it here. An applicant who is nervous about traveling on an airplane would need to disclose her use of Xanax for a flight. Any applicants taking anti-depressants would need to disclose that here. And in each of these examples, bar examiners would have no qualms admitting a candidate using such substances, so the question is absurdly broad.

Nevada's preamble still seems to require disclosure of situational counseling:

> Questions regarding professional counseling, treatment, and medication are not intended to unnecessarily invade the applicant's privacy or to discourage applicants from seeking professional assistance. The Board of Bar Examiners and the Character and Fitness Committee seek this information pursuant to their character and fitness guidelines. Applicants must disclose this information. Occasional short-term counseling for relationship problems or situational stress, standing alone, are not reasons for further inquiry.[243]

Nevada's application does state that situational counseling alone is not a reason for "further inquiry," but given

---

[242] SUP. CT. OF ARK. OFF. OF PROF'L PROGRAMS, APPLICATION FOR ADMISSION ON MOTION 6-7, *available at* https://courts.arkansas.gov/sites/default/files/tree/AOM%20ap%202013%20in%20PDF.pdf (last visited Mar. 16, 2015).

[243] STATE BAR OF NEV., APPLICATION FOR ADMISSION (on file with author).

that this is true, applicants should not need to disclose such counseling at all.

Iowa's disclaimer language, on the other hand, is particularly good. It reads as follows:

> The Board understands that mental health counseling or treatment is a normal part of many persons' lives and such counseling or treatment does not of itself disqualify an applicant from the practice of law. Furthermore, the Board does not wish to pry into the private affairs of applicants. However, the Board is obligated by the Supreme Court of Iowa's rules governing admission to the Bar to determine whether an applicant is physically and mentally fit to practice law, and therefore, must inquire into such matters to the extent necessary to make such determination. The Board is not seeking disclosure of counseling or treatment for a traumatic or upsetting event such as death, break-up of a relationship, or a personal assault, even if such event does affect the applicant's ability to practice law for a limited time.[244]

While many states include similar disclaimers, Iowa's disclaimer is well-crafted because it recognizes that mental health counseling is "a normal part of many persons' lives" and expresses the Board's distaste for prying into a candidate's private life. The specific exclusion of situational counseling is good, although given the stress of law school[245] and the high number of law students who could benefit from counseling to better manage this stress, Iowa ought to add "stress of law school" to its list.[246]

4. Other Types of Questions

Georgia uses two of the NCBE questions and also asks, "Has your functioning at school or at work ever been sufficiently impaired (as the result of substance abuse, alcohol abuse, or a mental, emotional, or nervous or behavior disorder or condition) as to require inpatient or outpatient

---

[244] IOWA JUDICIAL BRANCH, BAR EXAM APPLICATION FORM 21 [hereinafter IOWA APP. FORM], *available at* http://www.iowacourts.gov/wfdata/files/ProfessionalRegulation/BarExam/Bar_Application.pdf (last visited Apr. 20, 2015).

[245] *See supra* note 232.

[246] Further to Iowa's credit, it asks applicants only "Do you have any condition or impairment that currently impairs your ability to practice law?" IOWA APP. FORM, *supra* note 244, at 22. It then defines "condition or impairment" as "any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism," and defines "ability to practice law." *Id.* at 20-21. This question is permissible under the ADA because it allows a candidate whose mental illness is well controlled to answer in the negative and does not screen out applicants with disabilities.

treatment?"[247] Georgia does include a preamble that states it does not seek information about situational counseling. This question could be viewed as appropriately focused on conduct, or it could be seen as overbroad, particularly because "outpatient" treatment could mean a weekly session with a therapist. If an applicant seeks treatment before she becomes impaired, does she answer this question with a yes or a no? The question seems to be asking about only conditions that impair functioning, but it is not clear.

Ohio revised its questionnaire in March 2014, at the same time the NCBE was revising its questions, but Ohio opted to continue using questions that violate the ADA. Its application asks if applicants have "suffered from, been diagnosed with, or been treated for bipolar disorder, schizophrenia, delusional disorder (paranoia), or any other psychotic disorder" within the last 10 years.[248] It then asks about any "physical condition (e.g., stroke, head injury, dementia, brain tumor, heart disease) that has resulted in significant memory loss, significant loss of consciousness, or significant confusion" within the last 10 years.[249] This question is quite broad. It seems that even a candidate who suffered a concussion from sports or a car accident would need to answer affirmatively.

Minnesota asks an odd question: "Within the past two years, have you discontinued treatment or medication for a condition that at any time impaired your ability to meet the Essential Eligibility Requirements for the practice of law set forth in Rule 5A?"[250] This question is overbroad because it would require an applicant who has been functional for two years to disclose past treatment if her condition has improved to the point that her treatment plan has been reduced. In effect, the application punishes an applicant for "improving" enough to no longer need medication.

Virginia asks the specific diagnosis discussed in Part III.A.1, but Virginia's list includes major depression.[251]

---

[247] SUP. CT. OF GA. OFFICE OF BAR ADMISSIONS, APP. OF FITNESS TO PRACTICE LAW IN GA., *available at* https://www.gabaradmissions.org/browseprintform.action?formId=1 (last visited Mar. 14, 2015).

[248] SUP. CT. OF OHIO, OFFICE OF BAR ADMISSIONS, NAT'L CONF. OF BAR EXAM'RS (NCBE), APP. TO THE BAR OF OHIO 15 (on file with author).

[249] *Id.*

[250] MINN. BD. OF LAW EXAM'RS, *App. for Adm.*, *available at* http://www.ble.state.mn.us/file/Bar%20Application%202014%20-%20fill%20in(6).pdf (last visited Apr. 5, 2015).

[251] VA. BD. OF BAR EXAMR'S, *Character and Fitness Questionnaire*, *available at* http://barexam.virginia.gov/pdf/SampleCFQ.pdf (last visited Apr. 5, 2015).

Texas largely retains the questions upheld in *Texas Applicants*:

> (a) Within the last ten (10) years, have you been diagnosed with, or have you been treated for, bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?
>
> (b) Have you, since attaining the age of eighteen or within the last ten (10) years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?
>
> If you answered "YES" to any part of Question 11, provide details on a *Continuation Form*. Include date(s) of diagnosis and treatment, a description of your course of treatment and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for each treatment. You may also include information as to why, in your opinion or that of your health care provider, your illness or disorder will not affect your ability to practice law in a competent and professional manner.[252]

The last sentence is particularly ridiculous. A candidate *may* include a statement from her doctor explaining that her condition will not affect her ability to practice law? If bar examiners do ask about mental illness, the inquiry should focus on one's ability to practice law, and the treating provider is the best source of such an evaluation.

B. States That Do Not Ask about Mental Health

Nine states do not ask about mental health history on their bar applications. Alaska first defines "ability to practice law," then asks only one question: "Are you currently suffering from any disorder that impairs your judgment or that would otherwise adversely affect your ability to practice law? If yes, please explain."[253] This question is well-formulated because it focuses on present abilities, not on history or on certain suspect diagnoses.

Arizona asks even less: "Is there any other information, incident(s), or occurrence(s) which is not otherwise referred to in your response to this application which, in your opinion, may have a bearing, either directly or indirectly, positively or negatively,

---

[252] TEX. APP., *supra* note 241.

[253] ALASKA BAR ASS'N, APPLICATION FOR ADMISSION TO THE ALASKA BAR ASS'N, *available at* https://www.alaskabar.org/servlet/download?id=1486 (last visited Mar. 14, 2015).

upon your ability to practice law actively and continuously? If yes, please explain fully in the comment box below."[254]

IV. IS THE INQUIRY "NECESSARY?"

As explained in Part I, Title II of the ADA prohibits state bar associations from applying any eligibility criteria that screen out a disabled individual unless that screening criteria "can be shown to be necessary for the provision of the service, program, or activity being offered."[255] The burden of proving that these inquiries are necessary falls on the bar examiners.[256] This Article argues that if bar examiners cannot show that their inquiries are *effective* at achieving the stated goal of reducing the number of unfit lawyers, then the inquiry cannot be *necessary*. This section shows that bar examiners' questions about mental health are not effective in reducing the number of unfit attorneys and therefore the questions are impermissible under the ADA.

A. There is No Adequate Justification for the Inquiry

1. Bar Examiners are Not Mental Health Experts

Bar examiners have, in many ways, an impossible task. Predicting which applicants are likely to commit misconduct in the future is extraordinarily difficult, perhaps near impossible.[257] This is in part because the rate of misconduct among the total number of attorneys is so very small—fractions of 1%.[258] Many authors have questioned the notion that bar examiners are capable of making accurate predictions about future fitness at all, not just on mental health grounds.[259]

---

[254] ARIZ. SUP. CT. CERT. AND LIC. DIV., CHARACTER AND FITNESS APP. FOR EXAM APPLICANTS 11, *available at* https://elicense02.az.gov/app/azsc/ (last visited Mar. 14, 2015).

[255] 28 C.F.R. § 35.130(b)(8) (2014).

[256] *See supra* notes 22-23 and accompanying text.

[257] *See, e.g.*, Stone, *supra* note 31, at 352-53.

[258] *See* AM. BAR ASS'N, SURVEY ON LAWYER DISCIPLINE SYSTEMS 2012-2013, *available at* http://www.americanbar.org/groups/professional_responsibility/resources/surveyonlawyerdisciplinesystems20122013.html (last visited May 11, 2015).

[259] In the 1970s, an ABA committee wanted to see if a character test could be developed to screen students for unfitness before those students began law school. *See* Alan M. Dershowitz, *Preventive Disbarment: The Numbers Are Against It*, 58 ABA J. 815, 815 (Aug. 1972). At that time, Alan Dershowitz warned that "[i]t would be unrealistic in the extreme . . . to attempt to predict all violations of ethical norms." *Id.* at 817. He explained that it is impossible to reduce the number of false positives (students wrongly predicted to be ethical violators in the future) due to the very low number of ethical violators in total. *Id.* He also attacked the efficacy of incorporating a "human element—the interviewer or investigator—" by explaining that science does not support the notion that individual experts would be more accurate at these

Bar examiners argue that applicants must disclose their mental health history "to enable bar examiners to evaluate sufficiency of [applicants'] treatment and to determine their current fitness."[260] But this argument is contingent on the assumption that bar examiners are capable of evaluating an applicant's treatment and current fitness. The evidence shows that they are not.

Mental health professionals have long recognized that predicting the future behavior of patients is extremely difficult. For example, a meta-analysis of the literature in 2010 concluded that various tools used to predict which mentally ill patients would become violent had only "moderate predictive" value.[261] As a result of this low level of accuracy, the authors of that study concluded that such predictions should not be used for "decision making that is contingent on a very high level of predictive accuracy."[262] Another study found that future incidences of violence were accurately predicted in 71.4% cases of schizophrenic patients and a lack of future violence was accurately predicted in 87.5% of cases.[263] Other studies about patients with a variety of diagnoses found that psychiatrists accurately predicted nonviolence in 88% of cases and accurately predicted violence in only 37%.[264]

No bar examiner should be comfortable denying a law license to an applicant given this level of inaccuracy. And these numbers are attempting to predict future incidences of *violent* behavior—something that has been studied for decades. In contrast, there are virtually no studies evaluating the connection between past mental health diagnosis or treatment and future misconduct of a much less serious nature, such as the mishandling of client funds or failure to communicate with a client.[265]

Mental health professionals agree that past diagnosis or treatment of mental illness has no predictive value on an applicant's ability to practice law in the future.

---

predictions than purely statistical evaluations. *Id.* at 818-19. Dershowitz was quite pessimistic about such a proposal, saying that "any attempt to predict attorney misconduct, whether among first-year law students or law school applicants, is necessarily doomed to failure." *Id.* at 819.

[260] Pobjecky, *supra* note 36, at 35.

[261] Min Yang et al., *The Efficacy of Violence Prediction: A Meta-Analytic Comparison of Nine Risk Assessment Tools*, 136 PSYCHOL. BULL. 740, 761 (2010).

[262] *Id.*

[263] Shing-Chia Chen et al., *Clinical Prediction of Violence Among Inpatients with Schizophrenia Using the Chinese Modified Version of Violence Scale: A Prospective Cohort Study*, 51 INT'L J. OF NURSING STUD. 198, 201 (2014).

[264] Rachel Haim et al., *Predictions Made by Psychiatrists and Psychiatric Nurses of Violence by Patients*, 53 PSYCHIATRIC SERVS. 622, 623 (2002).

[265] *See* discussion of Leslie C. Levin's study *infra* Part IV.A.2.

> Treatment for mental disorder provides no basis for assuming that an applicant's ability to practice law in a competent and ethical manner is impaired . . . . Research and clinical experience demonstrate that the receipt of mental health treatment is not predictive of a person's ability to carry out responsibilities with competence and integrity. Nor does the evidence in the field indicate that bar examiners or mental health professionals can predict inappropriate or irresponsible behavior on the basis of a person's mental status.[266]

Bar examiners are usually lawyers with no training in psychology or psychiatry. Mental health professionals acknowledge that *they* cannot accurately predict who will be unfit to practice law in the future and who will not.[267] Yet bar examiners, who have no expertise in mental health, believe that they can—and indeed, must—make these determinations. In a statement that can only be viewed with comic disbelief, one Florida bar examiner has defended bar examiners' ability to make these judgments. He explains that, armed only with the DSM-III,[268] "one need not have a background in psychology" to evaluate the mental health of bar applicants.[269] Ironically, at the time he made this statement, the DSM-III was two years out of date, having been replaced with the DSM-III-R in 1987.[270] One commentator has replied that "advocating the use of [the DSM] by nonexperts to make a finding of fact is irresponsible and unrealistic. It is analogous to giving a psychiatrist a criminal law hornbook and expecting him or her to successfully defend a client in a murder trial."[271]

The report of the special master (who had both a J.D. and an M.D.) in the *Rhode Island* case concluded that "[r]esearch has failed to establish that a history of previous psychiatric treatment can be correlated with an individual's capacity to function effectively in the workplace[,]" and that "there is no empirical evidence demonstrating that lawyers who have had psychiatric treatment have a greater incidence of subsequent disciplinary action by the bar or any other

---

[266] Herr, *supra* note 48, at 641 n.30, (quoting COMM'N ON DISABILITY LAW ON PROPOSED CONN. BAR ASS'N APPLICATION, REPORT OF THE SECTION ON HUMAN RIGHTS AND RESPONSIBILITIES AND THE RESOLUTION CONCERNING INQUIRIES INTO MENTAL HEALTH TREATMENT OF BAR APPLICANTS 5 (Feb. 1994)).

[267] Herr, *supra* note 48, at 642.

[268] The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is published by the American Psychiatric Association. It offers a common language and standard criteria for the classification of mental disorders and is widely relied upon by mental health professionals.

[269] Pobjecky, *supra* note 35, at 19.

[270] Maher & Blum, *supra* note 43, at 838 n.55.

[271] Gail Edson, Comment, *Mental Health Status Inquiries on Bar Applications: Overbroad and Intrusive*, 43 U. KAN. L. REV. 869, 896 (1995).

regulatory body in comparison with those who have not had such treatment."[272] Furthermore, "most disciplinary problems and grievance issues arise after an attorney has been in practice for a number of years, and in nearly all such cases no indicators of future difficulty manifested themselves at the time of original licensure."[273]

In *Clark*, the court placed great weight on the testimony of Dr. Howard Zonana, a medical doctor and professor at Yale University's medical and law schools.[274] Dr. Zonana testified that these questions are a very inefficient method of attempting to predict which applicants will be unfit lawyers.[275] The court noted that the bar committee performing the screening was composed of "lay individuals with no mental-health training" and "even mental-health practitioners would experience difficulty in predicting with accuracy the future threat posed during a lifetime of practicing law."[276]

The *ACLU of Indiana* plaintiffs argued that applicants who were currently in treatment for a mental disorder and functioning well did not pose a direct threat to public safety and thus should not have to answer questions about their mental health.[277] The court disagreed with this position on the grounds that few mental disorders can be cured[278] and stated that if it adopted this argument, bar examiners would not be permitted to ask applicants about their treatment, which was an important part of the analysis.[279] The court completely avoided any discussion of bar examiners' competence to evaluate an applicant's treatment history and to determine her current or future fitness.

The belief of some bar examiners that they are capable of assessing future mental stability is highly troubling. Some bar examiners seem to be aware of this disconnect. In 1994, the Utah State Bar Association conducted an informal study of 33 states. This study found that while most states asked about

---

[272] *In re* Petition & Questionnaire for Admission to the R.I. Bar (*Rhode Island*), 683 A.2d 1333, 1336 (R.I. 1996).

[273] *Id.*

[274] Herr, *supra* note 48, at 674 (citing Trial Transcript at 46, Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430 (E.D. Va. 1995)).

[275] *Id.*

[276] *Rhode Island*, 683 A.2d at 1336.

[277] ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *10 (S.D. Ind. Sept. 20, 2011).

[278] *Id.* ("[T]he Board's evidence shows that even if the applicant is seeking treatment, all available treatments have their limitations and there are few [mental] disorders where it is possible to be cured." (second alteration in original) (internal quotation marks omitted)).

[279] *Id.*

mental health on their applications, "only fifteen percent of examiners stated that they could support their use of mental health inquiries with statistical or anecdotal data."[280] It is hard to say which is worse: bar examiners who incorrectly believe they are capable of predicting future fitness, or bar examiners who realize that their inquiries are likely fruitless but continue to make them. The acknowledged use of "anecdotal data" is particularly worrisome.

A medical doctor who serves on the Georgia Board to Determine Fitness of Bar Applicants has stated that decisionmakers need to be aware of cognitive biases that can affect their judgments.[281] He explains that people who do not have wide experience with a particular situation tend to generalize all cases based on their knowledge of the situation of a friend, family member, or their own personal experience.[282] In this way, "[t]heir own experience tends to anchor their own understanding. They tend not to recognize that their own experience with an issue is not necessarily typical and so undervalue the often most important distinctions between their experience and the present case."[283] One can also imagine that bar examiners, after reviewing several files of applicants with a particular diagnosis, for example, begin to feel overly confident in their knowledge of that disorder.

2. Predicting Misconduct on Any Grounds Is Difficult

Only two studies have evaluated the accuracy of predicting future attorney misconduct based on bar applications. One was a very small Minnesota study involving 52 disciplined attorneys.[284] The author of that study later noted that it "was not conducted scientifically and involved a very small sample[.]"[285] The other was funded by the Law School Admissions Council (LSAC) and published in 2013 by Leslie C. Levin.[286] Levin's study confirmed what other authors have long argued: because the overall risk of an attorney being

---

[280] Edson, *supra* note 271, at 870.

[281] Ash, *supra* note 220, at 14-15.

[282] *Id.* at 14.

[283] *Id.*

[284] Carl Baer & Peg Coneille, *Character and Fitness Inquiry: from Bar Admission to Professional Discipline*, B. EXAM'R, Nov. 1992, at 5, 6-7.

[285] Margaret Fuller Corneille, *Bar Admissions: New Opportunities to Enhance Professionalism*, 52 S.C. L. REV. 609, 619 (2001).

[286] LESLIE C. LEVIN ET AL., LAW SCHOOL ADMISSIONS COUNCIL GRANTS REPORT SERIES, A STUDY OF THE RELATIONSHIP BETWEEN BAR ADMISSIONS DATA AND SUBSEQUENT LAWYER DISCIPLINE (2013), *available at* http://www.lsac.org/docs/default-source/research-(lsac-resources)/gr-13-01.pdf.

disciplined is so low, the data furnished by the bar application questions is "not helpful for predicting" which attorneys will be disciplined in the future.[287]

Levin's study looked at 1,343 lawyers admitted to the Connecticut bar from 1989 to 1992 and their subsequent discipline history, if any.[288] Her report was careful to acknowledge the limitations of her study, including that "discipline is an imperfect proxy for the presence of problematic conduct for a variety of reasons, as much lawyer misconduct is never detected, reported, or sanctioned through formal channels."[289] However, "bar discipline identifies much of the more serious misconduct"[290] and is the best measure available.

Levin's study revealed that most instances of attorney misconduct occur at least 10 years after the attorney's initial licensing.[291] A lawyer's career may span 30 years or more. This means that bar examiners must make a prediction about that applicant's likely mental state 30 years into the future,[292] knowing that many mental illnesses wax and wane throughout a person's lifetime.

Levin's study found that 23.68% of the disciplined lawyers may have had psychological issues which contributed directly or indirectly to the misconduct.[293] This is a significant percentage, certainly. However, it is not known if those lawyers had the psychological issues before their admission or whether their conditions developed later in life.

Levin further divides "discipline" into "severely disciplined" for the worst misconduct and "less severely disciplined" for more minor misconduct.[294] Levin found that there were *no* cases where an applicant who reported a mental health issue on her bar application was later severely disciplined.[295] However, there was an increased rate of less severe discipline among lawyers whose applications included a mental health issue.[296] The study found that the baseline probability of an applicant with no reported mental health problems to be disciplined was 2.5%, and the probability of an applicant with a

---

[287] *Id.* at 2.

[288] *Id.* at 5.

[289] *Id.* at 6.

[290] *Id.*

[291] *Id.* at 16.

[292] Maher & Blum, *supra* note 43, at 827 ("Even if there were some way to determine the mental and emotional fitness of applicants at the time of application, there is no guaranty that applicants' fitness will remain constant.").

[293] Levin, *supra* note 286, at 16.

[294] *Id.* at 19.

[295] *Id.* at 24.

[296] *Id.*

prior diagnosis or treatment for a mental health issue was 6%.[297] In short, past diagnosis or treatment for mental health significantly raised the probability that a lawyer will be disciplined "less severely" but significantly lowered the probability that a lawyer will be disciplined "severely."[298] Levin cautions that these results "must be interpreted with caution" because the applications likely underreported their mental health diagnoses and treatment.[299]

Interestingly, of the 29 disciplined lawyers who reported a mental health diagnosis or treatment on their application, none reported a serious mental health issue and none had been hospitalized.[300] Though the conclusions were drawn from a small sample, this data suggests that the belief that the "most serious" mental illnesses warrant the closest scrutiny may be incorrect.

Levin's overall conclusion was that "[t]he information collected during the character and fitness inquiry does not appear to be very useful in predicting subsequent lawyer misconduct."[301] Even the strongest factor—gender—which doubled the likelihood of being disciplined, only raised the probability from 2.5% to 5%.[302] No one is suggesting that men should be subjected to greater scrutiny than women purely on the basis of their sex, even though male attorneys are disciplined at twice the rate of female attorneys. The decision to deny bar admission to any applicant on the grounds that her chances of being disciplined in the future are 5%—especially where "discipline" might mean a single reprimand—is unsupportable.[303]

In addition to the difficulty of predicting a person's mental stability over the course of 30 or more years, there is the reality that "practicing law" is not a singular task.[304] In contemporary legal practice, there is no single vision of a lawyer's "work." Some attorneys are constantly facing tight deadlines in fast-paced, high-pressure environments. Others work in much steadier, lower stress offices. Some attorneys are frequently appearing in court; others work at their desks all day and may not interact with clients or other attorneys frequently. Any given attorney may flourish in one job but flounder in another. Therefore, it is impossible to predict

---

[297] *Id.* at 29.
[298] *Id.* at 37.
[299] *Id.* at 40.
[300] *Id.* at 41.
[301] *Id.* at 42.
[302] *Id.*
[303] *Id.*
[304] Stone, *supra* note 31, at 352 ("The broad spectrum of a lawyer's duties makes predicting future behavior an extremely burdensome responsibility.").

whether a given mental illness will render a person unfit to practice law. The same individual might be fit for one type of position and unfit for another, but both jobs fall within the umbrella of "practicing law."

There are no additional inquiries into an attorney's fitness once she is admitted to the bar, except under conditional admission programs. If it is essential for bar examiners to deny admission to attorneys with mental illnesses, why is there no continuing inquiry into mental health post-admission?[305]

3. Actual Attorney Misconduct Rates Do Not Reflect Pre-Admission Screening

Bar examiners argue that an inquiry into applicants' mental health history is necessary to prevent unfit attorneys from harming the public.[306] This argument is not supported by data. Because each state bar association writes its own application questions, the various states effectively serve as an experiment with different inputs. If these questions were successful in reducing the number of unfit attorneys, we would expect to see lower rates of attorney discipline in the states that ask about mental health on their bar applications, as compared to the states that do not ask about mental health. But this is not the case.

As a proxy for "unfit lawyers," this Article compares the rates of attorney discipline from three states that ask detailed mental health questions on their bar applications with three states[307] that have not asked any questions about mental health for years. This is, of course, an imperfect statistical analysis. Some attorneys who commit malpractice or other ethical violations will not be disciplined by their bar associations for various reasons—the attorney was not caught, the client did not pursue the issue, or other possibilities. Many factors other than the pre-admission mental health screening affect the rate of attorney discipline. The type of attorney discipline and level of enforcement vary in consistency from state to state.[308] Furthermore, the overall numbers of

---

[305] Herr, *supra* note 48, at 642.

[306] *See supra* Part I.B.

[307] The comparison states are three states that have not asked about mental health history for a number of years (Arizona, Pennsylvania, and Massachusetts) and three states that continue to ask some of the most intrusive and specific mental health questions (North Carolina, Florida, and Texas). North Carolina amended its application in early 2015.

[308] Fred C. Zacharias, *The Purposes of Lawyer Discipline*, 45 WM. & MARY L. REV. 675, 678 n.3 (2003). Each state sets its own disciplinary procedures and penalties.

disciplined attorneys are so tiny—fractions of one percent—that meaningful comparisons are difficult. However, the data is sufficient to show that bar examiners cannot meet their burden of showing the necessity of these questions.

This data was compiled from the ABA Survey on Lawyer Discipline Systems (SOLD) for 2009 through 2013.[309] The Misconduct Rate in Table 1 was calculated as the number of attorneys sanctioned, both privately and publicly, as reported in the SOLD, divided by the number of attorneys with active licenses, as reported by the same survey.

TABLE 1

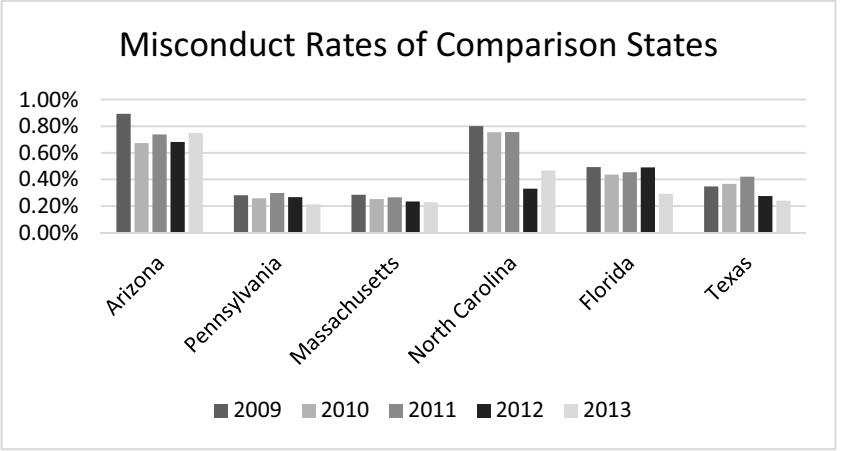


Table 1 demonstrates that asking about mental health as part of the character and fitness process does not produce lower rates of lawyer discipline. Pennsylvania and Massachusetts, which do not ask questions about mental health, have the lowest rates of misconduct over these five years. Arizona, which does not ask, and North Carolina, which does, have roughly similar rates.

Table 2 uses the same data but aggregates the comparison states that ask about mental health and the comparison states that do not ask. Here too, there appears to

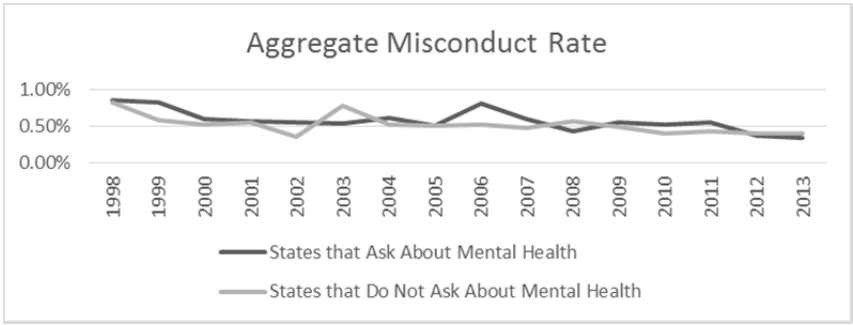
---

"Discipline" includes both formal proceedings to address more severe misconduct—with more severe sanctions—and more informal, confidential proceedings to address less serious violations. *Id.* at 677-82.

[309] *Historical A.B.A. S.O.L.D Studies*, AM. BAR ASS'N, *available at* http://www.americanbar.org/groups/professional_responsibility/resources/historicalabasoldsurveys.html (last visited May 19, 2015); SURVEY ON LAWYER DISCIPLINE SYSTEMS 2012-2013, *supra* note 258.

be no correlation between states that question applicants about their mental health and states that do not.

TABLE 2



Given the number of other variables present, this comparison should not be taken as a serious statistical endeavor. But it does show that bar examiners cannot meet their burden of proving that asking mental health questions on bar applications reduces the rate of attorney discipline in their state. These statistics are also supported by the opinions of experts and some courts: "there is simply no empirical evidence that applicants' mental health histories are significantly predictive of future misconduct or malpractice as an attorney."[310]

Proponents of these questions may argue that attorneys who commit ethical violations and have mental health problems are not disciplined in the ordinary channels but instead may be referred to confidential lawyer assistance programs.[311] This argument is also not borne out by the data. In viewing the total cases that lawyer assistance programs handle, the number involving mental health issues is not related to whether the bar application asked about mental health.[312]

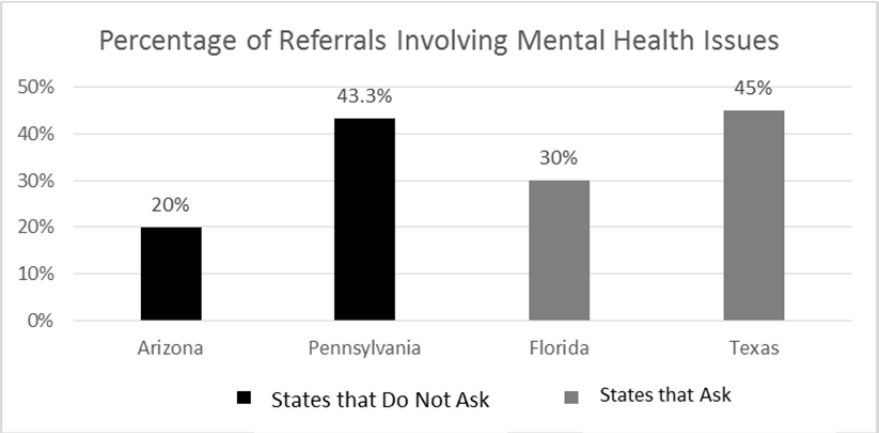
---

[310] Bauer, *supra* note 13, at 141; s*ee also* discussion *supra* Parts IV.A.1-2.

[311] *See, e.g.*, STATE BAR OF CAL., LAWYER ASSISTANCE PROGRAM, *available at* http://www.calbar.ca.gov/Attorneys/MemberServices/LawyerAssistanceProgram.aspx (last visited Mar. 14, 2015).

[312] *See* AM. BAR ASS'N COMM'N ON LAWYER ASSISTANCE PROGRAMS, 2012 COMPREHENSIVE SURVEY, OF LAWYER ASSISTANCE PROGRAMS A-18-19 (2012), *available at* http://www.americanbar.org/content/dam/aba/administrative/delivery_legal_services/ls_del_2012_lap_comprehensivesurvey.authcheckdam.pdf. Data for Massachusetts was not included in this survey.

TABLE 3[313]



If the states that ask about mental health on their bar applications were "weeding out" attorneys who are likely to be unfit due to mental illness, there should be lower rates of referrals to the confidential assistance program on mental health grounds. Instead, Table 3 shows no clear correlation at all. Arizona, which asks no questions about mental health, has the lowest rate of attorneys referred on mental health grounds. Pennsylvania, which does not ask, and Texas, which does ask, have almost equal referral rates.

Another variable that must be considered is conditional admittance programs, now offered by a number of states. These are essentially probationary programs for applicants about whom the bar examiners have doubts, usually because of mental health or substance abuse issues.[314] Under these programs, the applicant is licensed as long as she complies with a set of requirements set by the bar examiners. The requirements typically include regular meetings with a mental health provider, reports submitted by the mental health provider, random drug testing, or other types of monitoring. The length of time an applicant remains conditionally admitted varies and can last indefinitely in some states, such as Florida.[315]

The number of applicants admitted under conditional admission programs is very low. For example, the number of

---

[313] North Carolina and Massachusetts are omitted from Table 3 because they did not submit data to the survey.

[314] FLA. BD. OF BAR EXAM'RS, FREQUENTLY ASKED QUESTIONS, *available at* https://www.floridabarexam.org/web/website.nsf/faq.xsp#201A (last visited Mar. 14, 2015)

[315] *Id.* Conditional admission programs are suspect under the ADA as well, but they are not the primary subject of this Article. *See* DOJ Letter, *supra* note 108; LA. SETTLEMENT AGREEMENT, *supra* note 175.

applicants admitted on a conditional basis in Florida from 2005-2008 has ranged from 19 to 39 per year.[316] This small number does not explain the lack of a correlation between bar application mental health questions and attorney misconduct.

4. Few Applicants are Actually Denied on Mental Health Grounds

What is perhaps most puzzling about this issue is that, despite bar examiners' insistence that the mental health inquiry is essential to their mission, very few applicants are actually denied admission on these grounds. It is difficult to obtain information on the number of applicants denied bar admission for any character and fitness reason,[317] let alone precise data on the number denied specifically on mental health grounds. The data that is available suggests that very few applicants are denied bar admission on mental health grounds, although this is partly because some are diverted into conditional admission programs. Or it may be that applicants with a history of mental health treatment may choose not to apply for bar admission in certain states based on that state's application questions.

The number of applicants denied on *any* character and fitness grounds, not just mental health, is very low.[318] In the 1980s, Deborah Rhode found that only 0.2% of applicants were denied for character and fitness reasons.[319] In recent years, the national rate appears to range from 0.15% to 0.48%, and this includes those denied for current and ongoing substance abuse, criminal matters, academic integrity issues, and so on.[320]

According to *Texas Applicants*, the Texas Board of Bar Examiners received only 30 applications that raised mental health issues between August 1987 and the October 1994

---

316 FLA. BD. OF BAR EXAM'RS CHARACTER & FITNESS COMM'N, FINAL REPORT TO THE SUPREME COURT OF FLORIDA 30 (2009) *available at* http://www.floridasupremecourt.org/pub_info/documents/2009_FBBE_Character_Fitness_Report_Short_Version.pdf. In Florida, conditional admittances have been as follows:

2005 22
2006 39
2007 26
2008 19

Id. The reason for the conditional admission (substance abuse, etc.) is not provided.

317 LEVIN ET AL., *supra* note 286, at 4 n.20.

318 *Id.* at 4.

319 *Id.*

320 *Id.*

opinion.[321] Of those cases, 19 raised "serious"[322] mental health concerns.[323] Twenty-one of the 30 cases were set for hearing.[324]

Of the 19 "serious" cases, the outcomes were as follows: two were cleared by Board staff members; seven were approved by the Board (presumably following a hearing); one was denied admission on mental health grounds; one was denied for reasons other than mental health; one remained under investigation at the time of the decision for unstated reasons; one applicant's file was terminated when the applicant did not complete the medical records release form; one applicant's file was terminated when the applicant did not complete a Board-required examination; one was approved but the Board said it might require a mental health update later; one was approved for a temporary license subject to mental health counseling; one had been required to complete a post-hearing psychological evaluation, the results of which were pending at the time of the evaluation; and two had hearings set but not held, and the applicants had taken no further action.[325]

In total, of the 19 cases, nine applications were approved.[326] Only one was a clear denial on mental health grounds.[327] The others were either conditional approvals, still pending, or "effective" denials where the applicant declined to continue jumping through the Board's hoops.[328] The court further noted that only one person has been denied admission to the Texas bar on mental health grounds since 1986.[329]

In the 1995 *Clark* decision, the court learned that the Virginia Board of Bar Examiners had never denied an applicant on the basis of mental health treatment.[330] The evidence showed that over a five-year period, 47 out of roughly

---

[321] Applicants v. Tex. State Bd. of Law Exam'rs, No. A 93 CA 740 SS, 1994 WL 923404, at *4 (W.D. Tex. Oct. 11, 1994). The opinion does not state how many total applications were submitted.

