PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
APRIL 19, 2019
NOTICE OF REGULAR MEETING

PLACE: BOARD OFFICE

DATE: April 19, 2019

TIME: 7:30 a.m. – 4:00 p.m.

Call to Order – Gary Underhill, D.M.D., President

7:30 a.m.

OPEN SESSION

Review Agenda
Sign Wall Certificates

NEW BUSINESS
• Association Reports
  • Oregon Dental Association
  • Oregon Dental Hygienists’ Association
  • Oregon Dental Assistants Association

3. Committee and Liaison Reports
• WREB Liaison Report – Amy B. Fine, D.M.D.
• AADB Liaison Report – Todd Beck, D.M.D.
• ADEX Liaison Report – Hai Pham, D.M.D.
• CDCA Liaison Report – Hai Pham, D.M.D.
• Licensing, Standards and Competency Committee Meeting- May 24 @ 12 pm, Chair Dr. Amy B. Fine
• JCNDE request for Board Member to attend meeting

4. Executive Director’s Report
• Board Member & Staff Updates
• OBD Budget Status Report
• Gold Star Certificate for FY 2018
• Customer Service Survey
• 2019 Dental License Renewal
• Board and Staff Speaking Engagements
• Idaho Board of Dentistry Presentation Invitation
• AADA & AADB Mid-Year Meetings
• Dental Licensure Compact
• Database Migration Project
• 2019 Legislative Session
• IAA with OHA
• 2020 OBD Proposed Board Meeting Dates

5. Unfinished Business and Rules
• PDMP registration required for dentists with a DEA Registration
• OHA Dental Pilot Project #100 March 4 Advisory Committee Meeting materials
• OBD Public Comments on modification to DHAT Pilot Project to utilize Nitrous Oxide
• Board Member interest in serving on new Dental Pilot Project #300 Technical Review Board

6. Correspondence
• Oregon Dental Assistants Association Request
• Resuscitation Group Request
• Dr. Brett M. Sullivan – Request Board approval for a course in Intravenous Access or Phlebotomy
• Request for approval of Dental Assistant & Dental Hygiene Restorative Courses – OHSU CE Department
7. Other
   - Northwest Portland Area Indian Health Board – Dental Pilot Project #100 overview from Executive Director, Joe Finkbonner and Christina Peters
   - Oregon Academy of General Dentistry overview and update from Executive Director, Laura Seurynck and Dr. Kim Wright
   - Board of Denture Technology Proposed Rules
   - Proposed change to OAR 818-021-0017
   - Proposed change to OAR 818-021-0088
   - Election of Officers (President & Vice-President)

8. Articles & Newsletters (No Action Necessary)
   - HPSP Newsletter, February 2019
   - HPSP Newsletter, March 2019
   - ADEA Advocate, February 2019
   - ADEA Advocate, March 2019
   - OSAP-DANB-DALE Foundation Launch Website For Dental Infection Control Education and Certification
   - ADEA 2017-2018 Snapshot of dental Education
   - CODA 2019 Accreditation Actions
   - ADA News – Anesthesiology Recognized
   - WREB 2018 Dental Student Newsletter
   - CITA Letter – Announcing Merger
   - Recognition of Dr. Julie Ann Smith for 8 years of OBD service & Dr. Gary Underhill as President

EXECUTIVE SESSION 10:30 a.m.
The Board will meet in Executive Session pursuant to ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, and to consult with counsel. No final action will be taken in Executive Session.

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

LUNCH 12:00 p.m.

OPEN SESSION 2:00 p.m.
Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSE AND EXAMINATION
16. Ratification of Licenses Issued
17. License and Examination Issues

OPEN SESSION

OTHER BUSINESS

ADJOURN 4:00 p.m.
APPROVAL OF MINUTES
OREGON BOARD OF DENTISTRY
MINUTES
February 15, 2019

MEMBERS PRESENT:  Gary Underhill, D.M.D., President
                    Todd Beck, D.M.D.
                    Hai Pham, D.M.D.
                    Yadira Martinez, R.D.H.
                    Julie Ann Smith, D.D.S., M.D., M.C.R.
                    Jose Javier, D.D.S.
                    Alicia Riedman, R.D.H.
                    Chip Dunn
                    Jennifer Brixey

STAFF PRESENT:    Stephen Prisby, Executive Director
                  Daniel Blickenstaff, D.D.S., Dental Director/ Chief Investigator
                  Teresa Haynes, Office Manager (portion of meeting)
                  Shane Rubio, Investigator (portion of meeting)
                  Harvey Wayson, Investigator (portion of meeting)
                  Haley Robinson, Investigator (portion of meeting)
                  Samantha VandeBerg, Office Specialist (portion of meeting)
                  Winthrop “Bernie” Carter, D.D.S., Dental Investigator

ALSO PRESENT:    Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Jennifer Lewis-Goff, ODA; Cassie Leone, ODA; Lesley Harbison, 
                   R.D.H., ODHA; Susan Kramer, R.D.H., ODHA; Jim McMahan, 
                   D.M.D., ODA; Amy Coplen, R.D.H., Pacific University; Mary Harrison, 
                   ODAA; Heather Mobus, R.D.H., ODHA; Scott Hansen, D.M.D.; Barry 
                   Taylor, D.M.D., ODA; Phil Marucha, D.M.D., Ph.D., OHSU; Christina 
                   Peters, NPAIHB; Bruce Austin, D.D.S, OHA; Dana Hargunani, M.D., 
                   M.P.H., OHA; Cate Wilcox, OHA

Call to Order: The meeting was called to order by the President at 7:35 a.m. at the Board office; 
1500 SW 1st Ave., Suite 770, Portland, Oregon.

MINUTES
Dr. Smith moved and Dr. Javier seconded that the minutes of the December 14, 2018 Board 
Meeting be approved as amended. The motion passed unanimously.

NEW BUSINESS

ASSOCIATION REPORTS

Oregon Dental Association
Dr. McMahan reported that Dental Day will take place in Salem on February 26th, with 80 dentists 
signed up so far to participate. He also reported that the ODA is tracking approximately 85 
legislative bills for the upcoming legislative session, one of which being Bill 2220, which would
allow dentists to provide vaccines. He reported that the ODA has been very active in planning for the Oregon Dental Conference, which will take place on April 4th – 6th of this year. Dr. Marucha added that OHSU is in favor of the legislative bill which would allow dentists to administer vaccines.

**Oregon Dental Assistants Association**
Ms. Harrison reported that the ODAA has been actively planning for the upcoming Oregon Dental Conference in April.