[322] The court did not define "serious." *Id.*

[323] *Id.*

[324] *Id.* This raises the question of why at least two "non-serious" cases were set for hearing.

[325] *Id.*

[326] *Id.*

[327] *Id.*

[328] One wonders what became of those ten students. Did they drop out of law school? Did they complete law school and apply for bar admission in another state? Look for a job that did not require bar admission? Even though the formal number of applicants denied admission on mental health grounds is so low, the effective number of denials may be much greater when considering the students who never apply for bar admission because of their fears about disclosing their mental health history.

[329] *Tex. Applicants*, 1994 WL 923404, at *7.

[330] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 437 n.12 (E.D. Va. 1995).

10,000 applications[331] had answered the mental health question affirmatively, and only two of those cases were investigated further by the Board.[332] One of these two applicants was licensed when her health care provider wrote a letter stating the applicant was fit to practice law; the other applicant failed the written component of the bar exam.[333]

In the 2011 *ACLU of Indiana* case, the court found that 113 of 649 applicants answered one of the mental health questions affirmatively during 2009.[334] Seventeen of those were referred to Indiana's lawyer assistance program, which conducted further assessment and reported back to the Board.[335] Four applicants withdrew from the process, and no applicants were denied admission to the bar.[336] Even though the court called one of Indiana's questions "quite possibly the most expansive bar application question in the country,"[337] it appears that Indiana's bar examiners actually deny few or no applicants on mental health grounds.

The Assistant Dean and Senior Manager of Student Affairs at the University of Michigan Law School stated that in his decade of experience, he was unaware of any applicant who has been denied bar admission for mental health reasons.[338] Similarly, the Assistant Dean for Professional Development at the University of Miami School of Law stated that in his 27 years of experience, he was unaware of any Florida applicant's denial of bar admission on mental health grounds.[339]

B. The Only Rational Justification Violates the ADA

1. Stigma Explains This Discrepancy

If so few applicants are denied bar admission on mental health grounds and the effectiveness of the inquiry is questionable, why do some states persist in asking the

---

[331] *Id.* at 434. "The Board review[ed] approximately 2000 applications per year[ ]" during this time period. *Id.*

[332] *Id.*

[333] *Id.* n.6.

[334] ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *3 (S.D. Ind. Sept. 20, 2011).

[335] *Id.*

[336] *Id.*

[337] *Id.* at *9.

[338] David Baum, Assistant Dean & Senior Manager of Student Affairs at the Univ. of Mich. Law Sch., Remarks at *Suffering in Silence*, *supra* note 73, at 122.

[339] Interview with William P. VanderWyden III, Assistant Dean for Professional Development, University of Miami School of Law (July 24, 2014) (notes on file with author).

questions? The answer seems to be rooted in fear and stereotypes based on a limited understanding of mental illness.[340] Some authors have argued that these questions have "an insincere purpose" because they are not actually screening prospective attorneys in a meaningful way, but rather "reflect biases against mental health care and allegiance to those biases."[341] Other commentators give bar examiners the benefit of the doubt, saying that they probably "genuinely believe this is an important enterprise," but even so their beliefs are based on stereotypes about people with mental illness.[342]

Bias against people with mental illness remains widespread in American culture. When surveyed, 68% of Americans said they would not want a person with a mental illness to marry into their family, and 58% would not want a person with a mental illness in their workplace.[343] Many people wrongly believe that individuals with a mental illness tend to be violent.[344] In one study, although the participants agreed that there was a biochemical reason that caused depression, 45% of participants "believed depressed people are unpredictable, and [20%] said that depressed people tend to be dangerous."[345]

Even among educated lawyers and law professors, mental illness still carries a profound stigma.[346] Courts have acknowledged that many people seek mental health counseling for "acceptable" reasons such as the death of a loved one or the stress of law school, and many bar associations now exclude such situational counseling from their application questions.[347] But the same fears and prejudices that motivated bar associations to ask about situational counseling 20 years ago are prompting bar associations to continue to ask about specific diagnoses today. Bar examiners previously considered any person who had visited a counselor as suspect. Today, only people with certain diagnoses

---

[340] Burnim, *supra* note 73, at 130 ("[T]he entire system of inquiry by the bar . . . is essentially an expression of prejudice and stereotypes . . . ."); Bauer, *supra* note 13, at 100; Coleman & Shellow, *supra* note 47, at 71.

[341] Wielobob, *supra* note 211, at 14.

[342] Burnim, *supra* note 73, at 135.

[343] Sadie F. Dingfelder, *Stigma: Alive and Well*, MONITOR ON PSYCHOL., June 2009, at 56, 57.

[344] *Id.*

[345] *Id.* at 59.

[346] Kevin H. Smith, *Disabilities, Law Schools, and Law Students: A Proactive and Holistic Approach*, 32 AKRON L. REV. 1, 30 (1999).

[347] *See, e.g.*, Doe v. Jud. Nominating Comm'n, 906 F. Supp. 1534, 1544-45 (S.D. Fla. 1995); Discussion of Preamble to New York Bar Application *supra* Part III.A.3; *but see* STATE BAR OF NEV., *supra* note 243 (suggesting that although "[o]ccasional short-term counseling for relationship problems or situational stress, standing alone, are not reasons for further inquiry[,]" such situational counseling must still be disclosed on the application).

are viewed with suspicion. But this approach is just as illogical and just as impermissible under the ADA. Limiting discrimination to a smaller pool of people does not make that discrimination any more legal or any more ethical.

Part III of this Article explained that people diagnosed with conditions such as bipolar disorder and schizophrenia can be highly functional and succeed in high-stress jobs.[348] Grouping together all people with a particular diagnosis, such as all bar applicants with a diagnosis of bipolar disorder or schizophrenia, is precisely the type of stereotypical inquiry that the ADA was enacted to prohibit. The same concerns that spurred the passage of the ADA—stigma and a misplaced fear of people with mental illness—are the same reasons courts have wrongly continued to permit these questions on bar applications.

Many authors have criticized the character and fitness inquiry generally.[349] Some authors argue that character and fitness inquiries—on all topics, not just mental health—are overly intrusive and ineffective.[350] Even the United States Supreme Court has described the character requirements as "unusually ambiguous" and with "shadowy rather than precise bounds."[351]

In the past, bar associations have used the character and fitness process as a way to keep "undesirables" out of their ranks. Exactly whom was viewed as undesirable has changed over time. In the nineteenth century, character and fitness standards were used to exclude women from the bar.[352] In the early twentieth century, character and fitness standards were used to exclude immigrants, particularly Jewish applicants.[353] In the later twentieth century, the standards worked against suspected communists.[354] In the 1970s and 1980s, bar examiners inquired into applicants' sexual orientation.[355] Bar

---

[348] *See supra* Part III.A.1.

[349] As one author notes, "[t]here is no shortage of critiques of the character and fitness requirement." LEVIN ET AL., *supra* note 286, at 4; *see also* Aaron M. Clemens, *Facing the Klieg Lights: Understanding the "Good Moral Character" Examination for Bar Applicants*, 40 AKRON L. REV. 255, 257 (2007); Deborah L. Rhode, *Moral Character as a Professional Credential*, 94 YALE L. J. 491, 493-94 (1984-85).

[350] *See, e.g.*, Patrick L. Baude, *An Essay on the Regulation of the Legal Profession and the Future of Lawyers' Characters*, 68 IND. L.J. 647, 648 (1993); Stone, *supra* note 31, at 353.

[351] Clemens, *supra* note 349, at 257 (quoting Konigsburg v. State Bar of Cal., 353 U.S. 252, 263 (1957); *see* Schware v. Bd. of Bar Exam'rs of N.M., 353 U.S. 232, 249 (1957).

[352] Bauer, *supra* note 13, at 206.

[353] *Id.*; *see also* Baude, *supra* note 350, at 649 (At one point, the goal was to "keep[ ] the American bar as Anglo-Saxon as possible."); Clemens, *supra* note 349, at 260.

[354] Bauer, *supra* note 13, at 206-07.

[355] *See, e.g.*, Barbara Blackford, Comment, *Good Moral Character and Homosexuality*, 5 J. LEGAL PROF. 139 (1980); Mark A. Williams, Comment, *Homosexuality and the Good Moral Character Requirement*, 56 U. DET. J. URB. L. 123 (1978-79).

examiners insisted they "ha[d] an interest in preventing [the bar's] reputation from being tarnished by public disaffection with the sexual practices of a given attorney."[356]

In the Bar Examiners Handbook, published in 1991, bar examiners had to be told "not [to] ask judgmental, life-style questions about an applicant's living arrangements, social activities, or sexual activities or preferences" or not to "judgmentally question or comment upon an applicant's ethnic background or country of origin" and even "not ask a female applicant about her failure to change her surname after marriage."[357] Perhaps in another twenty years, we will look back on mental health questions as equally McCarthy-esque.

2. Florida as a Case Study

The state of Florida serves as an interesting case study. Florida has long been regarded as one of the states with the most intrusive mental health questions,[358] and two of the most important lawsuits on this question, *Ellen S.*[359] and *Doe*,[360] were litigated in Florida. Florida appears to have been the first state to ask about outpatient mental health treatment on its bar application.[361]

Florida's bar examiners also chime in when the issue is litigated in other states. During the *Clark* litigation in Virginia, a former member of the Florida Board of Bar Examiners testified as an expert witness for the Virginia Board of Bar Examiners.[362] Of the many commentators, which included psychiatrists, mental health organizations, state agencies, bar applicants, admitted attorneys, a law school dean, and the DOJ, only the Florida Board recommended retaining the questions.[363]

Over the years, the Florida Board has stubbornly resisted any efforts to limit or reduce the scope of the mental health questions asked on its bar application. As far back as 1987 (predating the ADA), the Ethics Committee of the American Psychological Association held that "the Florida Board of Bar Examiners' method of requesting the specifics of

---

[356] Williams, *supra* note 355, at 128.

[357] NAT'L CONF. OF BAR EXAM'RS, *supra* note 52, at 73:6015.

[358] Maher & Blum, *supra* note 43, at 824 ("In Florida, the examiners make particularly intrusive inquiries about all forms of psychiatric treatment, from counseling to hospitalization.").

[359] Ellen S. v. Fla. Bd. of Bar Exam'rs, 859 F. Supp. 1489, 1491 (S.D. Fla. 1994).

[360] Doe v. Jud. Nominating Comm'n, 906 F. Supp. 1534, 1536 (S.D. Fla. 1995).

[361] Bauer, *supra* note 13, at 103 n.29.

[362] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 436 (E.D. Va. 1995). The *Clark* court was not persuaded by Dr. Mutter's arguments. *Id.*

[363] Bauer, *supra* note 13, at 107-08 & n.48.

treatment of law student clients is asking the psychologist to violate the Ethical Principles of Psychologists."[364]

In 1989, Florida's application asked the following questions:

> Consultation with Psychiatrist, Psychologist, Mental Health Counselor, or Medical Practitioner.
>
> _____ Yes _____ No Have you ever consulted a psychiatrist, psychologist, mental health counselor or medical practitioner for any mental, nervous or emotional condition, drug or alcohol use? If yes, state the name and complete address of each individual you consulted and the beginning and ending dates of each consultation.
>
> a. _____ Yes _____ No Have you ever been diagnosed as having a nervous, mental or emotional condition, drug or alcohol problem? If yes, state the name and complete address of each individual who made each diagnosis.
>
> b. _____ Yes _____ No Have you ever been prescribed psychotropic medication? If yes, state the name and complete address of each prescribing physician. Psychotropic medication shall mean any prescription drug or compound effecting the mind, behavior, intellectual functions, perceptions, moods, or emotions, and includes anti-psychotic, anti-depressant, anti-manic and anti-anxiety medications.[365]
>
> 28. _____ Yes _____ No Have you ever been declared legally incompetent or have you or your property been placed under any guardianship, conservator, or committee? If yes, please give full details as to court, date and circumstances.
>
> 29. a._____ Yes _____ No Have you ever received diagnosis of amnesia, emotional disturbance or nervous or mental disorder, whether temporary or otherwise? If yes, state the name, street number or PO box, city, state and zip of each psychologist, psychiatrist, or other medical practitioner who made such diagnosis.
>
> b. _____ Yes _____ No Have you ever received REGULAR treatment for any such amnesia, emotional disturbance, nervous or mental disorder? If yes, state the name, street number or PO box, city, state and zip of each psychologist, psychiatrist, or other medical practitioner who treated you and the date you began treatment. (Regular treatment shall mean consultation with any such person more than four times within any 12-month period.)
>
> You must enclose copies of letters which direct each such practitioner and hospital and other facility to furnish to the Board any information the Board may request with respect to any such diagnosis or treatment.
>
> c._____ Yes _____ No Have you ever been hospitalized or institutionalized or entered any other treatment facility for treatment of any condition or disorder listed in Items 29(a) and (b),

---

364 Maher & Blum, *supra* note 43, at 836.

365 Ellen S. v. Fla. Bd. of Bar Exam'rs, 859 F. Supp. 1489, 1491 n.1 (S.D. Fla. 1994).

> above? If yes, state the name, street number or PO box, city, state and zip of each hospital or other treatment facility, the dates of treatment, and the name of each of the attending practitioners.[366]

The questions included the following preamble:

> Questions regarding psychiatric treatment are not intended to invade unnecessarily the privacy of an applicant or to probe into desirable treatment or counseling for most nervous or depression related disorders. Rather, the Board is concerned with forms of serious mental disorder which may impact adversely on an applicant's fitness to practice law. *However, only through full disclosure of all known treatment can a fair and adequate evaluation be made.* Your confidential cooperation in this sensitive area is appreciated.[367]

Thus, Florida insisted that all counseling, including situational counseling, must be disclosed so that the bar examiners could make an adequate determination of a candidate's fitness.[368] One Florida bar examiner explained that Florida's "mental health inquiries [were] intentionally broad in scope to eliminate subjective decision making by bar applicants as to what must be disclosed."[369] Today, most states' applications direct that situational counseling need not be disclosed, although Florida's application does not specify either way.

In 1987, several Florida law schools approached the Board and proposed an alternative question: "Have you ever had a substantial mental disorder that significantly impaired your judgment, behavior or your ability to cope with ordinary demands of life?"[370] The proposal seemed to backfire. The Board rejected the proposed question on the grounds that the "modifiers 'substantial' and 'significantly' would provide bar applicants with the basis to conceal even the most serious mental problems."[371] After this meeting, the Board decided to expand its application to require applicants to disclose even a single counseling visit (instead of the previous limitation of four or more sessions within 12 months).[372]

Today, Florida's questions are less far-reaching than previous versions but still among the most intrusive in the

---

366 Pobjecky, *supra* note 35, at 16-17.

367 *Id.* at 17.

368 Interestingly, even at the time, the preamble was criticized as being "inconsistent with the examiners' actual practice[,]" Maher & Blum, *supra* note 43, at 833 n.36, and the Board would routinely recommend applicants for admission who reported the use of situational counseling. Pobjecky, *supra* note 35, at 18.

369 Pobjecky, *supra* note 36, at 32.

370 *Id.* at 37.

371 *Id.*

372 Maher & Blum, *supra* note 43, at 847.

nation.[373] The Florida Board of Bar Examiners website currently states:

> The Florida Board of Bar Examiners must assess effectively the mental health of each applicant. A lawyer's untreated or uncontrolled mental disorder, if severe, could result in injury to the public. The board assures each applicant that the Supreme Court, on the board's recommendation, regularly admits applicants with a history of both mental ill-health and treatment by mental health professionals. The board considers satisfactory mental health to include: (1) the current absence of an untreated, uncontrolled mental illness that impairs or limits an applicant's ability to practice law in a competent and professional manner; and (2) the unlikelihood of a relapse of such a prior mental illness. With respect to either, evidence of treatment by a mental health professional is useful. The board encourages applicants to seek the assistance of mental health professionals, if needed.[374]

Even after the DOJ settlement with Louisiana, the Florida Board of Bar Examiners has refused to amend its questions. As of December 2014, the DOJ was investigating Florida's bar admission procedures, but Florida continued to ask questions about mental health in violation of the ADA.[375]

The Florida example shows that some bar examiners will fight efforts to limit or eliminate these questions to the

---

[373]

> 26.a. During the last 10 years, have you been hospitalized for treatment of any of the following: schizophrenia or other psychotic disorder, bipolar or major depressive mood disorder; drug or alcohol abuse; impulse control disorder, including kleptomania, pyromania, explosive disorder, pathological or compulsive gambling; or paraphilia such as pedophilia, exhibitionism, or voyeurism? . . .
>
> 26.b. During the last 5 years, have you received treatment for (whether or not you were hospitalized) or have you received a diagnosis of any of the following: schizophrenia or other psychotic disorder, bipolar or major depressive mood disorder; drug or alcohol abuse; impulse control disorder, including kleptomania, pyromania, explosive disorder, pathological or compulsive gambling; or paraphilia such as pedophilia, exhibitionism, or voyeurism? . . .
>
> 26.c. During the past twelve months have you been hospitalized for treatment of any mental, emotional, or psychiatric illness, whether or not the diagnosis was one listed in Item 26.a.? . . .
>
> 26.d. Do you currently (as hereinafter defined) have a mental health condition (not reported above) which in any way impairs or limits, or if untreated could impair or limit, your ability to practice law in a competent and professional manner? If yes, are the limitations or impairments caused by your mental health condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring or counseling program? . . ."

Online Bar Application, FLA. BOARD OF B. EXAMINERS (on file with author).

[374] FLA. BD. OF BAR EXAM'RS, *supra* note 314.

[375] Julie Kay, *Florida Bar Investigated Over Mental Health Questioning*, DAILY BUS. REV., Mar. 27, 2015, at A1, A1-A2.

bitter end. But with each incremental change to the questions, the sky has not fallen. Based on the experience of other states,[376] there is no reason to believe that the fitness of Florida attorneys will change if these questions are eliminated from the application.

C. The Appropriate Inquiry Is Conduct, Not Status

The ADA clearly prohibits discrimination based on an applicant's status as a person with a disability. Given that bar examiners have a duty to ensure applicants are fit to practice law,[377] what should the examiners consider if they do not ask about mental health history?

The appropriate inquiry should be the applicant's history of behavior. This is legal under the ADA and has the considerable benefit of being a more accurate predictor of future fitness.[378] Applicants who are emotionally unstable or whose actions are morally questionable should be evaluated on the basis of those actions. The mere existence of a particular mental health diagnosis has no probative value.

An inquiry into behavior, rather than diagnosis, will likely yield more accurate results. Some authors have found that "in the few cases where mental illness might have played a role in the applicant's rejection, questions and answers about mental illnesses actually seemed to be superfluous. The applicant's previously bizarre behavior—whether a manifestation of disability or something else—should have been sufficient to alert bar examiners to potential problems."[379]

As far back as 1982, commentators have reasoned that "the law school program is sufficiently demanding that those who are mentally unfit are unlikely to complete it."[380] Successfully completing law school and passing the written bar exam ought to establish a rebuttable presumption of fitness. Many mental illnesses are exacerbated by stress,[381] and many students who coped well with their disorders during undergraduate studies have difficulties when they enroll in law

---

[376] *See supra* Part IV.A.3.

[377] And assuming that such a task is even possible. *See supra* note 349 and accompanying text (discussing general critiques of character and fitness inquiry).

[378] Wielobob, *supra* note 211, at 14.

[379] Phyllis G. Coleman & Ronald A. Shellow, *Comply With the Americans With Disabilities Act: Judicial Nominating Commission Must Ask About Conduct, Not Disability*, FLA. B.J., July/Aug. 1996, at 56, 58.

[380] Elliston, *supra* note 65, at 14.

[381] Smith, *supra* note 346, at 28.

school, a time of great stress.[382] Law school and studying for the written bar examination is arguably more stressful than law practice for many attorneys. Therefore, if a candidate successfully completes three years of law school, that candidate is also likely to successfully navigate a legal career.

Some bar examiners have argued that asking about prior conduct instead of treatment will not work because it could call for "bar examiners to perform as unlicensed mental health professionals[.]"[383] But this is precisely what bar examiners *are* doing under the present system.[384]

A Florida bar examiner, Thomas Pobjecky, attempts to rebut the argument that bar examiners can learn of an applicant's unfitness through "other aspects of the character and fitness background investigation."[385] But his replies only explain why the third party reference forms, rather than the application package as a whole, may not be sufficient. He states that a reference "may be unaware of an applicant's mental problems."[386] If this is so, then it is evidence that the applicant may not have a "mental problem." If the applicant has functioned well in his place of employment or school, that is more useful information than whether the applicant has a particular mental health diagnosis. Second, Pobjecky states that "a lay person may not perceive anything unusual or bizarre in the applicant's conduct which would justify notification to bar examiners of a possible mental problem."[387] Again, this yields a conclusion opposite of what Pobjecky seeks. If the applicant does nothing "unusual or bizarre," there is nothing to investigate.

Furthermore, Pobjecky's argument rests only on the third party reference form. An applicant with serious fitness concerns will reveal those concerns through other information gathered by the application, such as a leave of absence from school or work, credit problems due to a failure to pay bills, an employment history revealing multiple terminations, or other signs of instability.

Some courts have also suggested that conduct is the more appropriate inquiry. The court in *Brewer v. Wisconsin Board of Bar Examiners* reasoned that without a current psychological evaluation, the Board was able to look at the

---

382 *Id.*; *see also* discussion of stress caused by law school, *supra* note 232.
383 Moeser, *supra* note 40, at 36.
384 *See supra* Part IV.A.1.
385 Pobjecky, *supra* note 36, at 36.
386 *Id.*
387 *Id.*

plaintiff's past conduct and behavior to evaluate her fitness to practice law, just as it did for applicants without disabilities.[388] And in *Clark*, the court took note of testimony from the plaintiff's expert witness, who stated that an applicant's past behavior "provides the best indicator of an applicant's present ability to function and work."[389] The expert further stated that the behavioral or "characterological" questions on a bar application would elicit the appropriate information.[390]

There is certainly a possibility that some students will ably complete law school and become licensed attorneys, only to experience a debilitating episode of mental illness later in life. The problem is that there is no way of identifying which students will and which students will not. Their psychologists cannot make such a prediction, and lay people with no mental health training—such as bar examiners—absolutely cannot make such a prediction. Therefore, the inquiry is not likely to produce an accurate prediction of future fitness, and it fails to be "necessary" under the ADA.

CONCLUSION

Seventeen years ago, Stanley S. Herr wrote that "[t]he visibility of bar admission activities, the legal training of aggrieved applicants and the interest of the [DOJ] in this subject all point to the potential for further litigation. Bar officials, however, can and should take preventive action by revamping questionnaires now."[391] No doubt he expected much greater progress than has actually been achieved.

Most law students are not in a position—or necessarily even interested—to bring a lawsuit against the bar association. Most of them simply want to obtain their law licenses and begin their careers, not spend several years battling with the bar.[392] And of course, lawsuits are expensive. Particularly in today's market, where most law students are graduating with a heavy student debt load, students do not have excess funds available for a lawsuit, and they are generally not in a position to forego a steady paycheck while their law license remains pending. Many law firms will be reluctant to hire a recent

---

[388] Brewer v. Wis. Bd. of Bar Exam'rs, No. 04-C-0694, 2006 WL 3469598, at *12 (E.D. Wis. Nov. 28, 2006).

[389] Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 435 (E.D. Va. 1995).

[390] *Id.*

[391] Herr, *supra* note 48, at 671.

[392] Ira Burnim, Legal Dir. of the Bazelon Ctr. for Mental Health Law, Remarks at *Suffering in Silence*, supra note 73, at 133.

graduate who not only is not admitted to the bar but is "the one suing the bar because he's mentally ill and didn't want to disclose it on his application." The bar application process has been described as one in which the bar examiners have all the power and applicants are mere "supplicants."[393] The majority of students will jump through whatever hoops they must in order to not waste their three years—and thousands of dollars—of legal education.

The DOJ-Louisiana settlement was a landmark moment and led to 14 states promptly amending their applications to comply with the ADA. But some states remain reluctant, even openly defiant. Arkansas amended its application but continues to ask questions that violate the ADA, including the broadest question in the country about the use of prescription or over-the-counter drugs for any mental condition. Ohio too revised its questions in 2014 but did so in a way that still violates the ADA.[394] The DOJ is now investigating Florida because Florida has not amended its application questions.[395]

Even the DOJ cannot necessarily compel states to comply. Louisiana reached a settlement, but a particularly recalcitrant state might require the DOJ to litigate the matter, rather than settle. On the one hand, this might be beneficial because it would force a court decision. But again, lawsuits are costly and slow. The DOJ also has competing priorities and limited resources. And there is no guarantee that the DOJ would succeed. As this Article explains, the inquiries are impermissible under the ADA, but some courts have nevertheless reached the wrong conclusion (*Texas Applicants*[396] and *ACLU of Indiana*[397]). The risk exists that a future court will simply follow the prior decisions and uphold the questions, and then all parties must wait for an appellate court to hear the case.

There is a role for law schools to play in this process. Bar associations require schools to certify their applicants for admission, and those certification forms often include questions about the applicants' mental health. If the law schools in a particular state decided collectively to 1) stop answering those questions on the certification forms, and 2) direct their

---

[393] McFarlain, *supra* note 1, at 30. One attorney who has represented numerous applicants before the Florida Board of Bar Examiners states "the applicant . . . must defend his past in a procedure in which he has no leverage." *Id.* at 29.

[394] *See* discussion *supra* Part III.A.4.

[395] Kay, *supra* note 375, at A1.

[396] Applicants v. Tex. State Bd. of Law Exam'rs, No. A 93 CA 740 SS, 1994 WL 923404 (W.D. Tex. Oct. 11, 1994).

[397] ACLU of Ind. v. Ind. State Bd. of Law Exam'rs, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470 (S.D. Ind. Sept. 20, 2011).

students to stop answering those questions on their individual applications, the bar associations might take notice.[398]

Precedent exists for this type of collective action. In 1994, the deans of the three Minnesota law schools wrote a petition that convinced the Minnesota Supreme Court to revise its bar application.[399] Although the court stated that it was "in doubt" as to whether the ADA applied to the disputed questions, it held that the questions should be removed from the application because they deterred students from seeking necessary counseling and that questions related only to conduct could elicit the necessary information "for the most part."[400] However, it appears that something went awry in the intervening years, because the Minnesota bar application now asks several odd questions about mental health.[401]

In Maryland in 1996, an Associate Dean of the University of Maryland School of Law and the school's Clinical Law Office successfully worked with the state bar admission to amend the questionnaire.[402] But Maryland retained mental health questions on its application until 2014. And in Florida, bar examiners rejected a similar request in 1990 and even broadened their application questions, rather than limiting the question, as the Florida schools suggested.[403]

Some commentators have pointed out the irony of lawyers committing discrimination in their own licensing process. "Lawyers have worked hard to impose antidiscrimination rules on schools, employers, housing providers, federal contract officers, and keepers of building and other spaces open to the public. But on themselves? Not so much."[404]

Now is the time for lawyers and law schools to eliminate discrimination in the very process that licenses attorneys. The bar should respect not only the letter but also the *spirit* of the

---

[398] One commentator has suggested that if law schools agreed amongst each other to simply stop reporting this information, that would end the whole inquiry. Laura Rothestein, Professor of Law & Distinguished Univ. Scholar at the Louis D. Brandeis Sch. of Law at the Univ. of Louisville, Remarks at *Suffering in Silence*, *supra* note 73, at 135.

[399] Herr, *supra* note 48, at 685.

[400] *In re* Frickey, 515 N.W.2d 741, 741 (Minn. 1994).

[401] MINN. BD. OF LAW EXAM'RS, APPLICATION FOR ADMISSION 9-10 (Mar. 2014), *available at* http://www.ble.state.mn.us/file/Bar%20Application%202014%20-%20fill%20in(1).pdf.

[402] Herr, *supra* note 48, at 685-86.

[403] *See supra* Part IV.B.2; Maher & Blum, *supra* note 43, at 847.

[404] Bernstein, *supra* note 228, at 391; *see also* Jolly-Ryan, *supra* note 215, at 130 ("Although lawyers work hard to assure that the antidiscrimination laws are fairly applied to most other people's employment, education, and housing situations, they often fail to apply antidiscrimination laws to their own profession.").

ADA.[405] Rather than continuing to quibble over which questions comply with the ADA, bar examiners should eliminate these questions entirely to comply with the spirit of the ADA. It would be to the shame of this profession if the remaining 14 states wait for the DOJ to force them to amend their applications, rather than taking action now to bring their processes into compliance with the ADA.

The very first court to consider this question decided it correctly. In *Medical Society of New Jersey*, the court held that the appropriate questions asked about behavior and capability.[406] More than two decades later, we are still waiting for some states to comply with the law.

[405] Smith, *supra* note 346, at 80.

[406] Med. Soc'y of N.J. v. Jacobs, No. 93-3670 (WGB), 1993 WL 413016, at *1 (D.N.J. Oct. 5, 1993).

Removal of Intrusive Mental Health & Substance Use Disorder Questions on Credentialing Application

Reference List

In *The Medical Society of New Jersey v The New Jersey Board of State Medical Examiners,* U.S. District Court for the District of New Jersey decided
that ADA's prohibition on discrimination based upon an individual's mental health and substance dependency history places neither the public nor the medical profession at risk. The Court to conclude that the Board's relicensure program violates title II of the ADA. https://archive.ada.gov/briefs/mednjbr.pdf

Americans with Disabilities Act U.S. Department of Justice Civil Rights Division. (2024, November 14). *Opioid use disorder. The ADA and Opioid Use Disorder: Combating Discrimination Against People in Treatment or Recovery.* ADA. https://www.ada.gov/resources/opioid-use-disorder/

Mayo Clinic. (2024, November 14). *Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions* . Mayo Clinic Proceedings. https://www.mayoclinicproceedings.org/article/S0025-6196(17)30522-0/abstract

American Psychological. Association. (2024, November 14). *Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing*. APA Official Actions. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Inquiries-about-Diagnosis-and-Treatment-of-Mental-Disorders-in-Connection-with-Professional-Credentialing-and-Licensing.pdf

Licensing and credentialing bodies' inquiry of physician mental health. American Medical Association. (2024, November 14). https://www.ama-assn.org/system/files/regulatory-myths-mental-health.pdf

States remove stigmatizing mental health questions from licensure applications. American Dental Association. (2024, November 14). https://adanews.ada.org/ada-news/2024/october/states-remove-stigmatizing-mental-health-questions-from-dental-licensure-applications/?md5=ea456925eb7f51f49ecfd94ad7049e77&utm_medium=email&utm_source=adaMorning-10-10-24&mkt_tok=ODI0LVhPRy0wNTQAAAGWFSskFpYU31RA82-WmpTMFHLGYrVVsdgHnBHN_a1NKxaxxOCpT6JZ5pf_wFS-D3CYYSwDKm2AMQGCL26FZRRqgVIJjw6jFGZVPSvZ4we8jUfJ8zw

American Dental Association. (2024). *Preventing Mental Health and Substance Use Disorder Discrimination in Dentist Licensure and Credentialing – Resource Toolkit*. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/mental-health-toolkit/adatoolkitpreventingmentalhealthandsubstanceusedisorderdiscriminationindentistlicensureandcredential.pdf?rev=b2841ef16e8341ca85ad8bae9ae85a55&hash=174B105724EF8105FF484EEB8AE77531

From: Lisa Rowley <lisajrowley.rdh@outlook.com>
Sent: Tuesday, November 26, 2024 4:00 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc: Karan Bershaw <karanrdh@gmail.com>; Kimberly Perlot <perlotk@interdent.com>; Barry Taylor, DMD <btaylor@oregondental.org>; Brett Hamilton <bhamilton@oregondental.org>; Ginny Jorgensen <ginjorge53@gmail.com>; Mary Harrison <Mary2805@aol.com>
Subject: "Scaling Assistant" Training

I have an unsubstantiated report that a representative from Willamette Dental Group has contacted the dental programs director for Portland Community College to ask if they would train "scaling assistants."

The ODHA is strongly opposed to the training and use of "scaling assistants" in Oregon. I have attached the ODHA's "Overview of Scaling Assistant Legislation" document for your review.

I have also attached suggested revisions to OAR 818-042-0040 that are intended to clarify that the training and use of "scaling assistants" is not legal in Oregon.

The ODHA values the positive relationship that we have with the Oregon Board of Dentistry, the Oregon Dental Association and the Oregon Dental Assistants Association, and we are committed to working together to pursue positive strategies to address the dental workforce shortage.

Thank you for considering this issue.

Lisa J. Rowley, MSDH, RDH, CDA, FADHA
ODHA Advocacy Director
State Liaison to ADHA Institute for Oral Health Foundation
503-568-5825
lisajrowley.rdh@outlook.com

adha™ | Oregon DENTAL HYGIENISTS' ASSOCIATION

www.adha.org **www.odha.org**

Oregon DENTAL HYGIENISTS' ASSOCIATION

Overview of Scaling Assistant Legislation
November 2024

What is a scaling assistant?
Although the definition varies from state to state, in most cases a "scaling assistant" is a dental assistant who, after completing on-the-job training or a short course of study, can perform coronal (above the gumline) scaling under the supervision of a dentist. In some states a scaling assistant may be called a "preventive dental assistant."

When & where did this start?
In 1998 Kansas became the first state to allow dental assistants to perform coronal scaling. For many years prior to 1995, Kansas dentists particularly in rural areas had been delegating coronal scaling and polishing to their dental assistants. In 1995 the Kansas Attorney General ruled that dental assistants could not legally scale or polish above or below the gumline. The Kansas Dental Association believed that there was a shortage of dental hygienists and sought help from their state legislature. This resulted in passage of HB 2724 in 1998. This bill amended the Kansas dental law to allow a "non-licensed person" (dental assistant), who has completed a board approved course of study consistent with CODA standards, to scale and polish above the gumline under the direct supervision of a dentist except for patients who have undergone local or general anesthesia at the time of the procedure. Their definition of direct supervision is that "the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance."

What's happened in other states?
- In 2015 Illinois became the second state in the U.S. to allow dental assistants to scale teeth above the gumline on children 12 years of age and younger after attending a weekend course.
- In 2021 the Wisconsin Dental Association initiated legislation for an expanded duty dental assistant that included scaling. This section of the bill was removed after strong opposition by the Wisconsin Dental Hygienists' Association.
- In 2022 the Illinois Dental Society passed legislation that allows dental assistants with 32 hours of instruction to provide coronal scaling on Medicaid children 17 years of age and younger.
- In 2023 a House representative who was a dentist from the Bozeman area of Montana introduced HB 411 that if passed would have allow dental assistants to provide an oral prophylaxis on children aged 12 and under. This bill did not pass after strong opposition from the Montana Dental Hygienists' Association.
- In 2023 the Colorado Dental Association (CDA) adopted a resolution to develop and submit a Sunrise Review application to the Colorado Department of Regulatory Agencies that will address the expansion of dental assistant scope of practice to include periodontal probing and calculus removal under direct supervision of a dentist.

The Colorado Dental Hygienists' Association has been meeting with the CDA and other stakeholders to address workforce issues in Colorado.

- In 2024 the Washington state legislature considered House Bill 2176 that if passed would have created a licensed preventive dental assistant who, with no formal education, would be able to perform oral prophylaxis for healthy patients and periodontal probing after initial probing by a dentist or dental hygienist, both under the supervision of a dentist. This bill did not pass after strong opposition from the Washington Dental Hygienists' Association.

Why are some dentists supporting this?

- They think that a scaling assistant will help alleviate the current shortage of dental hygienists and improve access to dental care for their patients.
- They think that they can train their dental assistants to perform scaling and polishing above the gumline on-the-job in just a few months.
- They think that their dental assistant can be trained to perform scaling above the gumline because dental assistants already perform a variety of dental procedures.
- They think that child prophys are relatively easy compared to adult prophys.
- They think that they can pay a scaling assistant a wage lower than they would need to pay a dental hygienist.

Why is the ODHA opposed to this?

- An oral prophylaxis includes scaling both above and below the gumline to ensure that all calculus is removed. In most cases, scaling assistants may only perform scaling above the gumline, so they are not performing an oral prophylaxis and it cannot be billed to the patient's insurance company as such.
- Calculus that is present along the gumline usually extends below the gumline so scaling only above the gumline will not remove this calculus. If the gingival tissue heals over this remaining calculus below the gumline, the patient is at risk for developing periodontal abscesses.
- Scaling assistants have not completed a formal education program that is comparable to the 2-3 years of college-level accredited education that is required to become a licensed dental hygienist. During their formal education dental hygienists complete more than 500 hours providing dental hygiene care to a wide variety of patients under the supervision of licensed dentists and dental hygienists.
- If each dentist provides on-the-job training with no standard curriculum, each scaling assistant will likely receive different training from each dentist.
- Dentists are currently having a more difficult time finding dental assistants than dental hygienists, so it seems unreasonable that a dentist would give up a chairside assistant so that the dental assistant can become a scaling assistant.
- If a dentist can pay a scaling assistant a lower wage than they would pay a dental hygienist, the dentist might not pass this savings along to their patients.
- We value our dental assistants and do not want to see them put in a situation where they are asked to provide coronal scaling at a lower wage than what they would receive if they became a licensed dental hygienist.
- In most cases scaling assistants are not licensed and they do not need to report address changes to their state board of dentistry. This means that the board is not

able to track them, communicate with them or provide oversight for them. Scaling assistants who are not licensed cannot be disciplined by their state board of dentistry.
- In most cases patients do not know that their scaling is not being performed by a licensed dental hygienist and they are not given the opportunity to refuse treatment from an unlicensed provider.
- There are better ways to address the workforce shortage than having unlicensed providers with less education perform coronal scaling for patients especially children. Surveys show that dental assistants and dental hygienists are leaving the field due to negative workplace culture, low wages and feeling overworked. Dentists should consider creating a positive work culture, increasing wages and reducing stress for their staff.

Resources

- What happened in Kansas could happen in your state. Are you ready? RDH Magazine October 1998.
- Ethical Moment: Dental Assistants Performing Prophylaxes. JADA 2009
- The Montana Experience: Fighting House Bill 411 to Protect Children. RDH Magazine March 2023
- Dental Assistant Scope Expansion Explored, CDAonline 2023
- The Scaling Assistant Part I - Dental Products Report September 2023
- The Scaling Assistant Part II - Dental Products Report January 2024
- Dental Hygienist Shortage: Proposed Solutions and Why Assistants Scaling is not the Answer - Today's RDH May 2024

If you have any questions or need more information, please contact ODHA Advocacy Director Lisa J. Rowley at **lisajrowley.rdh@outlook.com.**

OAR 818-042-0040
Suggested Revisions

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), 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.
(??) Use hand instruments, air polishers, ultrasonic equipment or other devices to remove supragingival and subgingival stains and deposits from tooth surfaces.
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intraorally 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 **and periodontal probing**.
(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.

818-042-0070
Expanded Function Dental Assistants (EFDA)
The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:
(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge;
(2) Remove temporary crowns for final cementation and clean teeth for final cementation;
(3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;
(4) Place temporary restorative material in teeth providing that the patient is checked by a dentist before and after the procedure is performed;
(5) Place and remove matrix retainers for any type of direct restorations;

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.
(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.

CORRESPONDENCE

From: mary2805@aol.com <mary2805@aol.com>
Sent: Monday, November 25, 2024 9:37 PM
To: PRISBY Stephen * OBD <stephen.prisby@obd.oregon.gov>
Subject: HB3223

Greetings To you the members of the Oregon Board of Dentistry,

The Oregon Dental Assistants Association has concerns about HB 3223 and as Legislative Chairman I would like for you,
The Oregon Board of Dentistry to address this subject. The DAWSAC was established by request/direction from HB3223.
One motion came from the committee to extend the time for the Bill to go into effect by one year, that being June 25, 2026.
Stephen reported that he did present this to the governor's office and as far as I understand, there has been no response.
One of the issues SECTION 2. (b)was to have the exams offered in plain language in English, Spanish and Vietnamese.
This has been answered by DANB and will be completed by the requested date.
Making it possible to keep all exams rather than losing them.
There are several areas in the bill that are somewhat confusing and an example of this is in
SECTION 2. (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.
Does this mean if an applicant wants to become an EFDA, or EFODA there will or can be only one exam?
Which one will the OBD choose? The RHS exam or the one related to the the certificate desired?
Restorative, Local Anesthetic will there be only one exam, really?
This is only one example of the poorly written and passed HB 3223.
The bill is confusing and will, no doubt, cause anyone trying to follow and work through it many questions and misunderstandings.
I would ask you the board to review and perhaps form a committee to look into making recommendations for what can be done to
correct in some way to make this a workable document.

Since this has been passed in legislature, it seems to me the Oregon Board of Dentistry becomes the agency that has to work through
this legislation. If it is not possible because of the way it is written what happens?
Thank you in advance for helping with these issues,

Regards,

Mary Harrison CDA Emiratis, EFDA, EFODA, FADAA

Outlook

ADA 2024 House of Delegates Resolutions

From Lisa Rowley <lisajrowley.rdh@outlook.com>
Date Tue 11/26/2024 4:28 PM
To PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc Karan Bershaw <karanrdh@gmail.com>; Kimberly Perlot <perlotk@interdent.com>; Barry Taylor, DMD <btaylor@oregondental.org>; Brett Hamilton <bhamilton@oregondental.org>; Ginny Jorgensen <ginjorge53@gmail.com>; Mary Harrison <Mary2805@aol.com>

4 attachments (1 MB)

2024 11-26 ODHA Letter re ADA HOD.pdf; 2024 10-11 ADHA Letter re ADA Resolutions.pdf; 2024 11-08 ADHA Letter re ADA Resolutions.pdf; 2024 11-15 ADA Response to ADHA.pdf;

You asked ODA, ODHA & ODAA to provide some context about the ADA 2024 House of Delegates resolutions that address CODA faculty-student ratios and allowing dental students and internationally trained dentists to practice dental hygiene, and that we report back to you at the Oregon Board of Dentistry meeting on December 13, 2024.

The ODA, ODHA & ODAA met to discuss this issue on November 6, 2024, along with positive strategies to address the dental workforce shortage.

I have attached a letter that summarizes ODHA's concerns about the ADA 2024 House of Delegates resolutions. I have also attached two letters that were sent from the ADHA to all of their members, as well as a response to ADHA that appeared in the November 15 issues of ADA News.

I am happy to answer any questions or provide additional information about this issue.

Lisa J. Rowley, MSDH, RDH, CDA, FADHA
ODHA Advocacy Director
State Liaison to ADHA Institute for Oral Health Foundation
503-568-5825
lisajrowley.rdh@outlook.com

adha™ | Oregon DENTAL HYGIENISTS' ASSOCIATION

www.adha.org www.odha.org

November 26, 2024

Stephen Prisby, Executive Director
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201-5837

Dear Mr. Prisby,

The Oregon Dental Hygienists' Association (ODHA) is aware that several resolutions were proposed during the American Dental Association (ADA) 2024 House of Delegates meetings in October 2024 that were identified as ways to alleviate the dental workforce shortage.

The ODHA is **strongly opposed** to the following resolutions that were adopted:

401 – Adopted
The ADA urges CODA to revise the Accreditation Standards for each of the allied dental education programs in regard to faculty-student ratios to align with the Accreditation Standards for Predoctoral Dental Education Programs, and the ADA urges CODA to adopt the following language currently in the Accreditation Standards for Predoctoral Dental Education Programs to each of the allied dental education programs: The number, distribution and qualifications of faculty and staff must be sufficient to meet the dental program's stated purpose/mission, goals and objectives, at all sites where required educational activity occurs.

The Current Accreditation Standards for Dental Hygiene Education Programs require a minimum of a faculty-student ratio of 1 clinical instructor for every 5 students who are treating patients. This ratio is critical to allow faculty adequate time to teach and evaluate clinical skills and to ensure patients receive safe and appropriate care. Some dental hygiene education programs may be facing challenges with filling their open positions for clinical instructors, however increasing the faculty-student ratio will only make their jobs more difficult and discourage dental hygienists from applying for clinical instructor positions.

513H – Adopted
The states should be encouraged to adopt policies to allow active dental students and residents who have completed all of their required hygiene competencies to practice dental hygiene or to practice as other dentist-supervised team members, subject to state licensure requirements.

514B – Adopted
States should be encouraged to adopt policies allowing dentists who have complete a dental education program outside the United States, subject to state licensing board requirements, to obtain a license to practice dentistry.

As you know, Oregon Revised Statutes require that candidates for dental hygiene licensure in Oregon must successfully complete a dental hygiene education program that is accredited by the Commission on Dental Accreditation (CODA). Oregon currently has eight (8) CODA accredited dental hygiene education programs that will graduate approximately 175 dental hygiene students in 2025. There are 4,288 licensed dental hygienists in Oregon and 3,765 licensed dentists in Oregon. We see no viable reason to change the current requirement that candidates for dental hygiene licensure must successfully complete a CODA accredited dental hygiene education program.

The ODHA is relieved that the following resolution was **not** adopted:

411 – Not Adopted
The appropriate ADA agency partner with interested state dental associations to determine the feasibility of developing alternative accreditation standards for dental hygiene and dental assisting education programs by a USDE-recognized programmatic accrediting agency other than CODA.

The Commission on Dental Accreditation (CODA) has accredited dental hygiene and dental assisting education programs for many years. CODA currently operates under the auspices of the American Dental Association (ADA) and is recognized by the U.S. Department of Education. The Oregon Revised Statutes list CODA as the accrediting agency for predoctoral, advanced dental, dental therapy, dental hygiene and dental assisting education programs. We see no viable reason to investigate alternatives to CODA as the accrediting agency for dental hygiene and dental assisting education programs.

I have attached two letters that were emailed from ADHA President Erin Haley-Hitz to all ADHA members. These letters express ADHA's concerns with these resolutions. In the ADHA President's second letter, one of the positive actions she recommends is to **meet with your state dental association** to discuss "constructive solutions to workforce issues." I am happy to report that representatives from ODAA and ODHA have been meeting with Dr. Barry Taylor, ODA Executive Director, and Brett Hamilton, ODA Director of Government & Regulatory Affairs, since August 2024 to discuss positive strategies we can pursue together to address the dental workforce shortage.

Please feel free to contact me if you have any questions or need more information.

Sincerely,

Lisa J. Rowley

Lisa J. Rowley, MS, RDH, CDA, FADHA
Advocacy Director 2024-2026
Oregon Dental Hygienists' Association

Attachments:
2024 10-11 Letter from ADHA President Erin Haley-Hitz
2024 11-09 Letter from ADHA President Erin Haley-Hitz

AMERICAN DENTAL HYGIENISTS' ASSOCIATION™

444 Michigan Ave, Ste 400 | Chicago, IL 60611 | 312.440.8900 | adha.org

October 11, 2024

Dear Colleagues and Members of the Healthcare Community,

Recently proposed resolutions by the American Dental Association (ADA) aim to remove faculty-to-student ratios in dental hygiene programs and allow dental students and foreign trained dentists to practice dental hygiene in the United States, without passing a state licensing exam.

As the leading voice for dental hygienists in the U.S., the American Dental Hygienists' Association (ADHA®) is submitting written testimony in strong opposition of these resolutions. We believe they pose significant risks to educational standards and patient safety, and we urge the ADA House of Delegates to reject these proposals.

The resolutions are outlined below, followed by the points the ADHA has prepared for consideration by the ADA House of Delegates reference committees.

Resolution 401, "Increasing Allied Personnel in the Workforce", aims to align faculty-student ratios in dental hygiene programs with those of predoctoral dental education programs and raises the following concerns:

- **Compromised Education Quality:** Altering faculty-student ratios risks diluting and compromising the quality of education or the financial viability of allied dental programs. Smaller ratios ensure students receive the necessary hands-on guidance and oversight for mastering dental hygiene's clinical and theoretical components.
- **Not an Enrollment Mechanism:** Eliminating faculty-student ratios is not a mechanism for increasing student enrollment and may even decrease the appeal of attending a program.
- **Educator Burnout:** With the existing shortage of dental hygiene educators, eliminating faculty-student ratios may exacerbate educator burnout, further weakening academic programs and reducing educator retention.
- **Established Standards:** The Commission on Dental Accreditation (CODA) has already determined that existing faculty-to-student ratios in dental hygiene programs are essential for maintaining education standards and should remain unchanged.

Dental hygiene education, including clinical instruction, is distinct from dental student education. Requiring different structures, oversight and expertise. Dental hygiene educators are best positioned to determine the appropriate instruction and supervision levels necessary for effective clinical training of dental hygiene students and to uphold the educational standards of our profession.

Resolution 513, "Resolution Dental Students and Residents as Dental Hygienists", proposes to allow dental students and residents to practice as dental hygienists after completing their dental competencies. This resolution raises the following concerns:

- **Inadequate Training:** Dental students and residents do not receive the same comprehensive education and specialized training required for providing preventive and therapeutic dental hygiene services. Their training and resulting qualifications in this area are extremely limited in comparison.

- **Risks to Patient Safety:** Employing individuals in roles they are not licensed for is irresponsible and can have serious legal and ethical consequences. For the safety and trust of the public, it is essential to maintain a clear line of licensure and qualifications in healthcare.
- **Erosion of Professional Standards:** The ADHA believes that maintaining the integrity of professional standards is paramount to ensuring quality patient care. Lowering the bar for licensure threatens to dilute the high standards of the dental hygiene profession and compromises patient care quality and safety.
- **Fostering Meaningful Work and Professional Development:** Rather than lowering professional standards, the ADHA believes efforts should be directed to improving workplace culture, enhancing professional development opportunities, and offering competitive benefits. These measures can attract new talent and retain qualified dental hygienists without sacrificing the integrity of the dental hygiene profession.

Resolution 514/514B, "Internationally Trained Dentists as Dental Hygienists" seeks to integrate internationally trained dentists into the dental hygiene workforce. This resolution raises the following concerns:

- **Inconsistent Education Standards:** Dental education standards vary widely across countries, and internationally trained dentists are unlikely to have the specific knowledge and clinical expertise necessary for practicing dental hygiene in the U.S.
- **Patient Safety Concerns:** Allowing individuals to practice as dental hygienists without proper U.S.-based training could jeopardize patient safety and care quality.
- **Appropriate Pathways:** Foreign-trained dentists who wish to practice as dental hygienists in the United States should follow the established pathway by enrolling in programs that are accredited by CODA to gain the specific expertise and ensure they are qualified for the roles they intend to fulfill. Creating alternative routes without proper accreditation undermines both the dental and dental hygiene professions.

We urge the ADA House of Delegates to reject these resolutions and focus on solutions that respect the distinct professional roles within dentistry and dental hygiene. The integrity of dental hygiene as a profession, and the quality of care provided to patients, depends on maintaining stringent educational and licensure standards.

Sincerely,

Erin Haley-Hitz
RDH, BSDH, MS, FADHA, MAADH
ADHA President 2024-2025

Lancette VanGuilder
BS, RDH, PHEDH, CEAS, FADHA
ADHA President-Elect 2024-2025

Jessica August
MSDH, CDA, RDH, FADHA
ADHA Vice President 2024-2025

Outlook

How to Take Positive Action Following ADA's Resolutions. Start the Conversation.

From Erin Haley-Hitz, RDH, BSDH, MS, FADHA, MAADH <communications@adha.net>
Date Fri 11/8/2024 2:17 PM
To lisajrowley.rdh@outlook.com <lisajrowley.rdh@outlook.com>

View this email in your browser.

adha AMERICAN DENTAL HYGIENISTS' ASSOCIATION™

November 8, 2024

Dear ADHA Member,

Following **my letter to you on Tuesday regarding ADHA's objections to the recently passed ADA resolutions**, I received responses from members and leaders with messages of support, concern and readiness to take action. I am inspired by how our remarkable dental hygiene community stands united and approaches challenges with professionalism and determination.

When our professional standards and patient care are at risk, it's natural to feel uncertain and frustrated. However, the most effective way forward is through positive action.

What Can You Do?

1. **Talk With Your Employer.** Start an open conversation and ask questions. Not everyone follows updates from professional organizations closely – this includes ADHA and ADA. Your employer may not be aware of these developments. If they share your concerns, they can voice their objections to their state dental association.

2. **Renew Your Membership.** Your voice is part of the community that is advocating for our profession. Now it's more important than ever to continue to support our professional integrity and help protect our professional standards by uniting and working together. If you haven't renewed and you're not on an autorenewal plan, make sure to **renew today**.

3. **Support Your State Association.** Your membership includes representation at the state level. Encourage your state leaders to invite the state dental association to a discussion about constructive solutions to workforce issues that improve the retention of dental hygiene staff and maintain the integrity of our profession.

On the national level, we have already taken this step, and we have encouraged state leaders to do the same. While we wait for a response from the ADA, it is important for these conversations to happen at the state, local and personal levels. Awareness and dialogue can lead to positive solutions.

Advocating for dental hygienists and protecting our profession is a cornerstone of this organization and why we are determined to work toward professional autonomy and self-regulation. Save the date to join us on January 15, 2025 to start the year off with a special webinar on autonomy for dental hygienists.

ADHA stands up for your professional interests and we will continue to keep you, and the healthcare community informed of any developments.

Sincerely,

Erin Haley-Hitz, RDH, BSDH, MS, FADHA, MAADH
ADHA President 2024-2025

ADANews

New ADA policies empower states to alleviate dental workforce shortage

ADA cites urgency, flexibility, commitment to high standards in response to American Dental Hygienists' Association

by **Olivia Anderson**

November 15, 2024

The ADA House of Delegates passed a series of resolutions that aim to address the dental workforce shortage, an issue ADA leaders say is among their top priorities. With an insufficient workforce, the ADA said, care cannot be delivered to patients.

Included are three resolutions that cover allowing internationally trained dentists a path to U.S. licensure; letting active dental students and residents practice hygiene if they've met certain competency requirements; and increasing the number of faculty and students in allied dental education programs.

In a Nov. 1 letter to ADA President Brett Kessler, D.D.S., Erin Haley-Hitz, American Dental Hygienists' Association President and registered dental hygienist, expressed concern about the three resolutions' potential effect on patient safety, educational standards and professional integrity.

"Such changes fail to address oral-systemic health and the underlying issues that are driving many dental hygienists to leave the profession. The measures proposed in these resolutions — whether intended or not — threaten professional integrity and patient outcomes and fundamentally undermine the dental hygiene profession," Ms. Haley-Hitz wrote in the letter.

In a Nov. 14 response to Ms. Haley-Hitz, Dr. Kessler reassured her that the ADA remains committed to the highest standards of education and patient safety in dentistry.

"These resolutions were developed with a careful eye toward addressing the workforce shortages that are impacting patient access to care, while also maintaining licensure and practice standards," reads the letter. "In short, our goal is to find practical and responsible solutions to fill critical staffing gaps with qualified, well-trained individuals — without compromising on the standards that our patients deserve."

The letter goes on to state that the resolutions help address the workforce shortage by allowing dental professionals a voice in working towards better access to oral health care. Although the ADHA expressed concern specifically regarding resolutions 401H-2024, 513H-2024 and 514H-2024, the ADA said each one upholds stringent licensure standards and ensures only qualified professionals practice in roles that match their training.

“The ADA also shares ADHA’s commitment to enhancing workplace culture, professional development, and support for all members of the dental workforce. These resolutions are intended not only to help address the staffing shortage, but also to reduce the strain on current dental teams,” wrote Dr. Kessler.

ADA Health Policy Institute survey data tracks dental team recruitment challenges. In the third quarter of 2024, for instance, 33.9% of dentists indicated they were currently recruiting or had recruited a dental hygienist in the prior three months. Among those dentists, 91.7% indicated recruitment was very challenging or extremely challenging.

“We value and respect the essential role of dental hygienists in providing quality care, and we see these new policies as ways to complement — not replace — the vital role of hygienists on the dental team,” the ADA letter reads.

Under 514H-2024, the ADA would encourage states to adopt policies allowing dentists who have completed a dental education program outside the U.S., subject to state licensing board requirements, to obtain a license to practice dental hygiene. Dr. Kessler reiterated in his letter that the ADA would not encourage states to adopt any policy allowing internationally trained dentists to work as dental hygienists unless that policy required applicants to pass board examinations demonstrating their competency. The ADA said this new policy would allow it to give dentists a seat at the table on dental workforce issues, as some states already license internationally trained dentists as dental hygienists and other states are considering similar legislative proposals.

Under 513H-2024, the ADA would encourage states to adopt policies allowing active dental students and residents who have completed all their required hygiene competencies to practice

dental hygiene, or to practice as other dentist-supervised allied dental team members, subject to state licensure requirements. Dr. Kessler noted in his response that any policy under consideration would have to require dental students to meet state licensure requirements for hygiene before the ADA would encourage states to allow them to be licensed to practice hygiene.

Under 401H-2024, the ADA urges the Commission on Dental Accreditation to revise the accreditation standards for each of the allied dental education programs regarding faculty-student ratios to align with the accreditation standards for predoctoral dental education programs. Dr. Kessler said updating the standard would allow allied dental training programs more flexibility to increase class sizes, which are currently restricted due to the need to hire additional faculty.

Shane Ricci, D.D.S., chair of the ADA Council on Dental Practice, said he looks forward to addressing workforce challenges in the coming months.

“The Council on Dental Practice is eager to collaborate with other stakeholders to expedite priorities outlined in the ADA’s Strategic Forecast which include multifaceted opportunities to address workforce challenges,” he said.

From: Jenna Shanks <jenna.shanks@aol.com>
Sent: Wednesday, November 20, 2024 7:15 PM
To: PRISBY Stephen * OBD <stephen.prisby@obd.oregon.gov>
Subject: Request to Add Proposal to December 13th Agenda

Hello Stephen Prisby,

I hope you're doing well. I've updated my document regarding the proposition to allow dental hygienists to administer Botox in Oregon. I kindly request that this be added to the agenda for the December 13th meeting, as it was not called to vote at the last meeting.

Thank you so much, and have a great night!

Best regards,

Jenna Shanks, RDH

Jenna Shanks

Expanding Scope of Practice: Advocating for Dental Hygienists to Administer Botox Injections in Oregon

Introduction

The integration of Botox into dental practice offers significant benefits for patients with various conditions, including TMJ disorders, bruxism, and excessive gingival display. As trained oral health professionals, dental hygienists possess the foundational knowledge and skills necessary to safely administer Botox under appropriate supervision.

Current Landscape

Currently, only Kansas and Oklahoma allow dental hygienists to administer Botox with direct supervision from a dentist, reflecting a growing recognition of their capability in this area (RDH Magazine, 2023). In Oregon, advocacy is ongoing to broaden these permissions, highlighting the need for updated regulations that reflect the evolving role of dental hygienists in patient care.

Benefits of Allowing Dental Hygienists to Administer Botox

1. **Enhancing Patient Care**: Granting dental hygienists the authority to administer Botox would significantly improve patient care quality and access, particularly for those suffering from TMJ disorders and related issues (Mayo Clinic, 2023).
2. **Leveraging Existing Expertise**: Dental hygienists have extensive training in oral health and anatomy, positioning them well to perform Botox injections safely and effectively (American Dental Association, 2020). Their education prepares them to understand the techniques and considerations necessary for this procedure.
3. **Meeting Increasing Demand**: With the rising popularity of Botox, allowing dental hygienists to provide these injections can help meet patient demand for non-surgical treatment options, ensuring more individuals can access these services (American Society of Plastic Surgeons, 2020).
4. **Broadening Treatment Options**: Enabling dental hygienists to administer Botox can expand the range of treatments available within dental practices, fostering comprehensive care that addresses both aesthetic and medical needs (RDH Magazine, 2023).
5. **Improving Accessibility**: By allowing dental hygienists to perform Botox injections, patients can access these services during their regular dental visits, reducing the need for referrals to outside specialists (Today's RDH, 2023).
6. **Promoting Safe Administration**: With proper training and oversight, dental hygienists can safely administer Botox, thus minimizing the risks associated with injections from inadequately trained providers in less regulated environments (American Academy of Dermatology Association, 2023).

7. **Facilitating Interprofessional Collaboration**: Permitting dental hygienists to administer Botox encourages collaboration between dental and medical professionals, leading to more integrated and holistic patient care (Mayo Clinic, 2023).
8. **Addressing Regulatory Gaps**: Updating regulations to permit dental hygienists to provide Botox aligns Oregon with other states that have successfully integrated this practice, thereby enhancing the competitiveness of dental care in the state (American Dental Association, 2020).
9. **Enhancing Patient Education**: Dental hygienists are well-equipped to educate patients about the risks and benefits of Botox, ensuring informed consent and fostering patient understanding, which enhances overall safety and satisfaction (American Academy of Dermatology Association, 2023).
10. **Adapting to Evolving Roles**: Allowing dental hygienists to administer Botox reflects the evolving landscape of healthcare, recognizing the increasing value of multidisciplinary approaches in providing comprehensive patient care (RDH Magazine, 2023).

Below is a table detailing Botox's therapeutic and cosmetic applications in dentistry, based on information from *Today's RDH*. Offering Botox in dental offices could not only provide valuable treatments but also attract more patients seeking these services. By addressing both pain management and cosmetic goals, dental practices offering Botox can meet a broader range of patient needs and draw in new patients interested in these versatile treatments.

Table 1: Therapeutic and cosmetic uses of Botox in dentistry

Disorder/condition	Outcome/benefit
Migraine	Pain relief. The mechanism is not fully understood, but it appears the reduction of muscle innervation leads to pain relief.
Pathologic clenching and bruxism, leading to trauma, attrition, etc.	Injections into the temporalis and masseter muscles help alleviate the symptomatology of bruxism.
Trigeminal neuralgia	An injection can relieve headaches and pain associated with this condition.
Temporomandibular joint disorders	Injecting with Botox helps ease and reduce pain and relax the muscle, leading to less wear on restorations.
Oromandibular dystonia movement disorder	Improves the function of chewing and speaking.
Masseteric hypertrophy—increased size of muscle; jaw looks swollen or misshapen	A sequence of three injections into the masseter muscle produces selective loss of muscle function.
"Gummy smile" or lip deformities	Injecting into the lip elevator muscles decreases the elevation of the upper lip; more gingiva is covered when smiling.
Sialorrhea	Botox injections can reduce secretions from the salivary gland.
Myofascial pain	Injecting into the painful muscles inhibits muscle contraction.

Currently, the following licensed professionals are authorized to administer Botox, while concerns exist about untrained individuals performing this procedure without medical qualifications:

1. **Nurse Practitioners**: These professionals can administer Botox independently, without the need for physician oversight (American Association of Nurse Practitioners, 2023).

2. **Physician Assistants**: They are permitted to inject Botox but must operate under the supervision of a physician (American Academy of Physician Assistants, 2023).
3. **Aestheticians**: In certain jurisdictions, aestheticians can administer Botox, provided they do so under the supervision of a licensed physician (National Laser Institute, 2023).
4. **Medical Assistants**: Medical assistants are also allowed to administer Botox under the supervision of a physician (American Association of Medical Assistants, 2023).
5. **Registered Nurses**: Registered nurses can perform Botox injections with supervision from a licensed physician or nurse practitioner. They must hold a valid nursing license, graduate from an accredited nursing program, and possess the necessary knowledge and skills to administer the procedure safely. Additionally, specialized training in injectables is often recommended (American Nurses Association, 2023).

However, there is a growing concern regarding individuals without medical training who are performing Botox injections, highlighting the need for stricter regulations and oversight to ensure patient safety.

Nursing vs. Dental Hygiene Curriculum at MHCC

Category	Nursing Courses (NRS)	Dental Hygiene Courses (DH)
Foundations	**Nursing Foundations**	**Clinical Principles**
	NRS110A: Health Promotion - A	DH112: Clinical Dental Hygiene
	NRS110B: Health Promotion - B	DH113: Dental/Oral Anatomy
	NRS111A: Chronic Illness I - A	DH114: Oral Microbiology
	NRS111B: Chronic Illness I - B	DH115: Professionalism and Cultural Competency
Acute Care	**Nursing in Acute Care**	**Clinical Theory and Practice**
	NRS112A: Acute Care I - A	DH121: Dental Hygiene Clinical Theory I
	NRS112B: Acute Care I - B	DH122: Dental Hygiene Clinic I
Chronic Illness & End-of-Life	**Chronic Illness II & End of Life**	**Advanced Oral Studies**
	NRS221A: Chronic Illness II - A	DH123: Oral Histology and Embryology

	NRS221B: Chronic Illness II - B	DH124: Oral Radiology I
	NRS222A: Acute Care II - A	DH125: General Pathology
	NRS222B: Acute Care II - B	DH131: Dental Hygiene Clinical Theory II
Clinical Practicum	**Integrative Practicum**	**Advanced Clinical Skills**
	NRS224A: Practicum I - A	DH132: Dental Hygiene Clinic II
	NRS224B: Practicum I - B	DH134: Oral Radiology II
Pharmacology & Pathophysiology	**Pharmacology & Pathophysiology**	**Specialized Dental Studies**
	NRS230: Clinical Pharmacology I	DH135: Oral Pathology
	NRS231: Clinical Pharmacology II	DH136: Pharmacology
	NRS232: Pathophysiological Processes I	DH137: Head and Neck Anatomy
	NRS233: Pathophysiological Processes II	DH211: Dental Hygiene Clinical Theory III
Expanded Practice & Specialization	**Specialization & Expanded Functions**	**Periodontology, Community Health & Restorative Dentistry**
		DH212: Dental Hygiene Clinic III
		DH213: Expanded Functions
		DH214: Periodontology for Dental Hygienists I
		DH215: Dental Materials
		DH216: Community Dental Health
		DH217: Local Anesthesia
		DH218: Introduction to Restorative Dentistry

		DH219: Nitrous Oxide-Oxygen Sedation
Advanced Clinical Practice	**Advanced Dental Hygiene Theory & Practice**	**Public Health, Management & Ethics**
		DH221: Dental Hygiene Clinical Theory IV
		DH222: Dental Hygiene Clinic IV
		DH223: Public Health and Dental Research
		DH224: Periodontology for Dental Hygienists II
		DH225: Restorative Dentistry Lab
		DH231: Dental Hygiene Clinical Theory V
		DH232: Dental Hygiene Clinic V
		DH233: Ethics and Jurisprudence
		DH234: Practice Management and Dental Hygiene Issues
		DH235: Restorative Dentistry Clinic

Total Credits

- **Nursing**: 60 Credits
- **Dental Hygiene**: 87 Credits

https://catalog.mhcc.edu/courses-az/dh/

https://catalog.mhcc.edu/courses-az/nrs/

Currently, the curricula for nursing and dental hygiene programs differ significantly in their focus areas. Nurses are trained through a broad range of courses that cover various aspects of the human body, emphasizing holistic patient care. In contrast, dental hygienists concentrate primarily on the head and neck region, making their education particularly relevant for administering Botox.

This specialized training equips dental hygienists with a deeper understanding of facial anatomy and the specific skills required for procedures involving Botox. Given their focused coursework and expertise as head and neck specialists, dental hygienists are well-suited to perform Botox injections effectively and safely.

Below is a summary of the requirements dentists must meet to administer Botox. I believe that dental hygienists, with similar training, should be allowed to take the same course and administer Botox as well. This approach could expand services in dental offices and attract more patients interested in cosmetic options offered by trusted dental professionals.

OAR 818-012-0005 (3) and (4):

(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.

The Board also views "cosmetic dentistry" as within the scope of practice, as long as there is a dental justification for the procedure.

Please contact the Board Office if you have any questions or need additional information.

Botox Safety Overview

Botox (Botulinum toxin type A) is considered safe when administered by trained professionals, with an established safety profile from extensive research and therapeutic use.

1. **Safety Profile**
    - **FDA Approval**: Approved for medical (e.g., migraines, hyperhidrosis, spasticity) and cosmetic uses.
    - **Controlled Dosage**: Small, regulated doses are used in procedures, reducing serious risks.
    - **Temporary Effects**: Effects typically last 3-6 months, with muscle function returning gradually.
2. **Common Side Effects**
    - **Local Reactions**: Redness, swelling, and mild pain at the injection site.
    - **Systemic Effects**: Some may experience headaches or flu-like symptoms.
    - **Localized Muscle Weakness**: Rarely, Botox can cause temporary weakness if it spreads beyond the injection area.
3. **Rare Serious Side Effects**
    - **Spread of Toxin Effects**: Larger medical doses can, in rare cases, cause swallowing or breathing difficulties.
    - **Allergic Reactions**: Severe allergies are rare but can include rash or wheezing.

4. **Safety Precautions**
    - **Qualified Practitioners**: It's crucial to have Botox administered by licensed, trained professionals.
    - **Patient Screening**: Pre-screening for contraindications like neurological disorders or pregnancy reduces risks.
5. **Reversal and Long-Term Safety**
    - **Natural Reversal**: Botox naturally wears off within months.
    - **No Direct Antidote**: No specific reversal agent exists; adverse effects are generally managed symptomatically.
    - **Long-Term Use**: Safe for repeated treatments, though rare resistance may develop with high/frequent doses.

Conclusion

Botox is generally safe for medical and cosmetic use, with temporary effects and manageable risks. Receiving treatment from trained professionals is key to minimizing potential complications. In conclusion, dental hygienists in Oregon should be granted the ability to administer Botox. As one of the most progressive states in the country for dental hygiene, Oregon is well-positioned to expand the scope of practice for dental hygienists, especially given the high demand and market for Botox treatments. Allowing hygienists to administer Botox would enhance patient care options, attract more clients to dental offices, and reflect the extensive training and qualifications that hygienists already possess. The arguments presented here demonstrate both the readiness and capability of hygienists to safely and effectively provide Botox, supporting the case for a broader, more versatile practice in Oregon.

Sources:

1. Allergan, Inc. (n.d.). *Botox Cosmetic and Medical FDA Approval Documents*.
2. American Academy of Dermatology Association. (2023). *Botox: Safety and Effectiveness*. Retrieved from https://www.aad.org
3. American Academy of Physician Assistants. (2023). *Physician Assistant Practice*. Retrieved from https://www.aapa.org
4. American Association of Medical Assistants. (2023). *Medical Assistant Scope of Practice*. Retrieved from https://www.aama-ntl.org
5. American Association of Nurse Practitioners. (2023). *Nurse Practitioner Scope of Practice*. Retrieved from https://www.aanp.org
6. American Dental Association. (2020). *The Role of Dental Hygienists*. Retrieved from https://www.ada.org
7. American Nurses Association. (2023). *Nursing Scope and Standards of Practice*. Retrieved from https://www.nursingworld.org
8. American Society of Plastic Surgeons (ASPS). (2020). *Botox Overview*. Retrieved from https://www.plasticsurgery.org
9. American Society of Plastic Surgeons (ASPS). *Botox: What Patients Need to Know*. Retrieved from https://www.plasticsurgery.org
10. Carruthers, A., & Carruthers, J. (2007). *Clinical research on Botox for cosmetic and medical uses*.

11. Mayo Clinic Staff. (2023). *Botox*. Retrieved from https://www.mayoclinic.org/tests-procedures/botox/about/pac-20384658
12. National Laser Institute. (2023). *Aesthetic Injection Training*. Retrieved from https://nationallaserinstitute.com
13. RDH Magazine. (2023). *The Buzz About Botox*. Retrieved from https://www.rdhmag.com/patient-care/article/14296010/the-buzz-about-botox-what-dental-hygienists-need-to-know
14. Today's RDH. (2023). *Understanding the Therapeutic Dental Applications of Botox*. Retrieved from https://www.todaysrdh.com/understanding-the-therapeutic-dental-applications-of-botox/

Jenna Shanks

Expanding Scope of Practice: Advocating for Dental Hygienists to Administer Botox Injections in Oregon Continued

Complications of Local Anesthesia vs. Botox in Dentistry

Complications associated with Botox are generally minimal compared to those of local anesthesia used in dentistry. Botox complications typically include temporary side effects such as mild bruising, pain at the injection site, headache, rash, or minor facial asymmetry. In rare cases, patients may experience allergic reactions or muscle weakness, particularly if contraindications like neuromuscular disorders are present. Botox treatments are localized and generally have a high safety profile when administered correctly, especially since doses for dental applications are significantly below toxic levels (Ocean State Oral & Maxillofacial Surgery, *What is DAANCE?*, https://www.oceanstateoms.com/files/2011/08/What-is-DAANCE.pdf).