**Oregon Dental Hygienists' Association**
Ms. Mobus reported that the ODHA is in support of the ODA’s legislative agenda for 2019. Lisa Rowley, R.D.H., submitted a letter to the Oregon Health Authority stating that the ODHA opposes the modifications that would allow DHAT’s to administer nitrous oxide.

**COMMITTEE AND LIAISON REPORTS**

**WREB Liaison Report**
Nothing to report.

**AADB Liaison Report**
Mr. Prisby reported that he, Ms. Martinez and Ms. Lindley will be attending the AADB mid-year meeting in Chicago on March 9th -11th, with Ms. Lindley leading the Attorney’s Round Table at the meeting.

**ADEX Liaison Report**
Dr. Pham reported that the ADEX annual meeting will take place on August 9th – 10th of this year.

**CDCA Liaison Report**
Nothing to report.

**Proposed 2019 Committee and Public Rulemaking Meeting Dates**

- **Licensing, Standards and Competency Committee Meeting** (this meeting will probably be at least 2-3 hours long due to the number of agenda items)
  - **Friday, May 24 @ 12 pm**
    - Board Meeting June 21 – move items to the Rules Oversight Committee

- **Rules Oversight Committee Meeting** (this meeting will probably be 2 hours long due to the number of agenda items)
  - **Friday, August 2 @ 9 am**
    - Board Meeting August 23 – move items forward to public rulemaking hearings

- **Public Rulemaking Hearings**
  - **Tuesday, September 10 @ 6 pm**
  - **Friday, October 11 @ 9 am**
    - Board Meeting October 25 – Board may vote on proposed rule changes

Dr. Pham moved and Dr. Smith seconded that the Board approve the Committee Meetings and Public Rulemaking dates as proposed. The motion passed unanimously.
Anesthesia Committee
The OBD created an anesthesia survey based on the recommendations from the Anesthesia Office Evaluation Workgroup. The Board reviewed and discussed the survey results.

EXECUTIVE DIRECTOR’S REPORT

Board Member & Staff Updates
Mr. Prisby reported that there will be a vacancy on the Board, with Dr. Julie Ann Smith’s second term of service ending in May 2019.

The Board welcomed Dr. Winthrop (Bernie) Carter as our new dental investigator on February 1, 2019. Dr. Carter comes to the OBD after completing 15 years at the OHSU School of Dentistry. Dr. Carter also chaired the OHSU Department of Periodontology for over nine years. A total of 47 periodontal residents have been trained by Dr. Carter. Dr. Carter also completed over 20 years of active duty with the US Navy prior to arriving in Portland 2002. Dr. Carter has practiced General Dentistry for 14 years, and Periodontics for 30 years, and Implant surgery for 25 years.

OBD Budget Status Report
Mr. Prisby presented the budget report for the 2017 - 2019 Biennium. This report, which is from July 1, 2017 through December 31, 2018, shows revenue of $2,723,763.09 and expenditures of $2,242,611.41.

Customer Service Survey
Mr. Prisby presented the legislatively mandated survey results from December 1, 2018 – January 31, 2019 with the new Survey Monkey format. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements
Mr. Prisby reported that Licensing Manager, Ingrid Nye, and Office Manager, Teresa Haynes, were scheduled to give a License Application Presentation to the graduating Dental Hygiene Students at Oregon Institute of Technology in Salem on Wednesday, February 13, 2019, but had to reschedule to March 7th, due to weather.

2019 Dental License Renewal
Mr. Prisby reported that approximately 2,100 postcard notices were mailed to Oregon licensed dentists in mid-January for the March 31, 2019 Renewal Cycle, and approximately 35% of dentists have renewed so far.

2019 Legislative Session
Mr. Prisby reported that the legislative session started on January 22nd. He provided information to the Board on reading legislative measures and a report on Bills that may impact the Board.

New OBD Website
Mr. Prisby reported that the new website went operational on January 8, 2019. Office Manager, Teresa Haynes continues to make modifications and update information.
UNFINISHED BUSINESS & RULES

Secretary of State Audit – Prescription Drug Monitoring Program
Mr. Prisby reported that there was an audit by the Secretary of State on the Prescription Drug Monitoring Program (PDMP). Potential legislative changes to the PDMP could make it more user-friendly and allow licensing boards to use their data without restriction. The audit also showed that dentists over-prescribed opioids on numerous occasions, but utilized limited data in its report.

Dental Public Health
The Board discussed the definition of “Dental Public Health” as used in OAR 818-001-0002. No motion was made.

818-001-0002(11)(a)

(11) "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 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.

Oregon Health Authority (OHA) presentation: Dental Pilot Projects Program
Dr. Bruce Austin, Dr. Dana Hargunani and Cate Wilcox gave an overview presentation of the Dental Pilot Projects. They took the time to answer questions and address concerns presented by the Board.

CORRESPONDENCE

Dr. Aldrich and Dr. Ross Correspondence re: Dental Sleep Medicine
Kimberly Ross, D.D.S., and Michelle Aldrich, D.M.D., submitted a letter to the Board to open the discussion of developing the standards of care in Oregon regarding the training required for dental sleep medicine. No motion was made.

Oregon Dental Assistants Association re: OAR 818-042-0060 – Certification- Radiologic Proficiency & OAR 818-042-0080 Certification- Expanded Function Dental Assistant (EFDA)
Ginny Jorgensen and Mary Harrison submitted a letter to the Board, asking the Board to consider making changes to the Oregon dental assistant certification process. The Board requested that Ms. Harrison submit a list of suggested rule changes that could potentially alleviate the dental assistant shortage and make the education, examination and certification process more streamlined.

Dr. Kim Wright Correspondence re: OAR 818-012-0005(3) - Botulinum Toxin Type A and Dermal Fillers
Kimberly Wright, D.M.D., submitted a letter to the Board to ask the Board to consider making a slight change to the educational requirements for Botulinum Toxin and Dermal Fillers. She would like to ask the Board to consider separating them into two education requirements each of ten hours long, rather than a 20-hour course that incorporates both topics.

818-012-0005(3)
Scope of Practice
(3) A dentist may utilize Botulinum Toxin Type A and dermal fillers to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 20 hours in a hands on clinical course(s), which includes both Botulinum Toxin Type A and dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).

Dr. Beck moved and Dr. Pham seconded that the Board move the discussion of separating the educational requirements for Botox and Dermal Fillers to the Licensing, Standards and Competency Committee for further discussion. The motion passed unanimously.

OTHER ISSUES

Request for Approval of Soft Reline Course – Jannet Garcia
The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090 – Additional Functions of EFDAs.

Dr. Beck moved and Dr. Javier seconded that the Board approve Ms. Garcia's soft reline course as requested. The motion passed unanimously.