In contrast, complications from local anesthesia in dentistry can be more severe and potentially life-threatening. These include nerve damage leading to persistent paresthesia, trismus, hematoma, allergic reactions, and systemic toxic effects like cardiovascular collapse in cases of overdose. Hemorrhage, broken needles, and infection from improper injection techniques are also risks. Management of these complications often requires more immediate and advanced medical intervention than Botox-related issues. Below is a list of complications associated with local anesthesia:

- **Nerve Damage**: Paresthesia, or prolonged numbness, can result from nerve trauma during the injection process. This is typically temporary but can occasionally be permanent.
- **Hematoma**: Bleeding into surrounding tissues due to vessel puncture can lead to swelling and bruising.
- **Trismus**: Muscle spasms or tissue damage can cause difficulty in opening the mouth.
- **Infections**: Though rare, infections may occur at the injection site if sterilization protocols are not followed.
- **Needle Breakage**: Improper technique or equipment failure can lead to a broken needle, potentially requiring surgical intervention.
- **Systemic Toxicity**: Overdose or inadvertent intravascular injection of anesthetic can result in cardiovascular or central nervous system effects, such as seizures or collapse.
- **Allergic Reactions**: While uncommon, hypersensitivity to the anesthetic or preservatives can cause mild to severe allergic responses, including anaphylaxis.
- **Facial Nerve Paralysis**: Temporary paralysis can occur if the anesthetic is inadvertently administered near a major nerve.

These complications emphasize the importance of proper training and technique for safe administration (Columbia University, 2007, *Complications of Local Anesthesia*; “Understanding the Therapeutic Dental Applications of Botox,” *Today’s RDH*).

Training and Education in Oregon

In Oregon, dental hygienists receive extensive and rigorous training to safely administer local anesthesia. Their education includes comprehensive coursework on the anatomy and physiology of the oral and maxillofacial regions, pharmacology of anesthetic agents, patient assessment, and injection techniques. This is followed by clinical practice under supervision to ensure competence. Hygienists must pass both written and clinical examinations to become certified, ensuring they meet high safety standards and are well-prepared to manage potential complications.

By contrast, dental assistants receive significantly less training. The DAANCE program (Dental Anesthesia Assistant National Certification Examination) is a 36-hour self-study course designed to prepare dental assistants to assist with anesthesia administration under oral and maxillofacial surgeons. While it provides essential skills in patient monitoring and emergency preparedness, it lacks the in-depth anatomical, pharmacological, and hands-on injection training required to directly administer local anesthesia independently (TeacherTina, *LA Cert - Dental Assistant - Oregon*, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON).

Comparison of Education and Training

The training required for dental hygienists in Oregon is far more extensive than that for dental assistants. Dental hygienists complete accredited dental hygiene programs that typically span two to four years, covering advanced anatomy, neuroanatomy, pain management, pharmacology, and hands-on clinical practice. This rigorous training equips them with the skills to administer local anesthesia with a high degree of competence and safety (American Association of Oral and Maxillofacial Surgeons, *DAANCE FAQ*, https://aaoms.org/practice/anesthesia/anesthesia-assistants/education/daance/daance-faq/).

In contrast, dental assistants in Oregon undergo a much shorter training period. The Pacific Northwest Dental Assisting School offers a condensed 12-week program for dental assistants, which is far shorter than the two-to-four-year education required for dental hygienists. While the program focuses on speed, it lacks the comprehensive education and hands-on clinical experience necessary to safely administer local anesthesia. This raises questions about whether the brief DAANCE certification is sufficient to prepare dental assistants for the complexity of anesthesia administration (TeacherTina, *LA Cert - Dental Assistant - Oregon*, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON).

.

Sources:

1. American Association of Oral and Maxillofacial Surgeons. *DAANCE FAQ*. AAOMS, https://aaoms.org/practice/anesthesia/anesthesia-assistants/education/daance/daance-faq/.
2. Columbia University College of Dental Medicine. "Complications of Local Anesthesia." *Columbia University*, 2007, https://www.columbia.edu/itc/hs/dental/d6401/2007/complicationsColor.pdf.
3. Ocean State Oral & Maxillofacial Surgery. *What is DAANCE?* Ocean State OMS, https://www.oceanstateoms.com/files/2011/08/What-is-DAANCE.pdf.
4. TeacherTina. *LA Cert - Dental Assistant - Oregon*. TeacherTina, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON.
5. Today's RDH. "Understanding the Therapeutic Dental Applications of Botox." *Today's RDH*, https://www.todaysrdh.com/understanding-the-therapeutic-dental-applications-of-botox/.

.

MCNEAL Kathleen * OBD

From: Tina Clarke <tina@teachertinardh.com>
Sent: Thursday, November 7, 2024 2:19 PM
To: MCNEAL Kathleen * OBD
Subject: Local Anesthesia For Dental Assistants
Attachments: OBD Letter for Course Approval-Tina Clarke.docx; LOCAL ANESTHESIA CURRICULUM FOR DENTAL ASSISTANTS.pdf

Hello Kathleen,

Attached you will see a letter to the board and course curriculum for the board to consider for the local anesthesia certification of dental assistants in the state of Oregon.

Please let me know if there are any questions or if I need to provide any additional information.
Tina

--
Tina Clarke RDH MEd FADHA

Founder and Owner Teacher Tina RDH
Certified CPR Instructor
Industry Leader
www.teachertinardh.com

November 7, 2024

To: Members of the Oregon Board of Dentistry

From: Tina Clarke RDH M.Ed

Dear members of the OBD,

Thank you for taking the time to review the proposal for dental assistants' ability to administer local anesthesia in the state of Oregon. As a dental hygiene educator who specializes in local anesthesia administration and is an approved provider of this education for dental hygienists in the states of Oregon and Georgia, I hold the education of this topic to its highest standards.

As you may know, I've been an advisor for the group of individuals who brought this topic forward and provided an outline of what educational process for the certification of dental assistants administering local anesthesia.

As you consider the attached proposal, please note the required and recommend textbooks/educational resources may change over time as new and updated resources become available.

Should you have any questions or thoughts I am happy to be of service.

Thank you for your consideration.

Tina Clarke RDH, M.Ed

tina@teachertinardh.com

503-559-9039

COURSE TITLE: FUNDAMENTALS OF LOCAL ANESTHESIA FOR DENTAL ASSISTANTS: A CERTIFICATION COURSE.

COURSE DESCRIPTION:

This course reviews the concepts of pain management with the use of local anesthetic agents. Participants learn fundamental principles of pharmacology of anesthetic solutions, dosages, vasoconstrictors, drug interactions, neural physiology, anatomical features, medical history evaluation, contraindications of local anesthesia delivery, and management of adverse side effects including medical emergencies. Laboratory and clinical practice of local anesthesia basic injection techniques including block and infiltration.

COURSE PREREQUISITES:

Prior to beginning this course, participants must provide proof of:

1. EFDA certification from the Oregon Board of Dentistry
2. BLS for Healthcare Providers certification or its equivalent
3. Professional liability insurance
4. One year experience working as a dental assistant

COURSE REQUIREMENTS:

To successfully complete this course, the participant must:

1. Participate in all lecture and clinical sessions
2. Pass the lecture examination at 75% or above
3. Demonstrate competency for each required injection

Course Hour Distribution:

- Minimum of 65 total hours of education
  - 35 hours lecture
  - 15 hours laboratory

- 15 hours clinical
- Passed at 75% or higher

RESOURCES:

Required Textbook

Bassett, KB, DiMarco, AC, Naughton, DK. Local Anesthesia for Dental Professionals 2nd ed. 2015. Pearson: Upper Saddle River, NJ.

Additional References

Malamed, SF. Handbook of Local Anesthesia, 7th Ed. 2019. Elsevier-Mosby:St. Louis, MO.

Clarke, T. Hit Me With Your Best Shot: Local Anesthesia For Dental Professionals. 2024 PDF

COURSE OBJECTIVES:

Upon completion participants will be able to:

1. Explain theories of pain control.
2. Select appropriate pain control modality.
3. Evaluate physiological aspects of pain control.
4. Identify anatomical structures and neural pathways for the purpose of oral local anesthesia.
5. Explain neurophysiology and its implications related to local anesthesia.
6. Describe the pharmacology of local anesthetics used in dentistry.
7. Describe the pharmacology of vasoconstrictors used in dentistry.
8. Identify armamentarium associated with local anesthesia delivery.
9. Conduct patient evaluation for local anesthesia.
10. Demonstrate competence in administering maxillary intraoral anesthesia.
11. Demonstrate competence in administering mandibular intraoral anesthesia.
12. Employ aseptic techniques with local anesthesia administration.

13. Demonstrate safe injection techniques.
14. Identify and manage adverse systemic and local complications associated with local anesthetics.
15. Manage medical emergencies involving local anesthesia.
16. Implement appropriate local anesthesia chart documentation.

COURSE OUTLINE

SECTION I: INTRODUCTION TO PAIN MANAGEMENT:

1. Explain theories of pain control.
    a. Pharmacological
    b. Non-pharmacological
2. Select appropriate pain control modality.
    a. Injectable
    b. Non-injectable
        i. Pharmacological
        ii. non-pharmacological
3. Evaluate physiological aspects of pain control.

SECTION II: ANATOMY REVIEW

1. Identify anatomical structures and neural pathways for the purpose of oral local anesthesia.
    a. Neuron
    b. Nerve bundle
    c. Neural chemicals
2. Explain neurophysiology and its implications related to local anesthesia.
    a. Sodium channel pump
    b. Action potential
3. Trigeminal Nerve Branches and Pathways:
    a. V1 Division
    b. V_2 Division
    c. V_3 Division
4. Vascular Flow of the head and neck region
    a. Arterial

   b. Venous
5. Boney anatomical features
   a. Maxilla
   b. Mandible
   c. Palatine bone
6. Anatomical Considerations:
   a. Review of anatomical landmarks used for injection placement.
   b. Use of radiographs, palpation, and visual cues to identify landmarks.

SECTION III: PHARMACOLOGY OF ANESTHETIC AGENTS

1. Describe pharmacology of local anesthetics used in dentistry.
   a. Actions and concentrations of commonly used anesthetics
   b. Biotransformation
   c. Factors that influence effectiveness of local anesthetic
   d. Maximum Recommended Dosage
      i. Proper dosage calculation
2. Describe the pharmacology of vasoconstrictors used in dentistry.
   1. Actions and concentrations of commonly used vasoconstrictors
   2. Maximum Recommended Dosage
      a. Proper dosage calculation
   3. Criteria for anesthetic selection (age, length of procedure, duration, potential for Post-op discomfort or self-mutilation)

SECTION IV: ANESTHESIA PREPARATION AND HANDLING

1. Conduct patient evaluation for local anesthesia.
   a. Medical history indications and absolute and relative contraindications to local anesthetics and vasoconstrictors
   b. Age
   c. Emotional state
   d. Blood pressure
   e. Systemic disease status (ASA)
   f. Physician consults
   g. Current medications

    h. History of reactions
2. *Pediatric Considerations:*
    a. Dosage
    b. Anatomy
    c. Behavioral management
    d. Post-op instructions
3. Identify armamentarium associated with local anesthesia delivery.
    a. Anatomy of needle
    b. Anatomy of cartridge
    c. Anatomy of syringe
4. Demonstrate safe injection techniques.
    a. Sharps safety
    b. Retraction methods
    c. Uncapping/recapping
5. Employ aseptic techniques with local anesthesia administration.
    a. Anesthetic storage
    b. Aseptic assembly and disassembly

SECTION V: LEGAL CONSIDERATIONS

1. Implement appropriate local anesthesia chart documentation.
2. State requirements for dental professionals

SECTION VI: INJECTION TECHNIQUES

1. Demonstrate competence in Maxillary Injection Techniques for the following injections: PSA, MSA, ASA, GP, AMSA, NP
    1. Nerve pathways
    2. Injection site and facial/oral landmarks
    3. Pathway of injections including anatomical structures in the area
    4. Depth of injections and type of needle
    5. Amount/type of solution and vasoconstrictor.
    6. Nerves, soft and hard tissues anesthetized.
    7. Percent positive aspiration
    8. Indications/contraindications

2. Demonstrate competence in administering Mandibular Injection Techniques for the following injections: IA, LB, G-G, Mental/Incisive

a. Nerve pathways
b. Injection site and facial/oral landmarks
c. Pathway of injections including anatomical structures in the area
d. Depth of injections and type of needle
e. Amount/type of solution and vasoconstrictor
f. Nerves, soft and hard tissues anesthetized
g. Percent positive aspiration
h. Indications/contraindications

3. *Supplemental Injection Techniques for the following injections: Papillary, Intraligamentary (PDL)*

a. Nerve pathways
b. Injection site and facial/oral landmarks
c. Pathway of injections including anatomical structures in the area
d. Depth of injections and type of needle
e. Amount/type of solution and vasoconstrictor
f. Nerves, soft and hard tissues anesthetized.

SECTION VII: LOCAL ANESTHESIA MANAGEMENT

1. Identify and manage adverse systemic and local complications associated with local anesthetics.
    a. Managing and avoiding systemic reactions
        i. Edema
        ii. Allergic reactions
        iii. Overdose
    b. Managing and avoiding local reactions
        i. Trismus
        ii. Hematoma
        iii. Tissue sloughing
        iv. Paresthesia
        v. Broken needle
        vi. Post-op self-mutilation
2. Manage medical emergencies involving local anesthesia.
    a. Managing and avoiding systemic reactions
    b. Relative overdose

c. Allergy
d. Syncope
e. Hyperventilation
f. Cardiovascular effects
    a. Importance of understanding blood pressure
    b. Cardiac arrest
    c. Myocardial infarction
    d. Stroke
g. Drug interaction
h. Seizure

SECTION VIII: Laboratory/Clinical Technique and Practice:

Laboratory practice consists of dry lab activities to include, but not limited to practice on typodont, skull, and various oral models.

Student partner anatomical identification of oral landmarks,

Demonstrate competence in syringe handling.

- Syringe set-up
- Uncapping
- Recapping
- Syringe dismantling
- Sharps management

Clinical practice consists of and may include but not limited to the following items:

Student partner practices technique positioning without needle penetration with the use of educational materials such as swabs, capped syringe, etc.

Student active administration of local anesthesia on student partners.

Demonstrate competence in maxillary and mandibular injection techniques.

Maxillary Injection Techniques for the following injections:

PSA, MSA, ASA, GP, NP, AMSA, local infiltration

Mandibular Injection Techniques for the following injections:

IA, LB, G-G, Mental/Incisive, local infiltration

OREGON ACADEMY of GENERAL DENTISTRY

Oregon Board of Dentistry
Licensing/Examinations
1500 SW 1st Ave. Suite 770
Portland, Oregon 97201

Dear Oregon Board of Dentistry,

The Oregon Academy of General Dentistry (OAGD) respectfully requests approval of our *Local Anesthesia Training for the Dental Assistant* course as a board-approved training course to qualify towards Oregon's Local Anesthesia Functions Certificate (LAFC).

Included with this letter are the course description, syllabus, and a CV for Dr. William (Bill) Jordan, who will teach the didactic portion of the course. Also included are the resumes/CVs for the dentists who will join Dr. Jordan as additional instructors for the hands-on portion of the training course.

Thank you for your time and consideration. Please do not hesitate to contact us if you require any additional information or have any questions.

Sincerely,

Katy Hester
Program Director
Oregon Academy of General Dentistry
503.228.6266
cedirector@oragd.org

Course Title:
Local Anesthesia Training for the Dental Assistant

CE Credits:
21 Credit Hours:
15 Lecture
6 Hands-On

Didactic Portion Instructor:
William (Bill) Jordan, DMD, MAGD

Hands-On Portion Instructors:
James (Jim) Flerchinger, DDS, MAGD
William (Bill) Jordan, DMD, MAGD
Travis Hunsaker, DDS, MAGD, DABO/ID
Gregory Williams, DMD, MAGD

Course Description:
This 21-hour course combines didactic and hands-on training to provide Expanded Function Dental Assistants (EFDA) with the knowledge and skills to safely and effectively administer local anesthesia under the supervision of a licensed dentist. In this program, participants will receive a comprehensive overview of pain management, dental anatomy, and anesthetic pharmacology. Participants will learn about the different types of maxilla and mandibular injections, including proper administration. Potential adverse reactions will be covered, including minor complications, major complications, and potential emergencies associated with local anesthesia. Also covered in the course is a comprehensive overview of armamentarium and proper chart documentation.

During the hands-on portion of the course, participants will pair up and practice the techniques learned under the direct supervision of the course instructors. The maximum participant-to-instructor ratio for hands-on activities will be 5:1.

Course Format:
The didactic portion of this course will include 15 hours of education delivered via on-demand webinar modules. Once a participant has completed the didactic portion, they must demonstrate an understanding of the material by passing a multiple-choice post-test with a score of 80% or higher before they can continue to the hands-on portion of the program. Participants must successfully complete all didactic modules and attend the hands-on session in its entirety before receiving a course completion certificate.

Prerequisite:
Participants must provide Oregon AGD with a copy of their Oregon EFDA certificate before starting the didactic portion of the course.

Special Note:
After completing the course, participants must obtain a Local Anesthesia Functions Certificate (LAFC) from the Oregon Board of Dentistry before administering local anesthesia to patients under the supervision of a licensed dentist.

Course Syllabus:

A. Introduction
   1. Anesthesia
   2. Regional Anesthesia/Local Anesthesia
   3. The Pain Experience
   4. Interruption of Pain

B. Patient Evaluation
   1. Physical Evaluation
   2. Visual Signs
   3. Vital Signs
   4. Fear, Nervousness and Anxiety
   5. Documentation

C. Anatomical Considerations
   1. Overview of Relevant Anatomy
   2. The Nervous System
   3. Neurophysiology
   4. Neuroanatomy of the Fifth Cranial Nerve
   5. Anatomical Landmarks for Local Anesthesia

D. Pharmacological Considerations
   1. Local Anesthetic Classification by Family
   2. Vasoconstrictors
   3. Topical Anesthetics
   4. Pharmacokinetics of Local Anesthetics
   5. Dosage Considerations
   6. Drug Interactions

E. Armamentarium
   1. Tray Set-Up for Local Anesthesia
   2. The syringe
   3. The Cartridge
   4. The Needle
   5. Assembly
   6. Recapping (Devices vs Scooping)
   7. Disassembly
   8. Disposal
   9. Broken Cartridges
   10. Bent Needle

11. Documentation

F. Complications
   1. Minor vs Major Complications
   2. Minor Complications
   3. Major Complications
   4. Medical Emergencies

G. Local Anesthetic Delivery
   1. Patient Management
   2. General Technique
   3. Aspiration

H. Maxillary Anesthesia
   1. Infiltrations
   2. Anterior Superior Alveolar Injection
   3. Middle Superior Alveolar Injection
   4. Anterior Middle Superior Alveolar Injection
   5. Infraorbital Injection
   6. Posterior Superior Alveolar Injection
   7. Nasopalatine Injection
   8. Greater Palatine Injection
   9. Palatal Infiltration

I. Mandibular Anesthesia
   1. Incisive Injection
   2. Inferior Alveolar Injection
   3. Gow Gates Injection
   4. Buccal Injection
   5. Mental Injection

OREGON ACADEMY of GENERAL DENTISTRY

COURSE INSTRUCTOR INFORMATION:

William Charles Jordan, D.M.D., M.A.G.D.
Home address: 21053 SW Ringer Street
Sherwood, Oregon 97140
Home phone: 503-625-2280 Cell phone: 503-730-7821

Education:

Undergraduate: Bachelor of Science Biology, University of Oregon 1985
Graduate: Doctorate in Medical Dentistry, Oregon Health Sciences University 1987

Teaching experience:

- 1986-1991 Clark College Pharmacology and Medical Emergencies
- 1990-2024 Mt. Hood Community College Pharmacology and Medical Emergencies
- 1993-2024 Mt. Hood Community College Oral Pathology
- 1995 Mt. Hood Community College Head and Neck Anatomy
- 1997-1998 OHSU School of Dentistry Removable Prosthodontics
- 1997-1998 OHSU School of Dentistry Operative Dentistry
- Instructor at numerous C.E. seminars on topics in pharmacology and oral pathology

Employment:

- 04/86-06/91 Clark College. Faculty
- 04/90-06/24 Mt. Hood Community College. Faculty
- 01/93-05/98 State of Oregon. Dentist
- 09/97-06/98 Oregon Health Sciences University School of Dentistry. Faculty
- 10/88-10/20 Bill Jordan, DMD, PC. Dentist
- 10/20-10/23 Jordan-Weber Dental. Dentist
- 03/24-07/24 Jordan-Weber Dental. Dentist Fill-in

Community experience:

- 2017-2023 Trustee Legacy Health System Foundation
- 1992-2023 Tualatin Core Area Parking District Board (many as chairperson)
- 1995 Dental Aid for Children Washington County Dentist of the Year
- 1993-2006 Coach of recreational soccer teams/basketball teams/T-ball teams
- 1995-1996 President of Washington County Dental Society
- 1994-1995 Vice-President of Washington County Dental Society
- 1993-1994 Treasurer of Washington County Dental Society
- '99-'17 Treasurer of the Tualatin Rotary Foundation
- 1995-1996 President Tualatin Rotary Club
- Participated in local career days at Tualatin High School

- Numerous dental missions including those to South America and Papua New Guinea
- Served multiple years at Oregon Mission of Mercy
- Dental missions to migrant camps in Washington County, Oregon
- 1996 Helped establish clinic for disadvantaged children in Brazil
- 1998 Helped establish second and third clinics for children in Brazil
- 1987-2009 Volunteer with Senior Smile Program for fixed income seniors
- 1986-1987 Member of the Oregon Health Sciences University Professional
- Skills and Judgement Committee
- 1993-1996 On staff at the State Mental Hospital providing dental services for psychiatric patients.
- 1996-1998 Provided dental services for Children's Services Division of Oregon at youth correctional facility.
- Nominated two times for the City of Tualatin Volunteer of the Year
- 2010-2016 Oregon Prescription Drug Monitoring Program Legislative Advisory Committee
- 2015-2017 Member of the Board of the Oregon Academy of General Dentistry
- 2017 President-Elect Oregon Academy of General Dentistry
- 2018 President Oregon Academy of General Dentistry
- 2014-2020-Childrens Ministry Team Board Member Countryside Church
- 2019 Established Dental Clinic at Buxar Orphanage, Bihar, India
- 2024 Provided Dental Services on Medical/Dental Mission to St. Lucia

Memberships:

- American Dental Association,
- Oregon Dental Association
- Washington County Dental
- Society
- Academy of General Dentistry
- Rotary International

Other:

- Fellowship in the Academy of General Dentistry Awarded 1996
- Phi Eta Sigma Honor Society University of Oregon
- Published in the Journal of the Academy of General Dentistry
- Mastership in the Academy of General Dentistry Awarded 2007
- Scientific Reviewer for the Journal of the Academy of General Dentistry
- Oregon Dentist of the Year AGD 2021
- Life Long Service and Recognition Award 2022

James (Jim) A. Flerchinger DDS, MAGD
PO Box 1705
Boring, Oregon 97009
971-998-6829

Education:

Washington State University
Bachelor of Science in Zoology 1974

Creighton University School of Dentistry
Doctor of Dental Surgery 1978

- ASN Jesuit University Honor Society
- OKU National Dental Honor Society

Employment:

Dentist at Chinook Falls Dental
Sandy, Oregon
2017-present

President/Owner/Dentist of Chinook Falls Dental Clinic P.C.
Sandy, Oregon
1991-2017

Co-Owner/Dentist at Cascade Springs Dental Clinic P.C.
Sandy and Welches, Oregon
1978-1991

Other:

- Associate Fellow American Academy of Implant Dentistry (AFAAID)
- Master Academy of General Dentistry (MAGD)
- Lifelong Learning and Service Recognition Academy of General Dentistry (LLSR)
- Life member of American Dental Association
- Fellow American Orthodontic Society
- Oregon AGD board and the current Secretary/ Treasurer
- Oregon AGD Foundation board.
- Medical Teams International Volunteer and currently on the advisory board for MTI.
- Compassion Clinics Volunteer
- St John's Church Parish Council.
- Welches School District Budget Committee for several years.
- ODA Wellness Committee
- Boring Water District budget committee.
- 9 years on the Timberline Rim Board of Directors Homeowners Association
- Board of Mt. Hood Chamber of Commerce

Travis J. Hunsaker, DDS, MAGD, DABOI/ID
4602 Viewcrest Rd. S.
Salem, OR 97302
503-551-7228

Education:

Marquette University, School of Dentistry
Dentistry Degree: DDS 2009

Oregon State University
General Studies (B.S), Pre-Dentistry, Minor in Chemistry 2004

Practice Ownership & Employment History

- Owner of Hunsaker Dental March 2020-Present
- Owner Hunsaker Dental (3rd location) 2016-Present
- Part Owner Hunsaker Dental-Monmouth March 2017-March 2020
- Owner/Doctor and Team Leader for Associate Dentists 2014-Present
- Part Owner Hunsaker Dental- Salem and Aumsville locations 2013-2020
- Clinical Director for Hunsaker Dental 2013-Present
- Associate Dentist for Hunsaker Dentist 2009-20012

Other:

- 8th Annual Day of Free Dentistry hosted for those in need in the Salem Oregon area. 75 people served and over $25,000 in dental care donated.
- 6/21: 7th Annual Day of Free Dentistry hosted for those in need in the Salem Oregon area. 75 people served and $25,000 in dental care donated.
- 6/19: 6th Annual Dentistry from the Heart day of free dentistry for those in need at our Salem office location. Served over 50 people and donated over $20,000 in dental care.
- 6/18: 5th Annual Dentistry From the Heart day of free dentistry for those in need at our Salem office location. In 5 years we have donated over $105,000 in free dental care.
- 7/17: 4th Dentistry From the Heart day of free dentistry for those in need at our Salem office location. Served 78 people and donated over $26,000 in dental care.
- 5/17: Medical Mission Trip to Haiti for 10 days. Served in various locations including refugee camps and orphanages, helping over 75 people. In conjunction with Corbin University in Salem, OR. Mentored pre-med and pre-dental students during trip.

- 6/16: 3rd Dentistry From the Heart day of free dentistry for those in need at our Salem office location. Served 61 people and donated over $19,000 in dental care.
- 5/16: Medical Mission Trip to Haiti for 10 days. Served in various locations including refugee camps and orphanages, helping over 75 people. In conjunction with Corbin University in Salem, OR. Mentored pre-med and pre-dental students during trip.
- 5/15: 2nd Dentistry From the Heart day of free dentistry for those in need at our Salem office location. Served 85 people and donated over $23,000 in dental care.
- 5/14: 1st Dentistry From the Heart day of free dentistry for those in need at our Salem office location. Helped 64 people and donated over $22,000 in dental care.
- 11/07: Volunteered for one week at the Southern Wisconsin Center Dental Clinic. Provided dental care to severely mentally handicapped patients. Emphasis was placed on behavioral management
- 11/07: Three day clinical rotation to Ministry Dental Clinic, Stevens Point, WI Provided service to underserved, low income patients.
- 2/07: Volunteered with Wisconsin Dental Association's "Give Kids a
- Smile" event as a Spanish language translator, which screened over 400 children and referred to volunteer dentists in the community
- 3/14/06 – 3/15/07 : Five days volunteering with "Smiles for the Future", a Marquette University School of Dentistry student organization which visits schools with disadvantaged children and places sealants.
- 11/1999 – 10/2001: Spanish speaking missionary for the Church of Jesus Christ of Latter-Day Saints in Fresno, California

Notable Continuing Education:

- 5/17/09 – Present 1725 Total Hours of completed CE.
- Over 800 hours of Oral Surgery, Perio, and Implant CE
- Over 110 hours of Orthodontic CE
- Over 150 hours of Anesthesia and Medical Emergency CE

Gregory A. Williams, DMD, MAGD
16850 SW King James Place, Ste. 40
Tigard, OR, 97224
503-620-2020

Education:

Brigham Young University. B.S. in Zoology, 1993
Oregon Health Sciences University. D.M.D., 1998, High Honor

Work History:

- Gregory A. Williams DMD, PC, Owner, Tigard, OR 1998-Present
- Tigard Family Dental, Owner, Tigard, OR 2011-Present
- Oregon Mobile Dentistry, PC, Owner, Tigard, OR 2012-Present

Notable Continuing Education:

- Sunset Study Club (former branch of Seattle Study Club)1998-2023
- PDX Study Club Kois Center Graduate, 2017, Seattle
- Oregon AGD Mastertrack Program 2018-2021
- AAID Rosemand Implant Mastertrack Program 2020-2021
- IV Moderate Sedation certification
- Over 1500 Documented hours of CE

Professional Activities:

- Participant, Give Back a Smile, AACD, 2006
- Clinician, Neighborhood Clinic, Portland, OR 1998-2001
- Clinic Organizer, Give Kids A Smile, 2004-2019
- Founder and President, Wide Open Humanitarian, Inc (a 501c3 international dental relief and instructional organization), 2007-Present
- Delegate, Oregon Dental Association, 1999 Participant
- Oregon Mission of Mercy, 2010,2011,2012,2014,2015 M
- Mentor, Oregon Dental Association, 2000-Present
- Adjunct Clinical Instructor, OHSU, 1998-Present
- Education Committee member, OAGD. 2022-Present
- Education Committee, PDX Study Club 2023-Present

Awards:

- Omicron Kappa Upsilon, Oregon Health Sciences University, 1998
- Student Award, American Academy of Periodontology, 1998

- Fellow, International Congress of Oral Implantologists, 2010 Diplomate, American Board of Oral Implantologists, 2022
- Master, Academy of General Dentistry, 2023
- Fellow, American Academy of Implant Dentsitry, 2023
- John C. Peterson Distinguished Alumni Award 2023

OREGON ACADEMY of GENERAL DENTISTRY

December 2, 2024

Oregon Board of Dentistry
Licensing/Examinations
1500 SW 1st Ave. Suite 770
Portland, Oregon 97201

Dear Oregon Board of Dentistry,

The Oregon Academy of General Dentistry (OAGD) respectfully requests approval of our *Comprehensive Training in Parenteral Moderate Sedation* program as a board-approved training course to qualify towards Oregon's Anesthesia Dental Assistant (AnA) certificate.

Included with this letter are the course description, syllabus, and CV for Dr. Ken Reed, the course director. Additionally, we have included verifications of Dr. Reed's dental license and anesthesia permits in both Oregon and Arizona.

In addition, the Oregon AGD kindly requests that the Oregon Board of Dentistry consider backdating the approval of this program to January 1, 2022. Since this date, the course location, curriculum, and faculty have remained consistent with the information enclosed.

Thank you for your time and consideration. Please do not hesitate to contact us if you require any additional information or have any questions.

Sincerely,

Katy Hester
Program Director
Oregon Academy of General Dentistry
503.228.6266
cedirector@oragd.org

Course Title:
Comprehensive Training in Parenteral Moderate Sedation

Course Description:

Safely and confidently treat your anxious or fearful adult patients by performing IV moderate sedation. This comprehensive certifying course includes lectures and clinical training by the renowned Drs. Kenneth Reed, Amanda Okundaye, Andrea Fonner, Stanley Malamed, Jason Brady and Jeff Kobernik. Didactic discussion includes pharmacology, patient evaluation, airway management, monitors and monitoring, ECG interpretation, geriatrics, medical emergencies, post-operative analgesics and venipuncture techniques. At the final session before clinic participants will practice managing anesthesia related emergencies on a high fidelity human simulator, which will provide you with valuable hands on experience. During the clinical portion of the course, participants will start IVs and administer sedative agents and perform clinical dentistry - just like you will in private practice.

Unlike other programs, we prepare participants for real-life clinical practice by having them simultaneously perform both the sedation and dentistry on a minimum of twenty patients. We allow participants to choose procedures with which they are most comfortable, and we supply the appropriate, pre-screened patients for this course.

Couse Objectives:

- Discuss the appropriate patient to receive parenteral moderate sedation
- Explain the pharmacology of benzodiazepines, opioids, adjunctive and reversal agents
- Describe venipuncture technique
- Outline a plan for the prevention, recognition and treatment of medical emergencies that may occur with sedation

Course Syllabus:

<u>Day One:</u>
Introduction (2 hours)
History of Dental Anesthesia (0.5 hours)
Definitions (1 hour)
Drugs, Death & Dentistry (1.5 hours)
Physical Evaluation- The Healthy Patient (2 hours)

<u>Day Two:</u>
Physical Evaluation- The Patient with Known Systemic Disease (4 hours)
Pharmacology of the Benzodiazepines (2 hours)
Pharmacology of the Opioids (1.5 hours)

Day Three:
Respiratory Depression and Apnea (1 hour)
Local Anesthesia (2 hours)
Adjunctive Agents (1.5 hours)
Airway Management (1.5 hours)
Monitoring and Monitors (1.5 hours)

Day Four:
ECG Interpretation (2 hours)
Documentation Standards for Moderate Sedation (1 hour)
Venipuncture Techniques (1.5 hours)
Complications of Venipuncture (0.5 hours)

Day Five:
Enteral Sedation (1.5 hours)
IV Sedation Techniques (1.5 hours)
Nitrous Oxide (1 hour)
Geriatrics (1.5 hours)
General Anesthesia Provider Options (0.5 hours)

Day Six:
Pharmacology of Emergency Drugs (1.5 hours)
Pediatrics (1.5 hours)
Medical Emergencies (4 hours)

Day Seven:
Medical Emergencies (2 hours)
Practical Aspects of IV Sedation (1 hour)
Post-Operative Analgesics (2 hours)
Case Selection & Assessment (1.5 hours)
State Board Exams (0.5 hours)
Introduction to Sim Man (0.5 hours)

Days Eight – Eleven:
Review of Didactic Materials/Clinic Orientation/Monitor Training (4 hours)
Clinic (43 hours)*
*during the clinic, assistants will provide chairside assistance and monitoring of vitals for a minimum of 20 patients with their doctor.

Course Location:

The course is held at the Oregon AGD Foundation Center: The Center | OAGD (oagdfoundation.org)

Oregon AGD Foundation Center
13333 SW 68th Pkwy. Ste. 010
Tigard, Oregon 97223

Course Format:

The course is held live and in person with no hybrid option.

Total Number of CE Hours:

The total number of hours for the course is 103, which breaks down into 60 didactic hours and 43 clinical hours. Renewal participants may attend as many of the didactic days as they wish. There are no separate courses offered within the overall course.

Faculty Bios:

Faculty bios for Dr. Ken Reed, Stanley Malamed, Amanda Okundaye, Andrea Fonner, Jason Brady and Jeff Kobernik can be found on Dr. Reed's website: Learn IV Sedation

Additional Instructor Information:

Dr. Ked Reed
Dental License: Oregon, Arizonia
General Anesthesia Permit: Oregon, Arizonia
Certificates of Specialty: Dental Anesthesia, Periodontics

Dr. Stanley Malamed
Dental License: New York
Certificate of Specialty: Dental Anesthesia

Dr. Amanda Okundaye
Dental License: Nevada
General Anesthesia Permit: Nevada
Certificate of Specialty: Dental Anesthesia

Dr. Andrea Fonner
Dental License: Washington
General Anesthesia Permit: Washington
Certificate of Specialty: Dental Anesthesia

Dr. Jason Brady
Dental License: Arizona
General Anesthesia Permit: Arizona
Certificate of Specialty: Dental Anesthesia

Dr. Jeff Kobernik
Dental License: Oregon
General Anesthesia Permit: Oregon
Certificate of Specialty: Dental Anesthesia

*Oregon AGD obtains temporary dental permits for the state of Oregon for all clinic dates for those instructors not licensed in the state of Oregon.

OREGON ACADEMY of GENERAL DENTISTRY

Course Director CV:

FULL NAME, Degree:	**Kenneth L. Reed, DMD**

EDUCATIONAL BACKGROUND including certifications received, residencies or fellowships attended (Begin: college level)

Name of School, City and State	**Yr. of Grad.**	**Certificate or Degree**	**Area of Study**
University of Arizona	1986	B.A.	General Studies
Oregon Health Sciences University, School of Dentistry	1989	DMD	Dentistry
Oregon Health Sciences University, School of Dentistry	1991	Certificate	Periodontology
Oregon Health Sciences University, School of Dentistry	1991	---	Anesthesiology
American Dental Society of Anesthesiology	1998	Fellowship	General Anesthesia
Lutheran Medical Center (now NYU Langone)	2013	Certificate	Anesthesiology

LICENSURE

State License (Do not include license number)	**From (Year)**	**To (Year)**
Oregon	1989	Present
Arizona	1990	Present

BOARD CERTIFICATION

Certifying Organization	**Specialty**	**Date certified**
American Dental Board of Anesthesiology	Anesthesiology	2015

TEACHING APPOINTMENTS ((Begin with current and include other teaching/mentoring experiences)

Name of Institution, City and State	Rank	Subjects/Content Areas Taught/ Administrative Responsibilities	From (Year)	To (Year)
NYU Langone, Brooklyn NY	Associate Program Director	Dental Anesthesiology	2013	Present
NYU Langone, Brooklyn NY	Attending in Anesthesiology & Periodontics Graduate Periodontics	Sedation and Anesthesia	2013	Present
Faculty of Medicine and Dentistry University of Alberta Edmonton, Alber Canada	Clinical Instructor	Anesthesia & Pharmacology	2011	Present
School of Dentistry The Oregon Healt Science University. Portland, OR.	Affiliate Assistant Professor	Parenteral Moderate Sedation	2011	Present
Lutheran Medical Center, Department of Dental Medicine, Brooklyn NY (now NYU Langone)	Attending in Anesthesiology Graduate Pediatric Dentistry	Sedation and Anesthesia	2010	Present
The University of Nevada Las Vegas School of Dental Medicine Las Vegas, NV.	Associate Professor in Residence	Anesthesia & Pharmacology	2009	2015
Lutheran Medical Center, Department o Dental Medicine, Brooklyn NY (now NYU Langone Hospitals)	Assistant Director Advanced Education in General Dentistry	Anesthesia & Pharmacology	2000	2013

The Ostrow School of Dentistry of the University of Southern California. Los Angeles, CA.	Clinical Associate Professor Endodontics, Oral and Maxillofacial Surgery and Orthodontics	Anesthesia & Pharmacology	1999	2015
Pima Community College	Adjunct Faculty	Anesthesia & Pharmacology	1993	2006

CURRENT TEACHING RESPONSIBILITIES

Name of Institution, City, State	**Clinical Training Site (Health Center) City, State**	**Type Residency Program (AEGD, GPR, Peds, etc.)**	**Please Check All That Apply**		
			Program Admin	**Didactic**	**Clinical**
NYU Langone, Brooklyn, NY	AZ/CA	Anesthesia	X	X	X
Faculty of Medicine and Dentistry University of Alberta Edmonton, Alberta, Canada	Edmonton, Alberta, Canada	Dental School	X	X	X
School of Dentistry The Oregon Health Science University. Portland, OR.	Portland, OR	Dental School	X	X	X
NYU Langone, Brooklyn NY	Arizona	Pediatric Dental		X	X

HOSPITAL APPOINTMENTS (Begin with current)

Name of Hospital	**City**	**State**	**From (Year)**	**To (Year)**
None				

OREGON ACADEMY of GENERAL DENTISTRY

PRACTICE EXPERIENCE (Begin with current)

Location (City and State)	Type of Practice	From (Year)	To (Year)
Los Angeles, CA	Anesthesia	2013	2018
Tucson, AZ	Anesthesia	1991	Present

CE COURSES TAKEN (Pertinent or in last 5 years)

Course Title	Course Content / Provider	Month and Year
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2020
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2020
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2019
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2019
Sedation and Anesthesia Update	American Dental Society of Anesthesiology	10/2019
Annual Session	American Dental Society of Anesthesiology	04/2019
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2018
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2018
Annual Session	American Dental Society of Anesthesiology	04/2018
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2017
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2017
Annual Session	American Dental Society of Anesthesiology	04/2017

MEMBERSHIP, OFFICES OR APPOINTMENTS HELD IN LOCAL, STATE OR NATIONAL DENTAL OR ALLIED DENTAL ORGANIZATIONS, INCLUDING APPOINTMENTS TO STATE BOARDS OF DENTISTRY AND CODA

Name of Organization	Position Held Title or Appointment	From (Year)	To (Year)
American Dental Board of Anesthesiology	Secretary	2021	Present
American Dental Board of Anesthesiology	Director	2021	Present
American Dental Society of Anesthesiology	President	2015	Present
American Dental Society of Anesthesiology	President Elect	2013	2015
American Dental Society of Anesthesiology	Vice-President	2011	2013
American Dental Society of Anesthesiology	Board of Directors	2003	2011
American Dental Association	Consultant	2011	Present
American College of Dentists	Fellow	2010	2019
American Dental Association	Chair ADA Standards Committee Working G 4.32 on Syringes, Cartridges, and Needles	2006	2016

OREGON ACADEMY of GENERAL DENTISTRY

PUBLISHED WORKS: (List articles in which you were the principal author that appeared in referred journals or text books, by author(s), title, publication, and date. If list is very extensive, include **the most recent five years**)

Author(s)	Title	Publication	Date
Reed, KL Okundaye, AJ.	Working with a Dentist Anesthesiologist.	Wright's Behavior Management in Dentistry for Children, Second Edition	2021
Reed, KL Okundaye, AJ.	Management of Emergencies Associated with Sedation for The Pediatric Dental Patient.	Wright's Behavior Management in Dentistry for Children, Second Edition	2021
Malamed SF, Reed KL, Okundaye AJ & Fonner AM.	Local and Regional Anesthesia in Dental and Oral Surgery	Complications of Regional Anesthesia: Principles of Safe Practice in Local and Regional Anesthesia	2017
Fonner, AM & Reed, KL.	Post-Operative Pain Management Strategies for Acute Dental Pain	Decisions in Dentistry	2017
Fonner, AM & Reed, KL.	Responding to Cardiac Arrest	Decisions in Dentistry	2016
Stevens, RL & Reed, KL.	Anesthetic Adversity: Failed Sedation	Anesthesia Complications in the Dental Office	2015
Reed, KL.	Section Editor, Section 3: Oral and Maxillofacial Surgery/Pain Control 2.0	Mosby's Review for the NBDE Part II, Second edition	2014
Okundaye, AJ, Reed, KL, Fonner, AM.	Why Capnography?	The Pulse	2014
Reed, KL Okundaye, AJ	Working with a Dentist Anesthesiologist	Behavior Management in Dentistry for Children	2014
Reed, KL Okundaye, AJ	Management of Emergencies Associated with Pediatric Dental Sedation	Behavior Management in Dentistry for Children	2014
Fonner, AM. Reed, KL.	Be Prepared - How to Manage a Medical Emergency in the Dental Office	Dimensions of Dental Hygiene	2013
Reed, KL., Malamed, SF., Fonner, AM	Local Anesthesia Part 2: Technical Considerations.	Anesthesia Progress	2012
Becker, DE. & Reed, KL	Local Anesthetics: Review of Pharmacological Considerations	Anesthesia Progress	2012
Reed, KL	TCI (Target Controlled Infusion).	The Pulse	2011
Stevens RL, Reed KL	The Impact of Regulation on Enteral Sedation in Dentistry	Dental Anesthesiology: A Guide to the Rules and Regulations of the United States of America	2011
Reed, KL	Allergy & Anaphylaxis	Inside Dentistry	2011
Malamed, SF., Reed, KL., Poorsattar, S	Needle Breakage: Incidence and Prevention.	Dental Clinics of North America	2010

Reed, KL	Basic Management of Medical Emergencies: Recognizing a Patient's Distress	JADA	2010
Reed KL.	The History and Current Status of Anesthesiology in Dentistry	NV Dent Assn J	2009
Reed KL.	The Geriatric Patient	Sedation: A Guide to Patient Management	2009
Reed KL.	The Physically Compromised Patient	Sedation: A Guide to Patient Management	2009
Reed KL.	Neurologic Illnesses and Other Conditions	Sedation: A Guide to Patient Management	2009

RESEARCH AND GRANT ACTIVITY:

Name	Awarded By	Years (s)
N/A		

HONORS OR AWARDS:

Name	Awarded By	Year
Fellow	American Dental Society of Anesthesiology	1998
Distinguished Teaching Award	Pima Community College	1993

SERVICE TO THE PROFESSION AND COMMUNITY: Include consulting services, community involvement, invited speaker, continuing education courses taught, military career, or any other dentally related activities. If appropriate, can add description

Service or Activity	Organization	Year
CE Courses Taught	Over 10,000 hours of CE provided in anesthesia related topics	1991-Present
Member, Anesthesia Committee	Arizona State Board of Dentistry	2011-2015, 1997-2006
Bare Bones Basic Emergency Drug Kit	ADA Seminar Series	2011
Course Faculty Airway Management Course	ADA	2010-2015
Assistant Editor	Anesthesia Progress	2004-Present
Scientific Advisory Panel	Journal of Endodontics	2004-2010

SERVICE TO THE PROFESSION AND COMMUNITY: Include consulting services, community involvement, invited speaker, continuing education courses taught, military career, or any other dentally related activities. If appropriate, can add description

Advisory Board, Dental Hygiene	Pima Community College	2003-2006
Editorial Review Board	Anesthesia Progress	2001-Present
Delegate	American Dental Society of Anesthesiology	2000-2007
Journal Reviewer	Indian Journal of Critical Care Medicine	2013-2016
Journal Reviewer	Journal of Oral and Maxillofacial Surgery, Medicine and Pathology	2012-2016
Journal Reviewer	Journal of Dentistry	2012-2016
Journal Reviewer	JADA	2011-2016
Journal Reviewer	Special Care in Dentistry	2008-2016
Journal Reviewer	Anesthesia Progress	1997-Present
Journal Reviewer	General Dentistry	1993-2012
Mission Piot	Flying Samaritans	2004-Present
Board of Directors	Flying Samaritans	2012-Present
Volunteer Pilot	Veteran's Airlift Command	2009-Present
Volunteer Pilot	Homeland Security Emergency Air Transportation System	2008-Present
Arizona Wing, Aviation safety Offi	Angel Flight West	2019-Present
Southern Arizona Area Coordinat	Angel Flight West	2006-Present
FAA Safety Team	FAA	2008-Present
Certified Parliamentarian	American Institute of Parliamentarians	2022-Present
Professional Registered Parliamer	National Association of Parliamentarians	2021-Present

Practitioner Name	Speciality Details	Location	Public Health	Action

Full Name : REED, KENNETH L

Primary Office Address : 13333 SW 68th Parkway, #010

City, State Zip : Tigard, OR 97223

Degree : D.M.D.

Licenses :

License Number	Status	License Date	Expiration Date	Restrictions	Case Number
D6566	Active	06/28/1989	03/31/2025		

Permits :

Permit	Issue Date
General Anesthesia	08/16/2013

Endorsements :

Endorsement Type	Endorsement Attained Date

Specialities :

Specialty	Issue Date
Certified in the Specialty of Dental Anesthesiology	01/07/2020
Certified in the Specialty of Periodontics	06/08/1991

Board Action / Malpractice :

Action Type	Document Link

Collaborative Agreement :

Collaborative Provider	Document

← Close detail

REED, MICHELLE MARIE		View Details
REED, REBECCA M	MEDFORD OR 97504	View Details
REED, ROBERT D	PALM DESERT CA 92260	View Details
REED, STACY D	TUALATIN OREGON 97062	View Details
Reed, Talysa		View Details
REED-HARMEL, CHELSEA M	WOODLAND HILLS CA 91367	View Details
REEDAL, THOMAS M	BEAVERTON OR 97003	View Details
REEDER, SHERYL M		View Details

ARIZONA
Arizona State Board
of Dental Examiners

DENTAL PROFESSIONAL PROFILE PAGE

Information Current as of 1/8/2024 2:00:17 PM

Home Search

General

Kenneth L. Reed DMD	
12090 N. Thornydale Road	
Suite 110 #286	
Marana, AZ 85658	
(520) 370-3693	

License Number:	**D04183**
License Status:	**Active**
License Type:	**Dentist License**
License Issued:	**09/06/1990**
Expiration:	**08/31/2024**

Additional Certifications

Dental General Anesthesia Permit

Status:	**Active**
Expiration:	**12/31/2028**

Education

School:	Oregon Health Sciences Univ.
Graduation Date:	06/09/1989

Disciplinary Board Actions

There are no disciplinary actions

Non-Disciplinary Board Actions

There are no nondisciplinary actions

From: Dr Christina
To: SMORRA Angela * OBD
Subject: Re: OBD- Request for letter to the Board discussing DA access to training and venipuncture PRP/PRF
Date: Friday, October 11, 2024 1:00:02 PM
Attachments: image001.png
oqmpslogo.png

Hi Dr. Smorra,

Thank you for reaching out to me. Oregon Health Authority is the governing branch of phlebotomy certification. According to their website:
According to Oregon Health Authority (specifically, Public Health Division), phlebotomists are not required to get a state license and/or certification in order to be allowed to practice.

What Is the Phlebotomy Certification/Licensing Process in Oregon?

Oregon has no formal certification or licensing requirements for phlebotomists in the state, but national certification is still highly recommended. Many employers will only hire nationally certified phlebotomists who have completed the requirements for one of the following organizations:

- National Center for Competency Testing
- American Society for Clinical Pathology
- American Medical Technologists
- National Phlebotomy Association
- American Society of Phlebotomy Technicians

We had two of our assistants certify at a community college provided program in our rural area almost 10 years ago. They have their little papers that show they were trained, albeit faded. It was an all day course provided by a licensed nurse. However, it has come to our attention by one of our newer assistants that this is no longer acceptable according to the OBD rule changes.

We are now wanting to get two of our assistants who have only been with us for two years certified and in doing so with all the changes being made with DANB began looking over the changes made in May 2024. It now specifically lists phlebotomy with the Dental Anesthesia assistant requirements, in 2021 there was not a subsection c under 818-042-0015. Now there is. There is no other mention of phlebotomy services anywhere I could find except in this area.

I guess I'm confused that my assistant can go work in a doctors office or hospital doing phlebotomy without a license, just her certification paper, but the way the wording appears in the aforementioned section now requires her to be an Expanded Function Dental Anesthesia

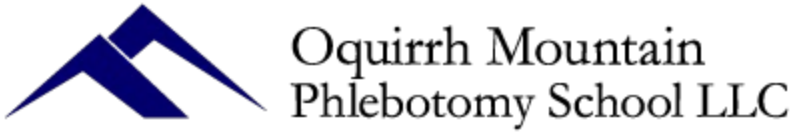
Assistant just to provide phlebotomy? Are we reading this incorrectly?

Now there is an approved list of certification for phlebotomy on the board page, and when we called the resuscitation group they said they will not do phlebotomy training until the assistants complete the Dental Anesthesia Assistant program.

It appears there needs to be a division in the rules here.

We just want to make sure we are doing things right.

This is the program we were planning on hiring to come and train our new assistants to provide phlebotomy as we are on the coast and it's a hardship for several of our assistants to travel so far to get their certification.



Their email is office@oqmps.com

They are approved by the National Phlebotomy Certification Testing Program.

Is this acceptable?

Your feedback is greatly appreciated.

My cell is (503)717-3543

Kind regards,

Christina Alexandroff DMD
Sent from my iPhone

Board Approved Courses for Oregon Anesthesia Dental Assistant (AnA) Certificate		
Course Title	**Program**	**Effective**
Dental Anesthesia Assistant National Certification Exam (DAANCE)	American Association of Oral and Maxillofacial Surgeons	OAR 818-042-0116(2a)
Oral and Maxillofacial Surgery Assistants Course	California Association of Oral and Maxillofacial Surgeons	OAR 818-042-0116(2b)
DANB Certified Oral and Maxillofacial Surgery Assistant (COMSA) exam	COMSA exam discontinued 2000	OAR 818-042-0116(2c)
Anesthesia Assistant Training Program	Resuscitation Group (Vancouver, WA) https://www.resuscitationgroup.com/	2/15/2019
Anesthesia Assistant Training Program/ IV Access Course	Dr. Jeffrey Kobernik	4/24/2020
Pending Board Approved Courses for Oregon Anesthesia Dental Assistant (AnA) Certificate		
Comprehensive Training in Parenteral Moderate Sedation-Dental Assistant participation	Oregon Academy of General Dentistry	Effective date January 1, 2022

Board Approved Courses for Oregon Anesthesia Dental Assistant with IV Therapy (Ana-IV) certificate

Course Title	Program	Effective
Intro to IV Therapy	Portland Community College	8/22/2002
Phlebotomy Skills	Portland Community College	10/2006
Phlebotomy	Medtexx Medical Corp	10/10/2008
IV Therapy	Medtexx Medical Corp	10/10/2008
Anesthesia Assistant Training Program	Resuscitation Group (Vancouver, WA) https://www.resuscitationgroup.com	2/15/2019
IV Access Course	Dr. Jeffrey Kobernik	4/24/2020
Comprehensive Training in Parenteral Moderate Sedation-Dental Assistant participation	OAGD	2/2/2024
IV Placement Certification and Techniques	OAGD	8/23/2024

Pending Board Approved Courses for Oregon Anesthesia Dental Assistant (AnA-IV) Certificate

Delegate to OBD Staff ability to accept hands on IV phlebotomy courses which meet minimum training requirements of 4 hours of hands CE hours and are approved by one of the following organizations: • National Center for Competency Testing • American Society for Clinical Pathology • American Medical Technologists • National Phlebotomy Association • American Society of Phlebotomy Technicians • National Phlebotomy Certification Testing Program	Effective Date-12/13/2024

From:	Sarmiento, Monica
To:	OBD Info * OBD
Subject:	Local Anesthesia for Dental Assistants Curriculum Proposal
Date:	Saturday, November 30, 2024 1:19:20 PM
Attachments:	Evaluation Criteria Infiltration CE.pdf Dental Assisting Course Proposal.pdf OBD Letter of Intent.pdf

---

Good morning,

We are submitting a Continuing Education course proposal that would prepare expanded function dental assistants (EFDA) to administer local anesthesia and anesthetic reversal agents under the direct supervision of dentists in Oregon.

Attached to this email, you will find the following documents for your review:

- Letter of Intent
- Curriculum Proposal
- Sample Clinical Evaluation Form

Please feel free to contact us with any questions or if additional materials are needed.

Thank you for your time and consideration.

Best regards,

Gail Aamodt
Melody McGee
Kathryn Bell
Mónica Sarmiento

To: Members of the Oregon Board of Dentistry

From: Amy Coplen RDH, DT, MS
Program Director
Pacific University, School of Dental Hygiene

Dear Oregon Board of Dentistry Members:

We are submitting a Continuing Education course proposal that would prepare expanded function dental assistants (EFDA) to administer local anesthesia and anesthetic reversal agents under the direct supervision of dentists in Oregon.

As a CODA approved dental hygiene program located in Hillsboro Oregon, we feel we have the knowledge, expertise and clinical facility to deliver a certification course that would help in the development of competent providers of this skill.

Please review the attached curriculum for our proposed “Hands-on Local Anesthesia Certification Course for Dental Assistants”. We look forward to hearing from you.

Thank you.

Proposal

Course Title: Hands-On Local Anesthesia Certification Course for Dental Assistants

Course Description: This combined online and hands-on course provides a study of anxiety and pain management techniques used in dental care. Components of pain, pain control mechanisms, topical anesthesia, local anesthetics, anesthetic reversal agents and techniques for the administration of local anesthesia are included. The student will practice skills in a supervised clinical laboratory setting.

This course meets the requirements for Local Anesthesia certification in Oregon. Participants should consult the Oregon Practice Act available from the Oregon Board of Dentistry for complete local anesthesia requirements.

Course Prerequisites
Prior to beginning this course, participants must provide proof of:

1. Current Expanded Functions Dental Assistant (EFDA) certification from the Oregon Board of Dentistry
2. BLS/CPR for Healthcare Providers certification
3. Current Professional Liability Insurance

Course Requirements
In order to successfully complete this course, the participant must:

1. Complete all online reading and recorded lectures prior to hands-on learning.
2. Complete the required 25-hour hands on learning experience at Pacific University, Hillsboro campus.
3. Pass a written exam at 75% or above
4. Demonstrate competency in the administration of the following injections: infiltrations, IA/L, PSA, GP, NP, Mental, MSA, LB

Preparation for the Course – Using the study guide provided, all course participants must complete the assigned readings of the required textbook, view the assigned videos and successfully pass the assigned quizzes prior to the hands-on portion of the certification course.

Topics

- Pain & Anxiety
- Neurophysiology
- Pharmacology of Local Anesthetics and Anesthetic Reversal Agents
- Pharmacology of Vasoconstrictors
- Anatomy Review
- Systemic Complications
- Local Complications
- Legal & Ethical Complications
- Armamentarium
- Successful Injection Technique
- Maxillary Injection Technique
    - Infiltration
    - ASA

    - IO
    - MSA
    - PSA
    - GP
    - NP
- Mandibular Injection Technique
    - Infiltration
    - Mental
    - IA/Lingual
    - Long Buccal

Course Hour Distribution: Online preparation (26 hours) delivered in a self-paced online format.

Clinical Hour Distribution: Hands-on clinical portion (24 hours) spread across 2 weekends.

Resources:

- Required Textbook: Bassett, KB, Dimarco, AC, Naughton, DK. Local Anesthesia for Dental Professionals, 2nd Edition. 2022 update

Additional Reference:

- Malamed, Stanley 2019. Handbook of Local Anesthesia, 7th Edition. Elsevier, Mosby. SBN: 9780323582070
- Logothetics, DD. Local Anesthesia for the Dental Hygienist, 3rd Edition. 2022 update

Objectives: Upon completion of this course, the student will satisfactorily:

Course Objectives
1. Discuss principles of pain management in terms of physiology and mechanism of action.
2. Understand the pharmacology of local anesthetics and vasoconstrictors.
3. Implement a physical and psychological evaluation of the patient including treatment planning strategies for the administration of local anesthetic.
4. Describe the armamentarium used for local anesthetic injections and how it is used utilizing aseptic technique.
5. Describe and demonstrate maxillary and mandibular injection techniques
6. Identify local and systemic complications related to the delivery of local anesthetic agents.
7. Discuss the legal aspects of pain management techniques

Specific Instructional Objectives

Discuss principles of pain management in terms of physiology and mechanism of action.

Upon completion of this unit of study, the student will be able to:

1. Identify all anatomical structures of a neuron and discuss their relevance to providing local anesthesia.
2. Compare and contrast motor and sensory neurons, describe the function of each.
3. Describe in detail the process by which an impulse is generated.
4. Describe in detail the process by which local anesthetics block nerve conduction.
5. Discuss how pH and pKa affect the uptake/effectiveness of local anesthesia.
6. Define tachyphylaxis and discuss its implications in providing care.

Discuss the pharmacology of local anesthetics and vasoconstrictors.

Upon completion of this unit of study, the student will be able to:

1. Identify local anesthetics (LA) available in North America.
2. Identify factors related to the duration of LA.
3. Know the approximate duration of action of LA.
4. Calculate the maximum doses of LA.
5. Select the appropriate LA based on the patient and tx.
6. Describe the action and distribution of LA.
7. Define “elimination half-life” and explain why its consideration is important for LA.
8. Discuss factors that affect blood levels of LA.
9. Describe biotransformation and excretion of esters and amides.
10. Describe effects of LA on all presented body systems.
11. Discuss purposes for which we use vasoconstrictors.
12. Describe the sympathomimetic effects of epinephrine (systemic reactions).
13. Describe considerations for selection of a vasoconstrictor.
14. Discuss absolute and relative contraindications for the use of epinephrine.
15. Describe side effects and overdose signs and symptoms of anesthetics
16. Describe the side effects and overdose signs and symptoms of epinephrine..
17. Describe drug interactions that need to be considered when electing to use a vasoconstrictor.

Discuss physical and psychological evaluation of the patient including treatment planning strategies.

Upon completion of this unit of study, the student will be able to:

1. Describe the four anesthetic administration techniques.
2. Describe patient preparation and rapport strategies inherent in stress reduction protocol used for all anesthetic procedures.
3. Describe & demonstrate the steps to providing a successful injection and the importance of each.

Describe the armamentarium used for local anesthetic injections and how it is used utilizing aseptic technique.

Upon completion of this unit of study, the student will be able to:

1. Correctly identify the following components of an anesthetic cartridge: rubber diaphragm, metal cap, cylinder, inscription and rubber stopper.
2. Correctly identify the following components of an anesthetic needle: lumen, bevel, hub, shank and protective shield (cap).
3. Differentiate between aspirating, self-aspirating and non-aspirating syringes.
4. Identify the proper care and handling of the syringe.
5. Discuss the advantages and disadvantages of each type of syringe.
6. Discuss the relationship between the gauge number of a needle, the corresponding size of the lumen, and the corresponding impact on the injection.
7. Demonstrate the proper care and handling of the needle.
8. Discuss the advantages and limitations of the three most commonly used needle gauges in dentistry.
9. State the lengths of the two needles most frequently used in dentistry.
10. Identify the only acceptable agent for the disinfection of the local anesthetic cartridge.
11. List the components of an anesthetic solution with and without a vasoconstrictor and their functions.
12. State the shelf life of an anesthetic cartridge.
13. Identify and discuss two factors which contribute to the deterioration of the solution within a cartridge.
14. State the volume of solution contained in the anesthetic cartridge most frequently used in dentistry and be able to determine volumes administered in any given situation.
15. Identify the following additional armamentarium and describe their use: topical anesthetic, applicator sticks, cotton gauze, hemostat, needle recapper.
16. List potential problems and their causes in the armamentarium including the syringe, needle and anesthetic cartridge.

<u>Describe and demonstrate maxillary and mandibular injection techniques.</u>

Upon completion of this unit of study, the student will be able to:

1. Locate all landmarks, nerves, arteries and veins important to the administration of local anesthesia.
2. Demonstrate safe and effective injection techniques for all infiltrations.
3. Demonstrate safe and effective injection techniques for all maxillary and mandibular nerve blocks.
4. Identify supplemental injection techniques available and identify the appropriate situations in which to employ each technique.
5. Identify changes to technique appropriate for administering LA to children.
6. List the tissues anesthetized by each type of injection and describe the target areas.
7. Locate and identify the anatomical structures used to determine the local anesthetic needle’s penetration site for each type of injection on a skull and a patient.

<u>Discuss local and systemic complications related to the delivery of anesthetic agents.</u>

Upon completion of this unit of study, the student will be able to:

1. Recognize all local complications of local anesthesia, discuss their causes, and management of the condition.
2. Discuss best practices of injection technique and how this relates to decreased incidence of local complications.

3. Understand the principles of drug actions.
4. Identify the classification of systemic reactions associated with local anesthetics.
5. Recognize and assist in the management of systemic complications that may result from the administration of anesthetic agents.

Discuss the legal aspects of the delivery of pain management techniques in the dental office.

Upon completion of this unit of study, the student will be able to:

1. Understand the scope of practice concerning local anesthetic administration.
2. Describe under what conditions an EFDA may administer LA.
3. Discuss the most common legal complaints regarding the administration of LA.
4. Understand how HIPAA, consent & breach of duty relate to the administration of LA.

Needle stick injury protocol.

Upon completion of this unit of study, the student will be able to:

1. Identify a bloodborne pathogen exposure during the handling of a syringe
2. Explain the steps to follow when an exposure has occurred
3. Identify who to notify of a needlestick exposure
4. Correctly document a needlestick exposure

Clinical Hour Distribution: Hands-on clinical portion (24 hours) spread across 2 weekends.

1. Students will demonstrate inspecting cartridges prior to use, loading a cartridge into the syringe, and engaging the harpoon.
2. Students will demonstrate the safe removal of the needle cap and recapping of the syringe.
3. Students will demonstrate the correct insertion site for all injections (on the left and right) utilizing the Safe-D-Needle.
4. Students will demonstrate the delivery of anesthetic solution at 1 minute per cartridge.
5. Students will deliver a minimum of 2 of each injection to a peer.
6. Students will successfully pass a process evaluation on each of the following injections: infiltration, PSA, and IA/L.

Evaluation criteria

Students will be evaluated on the following criteria in administering Infiltration, PSA, and IA injections. Students must pass all critical areas at a satisfactory level to achieve final competency for successful course completion. Please see attachment of sample evaluation criteria.

Evaluation Criteria Overview:

1. Adequate review of medical history
2. Prepared with all armamentarium
3. Identifies appropriate anesthetic, indicate intended amount to deposit, and MRD for patient
4. Prepares tissue for injection (topical anesthetic applied if appropriate)

5. Adequate visibility (mirror/lighting)
6. Identifies injection site & correct verbal cues
7. Stable fulcrum
8. Identifies correct angle & depth
9. Aspiration with correct verbal cues. Proceeds appropriately
10. Deposits anesthetic agent at a rate of 1 carpule per minute & watches patient's reaction.
11. Follows all safety/infection control procedures

Evaluation Criteria	**Infiltration Right Date**	**Infiltration left Date**	**Infiltration peer Right Date**	**Infiltration peer Left Date**	**Infiltration PE R or L Date**
1. Correct infection control and safety procedures	S I U	S I U	S I U	S I U	S U
2. **Adequate review of medical history** *(looks up all medications & supplements on Lexicomp, explains rationale for injection & choice of anesthetic).*	n/a (typodont)	n/a (typodont)			
3. Prepared with all armamentarium.	S I U	S I U	S I U	S I U	S I U
4. Prepares tissue for injection *Verbally states "blot dried area and applied topical anesthetic agent for 1 minute").*	S I U	S I U	S I U	S I U	S I U
5. Adequate visibility (mirror/lighting).	S I U	S I U	S I U	S I U	S I U
6. Holds tissue taut.	S I U	S I U	S I U	S I U	S I U
7. Identifies injection site & correct verbal cues. ***Verbally states "initial penetration the bevel is covered."***	S I U	S I U	S I U	S I U	S U
8. Stable fulcrum.	S I U	S I U	S I U	S I U	S I U
9. **Identifies correct angle & depth.** ***Verbally states "at target."***	S I U	S I U	S I U	S I U	S U
10. Aspiration with correct verbal cues. Proceeds appropriately. ***Verbally states " + aspiration" or " - aspiration."***	S I U	S I U	S I U	S I U	S U
11. Deposits anesthetic agent at a rate of 1 carpule per minute & watches patient's reaction.	S I U na	S I U na	S I U na	S I U na	S U
12. Correct MRD calculation	S I U na	S I U na	S I U na	S I U na	S U
13. Appropriate selection of anesthetic	S I U na	S I U na	S I U na	S I U na	S U
Result	Credit / Repeat	Credit / Repeat	Credit / Repeat	Credit / Repeat	Pass / Repeat
Faculty observing the injection					

Dr. Donald Woods
Excel Dental Educators
3441 Lebanon Pike #105
Hermitage, TN 37076
exceldentaleducators@yahoo.com
615-681-0174

09/25/24

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

Subject: Request for Approval to Teach Local Anesthesia Course to Dental Hygienists in the State of Oregon

Dear Members of Oregon State Board of Dentistry,

I hope this letter finds you well. My name is Dr. Donald Woods, and I am writing to request your kind consideration and approval to teach a Local Anesthesia course to Dental Hygienists in the state of Oregon. I have been an educator in the field of Dentistry for over a decade, successfully conducting Local Anesthesia courses in the state of Tennessee since 2010. Moreover, since 2010, I have been a nationally recognized provider of continuing dental education for the Academy of General Dentistry.

I wish to highlight the following aspects to support my request for approval:

1.Experience and Expertise: With extensive experience as an educator and a nationally recognized provider of continuing dental education, I have developed a deep understanding of teaching methodologies that engage and empower students to excel in their professional endeavors.
2. Proven Track Record: Throughout my tenure as an educator, I have consistently received positive feedback from students and colleagues, attesting to the quality and effectiveness of my teaching methods.
3. Approvals from Tennessee Board of Dentistry,Georgia Board of Dentistry, and North Carolina Board of Dentistry: Enclosed with letters, you will find the

approval letters from each board, granting me permission to conduct Local Anesthesia courses in the states. This approval demonstrates my adherence to regulatory standards and commitment to compliance.

4. Clinical Faculty and Resources: In addition to my personal expertise, I have assembled a team of highly skilled clinical faculty to provide comprehensive training and guidance to students during the Local Anesthesia course. Moreover, I have established well-equipped clinical sites both in Georgia and Tennessee, ensuring that students have access to the necessary resources for hands-on training.

I am dedicated to upholding the highest standards of education and ethics in the field of dentistry, and my ultimate goal is to empower dental hygienists in Oregon with the knowledge and skills necessary to administer local anesthesia safely and effectively, thereby contributing to improved patient care and outcomes in the state.

I am humbly enclosing the renewal approval letter from the Academy of General Dentistry and the approval letters from the Tennessee Board of Dentistry, Georgia Board of Dentistry and North Carolina Board of Dentistry. I believe that these documents further affirm my qualifications and dedication to dental education.

I kindly request the opportunity to present my Local Anesthesia course proposal before the Oregon Board of Dentistry for review and approval. I am confident that my experience and commitment to dental education align with the Board's mission to promote excellence in dentistry and protect the health and safety of the public.

Thank you for considering my request. I am available at your earliest convenience to provide any additional information or answer any questions you may have. Please find my contact information at the top of this letter.

I eagerly anticipate the possibility of contributing to dental education in Oregon and fostering the growth and development of dental hygienists in the state.

Sincerely,

Dr. Donald Woods

Enclosures:

Approval Letter from the Tennessee Board of Dentistry
Approval Letter from the Georgia Board of Dentistry
Approval Letter from the North Carolina Board of Dentistry
Renewal Approval Letter from the Academy of General Dentistry

EXCEL DENTAL EDUCATORS
3441 Lebanon Pike #105
Hermitage, TN 37076
email:exceldentaleducators@yahoo.com
6 1 5 - 6 8 1 - 0 1 7 4

Certification Course in Administration of Local Anesthesia

COURSE DESCRIPTION: This course will provide a comprehensive course of study in the Administration of Local Anesthesia. The course is designed to prepare the dental hygienist to competently administer local anesthesia for pain management in a safe atraumatic manner.
The total number of clock hours for this course are 70. The course has a lecture and clinical hand-on component. Topics examined include the mechanism of action, vasoconstrictors, review of essential anatomy, armamentarium, local and systemic effects, tissue diffusion and toxicity of anesthetic agents used in dentistry. Patient assessment including medical considerations, apprehension and pain threshold will be evaluated for determining the indications and contraindications of dental pain control. Selection of appropriate anesthetic agents and proper administration techniques will be emphasized. The pharmacology, principles of nitrous oxide-oxygen analgesia administration, patient considerations and legal issues will be discussed, and calculate maximum recommended doses of local anesthetic agents for children and adults. Identify possible adverse effects encountered during and following the administration of local anesthetics and the appropriate course of action to manage the adverse effects. The clinical component of the course will train the dental hygienist to administer the following injections: PSA, MSA, ASA, NP, GP, IANB, L, M, I, LB, and supplemental infiltration techniques. The students are required to pass a written and a clinical exam with scores of 75%.
Both lecture and clinical information will be taken from: Dr. Stanley F. Malamed, Handbook of Local Anesthesia.

HANDOUTS: All handouts are provided by Excel Dental Educators on the techniques and procedures for Administration of Local Anesthesia.

COURSE OBJECTIVES:
Upon completion of this course, the successful student should be able to:
1. Understand the philosophy and psychology of local anesthesia
2. Evaluate a patient's medical history and physical status including measurement of vital signs

3. Evaluate indications and contraindications for use of local anesthesia
4. Identify anatomical landmarks that pertain to administration of local anesthesia
5. Understand the physiology of nerve conduction
6. Understand the pharmacology of local anesthetics and vasoconstrictors
7. Be able to select and prepare the proper armamentaria for the administration of local anesthesia
8. Properly record the administration of local anesthetic procedures and complications
9. Be able to manage common medical emergencies as related to the administration of local anesthesia
10. Recognize and manage post-injection complications and reactions to injections
11. Employ infection control techniques including disposal of sharps
12. Administer local anesthetic agents with emphasis on: technique, aspiration, slow injection, and minimum effective dosage
13. Recognize, and manage toxic reactions to local anesthetics and vasoconstrictors
14. Recognize, and manage allergic reactions to local anesthetics and vasoconstrictors
15. Calculate highest safe dose based on patient's weight and/or age
16. Determine the need for reinjection
17. Administer local anesthesia for infiltration
18. Administer local anesthesia for nerve blockage
19. Monitor the patient's physical status while under the effects of local anesthesia
20.Discuss and describe the anatomy and neurophysiology of pain and pain control
21. Determine the pharmacology of anesthetic agents and vasoconstrictors
22. Recognize medical history status and administration of local anesthesia
23. Demonstrate local anesthesia techniques
24. Discuss the use of topical anesthetics and demonstrate proper administration
25. List steps taken in an emergency
27. Utilize proper infection control
28. Recognize proper prevention, recognition and management of complications
29. Administer local anesthesia in practice
30. Review all the head and neck anatomy
31. Properly record the administration of local anesthetic procedures and complications
32. Be able to manage common medical emergencies as related to the administration of local anesthesia
33. Recognize and manage post-injection complications and reactions to injections
34. Employ infection control techniques including disposal of sharps

35. Administer local anesthetic agents with emphasis on: technique, aspiration slow injection, and minimum effective dosage
36. Recognize, and manage toxic reactions to local anesthetics and vasoconstrictors
37. Recognize, and manage allergic reactions to local anesthetics and vasoconstrictors
38. Calculate highest safe dose based on patient's weight and/or age
39. Determine the need for reinjection
40. Administer local anesthesia for infiltration
41. Administer local anesthesia for nerve blockage
42. Monitor the patient's physical status while under the effects of local anesthetics
43. The ASA classifications of patients
44. And Much More!!!