Request for Board Approval for a Course in Intravenous Access or Phlebotomy – Dr. Russell Lieblick
On behalf of The Resuscitation Group, Russell A. Lieblick, D.M.D., submitted a letter requesting that the Board review The Resuscitation Group’s IV access course materials to determine whether their course meets the requirements for Certified Anesthesia Dental Assistants who wish to initiate IV infusion lines.

Dr. Smith moved and Dr. Beck seconded that the Board approve The Resuscitation Group’s IV Access course for Certified Anesthesia Dental Assistants as requested. The motion passed unanimously.

Request for Approval of a Local Anesthesia Course – University of Maine at Augusta
Dr. Beck moved and Dr. Pham seconded that the Board approve University of Maine at Augusta’s anesthesia course as requested. The motion passed unanimously.

Request for Approval to become a Board-Approved Continuing Education (CE) Provider for Expanded Practice Permit (EPP) – Oregon Health & Science University School of Dentistry Continuing Education Department
Dr. Beck moved and Dr. Pham seconded that the Board approve OHSU’s CE Department to become a Board approved CE provider for dental hygienists to obtain an expanded practice permit. The motion passed unanimously.

Request for Approval to become a Board-Approved Continuing Education (CE) Provider for Expanded Practice Permit (EPP) – Willamette Dental Group
Dr. Beck moved and Dr. Pham seconded that the Board approve Willamette Dental’s CE Department to become a Board approved CE provider for dental hygienists to obtain an expanded practice permit. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Beck, Ms. Martinez, Dr. Pham, Ms. Riedman and Mr. Dunn voting aye. Dr. Javier and Dr. Smith recused.
ARTICLES AND NEWS (no action necessary)
- HPSP December 2018 Newsletter
- HPSP January 2019 Newsletter
- CRDTS Winter 2018 Newsletter

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

PERSONAL APPEARANCES AND COMPLIANCE ISSUES
2019-0015 – The Licensee appeared in Executive Session

OPEN SESSION: The Board returned to Open Session.

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

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

2019-0023
Ms. Martinez moved and Dr. Beck seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with Dr. Underhill, Ms. Brikey, Dr. Beck, Dr. Javier, Ms. Martinez, Dr. Pham, Ms. Riedman and Mr. Dunn voting aye. Dr. Smith recused.

2018-0251
Dr. Pham moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to ensure that all of his continuing education requirements for licensure are met in a timely manner. The motion passed unanimously.

2019-0127
Dr. Smith moved and Dr. Javier seconded that the Board close the matter with a STRONGLY Words Letter of Concern reminding Licensee to ensure that all of her continuing education requirements for licensure are met in a timely manner. The motion passed unanimously.

GOODMAN-CHERRIER, EDWARD E. D.D.S. 2018-0182
Dr. Beck moved and Mr. Dunn seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $3,000.00 civil penalty, and 10 hours of Board approved community service. The motion passed unanimously.

**GRIEGO, TABITHA M. R.D.H; NGUYEN, BRUCE D.M.D. 2019-0130**
Mr. Dunn moved and Ms. Riedman seconded that the Board, in reference to Respondent #1, issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order in which Licensee would agree to be reprimanded and pay a civil penalty of $1,000.00; for Respondent #2, issue Licensee a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order in which Licensee would agree to be reprimanded and pay a civil penalty of $2000.00. The motion passed unanimously.

**HONNOLD, NANCY M. R.D.H. 2018-0260**
Ms. Riedman moved and Ms. Brixey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; a $1,000.00 civil penalty and completion of the six-hour balance of continuing education for the licensure period 10/01/15-9/30/17 within 60 days of the effective date of the Order. The motion passed unanimously.

**MCLIN, NICOLE L. R.D.H. 2019-0137**
Ms. Brixey moved and Dr. Beck seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $1,500.00 civil penalty and 10 hours of community service within 120 days of the effective date of the order. The motion passed unanimously.

**2018-0169**
Dr. Javier moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that the instruments he uses have been sterilized in an autoclave that is spore tested on a weekly basis. The motion passed unanimously.

**2018-0262**
Dr. Pham moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to ensure that all of his continuing education requirements for licensure are met in a timely manner. The motion passed unanimously.

Dr. Smith moved and Mr. Dunn seconded that the Board close the matters with No Further Action with the understanding that if and when the Licensee requests his dental license to be reactivated, these cases will be reopened and investigated. The motion passed unanimously.

**2019-0045**
Dr. Beck moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all instruments that she uses have been sterilized in an autoclave that is spore tested on a weekly basis, and to open investigation into the owner of the practice for missing biological monitoring 16 times in the year 2017. The motion passed unanimously.

**2018-0253**
Mr. Dunn moved and Ms. Riedman seconded that the Board close the matter with a **STRONGLY WORDED** Letter of Concern reminding Licensee to ensure that all of his continuing
education requirements for licensure are met in a timely manner. The motion passed unanimously.

WADDELL, KEN W. D.M.D. 2019-0083
Ms. Riedman moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $1,500.00, civil penalty, a refund to patient TD of $400.00, and Licensee shall pay $51,992.00 in restitution to patient TD within 21 months of the effective date of the Order. The motion passed unanimously.

WADDELL, KEN W. D.M.D. 2019-0003
Ms. Brixey moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and to offer Licensee a Consent Order incorporating a reprimand, pay a $2,155.82, refund to patient CE-G, pay $1,995.00 in restitution to patient CE-G, take a Board approved three hour continuing education course in Record Keeping, and pass the Oregon Board of Dentistry Jurisprudence Exam all within 30 days of the effective date of this Order. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

CALVIN, DANIEL J. R.D.H. 2019-0105
Dr. Javier moved and Ms. Brixey seconded that the Board issue a Final Default Order incorporating a reprimand and a $2,500.00 civil penalty. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Beck, Dr. Javier, Ms. Martinez, Dr. Pham, Mr. Dunn and Dr. Smith voting aye. Ms. Riedman recused.

CLARK, PAUL K. D.M.D. 2016-0202
Dr. Pham moved and Ms. Riedman seconded that the Board offer Licensee a Consent Order incorporating a reprimand, pay a civil penalty of $7,500.00 within two months from the effective date of the Order. The motion passed unanimously.

DOWLING, RICHARD C. D.M.D. 2018-0160
Dr. Smith moved and Dr. Beck seconded that the Board offer Licensee a Consent Order incorporating a reprimand. The motion passed unanimously.