INSTRUCTIONAL METHODS:
This course includes lecture, demonstration and clinical of all topic areas listed above,
encouraging proficiency with hands-on application of skills. Upon completion of the course
students shall be evaluated by written and clinical examination. The passing grade for the course is set at 75%.

ACADEMY of GENERAL DENTISTRY
560 W. Lake St.
Sixth Floor
Chicago, IL USA
60661-6600
312.440.4300
Fax 312.440.0559
Toll-free: 888.243.3368
agd.org

June 26, 2023

Provider ID# 347635
Excel Dental Educators
Donald Woods, DDS
4636 Lebanon Pike # 233
Hermitage, TN 37076

Via email: exceldentalcare122@yahoo.com

Dear Dr. Woods:

Congratulations! On behalf of the Academy of General Dentistry (AGD), I am pleased to inform you that Excel Dental Educators, provider ID # 347635, has received approval from the AGD Program Approval for Continuing Education (PACE) Council. Please use your provider ID number on all correspondence. The approval period extends from 4/1/2023 to 3/31/2026. Check your listing on the *Find a PACE Approved Provider* page of the AGD Website. E-mail PACE@agd.org if there are any corrections or updates to your information.

The AGD requires that you use the AGD PACE Logo and the following approval statement on all publicity:

PACE
ACADEMY of GENERAL DENTISTRY
PROGRAM APPROVAL FOR CONTINUING EDUCATION

Excel Dental Educators
Nationally Approved PACE Program Provider for FAGD/MAGD credit.
Approval does not imply acceptance by
any regulatory authority or AGD endorsement.
4/1/2023 to 3/31/2026.
Provider ID# 347635

Once logged onto the AGD website you can download the AGD PACE logo from the PACE area of the website. The terms "accreditation," "accredited" or "certified" must not be used in conjunction with PACE approval.

Approved providers have the obligation, if requested, to allow one monitor at least one time per year to monitor one of their programs. Details on the AGD monitoring program can be found in the PACE Program Guidelines.

AGD e-mails approval renewal notices to providers approximately eleven months and six months before their expiration date. All nationally approved PACE Providers are required to pay an annual non-refundable maintenance fee in addition to the non-refundable application fee. Providers will receive an e-mail invoice for this fee approximately 90 days prior to each due date. To learn more about PACE visit the PACE section of AGD Website often. This section is designed to help you manage your program.

Thank you again for your commitment to providing quality continuing dental education.

Sincerely,

Ronald D. Giordan, DDS, MAGD

Ronald D. Giordan, DDS, MAGD
Chair, Program Approval for Continuing Education (PACE) Council

TN Department of Health

TENNESSEE BOARD OF DENTISTRY
(615) 532-5073 or 1-800-778-4123 ext. 5325073

July 24, 2023

Excel Dental Educators
3441 Lebanon Pike #105
Hermitage, TN 37076

Dear Dr. Woods,

The following certification course was approved by the Board Consultant and will be reviewed by the Board at the October 5-6, 2023 board meeting.

Name of School: **Excel Dental Educators**

Certification Course: **Local Anesthesia**

Date Approval Expires: **December 31, 2025**

At least 30 days prior to the start of the course, the final list of instructors, date of course, and location of the course must be submitted to the Board's Administrative Office. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location or directorship.

Each course must submit the Application for Board Approval at least 30 days prior to the next scheduled board meeting when approval expires and the syllabus submitted must contain the number of hours in the course. It is in the best interest of the course provider not to advertise an upcoming course or distribute applications to students until after receiving approval.

If I can be of assistance, please contact me at (615) 532-5073.

Sincerely,
Ailene Macias
Ailene Macias
Director
Board of Dentistry

GEORGIA BOARD OF DENTISTRY

GOVERNOR
Brian P. Kemp

EXECUTIVE DIRECTOR
Eric R. Lacefield

2 Martin Luther King, Jr., Drive SE • East Tower, 11th Floor • Atlanta, Georgia 30334 • Tel: 404.651.8000 • Fax 470.386.6137
www.gbd.georgia.gov

September 12, 2023
Via Email Only

Dr. Donald Woods
Excel Dental Educators
3441 Lebanon Pike #105
Hermitage, TN 37076

Email: exceldentaleducators@yahoo.com

RE: Local Anesthesia Course Submission

Dear Dr. Woods:

At its recent meeting, the Georgia Board of Dentistry considered the course titled, "Certification Course in Administration of Local Anesthesia" offered by Excel Dental Educators. Please let this letter serve as notice that the course has been approved.

Should you have any questions, please feel free to contact our office at (404) 651-8000.

Sincerely,

Georgia Board of Dentistry

Local Anesthesia Course

From: Zaibun Alexander (zalexander@ncdentalboard.org)

To: exceldentaleducators@yahoo.com

Cc: mrichardson@ncdentalboard.org

Date: Wednesday, September 13, 2023 at 02:03 PM CDT

Hello Dr. Wood,

We received your letter and AGD PACE certification. Based on this you are approved to teach your course. Please ensure that along with the course description you provided, the following is also met:

a. A minimum of 16 lecture hours on pharmacology, physiology, equipment, block and infiltration techniques, legal issues, and medical emergencies, including systemic complications.
b. A minimum of eight clinical hours of instruction and experience in administering local anesthesia injections.
c. Completion of at least 12 block and 12 infiltration injections under the direct supervision of a licensed dentist during the class who must certify the applicant's competency. ***

Once the student has completed the above, please provide a letter of certificate that shows the above requirements. In addition, anyone who takes this course needs to have been practicing DH for the past 2 years and needs to also sign this affidavit https://www.ncdentalboard.org/PDF/affidavit.pdf
Both documents will need to be sent to Madeline at mrichardson@ncdentalboard.org

Let me know if you have any questions.

Thanks,

Zaibun Alexander
Licensing Coordinator
North Carolina State Board of Dental Examiners
2000 Perimeter Park Drive, Suite 160 • Morrisville, NC 27560
Office phone 919.678.8223 • Fax 919.678.8472
Email: zalexander@ncdentalboard.org
http://ncdentalboard.org

OTHER ISSUES

OREGON CLINICAL & TRANSLATIONAL RESEARCH INSTITUTE

Evaluation of Oregon Health Plan Dental Provider Enrollment

Conducted by Oregon Clinical & Translational Research Institute at Oregon Health & Science University in collaboration with the Oregon Health Authority Health Policy and Analytics Division

October 2024

BACKGROUND

Historically, Oregon has been at the forefront of recognizing and prioritizing health coverage for all with the development of the Oregon Health Plan (OHP) as the state's Medicaid program in the 1990s to the creation of Coordinated Care Organizations (CCOs) in 2011.[i] Since 2013, there has been a 131 percent increase in the total number of individuals enrolled in Medicaid/Child Health Improvement Plan (CHIP).[ii]

Not only are more people eligible and enrolled in OHP than ever before, but coverage has become increasingly more comprehensive, especially around oral health. For example, in 2014 Oregon used the passage of the Affordable Care Act (ACA) to expand its Medicaid dental program for children. Accompanying this legislation, Oregon expanded adult dental care coverage from offering only traditional emergency services to a comprehensive preventative and routine dental care program.[iii]

Despite policies contributing to more extensive OHP coverage for dental services, a gap between policy and implementation has emerged. For example, Oregon's Medicaid reimbursement is only 28.3 percent as a percentage of dentist charges for adult dental services, compared to neighboring states Washington and California that have higher rates at 42.9 percent and 44.9 percent respectively.[iv] According to the American Dental Association's most recent data from 2017, most dentists in Oregon did not treat Medicaid patients. Most (57 percent) dentists in Oregon are not enrolled Medicaid providers, and 11 percent are enrolled but have not seen a Medicaid patient.[v] This results in relatively few practices serving most Medicaid patients. Moreover, when comparing dental care utilization in 2021 between Medicaid insured children and privately insured children, 27 percent more privately insured children saw a dentist in the last 12 months.[vi] Oregon also falls below the national rate of dental care utilization among children. [v] About one quarter (24 percent) of adults covered by Medicaid have seen a dentist in the last 12 months, compared to 62 percent of privately insured Oregonians.[vii]

Grounded by this landscape of increasing coverage, yet under-utilization, there is a need to understand barriers to implementation. Given that large Federally Qualified Health Centers (FQHCs) and Dental Care Organizations (DCOs) serve the majority of Medicaid patients, this report investigates the implementation of Medicaid reimbursement from the point of view of dentists in Oregon. Special attention was paid to private practices in Douglas, Jackson, Josephine, and Lane counties, which are the focus of a Health Resources and Services Administration (HRSA) Oral Health Workforce Grant.

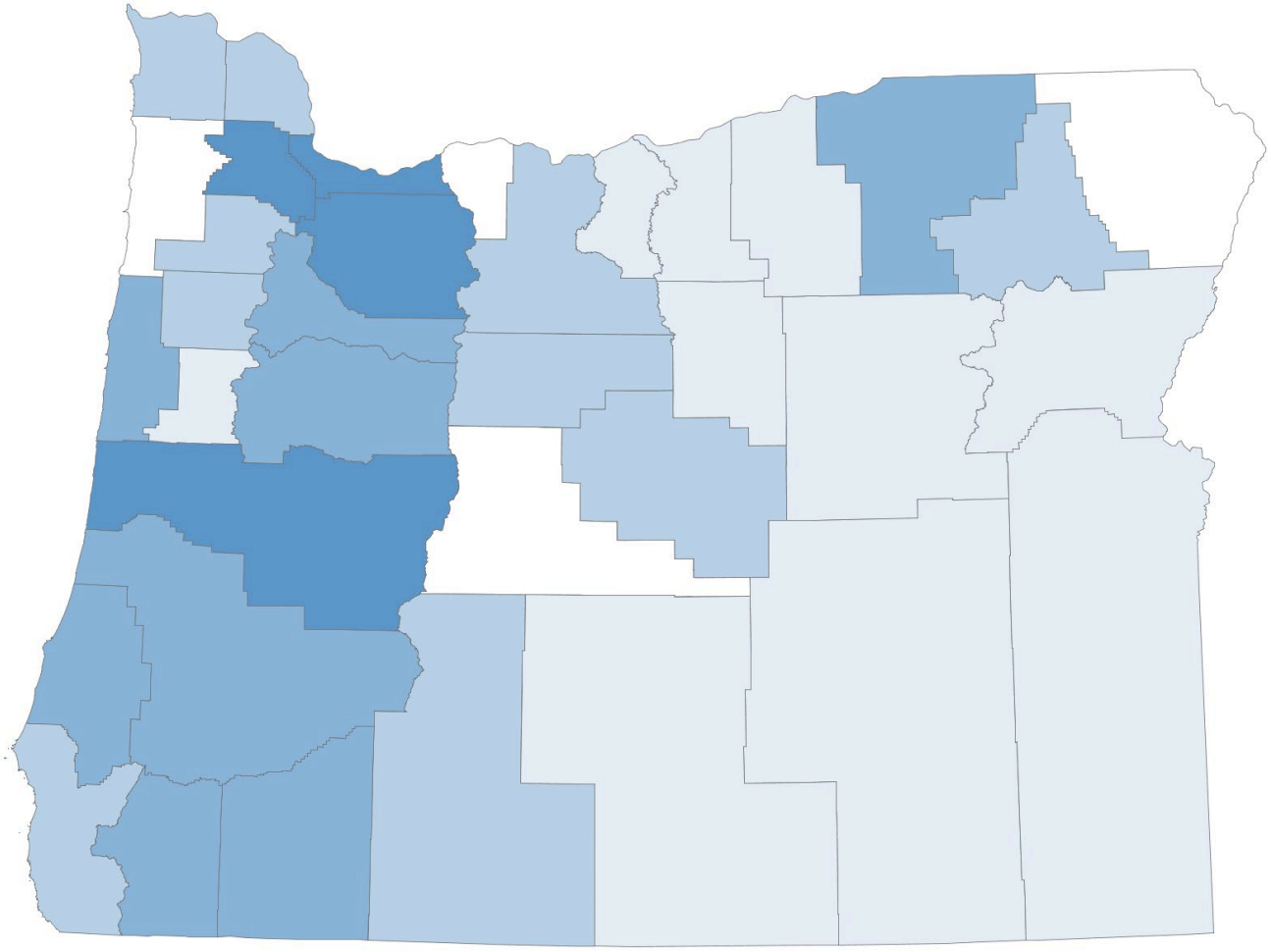
HRSA awarded Oregon Health Authority (OHA) the Grant in 2022 to address dental workforce needs and expand access in dental health professional shortage areas (dental HPSAs) for people experiencing health inequities in these four counties. Appendix 1 includes a map and more information on Oregon's dental HPSAs. OHA selected these counties for the Grant's focus because practices in the area face significant challenges in recruiting and retaining dental providers. OHA contracted with Oregon Clinical & Translational Science Research Institute (OCTRI) to lead the report analysis and drafting using Grant funds.

OREGON DENTAL COVERAGE

Thirty-two of Oregon's 36 counties (89 percent) lack adequate Medicaid dental full-time equivalents (FTE) to meet the needs of enrolled patients. Figure 1 on page 2 shows the Medicaid dental FTE needed to reduce shortage for OHP members in each Oregon county. See Appendix 2 for data sources, breakdown of Medicaid enrolled population, existing Medicaid dental FTE, and need by county, and calculations.

Most counties, noted by shades of blue, need more FTE. Higher need is concentrated in urban/metro areas, while many rural areas are shown to need less than one Medicaid dentist FTE. When considering need in rural counties, the geographic context and associated barriers must also be considered. People using Medicaid living in rural areas such as the HRSA grant's four counties face barriers around the distance to care such as the time and cost associated with transportation. Additionally, where people living in more densely populated areas may have multiple options of dental providers, people living in rural areas have more constrained choices and may be forced to see a provider that is not a good fit for them in terms of language, social identity positions, or treatment approach.

Figure 1. Medicaid dental FTE needed to reduce shortage for OHP members by county



Medicaid FTE dental provider shortage

- < 0
- 0.01 – 0.9
- 1.0 – 2.9
- 3.0 – 6.9
- 7.0 – 22.4

Sources: Medicaid claims and enrollment data, 2023. See Appendix 2 for more information on calculations

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted with two groups: (a) OHA employees engaged in the OHP provider enrollment process and (b) prominent members of oral health systems throughout Oregon. These interviews provided background and context around OHP dental provider enrollment statewide. These interviews were coordinated by and included OHA representatives.

The interviews with OHA employees engaged in OHP dental provider enrollment provided logistical context for program requirements, including the enrollment and reimbursement processes. The processes described by OHA employees were straightforward and clear. However, this narrative ran counter to the experiences described by dental practices. Practices reported conflicting accounts of the enrollment and reimbursement processes, particularly among private practices.

The interviews with prominent members of oral health systems in Oregon focused on broader initiatives to improve oral health access and communication methods around OHP. These interviews highlighted the innovative ways that members of the oral health community are working to expand access to all Oregonians, including the use of teledentistry, expanding the oral health workforce, and integrating oral health into whole body health. They also underscored the complex landscape of oral health in Oregon. They described the need to balance appealing to the altruistic nature of providers with business feasibility and held varied opinions about government involvement with health care when discussing OHP.

DENTAL PRACTICE INTERVIEWS

To better understand the decision-making process around enrolling dental providers in the OHP program among private practices, we conducted interviews with representatives from dental practices in OHA's HRSA Oral Health Grant focus areas: Douglas, Jackson, Josephine and Lane counties that historically have oral health access issues and trouble recruiting and retaining providers. Interviews covered practice background, status of OHP enrollment, and barriers/facilitators to OHP enrollment. See Appendix 3 for the full interview guide.

Eligibility and recruitment

Eligible practices were in Douglas, Jackson, Josephine, and Lane counties. Dental specialists (orthodontic, endodontic, periodontic or surgical) and Veterans Affairs-affiliated clinics were excluded. To ensure clinics serving patients in rural areas were included in the sample, we prioritized those practices in towns with less than 15,000 people.

Recruitment letters explaining the purpose of the project, an incentive for participating, and a QR code to a survey where they could indicate interest and provide contact information were sent to 25 dental practices in each county based on the criteria above. The initial recruitment round yielded seven interviews and met saturation for Josephine and Douglas counties. This process was repeated several months later with additional clinics from Lane and Jackson counties for a total of 12 interviews.

Interview demographics

In total, 12 interviews were conducted with representatives from dental practices in Douglas, Jackson, Josephine, and Lane counties. Sample demographics are detailed in the table on this page.

Interviewee Demographics	
County	
Douglas	4 (33%)
Jackson	3 (25%) *
Josephine	3 (25%) *
Lane	3 (25%)
Practice Type	
Private practice	10 (83%)
CCO/DCO	2 (17%)
OHP Status	
Currently Accept	5 (42%)
Previously Accept	1 (8%)
Never Accepted	6 (50%)
Role	
Dentist	5 (42%)
Practice Manager/Dental Director	7 (58%)
***One practice operated in both Jackson and Josephine counties**	

Altruism among dentists

A salient theme throughout all the interviews was a desire to provide optimal care to patients, which the interview participants felt was difficult with how OHP is currently structured. While charitable motivations led providers to seek out ways to address care gaps, such as providing services at a low or no cost rate for select patients, these values were also cited as a reason for not enrolling in OHP due to long wait times and restrictions to the types of procedures allowed under OHP, such as providing replacement dentures more than once every ten years. This led some provider types to become disillusioned with the program.

General challenges facing dental practices

While the overall purpose of the interviews was to discuss dental provider enrollment in OHP, interviewees also raised several challenges facing dental practices more generally in Oregon.

- **Workforce recruitment and retention are a common challenge for dental practices, particularly in rural areas.** Many providers or practice managers we spoke with shared constraints related to recruitment and retention such as clinics located in undesirable locations, lack of applicants, or competitive pay. This is especially true for dental hygienists, which limit their practice's capacity for expanding their patient panel. Several practices shared that it often could take a year or more to fill open positions.
- **Dental practices face substantial managerial burdens that additionally restrict capacity.** Many dentists described the administrative burden associated with billing and filing insurance claims on behalf of patients, particularly if they work with multiple payer types. This task diverts time and resources away from patient care, and a few dentists described relationships with payers influencing the types of services and quality of care they can provide. Moreover, a few providers shared they either already had transitioned or were planning to transition from accepting insurance to an in-office dental plan.
- **Dental providers shared that existing reimbursement rates are insufficient.** Providers shared that reimbursements for all insurance providers have not kept pace with rapidly rising costs for materials and staffing, and OHP reimbursements are less in comparison to rates offered by private insurance. Providers who accept OHP shared that they were "in the red" – not making money – for any service beyond routine dental exams. For providers who accept OHP, the challenge of low reimbursement was compounded by the variability in fee schedules set by different DCOs/CCOs and among dentists within the same practice. This financial strain makes it difficult for practices to maintain profitability while delivering high-quality care.

OHP dental provider enrollment barriers

In addition to the general challenges outlined above, interviewees cited the following additional barriers to participating (or continued participation) in OHP.

- **The administrative burden required to take OHP is a substantial hurdle, particularly for smaller dental practices.** Providers further emphasized the administrative processes for providing care to OHP patients are complex and confusing. Specific challenges included managing patient assignments, checking OHP eligibility for all patients, and navigating the claims process. Many practices did not have dedicated billing staff to manage these steps, and given challenges related to reimbursement rates and staffing, hiring to fill this gap is not a feasible solution. Variability in the processing time for denials and approvals adds to the complexity of managing OHP patients.
- **Poor communication about changes in covered services**. A few providers who accept OHP expressed frustration that there is limited communication about changes to covered services and that they often hear about updates through word of mouth, rather than from the DCOs/CCOs or OHA itself.
- **Constraints in covered services and equipment prevent dental practices from practicing dentistry at their desired standard.** Several dental providers complained that OHP does not cover the services that they would typically recommend to patients (for example, performing an extraction instead of a root canal). This leads to dentists experiencing moral injury; there is a high stated desire among providers to do well by their patients, but financial and administrative constraints limit their ability to do so. A few providers shared that they thought it was only feasible for private practices to take OHP if they were willing to cut corners or provide substandard care.
- **Enrollment for private practices into OHP is unclear and varies by DCO/CCO, leading to conflicting narratives about the process.** While OHA staff have a clear process for paperwork, the engagement between DCOs/CCOs and private practices remains ambiguous and varies significantly, which creates confusion for dental providers.
- **Some providers shared that the OHP patient population presents additional challenges.** A few providers shared their opinion that OHP patients are less likely to show up for their appointments and are more likely to require complex treatment.
- **Opinions on the capitation model are divided.** Some dental practitioners feel it restricts care to remain financially viable, while others appreciate the guaranteed income it provides.

OHP dental provider enrollment facilitators

Providers accepting OHP had several commonalities, which may speak to enrollment facilitators in the dental setting:

- **Several participating practices that accept OHP are part of an integrated practice offering both medical and dental services.** As one provider shared, integration with medical care made their services financially feasible; while

dental services are "in the red," medical services are "in the black" which offsets costs and facilitate acceptance of OHP patients in the dental setting.

- **Larger practices with multiple locations benefit from an economy of scale that facilitates OHP acceptance.** For example, these types of practices are better positioned to support dedicated billing teams, making the administrative burden of accepting OHP more manageable.

RECOMMENDATIONS

The recommendations included in this section are intended to be a starting point for improving access to oral health care in Oregon and increasing OHP enrollment/retention among private practices.

The following are **lower-effort strategies** that could help to improve OHP enrollment and retention in the short-term:

- **Conduct direct outreach to dentists and improve communication.**
  None of the dental practice representatives we spoke with indicated that they had been directly approached by OHA about accepting OHP, indicating a gap in proactive engagement. Key informant interviews indicated that prior to the COVID-19 pandemic, OHA employed a trainer to aid dentists in OHP enrollment and conduct outreach. However, that role no longer exists. Implementing a communication and outreach plan with dental practices may reduce misconceptions about OHP and provide a point of entry for participation in the program.
- **Clarify and standardize OHP dental provider enrollment process.**
  While OHA staff have a clear process for OHP enrollment, the engagement between DCOs/CCOs and private practices needs to be streamlined and made more transparent. Interviewees reported conflicting narratives about how DCOs/CCOs and private practices coordinate treatment of OHP patients and determine reimbursement. Standardization will reduce administrative burdens and facilitate participation in OHP.

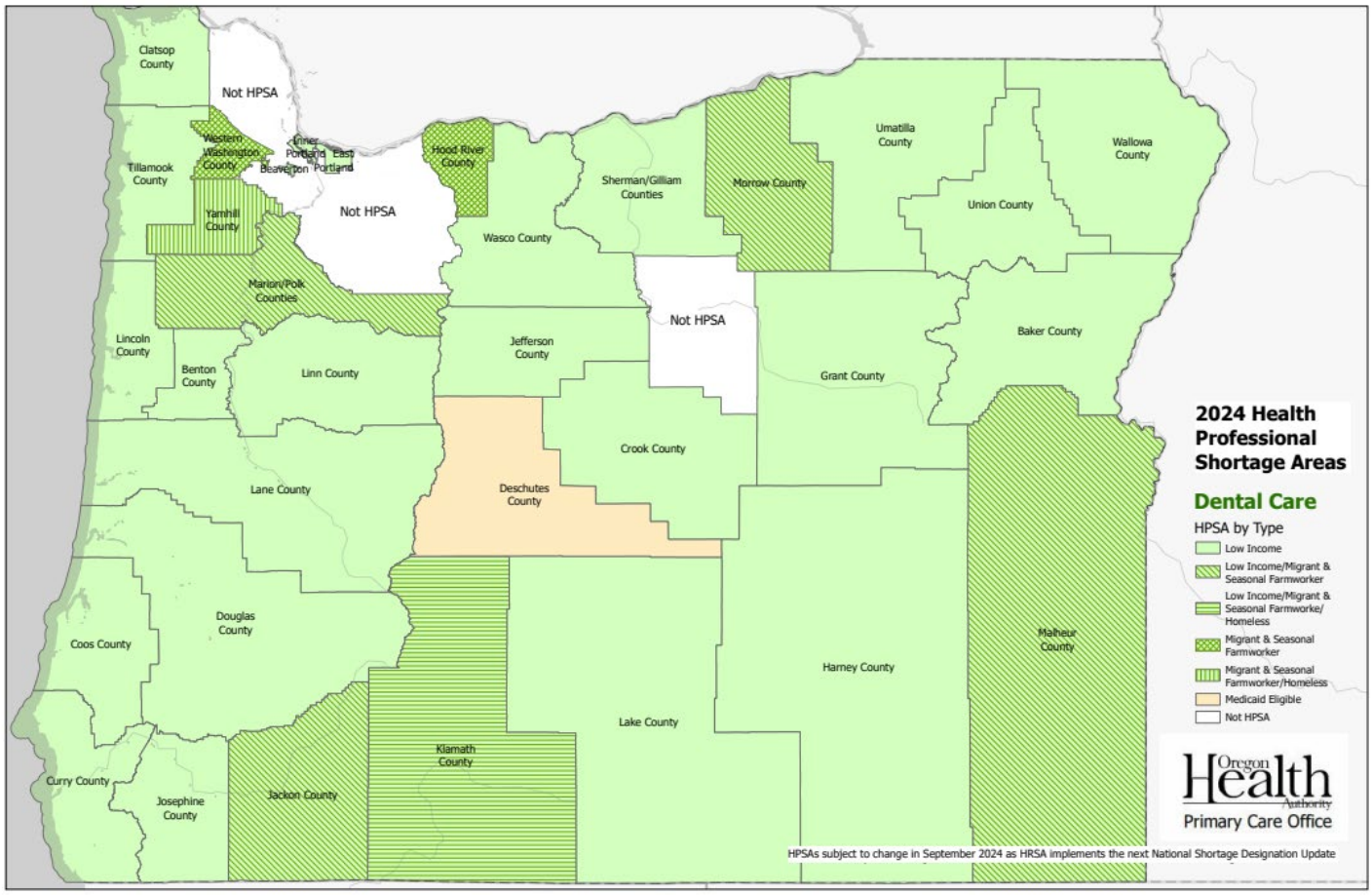
The following recommendations are **higher-effort strategies** that require financial investment and time to accomplish:

- **Increase reimbursement rates.**
  Inadequate reimbursement was the most common barrier to accepting OHP, and improving reimbursement would alleviate financial pressures for providers. Many providers who do not accept OHP shared that they would be interested in providing care for OHP patients, but they could not make it financially worthwhile.
- **Improve loan repayment incentives.**
  Several private practice dentists we spoke with highlighted that they had substantial student debt which influenced their decision to go into private practice and additionally constrains financial flexibility. Improving communication about existing student loan repayment options, as well as expanding eligibility, would likely increase interest among dentists.
- **Address workforce constraints.**
  Improvements to expand the dental workforce could alleviate pressures that all dental providers experience and redress constraints to caring for more patients. Addressing the broader shortage of oral health providers involves increasing training programs and expanding opportunities for dental therapists and dental hygienists. Subsidizing living costs for students in oral health training programs could expand the numbers enrolled. Additionally, educational institutions making a concerted effort to recruit students from rural areas will increase the likelihood of providers working in rural areas once licensed.
- **Add covered services to OHP.**
  Including services that providers deem necessary to meet the standard of care would align financial incentives with professional judgment and mitigate concerns that OHP patients are receiving substandard care.

ACKNOWLEDGEMENTS

Thank you to the dentists from across Oregon, OHA staff, and prominent members of Oregon's dental community who volunteered their time and shared their experiences for the interviews conducted as part of this evaluation. This work was made possible by funding from OHA's HRSA Oral Health Workforce Grant.

Appendix 1. Map of Oregon's Dental HPSAs



Dental HPSA scores are determined by several factors, including the availability of fluoridated water, population-to-provider ratios, distance to the nearest provider, and the prevalence of populations experiencing health inequities (e.g., Migrant Seasonal Farmworkers, homeless, and residents under the federal poverty threshold). Higher scores indicate a larger shortage of dental providers and lower access to care. For more information on the latest dental HPSA scores, please check https://data.hrsa.gov/tools/shortage-area.

Appendix 2. OHP/Medicaid enrolled population, existing OHP/Medicaid dental FTE, and FTE needed by county

	OHP Enrolled Patients (Dec 2023)	Existing OHP Dental FTE (2023)*	FTE Needed to reduce OHP Dental FTE Shortage**
Oregon	**1,465,893*** **	**196.96**	**96.21**
Baker	6,350	1.05	0.23
Benton	22,557	4.09	0.42
Clackamas	108,930	13.95	7.84
Clatsop	14,846	1.36	1.60
Columbia	16,078	1.76	1.46
Coos	27,215	2.24	3.21
Crook	10,577	0.36	1.76
Curry	9,085	0.56	1.26
Deschutes	61,285	16.99	(4.73)
Douglas	46,933	5.60	3.79
Gilliam	763	0.00	0.15
Grant	2,475	0.02	0.47
Harney	3,073	0.44	0.18
Hood River	8,800	2.04	(0.28)
Jackson	91,848	12.89	5.48
Jefferson	12,461	0.00	2.49
Josephine	42,840	5.20	3.37
Klamath	31,699	3.92	2.42
Lake	3,354	0.42	0.25
Lane	134,945	19.46	7.53
Lincoln	20,290	0.60	3.45
Linn	51,211	3.71	6.53
Malheur	16,491	3.19	0.11
Marion	141,423	25.20	3.09
Morrow	5,589	1.08	0.03
Multnomah	284,558	34.54	22.37
Polk	27,627	3.60	1.92
Sherman	697	0.00	0.14
Tillamook	10,215	2.41	(0.37)
Umatilla	32,801	2.47	4.09
Union	9,782	0.61	1.34
Wallowa	2,657	0.81	(0.28)
Wasco	10,940	1.04	1.14
Washington	159,856	20.69	11.29
Wheeler	442	0.05	0.04
Yamhill	33,834	4.62	2.15

* number of 2023 claims / 4,000
** Dental FTE needed to meet needs of Medicaid population – Existing Dental Medicaid FTE
*** Includes 1,366 individuals whose county is unknown

Calculations

- **Dental FTE needed to meet needs of Medicaid population:** number of Medicaid enrolled patients / 5,000. 5,000 is the population-to-provider ratio used by HRSA.
    - Data source: number of Medicaid enrolled patients pulled from OHA dashboard of December 2023 enrollment data
    - Calculation: HRSA Designated Health Professional Shortage Area Statistics

- **Existing Dental Medicaid FTE:** number of Medicaid claims / 4,000 equals one FTE, as defined by HRSA.
    - Data source: 2023 claims data provided by OHA Medicaid claims team
    - Calculation: HRSA Shortage Designation Management System (SDMS): Manual for Policies and Procedures. Dental Provider FTE Calculations

Appendix 3. OHP Evaluation Interview Script and Guide

Clinic ID:
Interviewee:
Interviewee role:

Interviewer:
Date and Time:

Introduction and Consent

Hello, thank you for participating in this interview. My name is [introduce self and notetaker, if applicable]. The purpose of this discussion is to better understand, from your practice's perspective, barriers and opportunities of Medicaid/Oregon Health Plan insurance coverage and participation. This information will help Oregon Health Authority recommend changes to OHP to try to improve the process and make it easier for dental practices.

Participating in this interview is completely voluntary – meaning you can stop the interview at any time. You may choose to skip any questions you do not want to answer. Please feel free to be honest, there are no right or wrong answers. This is not an audit nor evaluation of your specific practice. When we report findings back to OHA, we will not use your name nor your organization's name.

What questions do you have for me before we begin?
Is it okay with you if we record this discussion?

Interview Questions

1. To start, can you tell me more about your practice?
    a. How long has your practice been in business?
    b. Staffing?
    c. Space/facility?
    d. Catchment area? Community demographics?
    e. Are there any dental specialties your practice focuses on? If so, what are they?

2. What types of payments does your practice currently accept?
    a. How would you describe the breakdown of payments your patients present with?
    b. Have you worked with a DCO/CCO in your area?

3. How would you describe your current capacity to take on more patients?
    a. What does your wait time for a new appointment look like?
    b. What are barriers to taking on more patients? (e.g., limited space, staff capacity, COVID catch-up)

4. Does your practice currently accept Medicaid or Oregon Health Plan (OHP) insurance?

If yes:	**If no:**

• What are specific reasons your practice does accept OHP or Medicaid?
• Do you know how long your practice has accepted OHP or Medicaid?
• What has been your experience like filing OHP claims? Reimbursement process?
  ○ What barriers have you experienced accepting OHP or Medicaid?
  ○ What are the most common procedures billed at your practice? What does the OHP reimbursement rate look like for those?
• What are your future plans for OHP or Medicaid acceptance?
• From your practice's perspective, what would make accepting OHP or Medicaid easier?
• Capitated v fee for service
	• What are specific reasons your practice does not accept OHP or Medicaid? (e.g., reimbursement rates, administrative burden, staff or space capacity, limited-service coverage, population characteristics)
	• Do you know if your practice has accepted OHP or Medicaid in the past? If so, when? What was that experience like?
	• What do you tell OHP patients if they ask to be seen? Do you know where to refer OHP patients in your community?
	• From your practice's perspective, what are the biggest barriers to serving OHP patients?
	• Again, from your practice's perspective, what are some ways that could alleviate those barriers?

	• Is there anything that would make your practice consider accepting OHP or Medicaid? If so, tell me more about that.

5. What else would you like us to know about OHP/Medicaid and your practice?

6. Are there are any other providers in your community that you think we should talk to? We won't share anything about this interview or your name with anyone we reach out to.

Closing

That's all the questions I have, what questions do you have for me?

Thank you for your participation. We greatly appreciate your time and honesty. We will be following up with a gift card ($75) in appreciation for your time, is there an email or way to send it to you that works best?

We will be summarizing and sharing these results with OHA, who may use this information to try to improve the OHP process for dental. If you have any questions, you can email us at evaluation@ohsu.edu.

CITATIONS

[i] DiPrete, Bob, and Darren Coffman. 2007. *A Brief History of Health Services Prioritization in Oregon.* Oregon Health Authority. https://www.oregon.gov/oha/HPA/DSI-HERC/Documents/Brief-History-Health-Services-Prioritization-Oregon.pdf (Accessed September 10, 2024).

[ii] Kaiser Family Foundation (KFF). "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." April 2024. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[iii] Oregon Health Authority. "Dental Coverage Awareness Toolkit. KFF. "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." April 2024. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[iv] ADA Health Policy Institute. August 2023. "Medicaid Reimbursement for Dental Care Services- 2022 data update" https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid_reimbursement_dental_care_2022.pdf?rev=16c2f572ec974b01a787949294187ac6&hash=5869A65C6E259FED5733ECFEB5181E34.

[v] Vujicic M, Nasseh K, Fosse C. Dentist Participation in Medicaid: How Should It be Measured? Does It Matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf.

[vi] ADA Health Policy Institute. "Dental Care Utilization Rate for Children." https://www.ada.org/resources/research/health-policy-institute/child-dental-care-utilization-dashboard.

[vii] Vujicic M, Nasseh K, Fosse C. Dentist Participation in Medicaid: How Should It be Measured? Does It Matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf.

From: Ginny Jorgensen
To: PRISBY Stephen * OBD
Cc: SMORRA Angela * OBD
Subject: Re: Division 42
Date: Tuesday, November 5, 2024 8:19:38 AM
Attachments: image.png
ORCR 6-month rule.docx

Good morning,

I've attached the suggestion from DANB for the 6 month options...I think they look pretty good.

They also asked if we have decided on a certificate fee?

Thank you.
Ginny

On Wed, Oct 30, 2024 at 10:10 AM PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov> wrote:

> Thank you for the in-depth review! Enjoy your travels.
>
> With HB 3223 Section 2 effective July 1, 2025, we may need to redo a lot of Division 42 and many ways we regulate DA in Oregon.
>
> **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.
>
> Sincerely,
> Stephen
>
> ---
>
> **From:** Ginny Jorgensen <ginjorge53@gmail.com>
> **Sent:** Wednesday, October 30, 2024 6:29 AM
> **To:** SMORRA Angela * OBD <Angela.SMORRA@obd.oregon.gov>
> **Cc:** PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>

Subject: Division 42

Good morning Dr. Smorra,

I wanted you to know I have been investigating:) the wording of the "6-month" requirement and spoke with Jen Price, DANB/DALE F. and a DA instructor colleague regarding the statement/rule:

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 RHS or 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.

It seems a little complicated. Jen's team is going to meet tomorrow to discuss what their suggestions might be to reduce the confusion and rewrite a requirement that is easily understood and implemented for both OBD and DANB.