Mr. Dunn moved and Dr. Javier seconded that the Board deny Licensee an appearance to make oral argument before the Board. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Javier, Ms. Martinez, Dr. Pham, Ms. Riedman, Mr. Dunn and Dr. Smith voting aye. Dr. Beck recused.

Ms. Riedman moved and Dr. Smith seconded that the Board decline Licensee’s resolution offer. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Javier, Ms. Martinez, Dr. Pham, Ms. Riedman, Mr. Dunn and Dr. Smith voting aye. Dr. Beck recused.

Ms. Brixey moved and Mr. Dunn seconded that the Board ratify the Amended Proposed Order as issued on 1/14/19 and issue a Final Order incorporating a reprimand; a $38,750.00 civil
penalty to be paid within 90 days of the effective date of this Order; three hours of Board approved continuing education in the area of record keeping to be completed within 60 days; one year probation during which Licensee, on a quarterly basis, shall provide the Board with appointment book information so the Board can request and review appropriate charts of children under six and patients who were sedated to assure compliance with the Dental Practice Act – if Licensee does not practice in Oregon during the time of probation, the time will be tolled; and pay $41,987.00 in costs within 180 days of the effective date of this Order. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Javier, Ms. Martinez, Dr. Pham, Ms. Riedman, Mr. Dunn and Dr. Smith voting aye. Dr. Beck recused.

HILOU, LAUREN MARIE R.D.H. 2019-0035
Dr. Javier moved and Ms. Riedman seconded that the Board issue a Final Default Order of License Denial. The motion passed unanimously.

HODGERT, ROBERT H. D.M.D. 2018-0178
Dr. Pham moved and Ms. Riedman seconded to affirm the Board's vote of 12/14/18 and add the requirement that Licensee shall submit, by the fifteenth of each month, the results of the previous month’s weekly biological monitoring testing of sterilization devices. The motion passed unanimously.

HUGHES, PAMELA J. D.D.S. 2016-0083
Dr. Beck moved and Dr. Javier seconded that, in reference to Respondent #1, the Board accept Licensee’s offer of a Consent Order incorporating a reprimand. The motion passed with Dr. Underhill, Ms. Brixey, Dr. Beck, Dr. Javier, Ms. Martinez, Dr. Pham, Ms. Riedman and Mr. Dunn voting aye. Dr. Smith recused.

JANOFF, DONALD E. D.D.S. 2018-0222
Mr. Dunn moved and Dr. Javier seconded that the Board issue an Order of Dismissal, dismissing the Amended Order of Immediate Emergency Dental License Suspension, dated 10/9/18. The motion passed unanimously.

JANOFF, DONALD E. D.D.S. 2019-0025
Ms. Riedman moved and Dr. Beck seconded that the Board issue an Order of Dismissal, dismissing the Amended Order of Immediate Emergency Dental License Suspension, dated 10/9/18. The motion passed unanimously.

JOHNSON, MARVIN J. D.M.D. 2018-0158
Ms. Brixey moved and Dr. Smith seconded that the Board issue an Amended Notice of Proposed Disciplinary Action to Respondent #1, and to offer a Consent Order incorporating a reprimand, and a $10,000.00 civil penalty, and monthly submission of spore testing results for one year from the effective date of this Order. The motion passed unanimously.

TON, TRUC T. D.M.D. 2017-0155
Dr. Javier moved and Dr. Smith seconded that, for Respondent #1, move to issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action, dates 7/12/18, and close the matter with No Further Action; For respondent #2, move to issue an Amended Notice of Proposed Disciplinary Action removing Allegation #1, and offer Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a civil penalty of $2,000.00, and pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days of the effective date of the order. The motion passed unanimously.
Dr. Pham moved and Dr. Beck seconded that the Board deny Licensee’s request and require a minimum of two years of HPSP enrollment and monitoring from 7/25/18. The motion passed unanimously.

Dr. Smith moved and Dr. Pham seconded that the Board issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action, dated 6/30/17, and to close the matter with No Further Action. The motion passed unanimously.

Dr. Beck moved and Ms. Riedman seconded that the Board offer Licensee a Consent Order incorporating a reprimand, a refund to the patient of $4,800.00, and Licensee shall be restricted from restoring intraosseous implants without the general supervision of a Board approved mentor within a Board approved mentorship program until further notice of the Board. This general supervision will consist of consultation with the mentor prior to the placement of any implant by providing the mentor with the treatment plan for restoring the intraosseous implants, pre-restoration imaging, and post-restoration imaging prior to seating the restoration on the implant. The motion passed unanimously.

Mr. Dunn moved and Ms. Riedman seconded that the Board accept Licensee’s offer of a Consent Order incorporating a reprimand, 20 hours of community service to be completed within three months and completion of the balance of 24 continuing education hours for the licensure period 10/1/15 to 9/30/17 within 60 days. The motion passed unanimously.

Ms. Riedman moved and Ms. Brixey seconded that the Board issue a Final Default Order incorporating reprimand; a $2,000.00 civil penalty; ten hours of Board approved community service; three hours of Board approved continuing education in record keeping within 30 days; and passage of the Board’s Jurisprudence Exam within 30 days. The motion passed unanimously.

Ms. Brixey moved and Dr. Smith seconded that the Board close the matter with a finding of No Violation. The motion passed unanimously.

Dr. Javier moved and Dr. Smith seconded that the Board endorse the Interim Consent Order whereby Licensee agrees not to practice dental hygiene, pending further order of the Board. The motion passed unanimously.

Dr. Beck moved and Dr. Pham seconded that the Board deny the request and reaffirm the decision of 10/19/2018 to close the matter with a Letter of Concern reminding the Licensee to assure that his autoclaves are spore tested on a weekly basis. The motion passed unanimously.
**Ratification of Licenses**

Ms. Riedman moved and Dr. Smith seconded that the Board ratify the licenses in Tab 16. The motion passed unanimously.

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

<table>
<thead>
<tr>
<th>License #</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7774</td>
<td>ELIZABETH PONCE MAXON, R.D.H.</td>
<td>11/29/2018</td>
</tr>
<tr>
<td>H7775</td>
<td>BARBARA ANGEL WORTHHEY, R.D.H.</td>
<td>11/29/2018</td>
</tr>
<tr>
<td>H7776</td>
<td>SHELLY SINGH, R.D.H.</td>
<td>11/29/2018</td>
</tr>
<tr>
<td>H7777</td>
<td>XIN WANG, R.D.H.</td>
<td>11/29/2018</td>
</tr>
<tr>
<td>H7778</td>
<td>DANIEL PHAM, R.D.H.</td>
<td>12/10/2018</td>
</tr>
<tr>
<td>H7779</td>
<td>ANNIKA RASMUSON KIMARI, R.D.H.</td>
<td>12/21/2018</td>
</tr>
<tr>
<td>H7780</td>
<td>SARAH BETH COPE, R.D.H.</td>
<td>12/21/2018</td>
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<td>RUBEN HORACIO BEGINO, D.D.S.</td>
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OTHER BUSINESS
Nothing to report.