Here are some things to consider:

1. The RHS is a national exam and can be taken by anyone 18 and over. There are no requirements so DANB does not have a record nor do they want to keep a record of who has taken a course that is required in Oregon.
2. The start point of the 6-months would have to be connected to the date the applicant passed the RHS exam. (or EFDA exam)
3. Applicants cannot retake the RHS exam for 5 years if they were successful in passing the first time. This of course is to prevent people from taking the exam over and over and sharing the content with others. However, if, for example, a dental assistant wants to become a CDA (national certification) and they have been an EFDA for over 5 years, they would be required to retake the RHS exam and the other two exams: ICE & the General Chairside to obtain the CDA credential.
4. The original reason for having the 6-month time limit was due to the fact that DA's were not completing the RHS certificate application letter that included the endorsement letter or the EFDA Checkoff list... ever. Sometimes it's because they just forget to send in the DANB certificate application with the forms and the $50 fee and sometimes it's because they may have passed the written exam but have never completed a letter or check off list and didn't feel they needed to. Dentists don't typically ask for DA certificates although it's required they are to be posted. Most don't seem to know that and maybe because there is no discipline connected to it that it might not seem important..."just a certificate not a license". I believe the second reason is why the 6-month limit was added; to prevent this from happening without consequences. Why have clinical competency if it's not enforced? Oregon has always wanted there to be a demonstration of skill competency for those who graduate from non-CODA programs or OJT's. I believe this is really important. I spent 6 years at KP requiring job applicants to demonstrate their skills and it was amazing how many EFDA's couldn't perform the basics. That was before the skills check offs were required. It would be interesting to see if it has changed.
5. I spoke with a DA instructor colleague who agreed that this is a hard one to track. The letter OBD recently received from the assistant who went past the 6 months was just

> an honest assistant...otherwise DANB would not have noticed the delay between the exam date and the certificate application which means most likely she would have slid through. DANB currently does not track non-compliance of the 6-month limit.

It seems there is really no other way to track the 6 months except for having DANB confirm the written exam completion date when they receive the certificate application. So if the applicant is out of compliance (past 6 months) there should be a consequence. I'm not exactly sure what that should be. If it's a late fee, who will collect it? DANB or OBD? Who will keep track? How much more time will they have to complete the letter/endorsement form? Another 6 months? 30 days? YIKES! This can get complicated and I would highly suggest we wait to hear from the DANB team to get their feedback after their meeting tomorrow.

I know Stephen will cringe but it would sure be nice to track OR-EFDA's:)

Okay...that's all I know for now.

I'm heading out of town tomorrow for a few days but will be back next Tuesday. Whatever information I receive, I will share with you.

Thank you.
Ginny

ORCR pathway 1 (penalty is retaking course)

**Upon completion of both an Oregon Board approved radiography course and passing an approved exam (whichever is more recent), a dental assistant is authorized to perform radiographic procedures for six months under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency (ORCR) Certificate. The authorized dental assistant must submit the ORCR certificate application and included proficiency verification form to DANB within that 6-month period or they are no longer able to perform radiographs until they earn the ORCR certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their ORCR certificate, they will need to retake an OBD-approved radiography course and submit documentation of that new course completion to DANB to become eligible to earn the ORCR certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

Or

ORCR pathway 1 (penalty is direct vs indirect supervision)

**Upon completion of both an Oregon Board approved radiography course and passing an approved exam (whichever is more recent), a dental assistant is authorized to perform radiographic procedures for six months under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency (ORCR) Certificate. The authorized dental assistant must submit the ORCR certificate application and included proficiency verification form to DANB within that 6-month period or they are no longer able to perform radiographs until they earn the ORCR certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their ORCR certificate, they will <u>ONLY</u> be able to perform radiographic procedures under <u>DIRECT</u> supervision of a licensed <u>dentist</u> or <u>dental hygienist</u> until they submit the ORCR certificate application and included radiologic proficiency verification form to DANB and earn the ORCR certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFDA pathway 1

Upon completion of a CODA-accredited dental assisting program*, a dental assistant is authorized to perform expanded function duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFDA pathway 1 certificate application and CODA graduation documentation to DANB within that 6-month period or they are no longer able to perform expanded function duties under indirect supervision until they earn the EFDA certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their EFDA certificate, they will ONLY be able to perform expanded function duties under DIRECT supervision of a licensed dentist until they submit the EFDA certificate pathway 1 application and CODA graduation documentation and earn the EFDA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFDA pathway 2/3

**Upon passing the required exam(s), a dental assistant is authorized to perform expanded function duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFDA certificate application and included Licensed Dentist Endorsement form to DANB within that 6-month period or they are no longer able to perform expanded function duties under indirect supervision until they earn the EFDA certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their EFDA certificate, they will ONLY be able to perform expanded function duties under DIRECT supervision of a licensed dentist until they submit the EFDA certificate application and included Licensed Dentist Endorsement form to DANB and earn the EFDA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFODA pathway 1

Upon completion of a CODA-accredited dental assisting program*, a dental assistant is authorized to perform expanded function orthodontic duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFODA pathway 1 certificate application and CODA graduation documentation to DANB within that 6-month period or they are no longer able to perform expanded function orthodontic duties under indirect supervision until they earn the EFODA certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their EFODA certificate, they will ONLY be able to perform expanded function orthodontic duties under DIRECT supervision of a licensed dentist until they submit the EFODA certificate pathway 1 application to DANB and earn the EFODA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFODA pathway 2/3

Upon passing the required exam(s), a dental assistant is authorized to perform expanded function orthodontic duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFODA certificate application and included licensed dentist endorsement form to DANB within that 6-month period or they are no longer able to perform expanded function orthodontic duties under indirect supervision until they earn the EFODA certificate.

If a dental assistant goes beyond the 6-month authorization period without earning their EFODA certificate, they will ONLY be able to perform expanded function orthodontic duties under DIRECT

supervision of a licensed dentist until they submit the EFODA certificate application and included licensed dentist endorsement form to DANB and earn the EFODA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFPDA pathway 1

Upon completion of a CODA-accredited dental assisting program*, a dental assistant is authorized to perform expanded preventive duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFPDA pathway 1 certificate application and CODA graduation documentation to DANB within that 6-month period or they are no longer able to perform expanded function preventive duties under indirect supervision until they earn the EFPDA certificate.*

If a dental assistant goes beyond the 6-month authorization period without earning their EFPDA certificate, they will ONLY be able to perform expanded function preventive duties under DIRECT supervision of a licensed dentist until they submit the EFPDA certificate pathway 1 application and CODA graduation documentation and earn the EFPDA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

EFPDA pathway 2/3

Upon passing the required exam(s), a dental assistant is authorized to perform expanded function preventive duties under the indirect supervision of a dentist for six months. The authorized dental assistant must submit the EFPDA certificate application and included licensed dentist endorsement form to DANB within that 6-month period or they are no longer able to perform expanded function preventive duties under indirect supervision until they earn the EFPDA certificate.

If a dental assistant goes beyond the 6-month authorization period without earning their EFPDA certificate, they will ONLY be able to perform expanded function preventive duties under DIRECT supervision of a licensed dentist until they submit the EFPDA certificate application and included licensed dentist endorsement form to DANB and earn the EFPDA certificate.

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

Indirect Supervision: *A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.*

From: Molina, Bernadette <molinab@ada.org>
Sent: Thursday, November 7, 2024 2:36 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc: Molina, Bernadette <molinab@ada.org>
Subject: State Board Participation on 2025 Accreditation Site Visits - OR

Dear Mr. Prisby:

The Commission on Dental Accreditation (CODA) would like to extend an invitation to your State Board for participation in the upcoming 2025 site evaluation. To aid the Commission in preparing for the site visit evaluation, please complete the attached "***Confirmation of State Board Participation***" form and return it by **December 9, 2024**. **If additional time is needed, please let me know**.

The institutions listed below have indicated a willingness to have a representative of your state board participate in CODA's 2025 on-site evaluations of the following dental education programs:

Dental Hygiene Education Accreditation Site Visit:

2/26/2025 to 2/27/2025
Concorde Career College-Portland
Portland, OR

General Practice Residency Education Accreditation Site Visits:

4/9/2025
Oregon Health & Science University School of Dentistry
Portland, OR

9/25/2025
VA Portland Healthcare System
Portland, OR

Dental Hygiene and Dental Assisting Education Accreditation Site Visit:

11/12/2025 to 11/14/2025
Portland Community College
Portland, OR

Appointment Process: In accordance with the attached policy statement for state board participation on site visit teams, the state board of dentistry is requested to submit the names of ***two*** representatives who are ***current members*** of the board for each site visit listed. The Commission will then ask the institution to select ***one*** individual to participate on the visit. You will be notified when the institution has selected a representative. Prior to the visit, the representative will receive an informational packet from the Commission and the self-study document from the institution.

Confirmation of State Board Participation Form (to be returned): The board of dentistry is requested to complete this form for each program identified above. It must be returned by the due date, regardless of whether the response from the State Board is yes or no.

Once the completed form is received, we will notify the institution of your availability to participate. **Please note, the state board reimburses its members for ALL expenses incurred during the site visit**.

Conflicts of Interest: When selecting its representatives, the state board should consider possible conflicts of interest. These conflicts may arise when the representative has a family member employed by or affiliated with the institution; or has served as a current or former faculty member, consultant, or in some other official capacity at the institution. Please refer to the enclosed policy statements for additional information on conflicts of interest.

Time Commitment: **It is important that the selected representative be fully informed regarding the time commitment required**. In addition to time spent reviewing program documentation in advance of the visit, the representative **should be available the evening before the visit to meet with the Commission's site visit team**. Only one state board representative may attend each site visit to ensure that continuity is maintained; the representative is expected to be present for the entire visit.

Confidentiality and Distribution of Site Visit Reports: Please note that, as described in the enclosed documents, state board representatives attending CODA site visits must consider the program's self-study, site visit report, and all related accreditation materials confidential. Release of the self-study, report, or other accreditation materials to the public, including the state board, is the prerogative of the institution sponsoring the program. **State Board representatives who attend a site visit will be requested to sign a confidentiality agreement. If the confidentiality agreement is not signed, the individual will not be allowed to attend the site visit.**

If the Commission can provide further information regarding its site visit evaluation process, please feel free to contact me. Thank you in advance for your efforts to facilitate the board's participation in the accreditation process.

Attachment: *(to be returned by December 9, 2024)*

- *Confirmation of State Board Participation Form*

Additional Informational Documents:

- *Policy on State Board Participation and Role During a Site Visit*
- *Policy on Conflict of Interest*
- *Policy on Public Disclosure and Confidentiality*
- *Name or Contact Information Change Form*

Thank you,
Bernadette

Bernadette Molina molinab@ada.org
Site Visit Coordinator
Commission on Dental Accreditation (CODA)
312-440-2668 Office

Commission on Dental Accreditation
Confirmation of State Board Participation
on Dental Education Site Visits

Name of Institution: _____

Program(s) to be Evaluated: _____

Dates of Site Evaluation: _____

To aid the Commission in preparing for the site evaluation noted above, please promptly check the appropriate statements and complete the information requested **or call if additional time is needed.**

_____ The State Board is unable to participate in the site evaluation.

_____ The State Board wishes to participate in the site evaluation and submits the following names of current Board members for the institution's consideration.

Name:	_____	Name:	_____
Home Address:	_____	Home Address:	_____
City:	_____	City:	_____
State/Zip:	_____	State/Zip:	_____
Cell /Phone:	_____	Cell/Phone:	_____
Fax:	_____	Fax:	_____
E-Mail:	_____	E-Mail:	_____

Authorized Signature _____ Date: _____

Name: _____

Title: _____

Phone: _____ E-Mail: _____

Return by email to molinab@ada.org

Attn: Ms. Bernadette Molina
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

EXECUTIVE DIRECTOR CHANGES

If the Executive Director of your State Board has changed, or if the contact information for your current Executive Director has changed, please indicate as such below:

Contact Information for **New** Executive Directors (add new contact information below):

Name of State Board: _____

Name of New Exec Director: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Contact Information Updates for **Current** Executive Directors (update as appropriate):

Name of State Board: _____

Name of Current Exec Director: _____

Updated Address: _____

Updated City, State, Zip: _____

Updated Phone: _____

Updated Email: _____

_____

Return by email to molinab@ada.org

Attn: Ms. Bernadette Molina
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

CODA
Commission on Dental Accreditation

L. POLICY ON STATE BOARD PARTICIPATION DURING SITE VISITS

It is the policy of the Commission on Dental Accreditation that the state board of dentistry is notified when an accreditation visit will be conducted in its jurisdiction. The Commission believes that state boards of dentistry have a legitimate interest in the accreditation process and, therefore, strongly urges institutions to invite a current member of the state board of dentistry to participate in Commission site visits. The Commission also encourages state boards of dentistry to accept invitations to participate in the site visit process.

If a state has a separate dental hygiene examining board, that board will be contacted when a dental hygiene program located in that state is site visited. In addition, the dental examining board for that state will be notified.

The following procedures are used in implementing this policy:

1. Correspondence will be directed to an institution notifying it of a pending accreditation visit and will include a copy of Commission policy on state board participation. The institution is urged to invite the state board to send a current member. The Commission copies the state board on this correspondence.
2. The institution notifies the Commission of its decision to invite/not invite a current member of the state board. If a current member of the state board is to be present, s/he will receive the same background information as other team members.
3. If it is the decision of the institution to invite a member of the state board, Commission staff will contact the state board and request the names of at least two of its current members to be representatives to the Commission.
4. The Commission provides the names of the two state board members, to the institution. The institution will be able to choose one of the state board members. If any board member is unacceptable to the institution, the Commission must be informed in writing.
5. The state board member, if authorized to participate in the site visit by the institution, receives the self-study document from the institution and background information from the Commission prior to the site visit.
6. The state board member must participate in all days of the site visit, including all site visit conferences and executive sessions.
7. The state board member serves as a silent observer in all sessions except executive sessions with the site visit team.
8. In the event the chair of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, only team members representing the Commission will be allowed to vote.
9. The state board reimburses its member for expenses incurred during the site visit.

The following statement was developed to assist state board members by clearly indicating their role while on-site with an accreditation team and what they may and may not report following a site visit. The statement is used on dental education, advanced dental education and allied dental education site visits. The state board member participates in an accreditation site visit in order to develop a better understanding of the accreditation site visit process and its role in ensuring the competence of graduates for the protection of the public. The dental, advanced dental and allied dental education programs are evaluated utilizing the Commission's approved accreditation standards for each respective discipline.

The state board member is expected to be in attendance for the entire site visit, including all scheduled conferences and during executive sessions of the visiting committee. While on site the state board member:

- provides assistance in interpreting the state's dental practice act and/or provides background on other issues related to dental practice and licensure within the state.
- on allied dental education visits: assists the team in assessing the practice needs of employer-dentists in the community and in reviewing those aspects of the program which may involve the delegation of expanded functions.
- on dental school visits: functions primarily as a clinical site visitor working closely with the clinical specialist member(s) who evaluate the adequacy of the preclinical and clinical program(s) and the

clinical competency of students.

Following the site visit, state board members may be asked to provide either a written or oral report to their boards. Questions frequently arise regarding what information can be included in those reports while honoring the Agreement of Confidentiality that was signed before the site visit. The following are some general guidelines:

- What You May Share:
  - Information about the Commission's accreditation standards, process and policies.

- What You May Not Share:
  - The school's self-study;
  - Previous site visit reports and correspondence provided to you as background information;
  - Information revealed by faculty or students/residents during interviews and conferences;
  - The verbal or written findings and recommendations of the visiting committee; and
  - Any other information provided in confidence during the conduct of an accreditation visit.

The Commission staff is available to answer any questions you may have before, during or after a site visit.

Revised: 2/24; 7/09, 1/00; Reaffirmed: 8/24; 8/19; 8/10, 7/07, 7/04, 7/01, 12/82, 5/81, 12/78, 12/75;
Adopted: 8/86

CONFLICT OF INTEREST POLICY

Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission's operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, site visitors, and Commission staff.

In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

On occasion, current and former volunteers involved in the Commission's accreditation process (site visitors, review committee members, commissioners) are requested to make presentations related to the Commission and its accreditation process at various meetings. In these cases, the volunteer must make it clear that the services are neither supported nor endorsed by the Commission on Dental Accreditation.
Further, it must be made clear that the information provided is based only on experiences of the individual and not being provided on behalf of the Commission.

Revised: 8/15; 8/14; Reaffirmed: 8/23; 8/18; 2/18; 8/12, 8/10

1. Visiting Committee Members: Conflicts of interest may be identified by either an institution/program, Commissioner, site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, site visitor or Commission staff because of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict.

All active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the

Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. Following service on the site visit team, an active site visitor is prohibited from independently consulting with the program that they evaluated within the past ten (10) years. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.

Conflicts of interest include, but are not limited to, a site visitor who:

- is a graduate of the institution;
- has served on the program's visiting committee within the last seven (7) years;
- has served as an independent consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is a former employee of the institution or program;
- previously applied for a position at the institution within the last five (5) years;
- is affiliated with an institution/program in the same state as the program's primary location;
- is a resident of the state; and/or
- is in the process of considering, interviewing and/or hiring key personnel at the institution.

Note: Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual's assignment for other reasons.

If an institutional administrator, faculty member or site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chair, Vice-Chair and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 8/24; 2/24; 2/21; 8/18; 2/18; 2/16; 8/14; 1/14; 2/13; 8/10; Reaffirmed: 8/23; 8/12

2. Commissioners, Review Committee Members And Members Of The Appeal Board:
The Commission firmly believes that conflict of interest or the appearance of a conflict of interest must be avoided in all situations in which accreditation recommendations or decisions are being made by Commissioners, Review Committee members, or members of the Appeal Board. No Commissioner, Review Committee member, or member of the Appeal Board should participate in any way in accrediting decisions in which he or she has a financial or personal interest or, because of an institutional or program association, has divided loyalties and/or has a conflict of interest on the outcome of the decision.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review process. This applies only to site visits that would be considered by the same review committee on which the site visitor is serving. Review committee members may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, review committee members may not serve as a site visitor for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner or appeal board member, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, Commissioners or appeal board may not serve on a site visit team during

their terms.

Areas of conflict of interest for Commissioners, Review Committee members and/or members of the Appeal Board include, but are not limited to:

- close professional or personal relationships or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as an independent consultant or mock site visitor to the institution/program;
- being a graduate of the institution/program;
- being a current employee or appointee of the institution/program;
- previously applied for a position at the institution within the last five (5) years;
- being a current student at the institution/program;
- having a family member who is employed by or affiliated with the institution;
- manifesting a professional or personal interest at odds with the institution or program;
- key personnel of the institution/program having graduated from the program of the Commissioner, Review Committee member, or member of the Appeal Board;
- having served on the program's visiting committee within the last seven (7) years; and/or
- no longer a current employee of the institution or program but having been employed there within the past ten (10) years.

To safeguard the objectivity of the Review Committees, conflict of interest determinations shall be made by the Chair of the Review Committee. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Review Committee member has a conflict of interest in connection with a particular program, the Review Committee member will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any committee member who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Commission, conflict of interest determinations shall be made by the Chair of the Commission. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Commissioner has a conflict of interest in connection with a particular program, the Commissioner will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any Commissioner who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Appeal Board, any member who has a conflict of interest in connection with a program filing an appeal must inform the Director of the Commission. The Appeal Board member will be instructed to not access the report for that program either in advance of or at the time of the meeting, and the individual must leave the room when the program is being discussed. If necessary, the respective representative organization will be contacted to identify a temporary replacement Appeal Board member. Conflicts of interest for Commissioners, Review Committee members and members of the Appeal Board may also include being from the same state, but not the same program. The Commission is aware that being from the same state may not itself be a conflict; however, when residence within the same state is in addition to any of the items listed above, a conflict would exist.

This provision refers to the concept of conflict of interest in the context of accreditation decisions. The prohibitions and limitations are not intended to exclude participation and decision-making in other areas, such as policy development and standard setting.

Commissioners are expected to evaluate each accreditation action, policy decision or standard adoption for the overall good of the public. The American Dental Association (ADA) Constitution and Bylaws limits the involvement of the members of the ADA, the American Dental Education Association and the American Association of Dental Boards in areas beyond the organization that appointed them. Although Commissioners are appointed by designated communities of interest, their duty of loyalty is first and foremost to the Commission. A conflict of interest exists when a Commissioner holds appointment as an officer in another organization within the Commission's communities of interest. Therefore, a conflict of interest exists when a Commissioner or a Commissioner-designee provides simultaneous service to the Commission and an organization within the communities of interest. (Refer to Policy on Simultaneous Service)

Revised: 2/21; 8/16; 2/16; 2/15; 8/14; 1/14, 8/10; Reaffirmed: 8/23; 8/18; 8/12

3. Commission Staff Members: Although Commission on Dental Accreditation staff does not participate directly in decisions by volunteers regarding accreditation, they are in a position to influence the outcomes of the process. On the other hand, staff provides equity and consistency among site visits and guidance interpreting the Commission's policies and procedures.

For these reasons, Commission staff adheres to the guidelines for site visitors, within the time limitations listed and with the exception of the state residency, including:

- graduation from a dental program at the institution within the last five (5) years;
- service as a site visitor, employee or appointee of the institution within the last five (5) years; and/or
- close personal or familial relationships with key personnel in the institution/program which would from the standpoint of a reasonable person, create the appearance of a conflict.

Revised: 2/24; 8/14; 8/10, 7/09, 7/07, 7/00, 7/96, 1/95, 12/92; Reaffirmed: 8/23; 8/18; 8/12, 1/03; Adopted: 1982

E. CONFIDENTIALITY POLICY

All materials generated and received in the accreditation process are confidential. In all instances Protected Health Information (PHI), Personally Identifiable Information (PII) and student/resident/fellow identifying information must not be improperly disclosed. The Commission's confidentiality policies apply to Commissioners, Review Committee members, members of the Appeal Board, and site visitors. Confidential materials are maintained to ensure the integrity of the institution/program and of the accreditation process, and may be shared by the Commission in instances related to USDE re-recognition or responding to state or federal legal requirements, as appropriate. Because of the confidential nature of the accreditation process, the Commission identifies three (3) points of contact with whom Commission staff is authorized to communicate, either in writing or verbally. These individuals are designated by the sponsoring institution and include the chief executive officer (university president/chancellor/provost or medical center director), the chief academic officer (dean/academic dean/chair/chief of dental service, etc.), and the program director. Commission staff is not authorized to discuss program-specific situations or share confidential material with any other individual(s).

Confidentiality applies without limitation, to the following:

SELF-STUDY DOCUMENT: At the discretion of the institution, the administration may either release information from this document to the public or keep it confidential. The Commission will not release the self-study document.

SITE VISIT REPORT**:** The preliminary draft of a site visit report is an unofficial document and remains confidential between the Commission and the institution's executive officers and may not, under any circumstances, be released. Members of a visiting committee who review preliminary drafts of the report must consider the report as privileged information and must not discuss it or make its contents known to anyone, under any circumstances. Oral comments made by site visit team members during the course of the site visit are not to be construed as official site visit findings unless documented within the site visit report and may not be publicized. Further, publication of site visit team members' names and/or contact information is prohibited. Reasons for assigning any non-adverse status other than full approval remain confidential between the institution and the Commission unless the institution wishes to release them. Public release of the final draft of the site visit report that is approved by the Commission is at the sole discretion of the institution. If there is a point of contention about a specific section of the final site visit report and the institution elects to release the pertinent section to the public, the Commission reserves the right to make the entire site visit report public.

INSTITUTION'S RESPONSE TO A SITE VISIT REPORT: Release of this information is at the sole discretion of the institution. An institution's response must not improperly disclose any Protected Health Information; however, if any such information is included in the response, such information will not be made public.

TRANSMITTAL LETTER OF ACCREDITATION NOTIFICATION: Information such as accreditation status granted and scheduled dates for submission of additional information is public information. However, release of other information or details is at the sole discretion of the institution and will not be disclosed by the Commission.

PROGRESS REPORT: The scheduled date for submission of progress reports is public information. Release of the content of a progress report is at the sole discretion of the institution. If there is a point of contention about a particular portion of the progress report and the institution elects to release the pertinent portion to the public, the Commission reserves the right to make public the entire progress report. Progress reports must not disclose Protected Health Information (PHI) or Personally Identifiable Information (PII).

SURVEYS: Routinely gathered data are used in the accreditation process and also provide a national data base of information about the accredited dental and dental-related educational programs. The Commission may release to the public any portion of survey data that is collected annually unless the terms of confidentiality for a specific section are clearly indicated on the survey instrument. Subsections of each survey instrument containing data elements which are confidential are clearly marked. Any data which may be reported from confidential subsections are published in a manner which does not allow identification of an individual institution/program.

EXIT INTERVIEWS: The final conference or exit interview between the site visit committee and the chief executive officer, dental dean, chief of dental service or the program director(s) is also confidential. Additional people may be included at the discretion of the institutional administration. The interview is a confidential summation of the preliminary findings, conclusions, recommendations and suggestions which will appear in the site visit report to the institution. This is a preliminary oral report and the preliminary written report is often only in draft stage at this point; therefore, this session may not be recorded in either audio or video format. Note taking is permitted and encouraged.

ON-SITE INTERVIEWS AND ORAL COMMUNICATIONS: In order to carry out their duties as on-site evaluators, visiting committee members must communicate freely with administrators, faculty, staff and students and any other appropriate individuals affiliated with an education program. As part of their on-site accreditation duties, committee members are expected to share with other team members pertinent and relevant information obtained during interviews. All oral communications occurring on-site, however, are confidential. Interviews may not be recorded in either audio or video format. Note taking is permitted and encouraged. When the site visit ends, team members may communicate orally, or in writing, only with Commission staff or other team members about any on-site interview or conversation. All questions related to any aspect of the site visit including oral communications must be referred to the Commission office.

MEETING MATERIALS/DISCUSSIONS: Background reports and informational materials related to accreditation matters are regularly prepared for review by the Commission and its Review Committees. These materials and all discussions related to accreditation matters routinely remain confidential. All Ad Hoc and Standing Committee meeting materials remain confidential unless the Commission determines the materials warrant public distribution. The Commission determines when, and the manner in which, newly adopted policy and informational reports will receive public distribution.

PROTECTED HEALTH INFORMATION: Patients' protected health information, which includes any information that could identify an individual as a patient of the facility being site visited, may not be used by the site visitors, Review Committee members, or Commissioners for any purpose other than for evaluation of the program being reviewed on behalf of the Commission. Protected Health Information may not be disclosed to anyone other than Commissioners, Commission staff, Review Committee members or site visitors reviewing the program from which the Protected Health Information was received. Individual Protected Health Information should be redacted from Commission records whenever that information is not essential to the evaluation process. If a site visitor, Review Committee member, or Commissioner believes any Protected Health Information has been inappropriately used or disclosed, he/she should contact the Commission office.

MEETINGS: Policy portions of the Review Committee and Commission meetings are open to observers, while accreditation actions are confidential and conducted in closed session. All Ad Hoc and Standing Committee meetings, and all meetings related to CODA operations are confidential and conducted in closed session. All deliberations of the Appeal Board are confidential and conducted in closed session.

NOTICE OF REASONS FOR ADVERSE ACTION: Notice of the reasons for which an adverse accreditation action (i.e. deny or withdraw) is taken is routinely provided to the Secretary of the U.S. Department of Education, any appropriate state agencies, and, upon request, to the public.

Revised: 8/23; 8/20; 8/18; 2/18; 2/16; 8/14; 1/05, 2/01, 7/00; Reaffirmed: 8/12, 8/10; Adopted: 7/94, 5/93

F. POLICY ON PUBLIC DISCLOSURE

Following each meeting, final accreditation actions taken with respect to all programs, are disclosed to all appropriate agencies, including the general public. The public includes other programs or institutions, faculty, students and future students, governing boards, state licensing boards, USDE, related organizations, federal and state legislators and agencies, members of the dental community, members of the accreditation community and the general public. In general, it includes everyone not directly involved in the accreditation review process at a given institution**.**

If the Commission, subsequent to and following the Commission's due process procedures, withdraws or denies accreditation from a program, the action will be so noted in the Commission's lists of accredited programs. Any inquiry related to application for accreditation would be viewed as a request for public information and such information would be provided to the public. The scheduled dates of the last and next comprehensive site visits are also published as public information.

The Commission has procedures in place to provide a brief statement summarizing the reasons for which it takes an adverse accreditation action. If initial accreditation were denied to a developing program or accreditation were withdrawn from a currently accredited program, the reasons for that denial would be provided to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and to the public. In addition, the official comments that the affected institution or program may wish to make with regard to that decision, or evidence that the affected institution has been offered the opportunity to provide official comment will also be made available to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and to the public

All documents relating to the structure, policies, procedures, and accreditation standards of the Commission are available to the public upon written request. Other official documents require varying degrees of confidentiality.

Revised: 1/05, 2/01, 7/00; Reaffirmed: 8/23; 8/18; 8/12, 8/10; Adopted: 7/94, 5/93

NEWSLETTERS & ARTICLES OF INTEREST

The CRDTS Report

Over 50 Years of Testing Excellence

Central Regional Dental Testing Service, Inc. Fall 2024

Otto Dohm, DDS
President

FOOT ON THE GAS!

Happy Fall! Days are getting shorter and cooling off. Hope everyone enjoyed the Annual Meeting and got a chance to catch up with friends and take in some great continuing education. Thanks to everyone that made it possible.

Volume 20, Issue 2

The last few years have been challenging to say the least. Through the tremendous effort of our central office staff, professional staff and our countless volunteers, we have managed to position our organization very well for the uncertain future. We have industry leading hygiene examinations and continue to expand the schools where we test and the offerings we provide to these schools and to state boards. The dental examination continues to evolve in this age of simulated patient exams, and we are adding more and more exams to our schedule as word-of-mouth spreads about the benefits of the CRDTS examinations.

Through the foresight of some of the leaders of this organization we have developed the third point of a trident. The Special Programs Division of CRDTS is experiencing tremendous growth as we continue to develop and offer CARE (Calibration, Administration, Remediation and Re-education) to individuals and at the request of State Boards. To say the growth is exponential is to understate. We continue to develop new programming, i.e. CAMP (Calibration And Methodology Program), and exams for Dental Therapy, in response to requests from State Boards and schools we serve.

Sounds pretty good, right? It is, but challenges remain. We exist in an environment where professional licensure and examinations are changing daily. There are statewide licensing compacts, states that no longer require testing if you graduate from a school within that state, and folks who do not understand the importance of clinical licensure examinations. These changes are being driven by factors that are often outside the input of the dental professional. We can only control what we do, but we can educate others for the good of our profession. Some things are going to change despite our efforts. We must continue to be innovative leaders in simulated examination development and constantly improve our offerings to State Boards. The development and expansion of our special programs will continue to be a priority so that we can meet the needs of our profession and State Boards.

CRDTS is known for absolute integrity and professionalism. We will not compromise our principles in the misguided hope that we can affect some of the things we see changing. That is not our way forward.

As President of CRDTS, I will continue to charge the leadership with holding our course steady and keeping our foot on the gas. Stay tuned for more exciting developments from CRDTS!

Otto Dohm, DDS
President

Sheli Cobler, Executive Director

IF YOU HAVEN'T ALREADY HEARD, CRDTS IS DOING AMAZING THINGS!

The CRDTS Dental Hygiene Examination continues to add hygiene programs to the number of sites we administer the exam at. If you do not offer the CRDTS Dental Hygiene examination at your program, I encourage you to talk with peers at schools that do offer the CRDTS exam. What you will find is that CRDTS is second to none in the quality of our dental hygiene examination, our local anesthesia examination, the restorative auxiliary exam, and in the personal and professional manner in which we work with faculty members and students to help achieve the best outcome possible. Kelly Mandella, Director of Dental Hygiene Examinations, Trelawny Saldana, Assistant Director, or any of the professionals at Central Office would be happy to visit with you and provide more information. Give your students the best option in clinical licensure examinations!

Just as exciting is the number of dental exams being administered by CRDTS, which has grown significantly and continues to grow each year! If your school is not scheduled to host the CRDTS Dental Examination, you will want to contact us to learn more about the benefits to your school and your students. Among the things that set us apart is onsite grading – results are provided within hours of the examination-, next day retakes with the first part being complementary, and again, the professional, compassionate and personal touch that CRDTS is known for. We also have the unique ability to customize exam schedules to fit your school's needs. Feel free to reach out to Dr. Mark Edwards, Director of Dental Examinations or Central Office to schedule an exam or to learn more about the dental program.

Also, over the course of the past couple of years, CRDTS has developed several Special Programs to assist state dental boards with remediation needs, individual licensees with reeducation, and dental and dental hygiene schools with calibration and methodology. The Special Programs Division, led by Ms. Catrice Opichka, is growing rapidly and filling a void in dental education and remediation that is much needed through the CRDTS CARE Program. State dental boards across the nation now have a viable option for licensees coming before them. Even those who come reluctantly report that the program has helped them in many ways. They are reporting that their experience has been valuable, even when they did not believe they needed it initially. Furthermore, individual licensees who need additional education or reeducation for various reasons, such as an extended absence from their profession are finding the CARE Program to be very valuable. See the website for more information and testimony from attendees.

The Special Programs is more than CARE though. In the past couple of years, we have introduced the CAMP Program to schools to assist with Calibration And Methodology. If you do not know of this program, check it out on the crdts.org website under Special Programs. You will find the testimonies of those who have used the program to be positive and favorable. Ms. Opichka would be happy to hear from you if you have any questions or would like more information.

To say the past three years have flown by with excitement and progress is an understatement. There are still challenges and obstacles to face, but the CRDTS family is up for it. Standing strong together for what is right and just and doing it ethically is why we have seen so much success historically and in these recent few years.

That brings me to the exciting news that you may have already seen regarding the pending merger between CRDTS and SRTA! We are thrilled to be working toward becoming even **stronger together**. The CRDTS organization and the SRTA organization have each seen great success and have a rich history individually. Now we will bring the knowledge, education and experience from both groups together forming one agency. With like-minded philosophies, these two agencies will continue the excellence that state dental boards, schools and students have come to know. Watch the websites for more information about the merger as we work toward finalization.

Finally, as you may know CRDTS has had to take a stand against the two dental and dental hygiene compacts recently introduced, for very good reason. CRDTS is not against the idea of a compact but cannot support either of the two recent compacts as neither is in the best interest of the dental profession. I truly hope you will get involved and educate yourselves as to why states should not be passing either compact into legislation. Yes, the CSG compact has already been enacted after being passed through legislation in ten states thus far, and the AADB compact has been introduced in two states and is set to be introduced in several more states in 2025. However, it is not too late to get involved in protecting your state and your profession. You can learn more about the issues with these compacts on our website at crdts.org under news. Feel free to contact me as well, if you'd like to discuss the matter.

As always, I am grateful for the support of CRDTS and proud to be part of such a great organization full of hard-working ethical folks.

Sheli Cobler
CRDTS Executive Director

Mark Edwards, DDS, Director of Dental Examinations

Rod Hill, DDS, ERC Committee Chair

DENTAL NEWS

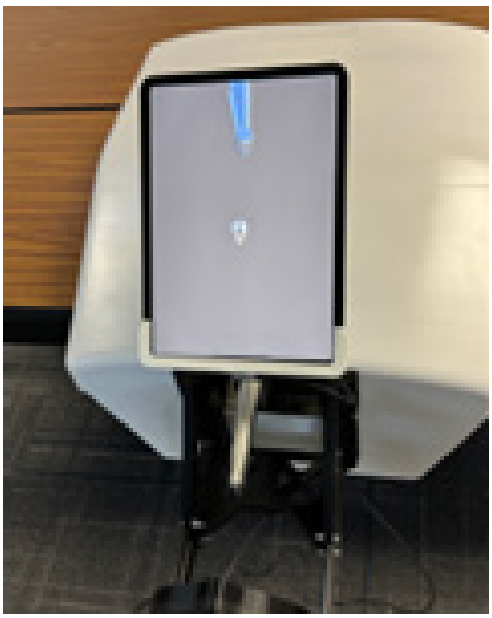
SIMtoCARE

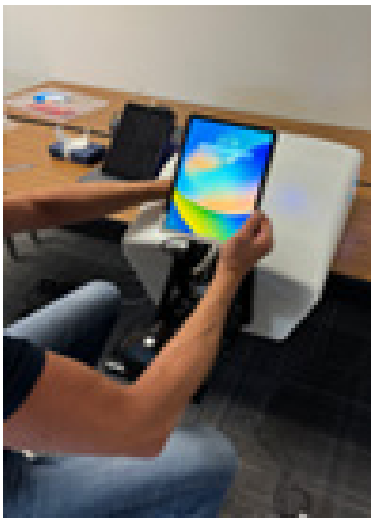
New and exciting programs are being developed through CRDTS association with virtual haptics and SIMtoCARE. Virtual haptics afford dental students more repetitions for procedures such as fixed prosthodontics, where limited patient numbers many times dictate minimal patient opportunities. When a patient cancellation occurs, a student can transition to a virtual haptic or manikin procedure, and potentially gain clinical credit for the lost clinical patient time. If the manikin preparation can be digitally scanned, or if it is performed on a virtual haptic machine, the work can be computer graded with results immediately available for the student and delivered to the faculty's computer desktop. SIMtoCARE has now begun to develop a virtual haptic desktop workstation that allows for unit portability and lowers cost, while giving students the benefit of a lifelike haptic feel.