ADJOURNMENT

The meeting was adjourned at 3:15 p.m. Dr. Underhill stated that the next Board Meeting would take place on April 19, 2019.

_________________________________________________________
Gary Underhill, D.M.D.
President
Nothing to report under this tab
COMMITTEE REPORTS
REGISTRATION INFORMATION FOR THE ANNUAL NDEAF MEETING, JUNE 26, 2019

The Joint Commission on National Dental Examinations (JCNDE) conducts an annual forum for representatives of state boards of dentistry for the purpose of exchanging information about National Board examinations.

The National Dental Examiners’ Advisory Forum (NDEAF) will be held on Wednesday, June 26, 2019 from 9:00 – 9:45 AM CENTRAL. The meeting will take place in the Board Room on the 22nd floor of the American Dental Association (ADA) at 211 E. Chicago Avenue, Chicago, IL. A continental breakfast will be provided.

PARTICIPATION: All interested members of state boards and others are welcome to attend the Advisory Forum. Funding, however, is limited to one current member of each state board for one day. There is no registration fee for the Advisory Forum.

Participants can also attend via NDEAF’s new webinar format that provides the opportunity for all members of every state dental board to participate, while minimizing disruptions to board members’ schedules. Information to access the webinar will be sent prior to the meeting to those registered.

Whether attending in person or via webinar, ALL attendees must be registered below for planning purposes.

REGISTRATION/FUNDING: To qualify for funding, a state board member must be officially designated as the board’s one representative through the below survey link no later than May 1, 2019. Funding will not be provided to attendees who are not officially designated by this date.

<table>
<thead>
<tr>
<th>Registration Form:</th>
<th>CLICK HERE TO REGISTER ATTENDEES</th>
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<tbody>
<tr>
<td>RSVP Date:</td>
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(Please note that this deadline cannot be extended. All designees MUST be submitted by May 1, in order to qualify for funding.)

TRAVEL ARRANGEMENTS FOR FUNDED REPRESENTATIVE: The American Dental Association will arrange for and pay for air travel to and from the home airport, one night of hotel stay up to $300/night including taxes and other associated expenses (i.e. parking, cab, train, bus, etc.) for one designee from each state board for one day. In addition, a daily stipend of $75 is provided for one travel day and one meeting day, which covers food, tips and other incidental expenses.
Once you have submitted the information for your dental board’s official designee, we will contact them with further instructions for filing their W9 (required for booking travel and for reimbursement) and for booking their flight and hotel. **Please note that your official designee MUST wait to receive the travel email from Betsey Palmer, DTS Meeting Coordinator, before booking travel. Travel not booked according to the instructions in the travel email may not be reimbursed.** Flights will be booked through the ADA’s travel agent, Fox World Travel.

**REIMBURSEMENTS:** The reimbursement request for your state dental board’s official designee must be filed using the ADA’s expense management system, Concur. Please note the following:

- All reimbursement requests MUST be submitted within 30 days of the meeting.
- Further details regarding reimbursement will be sent directly to designees.

If you have any questions or concerns, please contact Alexis Curtis at curtisa@ada.org.

We look forward to your participation at the 2019 National Dental Examiners’ Advisory Board!

**Alexis Curtis, B.A. curtisa@ada.org**
Manager, Volunteers and Meetings
Department of Testing Services
312.440.2620

**American Dental Association** 211 E. Chicago Ave. Chicago, IL 60611 [www.ada.org](http://www.ada.org)
EXECUTIVE DIRECTOR’S REPORT
Board Member & Staff Updates
On behalf of the OBD, I would like to thank Dr. Julie Ann Smith for her 8 years of service on the OBD from 2011 to 2019. Dr. Smith’s second term of service is ending in May. She previously served as OBD President, Chair of the Anesthesia Committee, chaired other workgroups and committees and helped shape the OBD’s 2017-2020 Strategic Plan. I hope the Board continues to attract members with her professional acumen, respect for the profession, level of engagement and professional courtesy.

Board member interest forms and applications have been submitted to the governor’s office and the governor’s staff has been reviewing them. The senate will have a confirmation hearing on May 8th and I plan to be in Salem to support and welcome our new Board member. OBD staff will conduct a new board member orientation and they will join the Board at the June 21 Board Meeting.

OBD Budget Status Report
Attached is the budget report for the 2017 - 2019 Biennium. This report, which is from July 1, 2017 through February 28, 2019, shows revenue of $3,385,255.28 and expenditures of $2,474,613.85. One important budget note is that the total revenue recorded includes civil penalties assessed (counted as receivables) that may not eventually come to the Board. Attachment #1

Gold Star Certificate for FY 2018
The State Controller’s Office has once again issued the OBD a Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information for FY 2018 in a timely manner. Attachment #2

Customer Service Survey
The new Survey Monkey Survey was launched in December 2018. Attached are the legislatively mandated survey results from December 2018 – March 31, 2019. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. Attachment #3

2019 Dental License Renewal
The following are the final numbers on the March 2019 Dental Renewal: As of April 9, 2019 Renewed 1668; Expired 160; Retired 41; Revoked 1; and Deceased 6.

Board and Staff Speaking Engagements
I gave a “Board Updates” Presentation to the Southern Oregon Dental Society in conjunction with TDIC in Medford on Friday, February 22, 2019 and Dr. Amy B. Fine participated as well.

Teresa Haynes gave a License Application Presentation via teleconference to the graduating Dental Hygiene Students at OIT in Klamath Falls on Friday, February 22, 2019.

I gave a “Board Updates and how to stay out of trouble” presentation to Pacific University dental hygiene students in Forest Grove on Wednesday, March 6, 2019.
Ingrid Nye and Teresa Haynes gave a License Application Presentation to the graduating Dental Hygiene Students at OIT in Salem on Thursday, March 7, 2019.

Dr. Daniel Blickenstaff gave a “The Oregon Board of Dentistry & the Dental Hygienist” presentation to Portland Community College dental hygiene students in Portland on Monday, March 11, 2019.

Dr. Daniel Blickenstaff gave a “Board Updates” presentation to the Gum Gardener Dental Hygiene Study Club in Portland on Monday, April 1, 2019.

Dr. Daniel Blickenstaff and I gave a “Board Updates” presentation to OHSU Dental School third year students in Portland on Wednesday April 3, 2019.

The Oregon Dental Conference was held at the Oregon Convention Center in Portland, April 4 - 6, 2019. The OBD had a table outside the Exhibit Hall with staff available to answer questions every day of the conference. Haley Robinson, Ingrid Nye and I made presentations on Thursday, April 4th covering a detailed overview of the Board, expanded practice permits and FAQs.

Dr. Blickenstaff and I also took part in the TDIC Risk Management Seminar on Thursday, April 4 regarding investigations and the enforcement process.

Dr. Blickenstaff and Haley Robinson gave a presentation on “Adequate Record Keeping and the Enforcement Process” on Friday, April 5.

Teresa Haynes participated in a dental assistants’ forum sponsored by DANB & the DALE Foundation at the ODC on Friday, April 5 updating the dental assistants on current and proposed rule changes.

I gave a brief overview of the Board to the Oregon Society of Oral and Maxillofacial Surgeons in Portland on Saturday, April 6, 2019.

Dr. Daniel Blickenstaff gave a presentation on TMD to the dental hygiene students at Portland Community College in Portland on Tuesday, April 9, 2019.

Ingrid Nye and Teresa Haynes plan to give a License Application Presentation to the graduating Dental Hygiene Students at Portland Community College on Wednesday, April 17, 2019.

Idaho Board of Dentistry Presentation Invitation
In June 2018, Lori Lindley and I gave a “Board Updates” Presentation to the Washington State Dental Quality Assurance Commission in Lacey, Washington. They reciprocated and presented an update on Washington State at our August 2018 Board Meeting. Now there is an opportunity to do the same with the Idaho Board of Dentistry. I have been invited to present a “Board Updates” presentation on Friday, July 26, 2019 in Boise, Idaho. I plan to invite their executive director to present updates on Idaho to you at a future Board meeting as well. I ask that the Board approve me to travel to Boise, Idaho to give a presentation to their Board of Dentistry.

ACTION REQUESTED
AADA & AADB Mid-Year Meetings
The American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) 2019 Mid-Year Meeting were held on March 9-10 in Chicago. Lori Lindley participated in the Board Attorneys’ Roundtable and Ms. Yadira Martinez attended the AADB meetings. I attended both meetings and we will share our experiences at this meeting. Attachment #4

Dental Licensure Compact
The Council of State Governments has started an effort to convene meetings regarding the prospects for a dental licensure compact. Information was gathered and shared from American Association of Dental Administrators’ President Sandra Reen. Attachment #5

Database Migration Project
The OBD will begin transitioning from our current database environment and vendor this year. I will have an update at the Board Meeting on the timeline, complexity and workload of this mission critical project.

2019 Legislative Session
The legislative session started on January 22nd and I attached bills I am tracking that may have an impact on our Licensees or our agency. Attachment #6

IAA with OHA
OHA must develop integration performance indicators for Year 2 (2021) of the CCO 2.0 contract. Since this is during the period when OHA will also be evaluating CCO applications, OHA conversations must be governed by conflict of interest agreements. OHA anticipates that they may want to consult with the Board of Dentistry about some of their integration concepts to ensure that they fall within the scope of practice of dental practitioners. Attachment #7

2020 Proposed Board meeting Dates
Attached is a draft of the proposed meeting dates for 2019. I ask that the Board consider adopting these dates for next year’s meetings. Attachment #8 ACTION REQUESTED
## REVENUES

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## SERVICES and SUPPLIES

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<thead>
<tr>
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<th>Budget Obj Title</th>
<th>Prior Month</th>
<th>Current Month</th>
<th>Bien to Date</th>
<th>Financial Plan</th>
<th>Unoblig</th>
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Attachment #1
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<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Prior Month</th>
<th>Current Month</th>
<th>Bien to Date</th>
<th>Financial Plan</th>
<th>Unoblig</th>
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996,272.22  43,246.24  1,039,518.46  1,394,714.00  355,195.54

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Attachment #1
Date: March 8, 2019

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

Re: FY 2018 GOLD STAR CERTIFICATE

It is a great pleasure to inform you that your agency has earned the Chief Financial Office’s Gold Star Certificate for fiscal year 2018.

The Chief Financial Office’s Gold Star Certificate is awarded to state agencies that provide accurate and complete fiscal year end information in a timely manner. Clearly, the Gold Star is a challenge to earn, and its achievement is due primarily to your agency’s diligent efforts to maintain accurate and complete accounting records throughout the year.

Your agency’s participation in the Gold Star Certificate program is important in meeting statewide fiscal performance goals and key to the timely preparation of Oregon’s Comprehensive Annual Financial Report (CAFR) and the statewide Schedule of Expenditures of Federal Awards. Your agency’s success in accounting and financial reporting is also critical to Oregon’s success in receiving a favorable audit opinion on both statewide documents.

The Chief Financial Office’s Gold Star Certificate is Oregon’s equivalent to the nationally recognized GFOA Certificate of Achievement for Excellence in Financial Reporting. Through the collaborative team effort of state agencies and the Chief Financial Office, Oregon has earned the GFOA Certificate every year since 1992. Gold Star agencies are key to making this possible.

The Gold Star Certificate was delivered to your agency’s lead CAFR accountants, Yienta Saephan and Carol Brandt. Congratulations to your agency and your fiscal team for this outstanding work!

Sincerely,

George Naughton, Chief Financial Officer
Chief Financial Office

Robert W. Hamilton, Manager
Statewide Accounting and Reporting Services
Q1 How would you rate the timeliness of services provided by the Oregon Board of Dentistry?

Answered: 62  Skipped: 0

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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<tr>
<td>Good</td>
<td>24%</td>
</tr>
<tr>
<td>Fair</td>
<td>3%</td>
</tr>
<tr>
<td>Poor</td>
<td>8%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>6%</td>
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TOTAL 62
Q2 How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>61%</td>
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<tr>
<td>Good</td>
<td>20%</td>
</tr>
<tr>
<td>Fair</td>
<td>7%</td>
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<tr>
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<td>7%</td>
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<td>Don't Know</td>
<td>7%</td>
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Answered: 61  Skipped: 1
**Q3 How do you rate the helpfulness of the Oregon Board of Dentistry employees?**

Answered: 62  Skipped: 0

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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</thead>
<tbody>
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<td>66%</td>
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<tr>
<td>Good</td>
<td>21%</td>
</tr>
<tr>
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<td>5%</td>
</tr>
<tr>
<td>Poor</td>
<td>3%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>5%</td>
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<tr>
<td>TOTAL</td>
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Q4 How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?