Stay tuned for new and improved simulation programs for use in dental and dental hygiene education and as an option in specific parts of dental licensure examination. Please don't hesitate to reach out if further information is desired.

Mark Edwards, DDS
Director of Dental Examinations

Rod Hill, DDS
ERC Committee Chair





Lisa Kucera
DHERC Committee Chair

NEW DENTAL HYGIENE EXAM REVIEW COMMITTEE CHAIR

I would like to take this opportunity to introduce myself as the new Dental Hygiene Exam Review Committee Chair! I am very excited to start this new role and look forward to the challenges and opportunities it may bring.

One of the best decisions I have ever made was to become a dental hygienist. When I look back at my career, I can't believe how it has changed. The opportunities and doors my education has opened for me have been amazing. I've had the privilege to work in private practice, sales, education, and serving on the NE Board of Dentistry. One of my best opportunities was to become a CRDTS Examiner! I believe in CRDTS, we are ethical, honest, and well calibrated professionals. CRDTS operates like a well-oiled machine and I look forward to continuing this by adhering to the processes and products we have in place. I also want to help CRDTS grow and maintain its reputation. CRDTS started changing with the pandemic because we had to and now, we can't stop creating and improving our offerings through Testing, the CARE Program and CAMP. The organization is adding such positive forward-thinking enhancements and programs, that you will want to stay tuned into CRDTS (crdts.org) as we move forward.

My experience as the Secretary/Treasurer for CRDTS was invaluable. I believe it has helped prepare me for my new role as the Chair of DHERC. I realize what it takes to keep us all doing what we are here to do. Each of us are committed to the effort that goes into each Exam, CARE Program and CAMP as well as building new programs. Gaining a better understanding of the contribution everyone makes will be helpful as I assume my new role. I am thankful to the Central Office team who work so hard every day with only rare occasions of downtime.

Please don't ever hesitate to reach out to me with ideas and concerns for CRDTS generally or for the Dental Hygiene program specifically. Your input is appreciated.

Lisa Kucera
DHERC Committee Chair

Deena Kuempel, DDS
President Elect

HELLO FROM IOWA.....

Thank you all for your attendance and feedback concerning our annual meeting. The consensus was it was a great success. We did read and accumulate all suggestions for this year's meeting (GOOD, BAD or MEH) and will take that information going forward in planning next year's meeting. Andrew and Renee deserve great thanks for the effort they put into this event to try to meet everyone's needs. We hope that it was a great time to network, and that the continuing education provided will be of value for each of you in practice. As always it cannot be a success without you. We will continue to welcome your comments and input to make next year even better.

We are coming into the testing season, and we will all begin to be very busy with that. I am always proud to talk about CRDTS testing and the reliability and validity that we hang our hat on. The occupational analysis surveys are in and we look forward to the final data and what that may mean in changes to our examination. Without the commitment and dedication of all of our examiners we would not be continuing to mount a comeback in the dental testing arena. One BIG ask we have of our member representatives is to PLEASE continue to talk to your own State Boards and State Legislators about the Compacts. The most important thing they need to hear from you is that Compacts may be the future, and we have no problem with the concept, but that at the very least if they are truly about portability ALL testing agencies should be allowed to administer that regional test required by the compact. In most cases monopolies are not looked upon favorably, this seems to be the anomaly to that opinion. Your voice is our strongest ally and we would be grateful if you would continue to educate all parties on what portability really means to our new graduates and also continue to set the record straight on how many states already accept CRDTS. I think there is some 'fake news' out there about the real numbers.

I feel all of us were excited to continue to learn more about our additional CRDTS programs and appreciate all the work that Catrice and Dr. Edwards along with their support staff are putting in to continue to find ways to separate CRDTS from any of the other examination agencies. This also will continue to provide an income stream to be reinvested in our future.

Again, thank you all for a great annual meeting. We look forward to the great things ahead for this agency, thanks to all the commitment and effort you put in.

Sincerely,

Deena Kuempel, DDS
President Elect

Kelly Mandella, RDH
Director of Dental Hygiene Examinations

Trelawny Saldana, RDH
Assistant Director of Dental Hygiene Examinations

DENTAL HYGIENE UPDATES

Greetings colleagues!

The CRDTS dental hygiene department has had a great year-to-date experience with our exams. We administered over 1800 hygiene exams in addition to 277 restorative auxiliary exams and over 550 local anesthesia clinical and written exams. In addition, we also administered EFDA exams in Nebraska. We are happy to add new programs for the 2025 testing season and look forward to including more and developing new connections and relationships.

CRDTS is known for our personal touch and we have shown this by hosting over eighty Q&A sessions for schools and their students. If you would like a Q&A, please contact us and we will make it happen.

We are pleased to announce that Arkansas has been added as a full member state. Welcome! We look forward to the Arkansas State Dental Board's participation in the development and enhancement of our examinations. Additionally, we continue to pursue the few remaining states that do not currently accept the CRDTS examinations so that candidates will have the best options in testing available to them as a pathway toward initial licensure.

Speaking of change, change is a constant and, on that note, you have probably heard about our pending merger with SRTA. This is an exciting union and we are confident that this partnership is advantageous to candidates, schools and state boards.

To ensure that our exams remain valid and reliable, we have contracted with Data Recognition Corporation to complete an Occupational Analysis. You likely have received this survey and hopefully completed it! There will be more information about the results once completed and compiled.

The Dental Hygiene Department attended many Dental Hygiene Seminar review courses, the ADHA Annual Meeting and RDH Under One Roof this year. We love getting out and saying hello to our fellow colleagues, prospective schools, educators and those involved in the dental field.

CAMP (Calibration And Methodology Program) continues to grow and we have had such excellent and positive feedback from faculty. Be sure and visit our website at www.crdts.org and look at our Special Programs to learn more.

We continue to look for new and innovative ways to assess competency through virtual haptic technology and simulated patients. Stay tuned!

Please accept our gratitude and appreciation. We would not be where we are without you. Your loyalty and dedication is appreciated.

Wishing you a beautiful Fall and successful upcoming term.

Kelly Mandella, RDH
Director of Dental Hygiene Examinations
Trelawny Saldana, RDH
Assistant Director of Dental Hygiene Examinations
(a/k/a Kellany)

SAVE THE DATE AUGUST 22-23, 2025!
ANNUAL MEETING IN OMAHA, NE

Catrice Opichka, RDH
Director of
Special Programs

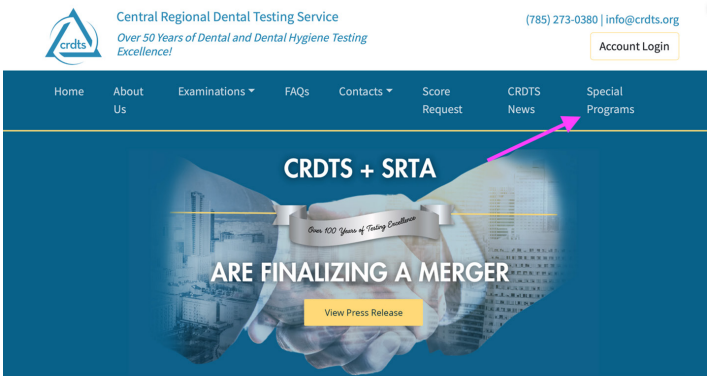
WELCOME TO THE NEW SPECIAL PROGRAMS WEB-SITE – CARE AND MUCH MORE

It was less than two years ago when CRDTS Leadership identified a need to create programs that would provide state dental boards a resource for dental remediation and reeducation. Since then, we have worked with many state dental boards to help provide education for their licensees, as well as helping self-referred individuals reinstate their lapsed professional license. Although many of you have already heard of CRDTS CARE, you may not realize that this is just one of many programs we are currently providing to dental professionals. For example, our CAMP (Calibration And Methodology Program) is going on its second official year, following a two-year pilot program. This program provides valuable education for dental hygiene faculty to help teams calibrate in areas like calculus detection and patient classification as well as providing education in adult teaching methodology. We are also helping dental schools reduce the burden of education as we work with SIMtoCARE to create educational modules through our EduCARE Program. This program provides structured curriculum that can be used with virtual haptic technology to provide repetitive practice in disciplines such as operative dentistry, local anesthesia, calculus removal, prosthodontic procedures, and many more.

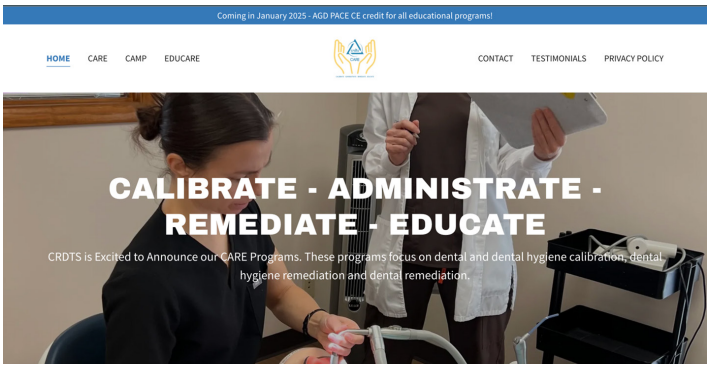
Because the CRDTS CARE program is so much more than one program, we are now referring to this area of CRDTS as "Special Programs". In fact, not only will you find "Special Programs" listed on the CRDTS website (www.crdts.org), but you can also find detailed information on all CRDTS current programs on our new Special Programs website (www.crdtscare.com).

We invite you to explore both the CRDTS websites to learn more about all the exciting things we are doing to expand our reach in helping dental professionals.

Check out CRDTS website for the link to our "Special Programs". www.crdts.org



Find out when CRDTS launches new programs and expands existing programming by visiting the new CRDTS CARE website. www.crdtscare.com



Catrice Opichka, RDH
Director of Special Programs

Andew Johnston, Vice President

VICE PRESIDENT'S MESSAGE

It's an exciting time to be a part of the CRDTS organization as we continue to grow and expand our services for dental and dental hygiene programs. If you attended the Annual Meeting you will have heard that we are in the strongest financial position, with the most exam sites since the pandemic. You will also have heard the exciting news about a pending merger. I will let others address that awesome news, but needless to say we continue to get bigger and better each year and have a roadmap to continue on this path.

I was just at an exam this past month and we had a chance to chat about how unique we are as an organization. We firmly believe in being objective and fair in our exams, which has led us to utilizing technology that is unmatched. The fact that we can continue to invest in these sometimes expensive options and still have the lowest cost exams for candidates is a testament to the leadership we have had over these years and the priorities they have had.

The last thing I wanted to mention is a heartfelt thank you for those who attended the annual meeting with an extension for those who completed the feedback survey. These are probably the best comments we have received in years because they were constructive and honest. This is crucial as it allows us to better understand your needs and wants for the meeting. During our wrap-up call, we reviewed every single comment that was left and promise to utilize them as we build out 2025's meeting. Beyond that, we are very pleased that you all find such value in the recent additions and also the changes to the schedule. If you were not able to complete the survey, please be sure to shoot me a message so that your input will be considered. It's an absolute honor serving in this position, and I am looking forward to this next year.

Andrew Johnston
Vice President

ANNUAL MEETING HIGHLIGHTS

KFF Health News

(OONA ZENDA/KFF HEALTH NEWS)

Dentists Are Pulling ‘Healthy’ and Treatable Teeth To Profit From Implants, Experts Warn

By Brett Kelman and Anna Werner, CBS News
Illustration by Oona Zenda
NOVEMBER 1, 2024

Becky Carroll was missing a few teeth, and others were stained or crooked. Ashamed, she smiled with lips pressed closed. Her dentist offered to fix most of her teeth with root canals and crowns, Carroll said, but she was wary of traveling a long road of dental work.

This story also ran on CBS News. It can be republished for free.

Then Carroll saw a TV commercial for another path: ClearChoice Dental Implant Centers. The company advertises that it can give patients “a new smile in as little as one day” by surgically replacing teeth instead of fixing them.

So Carroll saved and borrowed for the surgery, she said. In an interview and a lawsuit, Carroll said that at a ClearChoice clinic in New Jersey in 2021, she agreed to pay $31,000 to replace all her natural upper teeth with pearly-white prosthetic ones. What came next, Carroll said, was “like a horror movie.”

Carroll alleged that her anesthesia wore off during implant surgery, so she became conscious as her teeth were removed and titanium screws were twisted into her jawbone. Afterward, Carroll’s prosthetic teeth were so misaligned that she was largely unable to chew for more than two years until she could afford corrective surgery at another clinic, according to a sworn deposition from her lawsuit.

ClearChoice has denied Carroll’s claims of malpractice and negligence in court filings and did not respond to requests for comment on the ongoing case.

“I thought implants would be easier, and all at once, so you didn’t have to keep going back to the dentist,” Carroll, 52, said in an interview. “But I should have asked more questions … like, Can they save these teeth?”

Becky Carroll of New Jersey has alleged in a lawsuit that she suffered a botched dental implant surgery in 2021, leaving her unable to chew for more than two years. ClearChoice Dental Implant Centers has denied all wrongdoing in the ongoing suit. (NICOLE KELLER/CBS NEWS)

Dental implants have been used for more than half a century to surgically replace missing or damaged teeth with artificial duplicates, often with picture-perfect results. While implant dentistry was once the domain of a small group of highly trained dentists and specialists, tens of thousands of dental providers now offer the surgery and place millions of implants each year in the U.S.

Amid this booming industry, some implant experts worry that many dentists are losing sight of dentistry’s fundamental goal of preserving natural teeth and have become too willing to remove teeth to make room for expensive implants, according to a months-long investigation by KFF Health News and CBS News. In interviews, 10 experts said they had each given second opinions to multiple patients who had been recommended for mouths full of implants that the experts ultimately determined were not necessary. Separately, lawsuits filed across the country have alleged that implant patients like Carroll have

experienced painful complications that have required corrective surgery, while other lawsuits alleged dentists at some implant clinics have persuaded, pressured, or forced patients to remove teeth unnecessarily.

The experts warn that implants, for a single tooth or an entire mouth, expose patients to costs and surgery complications, plus a new risk of future dental problems with fewer treatment options because their natural teeth are forever gone.

“There are many cases where teeth, they’re perfectly fine, and they’re being removed unnecessarily,” said William Giannobile, dean of the Harvard School of Dental Medicine. “I really hate to say it, but many of them are doing it because these procedures, from a monetary standpoint, they’re much more beneficial to the practitioner.”

Giannobile and nine other experts say they are combating a false public perception that implants are more durable and longer-lasting than natural teeth, which some believe stems in part from advertising on TV and social media. Implants require upkeep, and although they can’t get cavities, studies have shown that patients can be susceptible to infections in the gums and bone around their implants.

“Just because somebody can afford implants doesn’t necessarily mean that they’re a good candidate,” said George Mandelaris, a Chicago-area periodontist and member of the American Academy of Periodontology Board of Trustees. “When an implant has infection, or when an implant has bone loss, an implant dies a much quicker death than do teeth.”

In its simplest form, implant surgery involves extracting a single tooth and replacing it with a metal post that is screwed into the jaw and then affixed with a prosthetic tooth commonly made of porcelain, also known as a crown. Patients can also use “full-arch” or “All-on-4” implants to replace all their upper or lower teeth — or all their teeth.

Dental implants have been used to replace damaged or missing teeth for decades. They generally consist of a metal anchor screwed into the bone, then capped with a prosthetic tooth, commonly made of porcelain. (MOMENT/GETTY IMAGES)

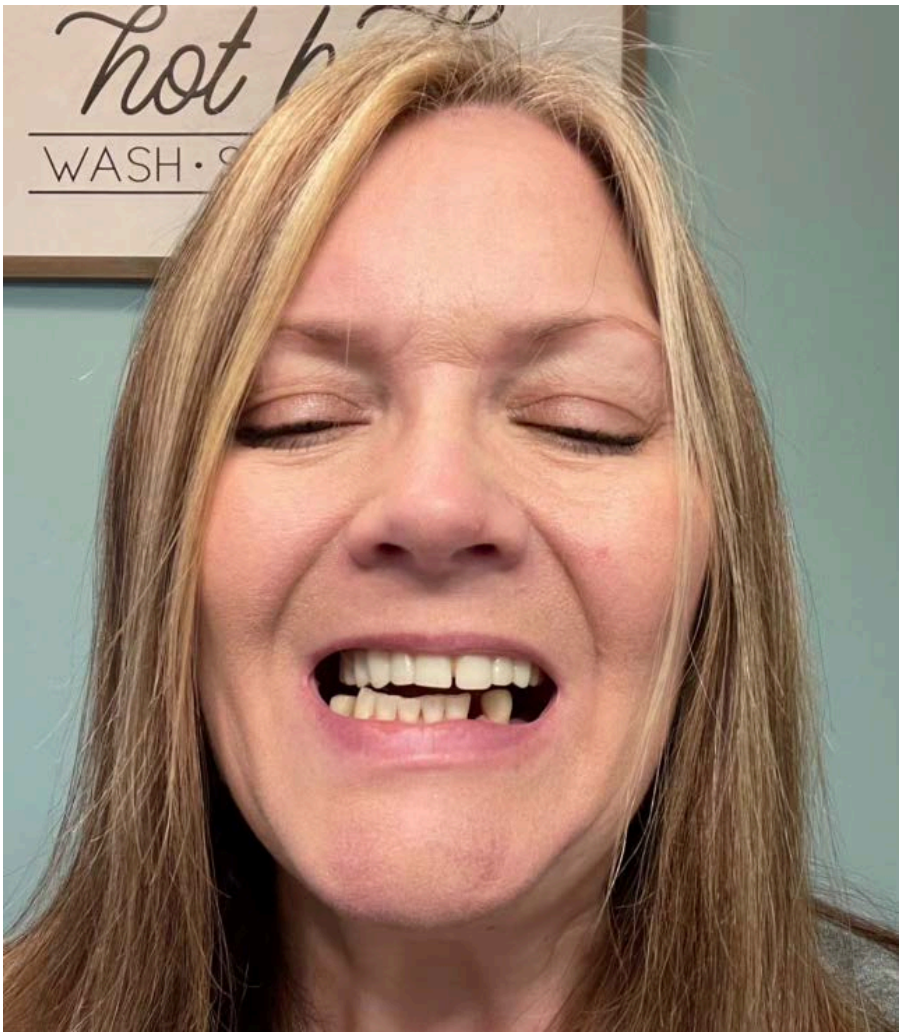
For this story, KFF Health News and CBS News sought interviews with large dental chains whose clinics offer implant surgery — ClearChoice, Aspen Dental, Affordable Care, and Dental Care Alliance — each of which declined to be interviewed or did not respond to multiple requests for comment. The Association of Dental Support Organizations, which represents these companies and others like them, also declined an interview request.

ClearChoice, which specializes in full-arch implants, did not answer more than two dozen questions submitted in writing. In an emailed statement, the company said full-arch implants “have become a well-accepted standard of care for patients with severe tooth loss and teeth with poor prognosis.”

“The use of full-arch restorations reflects the evolution of modern dentistry, offering patients a solution that restores their ability to eat, speak, and live comfortably — far beyond what traditional dentures can provide,” the company said.

Carroll said she regrets not letting her dentist try to fix her teeth and rushing to ClearChoice for implants.

“Because it was a nightmare,” she said.



Carroll displays the dental implants she got in her upper jaw in 2021. She has alleged in a lawsuit against ClearChoice that her implants were misaligned with her bottom teeth, leaving her unable to eat solid food. ClearChoice has denied all wrongdoing in the lawsuit. (REBECCA CARROLL)

‘They Are Not Teeth’

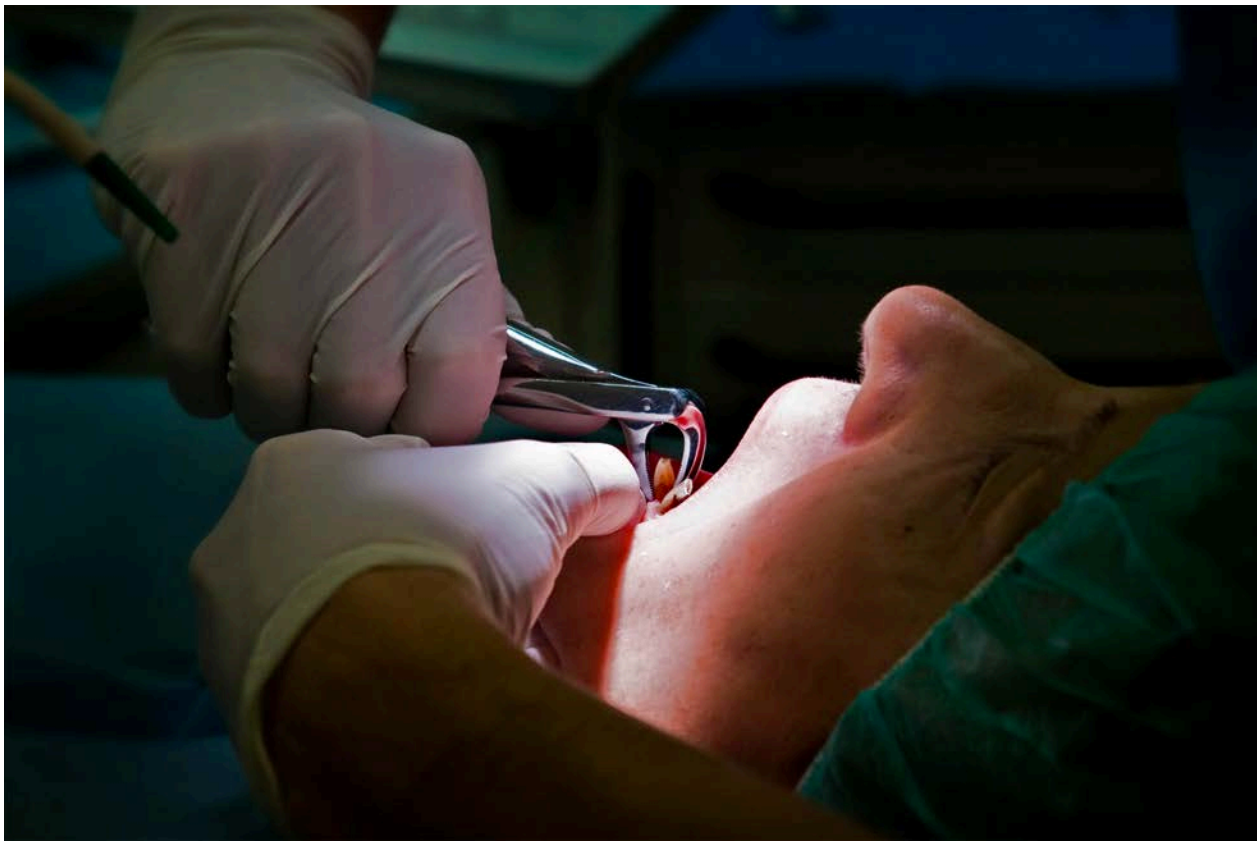
Dental implant surgery can be a godsend for patients with unsalvageable teeth. Several experts said implants can be so transformative that their invention should have contended for a Nobel Prize. And yet, these experts still worry that implants are overused, because it is generally better for patients to have their natural teeth.

Paul Rosen, a Pennsylvania periodontist who said he has worked with implants for more than three decades, said many patients believe a “fallacy” that implants are “bulletproof.”

“You can’t just have an implant placed and go off riding into the sunset,” Rosen said. “In many instances, they need more care than teeth because they are not teeth.”

Generally, a single implant costs a few thousand dollars while full-arch implants cost tens of thousands. Neither procedure is well covered by dental insurance, so many clinics partner with credit companies that offer loans for implant surgeries. At ClearChoice, for example, loans can be as large as $65,000 paid off over 10 years, according to the company’s website.

Despite the price, implants are more popular than ever. Sales increased by more than 6% on average each year since 2010, culminating in more than 3.7 million implants sold in the U.S. in 2022, according to a 2023 report produced by iData Research, a health care market research firm.



Dental implant surgery often involves extracting a patient’s natural tooth so it can be swapped for a prosthetic replacement. Patients can use “full-arch” or “All-on-4” dental implants to replace all their upper or lower teeth — or all their teeth. (GIOVANNI MEREGHETTI/UCG/UNIVERSAL IMAGES GROUP VIA GETTY IMAGES)

Some worry implant dentistry has gone too far. In 10 interviews, dentists and dental specialists with expertise in implants said they had witnessed the overuse of implants firsthand. Each expert said they’d examined multiple patients in recent years who were recommended for full-arch implants by other dentists despite their teeth being treatable with conventional dentistry.

Giannobile, the Harvard dean, said he had given second opinions to “dozens” of patients who were recommended for implants they did not need.

“I see many of these patients now that are coming in and saying, ‘I’ve been seen, and they are telling me to get my entire dentition — all of my teeth — extracted.’ And then I’ll take a look at them and say that we can preserve most of your teeth,” Giannobile said.

Tim Kosinski, who is a representative of the Academy of General Dentistry and said he has placed more than 19,000 implants, said he examines as many as five patients a month who have been recommended for full-arch implants that he deems unnecessary.

“There is a push in the profession to remove teeth that could be saved,” Kosinski said. “But the public isn’t aware.”

Luiz Gonzaga, a periodontist and prosthodontist at the University of Florida, said he, too, had turned away patients who wanted most or all their teeth extracted. Gonzaga said some had received implant recommendations that he considered “an atrocity.”

Dental implants are used to permanently replace damaged or missing teeth. They can restore a patient’s appearance and chewing ability. Implants are placed surgically and can’t be removed like most dentures. (MOMENT/GETTY IMAGES)

“You don’t go to the hospital and tell them ‘I broke my finger a couple of times. This is bothering me. Can you please cut my finger off?’ No one will do that,” Gonzaga said. “Why would I extract your tooth because you need a root canal?”

Jaime Lozada, director of an elite dental implant residency program at Loma Linda University, said he’d not only witnessed an increase in dentists extracting “perfectly healthy teeth” but also treated a rash of patients with mouths full of ill-fitting implants that had to be surgically replaced.

Lozada said in August that he’d treated seven such patients in just three months.

“When individuals just make a decision of extracting teeth to make it simple and make money quick, so to speak, that’s where I have a problem,” Lozada said. “And it happens quite often.”

When full-arch implants fail, patients sometimes don’t have enough jawbone left to anchor another set. These patients have little choice but to get implants that reach into cheekbones, said Sohail Saghezchi, an oral and maxillofacial surgeon at the University of California-San Francisco.

“It’s kind of like a last resort,” Saghezchi said. “If those fail, you don’t have anywhere else to go.”

‘It Was Horrendous Dentistry’

Most of the experts interviewed for this article said their rising alarm corresponded with big changes in the availability of dental implants. Implants are now offered by more than 70,000 dental providers nationwide, two-thirds of whom are general dentists, according to the iData Research report.

Dentists are not required to learn how to place implants in dental school, nor are they required to complete implant training before performing the surgery in nearly all states. This year, Oregon started requiring dentists to complete 56 hours of hands-on training before placing any implants. Stephen Prisby, executive director of the Oregon Board of Dentistry, said the requirement — the first and only of its kind in the U.S. — was a response to dozens of investigations in the state into botched surgeries and other implant failures, split evenly between general dentists and specialists.

“I was frankly stunned at how bad some of these dentists were practicing,” Prisby said. “It was horrendous dentistry.”

Many dental clinics that offer implants have consolidated into chains owned by private equity firms that have bought out much of implant dentistry. In health care, private equity investment is sometimes criticized for overtreatment and prioritizing short-term profit over patients.

Private equity firms have spent about $5 billion in recent years to buy large dental chains that offer implants at hundreds of clinics owned by individual dentists and dental specialists. ClearChoice was bought for an estimated $1.1 billion in 2020 by Aspen Dental, which is owned by three private equity firms, according to PitchBook, a research firm focused on the private equity industry. Private equity firms also bought Affordable Care, whose largest clinic brand is Affordable Dentures & Implants, for an estimated $2.7 billion in 2021, according to PitchBook. And the private equity wing of the Abu Dhabi government bought Dental Care Alliance, which offers implants at many of its affiliated clinics, for an estimated $1 billion in 2022, according to PitchBook.

ClearChoice and Aspen Dental each said in email statements that the companies’ private equity owners “do not have influence or control over treatment recommendations.” Both companies said dentists or dental specialists make all clinical decisions.

Private equity deals involving dental practices increased ninefold from 2011 to 2021, according to an American Dental Association study published in August. The study also said investors showed an interest in oral surgery, possibly because of the “high prices” of implants.

“Some argue this is a negative thing,” said Marko Vujicic, vice president of the association’s Health Policy Institute, who co-authored the study. “On the other hand, some would argue that involvement of private equity and outside capital brings economies of scale, it brings efficiency.”

Edwin Zinman, a San Francisco dental malpractice attorney and former periodontist who has filed hundreds of dental lawsuits over four decades, said he believed many of the worst fears about private equity owners had already come true in implant dentistry.

“They’ve sold a lot of [implants], and some of it unnecessarily, and too often done negligently, without having the dentists who are doing it have the necessary training and experience,” Zinman said. “It’s for five simple letters: M-O-N-E-Y.”

Hundreds of Implant Clinics With No Specialists

For this article, journalists from KFF Health News and CBS News analyzed the webpages for more than 1,000 clinics in the nation’s largest private equity-owned dental chains, all of which offer some implants. The analysis found that more than 70% of those clinics listed only general dentists on their websites and did not appear to employ the specialists — oral surgeons, periodontists, or prosthodontists — who traditionally have more training with implants.

Affordable Dentures & Implants listed specialists at fewer than 5% of its more than 400 clinics, according to the analysis. The rest were staffed by general dentists, most of whom did not list credentialing from implant training organizations, according to the analysis.

An Affordable Dentures & Implants location in the suburbs of Nashville, Tennessee. Affordable Dentures & Implants is part of Affordable Care, which was purchased by private equity firms for an estimated $2.7 billion in 2021. (BRETT KELMAN/KFF HEALTH NEWS)

ClearChoice, on the other hand, employs at least one oral surgeon or prosthodontist at each of its more than 100 centers, according to the analysis. But its new parent company, Aspen Dental, which offers implants in many of its more than 1,100 clinics, does not list any specialists at many of those locations.

Not everyone is worried about private equity in implant dentistry. In interviews arranged by the American Academy of Implant Dentistry, which trains dentists to use implants, two other implant experts did not express concerns about private equity firms.

Brian Jackson, a former academy president and implant specialist in New York, said he believed dentists are too ethical and patients are too smart to be pressured by private equity owners “who will never see a patient.”

Jumoke Adedoyin, a chief clinical officer for Affordable Care, who has placed implants at an Affordable Dentures & Implants clinic in the Atlanta suburbs for 15 years, said she had never felt pressure from above to sell implants.

“I’ve actually felt more pressure sometimes from patients who have gone around and been told they need to take their teeth out,” she said. “They come in and, honestly, taking a look at them, maybe they don’t need to take all their teeth out.”

Still, lawsuits filed across the country have alleged that dentists at implant clinics have extracted patients’ teeth unnecessarily.

For example, in Texas, a patient alleged in a 2020 lawsuit that an Affordable Care dentist removed “every single tooth from her mouth when such was not necessary,” then stuffed her mouth with gauze and left her waiting in the lobby as he and his staff left for lunch. In Maryland, a patient alleged in a 2021 lawsuit that ClearChoice “convinced” her to extract “eight healthy upper teeth,” by “greatly downplay[ing] the risks.” In Florida, a patient alleged in a 2023 lawsuit that ClearChoice provided her with no other treatment options before extracting all her teeth, “which was totally unnecessary.”

After Aspen Dental bought ClearChoice for an estimated $1.1 billion in 2020, the companies began opening “co-location” clinics, like this one in Charlotte, North Carolina. (FRED CLASEN-KELLY/KFF HEALTH NEWS)

ClearChoice and Affordable Care denied wrongdoing in their respective lawsuits, then privately settled out of court with each patient. ClearChoice and Affordable Care did not respond to requests for comment submitted to the companies or attorneys. Lawyers for all three plaintiffs declined to comment on these lawsuits or did not respond to requests for comment.

Fred Goldberg, a Maryland dental malpractice attorney who said he has represented at least six clients who sued ClearChoice, said each of his clients agreed to get implants after meeting with a salesperson — not a dentist.

“Every client I’ve had who has gone to ClearChoice has started off meeting a salesperson and actually signing up to get their financing through ClearChoice before they ever meet with a dentist,” Goldberg said. “You meet with a salesperson who sells you on what they like to present as the best choice, which is almost always that they’re going to take out all your natural teeth.”

Becky Carroll, the ClearChoice patient from New Jersey, told a similar story.

Carroll said in her lawsuit that she met first with a ClearChoice salesperson referred to as a “patient education consultant.” In an interview, Carroll said the salesperson encouraged her to borrow money from family members for the surgery and it was not until after she agreed to a loan and passed a credit check that a ClearChoice dentist peered into her mouth.

“It seems way backwards,” Carroll said. “They just want to know you’re approved before you get to talk to a dentist.”

CBS News producer Nicole Keller contributed to this report.

Brett Kelman: bkelman@kff.org, @BrettKelman

RELATED TOPICS

COST AND QUALITY HEALTH CARE COSTS HEALTH INDUSTRY STATES DENTAL HEALTH FLORIDA INVESTIGATION MARYLAND NEW JERSEY TEXAS

CONTACT US SUBMIT A STORY TIP

PRESIDENT'S ANNOUNCEMENT FOR EXECUTIVE SESSION

updated 12/2024 from attorney

The Board of Dentistry will now meet in Executive Session to review confidential investigations, consider exempt records and to consult with legal counsel. The Executive Session is held pursuant to ORS 192.660 (2)(f)(L); ORS 676.165, ORS 676.175(1) and ORS 679.320.

Representatives of the news media and designated staff will be allowed to attend the Executive Session. All other members of the audience are asked to leave the room. Representatives of the news media are specifically directed **not** to report on any of the deliberations during the Executive Session except to state the general subject of the session as previously announced.

No decision will be made in Executive Session. At the end of the Executive Session, we will return to open session and welcome the audience back in to the room.

LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8940	ANDERSON, BRIZIA	2024-10-16
H8941	KOVTUNENKO, VADYM	2024-10-17
H8942	SAAD, ALI HAMOUD	2024-10-24
H8943	CARTER, SOPHIA MARIE	2024-11-05
H8944	DUBE, JENNIFER	2024-11-06
H8945	SCOTTALINE, KIMBERLY NICOLE	2024-11-07
H8946	MOUKDARATH, SOMCHAY	2024-11-12
H8947	STEPHENS, ERICA ROSE	2024-11-12
H8948	COCHRAN, ANNA	2024-11-15
H8949	LAVERS, TASHA MARIE	2024-11-20
H8950	GALLAGHER, CAMILLE CURRY	2024-11-20
H8951	SHUKLA, NEETA	2024-11-26
H8952	AVRAM, FLORENTINA MARINELA	2024-11-26
H8953	TSYPLAKOVA, YANA	2024-11-27

DENTISTS

D12099	PFUNDHELLER, DUSTIN MARK	2024-10-16
D12100	GARFINKEL, DAVID PHILIP	2024-10-17
D12101	AMUNDSON, PETER BRENT	2024-10-22
D12102	THOMAS, ANDREW	2024-10-22
D12103	KNAPP, BRANDON	2024-10-25
D12104	LAPIDOT, DAFNA	2024-10-31
D12105	KRIPPAEHNE, ELLEN	2024-11-05
D12106	ANDREWS, KRISTIN MARIE	2024-11-12
D12107	JI, YISI DAISY	2024-11-20
D12108	ARORA, PAYAL MEGAN	2024-11-27
D12109	SAMPANG, MARK L.	2024-11-27
D12110	RUTGARD, DAVID S.	2024-12-03

LICENSE, PERMIT & CERTIFICATION

Nothing to Report Under This Tab