Answered: 62  Skipped: 0

<table>
<thead>
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<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>55%</td>
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<tr>
<td>Good</td>
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TOTAL 62
Q5 How do you rate the availability of information at the Oregon Board of Dentistry?

Answered: 62  Skipped: 0

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>58%</td>
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<tr>
<td>Good</td>
<td>26%</td>
</tr>
<tr>
<td>Fair</td>
<td>8%</td>
</tr>
<tr>
<td>Poor</td>
<td>5%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3%</td>
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<tr>
<td>TOTAL</td>
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Q6 How do you rate the overall quality of service provided by the Oregon Board of Dentistry?

Answered: 62  Skipped: 0

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<td>Good</td>
<td>27% 17</td>
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<td>3% 2</td>
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Q7 Final Question- How do you rate our new website?

Answered: 51   Skipped: 11

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TOTAL 51

Oregon Board of Dentistry
AADB MID-YEAR MEETING

CHICAGO, ILLINOIS

ADA Headquarters
211 East Chicago Avenue, Chicago, IL
March 9 – 10, 2019

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

About AADB
The American Association of Dental Boards is a national association that encourages the highest standards of dental education, promotes higher and uniform standards of qualification for dental practitioners, and advocates uniform methods in the conduct and operation of dental examining boards. Membership is comprised of boards of dentistry, advanced education boards, present and past members of those boards, board administrators, board attorneys, and dental and dental hygiene educators.

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

Board Attorneys’ Roundtable (BAR)
Meeting Room A
Saturday, March 9: 1 - 5 p.m.
Sunday, March 10: 8:30 a.m. - 1 p.m.

Saturday, March 9

7 – 8:30 a.m.  Coffee and Light Breakfast
7 – 7:30 a.m.  AADB Programs & Meetings Committee
               Meeting Room B
7:30 – 8 a.m.  AADB Board Liaisons
               Meeting Room D
7:30 – 8 a.m.  AADB New Members
               Meeting Room E
8-11 a.m.     American Association of Dental Administrators (AADA)
               Meeting Room C
8 - 11 a.m.   AADB Board of Directors Meeting
               Meeting Room A
10-5:30 p.m.  Registration
11-11:30 a.m. Dental Hygiene Caucus Meeting
               Meeting Room D

GENERAL ASSEMBLY – Session I
Harold Hillenbrand Auditorium
ADA Headquarters, Second Floor

12:30 - 12:35 p.m. President’s Opening Remarks
Dr. Luis J. Fujimoto

Attachment #4
Saturday, March 9  (continued)

12:35 – 12:40 p.m.  
Remarks by the American Dental Association  
Dr. Jeffrey M. Cole, ADA President

12:40 – 12:45 p.m.  
Remarks by the American Dental Education Association (ADEA)  
Dr. Denice Stewart, M.H.S.A.  
Chief Policy Officer, ADEA

12:45 – 12:50 p.m.  
AADB State-of-the-Organization  
Dr. Luis J. Fujimoto, AADB President

12:50 – 1:15 p.m.  
Trends in Dental Education  
Dr. Denise Stewart, M.H.S.A., Chief Policy Officer, American Dental Education Association

Information from the ADEA Snapshot of Dental Education and other sources will be presented to demonstrate key trends in dental education. Gathering and analyzing data, trends and information on contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public critical for the dental education community to make informed decisions and plan for the future. The American Dental Education Association (ADEA) is The Voice of Dental Education. Its members include all 76 U.S. and Canadian dental schools, more than 1,000 allied and advanced dental education programs, over 60 corporations and more than 20,000 individuals. ADEA is committed to conducting research into contemporary and emerging issues that are likely to impact decisions in the dental education and policy-making communities. Each year, ADEA collects data on topics of particular interest to dental school deans, program directors, faculty, students,
residents and fellows. The information in this report is taken from data compiled by ADEA, the American Dental Association and other sources.

Attendees will be able to:

1. Discuss key trends in dental school student applications, enrollment, and graduates.
2. Identify trends in graduating seniors’ plans upon graduation (advanced education and practice).
3. Discuss gender and age distribution of faculty and impact on academia in the future.

1:15 – 1:40 p.m.  
**Ethics - A Student Perspective**  
Ms. Roopali Kulkarni, President  
*American Student Dental Association (ASDA)*

A perspective on the history of student ethics and how it aligns with the AADB Core Values: Protecting the nation’s oral health care consumer; collaboration with organized dentistry, dental education, and dental regulation; and meeting the needs of its members.

1:40-2:40 p.m.  
**The Positive Effects of Marijuana: Its Impact on Our Patients, Culture and Healthcare**  
Dr. John William “Bill” Claytor, Jr., Dental Wellness Advisory Committee of the American Dental Association - Board Member

This session will focus on the apparent benefits of marijuana for our patients and explore a culture that is embracing its medicinal and recreational use in daily life. Patient care issues, legal issues and how to ask a patient about marijuana usage will be discussed. Special emphasis will be placed on how dental state boards may have to respond to patient-dentist interactions surrounding marijuana usage from not only the patient but the dentist. Finally, I will examine the research and science behind the theory that marijuana can be used to treat opioid addiction in light of the current opioid epidemic in the U. S.

Objectives:

1. Discuss the benefits of marijuana use and how it affects our patients in the U. S.
2. Identify issues surrounding patients using marijuana and its legal ramifications.
3. Prepare dental state boards to be able to address issues of marijuana use by patients and dentists.
4. Explore the truth about marijuana use in treating opioid addiction.

2:40 - 2:50 p.m.  
**Networking Break**

2:50 – 3:00 p.m.  
**Reports from AADB Representatives to Outside Agencies**
 Marijuana: A Growing Concern for the Dental Professional
Christopher K. Finch, Pharm.D., FCCP, FCCM
Director of Pharmacy, Methodist University Hospital, Memphis, TN

Session Description:
With the majority of U.S. states reducing legal restrictions on marijuana and some even legalizing it for medical and/or recreational purposes, usage is going up at rapid rate. In fact, it is estimated that 13% of the American adults currently use marijuana. Thus, it is imperative that the dental community familiarize themselves with not only the benefits of its' use; but also, the consequences. These detrimental effects are not simply limited to marijuana's impact on oral health. The ramifications if used by the dental professional can be also significant. This ramifications presentation will focus on the negative impact that marijuana can have on patients and the practice of dentistry.

Objectives:
1. Review the history and evolution of marijuana in the medical community
2. Describe the oral health consequences of smoking marijuana
3. Evaluate the impact that marijuana use may have on the dental professional

Substance Use Disorders in the Dental Community
Brian Fingerson, RPH, President, Kentucky Professionals Recovery Network (KYPRN)

Session Description:
The dental community is no different from any other community in the United States – professional or otherwise – when it comes to facing Substance Use Disorders – Addictions – in its members. How do we recognize it? How do we report it? How do we intervene? To whom to we refer for help? This presentation will attempt to provide some answers to those questions.

Objectives:
1. Upon completion of this educational activity, you will be able to:
   2. Recognize signs and symptoms of substance use disorders
   3. Discuss the proper way to report a person with symptoms of a substance use disorder
   4. Describe the structure and support that is provided for return to practice by Wellbeing Committee monitoring

Networking Break

AADB Open Forum
Dr. Frank Maggio, Moderator

This lively, interactive session will provide the General Assembly an opportunity to discuss regulatory concerns and other important topics encountered by state boards in a spontaneous, free-flowing setting. The goal of this forum is to stimulate conversation. Participate in the AADB Open Forum by asking questions, discussing challenges, and sharing your successful practices and innovations.
By participating in this session, attendees will:

- Learn about regulatory and other topics of interest to state boards.
- Understand how other jurisdictions are addressing important issues.

6:00 – 8:00 p.m.  
**President’s Reception**  
Ritz Carlton

Sunday, March 10

**General Assembly – Session II**

- **Registration**
  - 7 – Noon
  - 7:30 – 8:00 a.m.
    - North Caucus  Meeting Room B
    - South Caucus  Meeting Room C
    - East Caucus  Meeting Room D
    - West Caucus  Meeting Room E

- **Business Session**
  - 8 – 8:10 a.m.
    - Dr. Luis J. Fujimoto, President
    - Dr. John Carbery, Treasurer

- **Corporate Governance**
  - 8:10 – 8:20 a.m.
    - Bobby White, Esq., Administrator

- **Sponsor Recognition**
  - 8:20 – 8:30 a.m.

- **Dental Compact**
  - 8:30 – 9:15 a.m.
    - Rick Masters, Esq., Special Counsel, National Center for Interstate Compacts, The Council of State Governments

**Learning Outcomes with Regard to Interstate Compacts**

The attendees will be provided with an overview of the legal and statutory foundation for interstate regulatory compacts with a specific emphasis upon interstate licensure compacts as a means of facilitating the removal of barriers to licensure and facilitation of enhanced employment opportunities through interstate occupational licensure portability as well as the avoidance of antitrust liability in the administration of both licensure and discipline.
9:15 – 10:00 a.m.  
**Interstate Compacts in the Anti-Regulatory Environment**—Responding to antitrust concerns, protecting boards against monetary liability and becoming better regulators.

Nahale Freeland Kalfas, JD, Board Member, National Council of State Boards of Examiners for Speech and Language Pathologists and Audiologists (NCSB); Speech and Language Pathology and Audiology Interstate Compact Advisory Committee and Drafting Team

Attendees will be given a survey of national anti-regulatory sentiment and national active supervision and curative measures responsive to the FTC v. NC Dental Board holding and discuss interstate compacts as a mechanism for regulators to avoid antitrust liability in the occupational licensure setting.

10 – 10:10 a.m.  
**Networking Break**

10:10 – 11:00 a.m.  
**What’s Going on In Dentistry? Big Data Trends You Should Know**

Mr. Michael Urbach, President, P&R Dental Strategies

**Session Description:**

P&R Dental Strategies will illuminate the dental terrain from the perspective of “Big Data.” P&Rs team of analytics experts will share the latest trend insights to illustrate shifts in utilization and the dental work force.

About P&R Dental Strategies trends and insights are derived from DentaBase®, our multi-payer database containing aggregated claims data from over 60 dental payers across the U.S. including large national for-profits, not-for-profits and regional payers. The de-identified database has at least 1 claim in the last 12 months from 93% of the actively practicing dentists in the US. The statistically valid DentaBase® data set contains over 3 billion records—adding 75 million per quarter—and includes data from every state in the country.

11:10 – 11:20 a.m.  
**Caucus Reports**

11:20 - Noon  
**Attorney Update**

Lori H. Lindley, JD, Assistant Attorney General, Oregon Department of Justice

**Discussion Topics:**
1. Do patients have a right to treat themselves?
2. Do they have the right to employ outside agencies to assist them in their treatment?
3. At what point do Dental Boards have the obligation to intervene?
4. Since many patient assisting entities cross state lines and technology has surpassed the efficacy of many state statutes. And the SCOTUS North Carolina decision has impaired Boards authority to deal with such issues, as well as, FTC involvement, has this become a Federal Issue?
The Attorney Update is a popular fixture of AADB’s Mid-Year and Annual Meetings. Our speakers will explore a variety of legal topics of interest to state boards of dentistry.

By participating in this session, attendees will:
- Learn about legal topics of interest to state boards.
- Learn about legal topics of interest to state boards.
- Understand the current legal landscape and its impact on the business of state boards.
- Receive interpretation and insights about legal issues of importance.

Noon Adjournment

Noon – 1:30 p.m. Banquet Luncheon

AADB Speaker Disclosures
No speakers have relevant financial relationships to disclose.

Monday, March 11

8 – 9:00 a.m. Board of Directors Meeting – Meeting Room A

9 – 12 p.m. AADB Board of Directors Meetings with ADA/ADEA/ASDA/ADHA – Meeting Room A

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AA DB 136th Annual Meeting
September 3-4, 2019
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Hi Sandra

Scott Warnick forwarded me your email with your question regarding CSG’s interest in dentistry and why the quick scheduling of the next meeting.

On your first question, CSG received a Department of Labor grant to work with a consortium of states who are all focused on licensure reform. Written into our grant application was money for new compact development. We developed a list of occupations that DOL wanted the consortium to focus on which were sub-bachelors, entry level occupations licensed in at least 30 states. One of these occupations was dental hygienist which we thought was the most likely candidate for a compact so we reached out to ADHA and some other dental groups. After some conversations, we decided to open it up to dentists and dental hygienists.

As far as the scheduling, at the last meeting the group had decided on the week of April 8-12. The results of the doodle poll I distributed were pretty conclusive that 4/10 and 4/11 were the best dates for folks so we went ahead with those.

Let me know if you have any more questions.

Best,

Matt Shafer, MPA
Senior Policy Analyst | The Center of Innovation
The Council of State Governments
1776 Avenue of the States, Lexington, KY 40511
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www.csg.org

The Council of State Governments
DISCUSSION OF A DENTAL LICENSING COMPACT

Background
The Council of State Governments ("CSG") convened a meeting regarding the prospects for an occupational licensure compact for the dental profession on February 12 and 13, 2019. The purpose of the meeting was to discuss the current state of occupational licensure compacts, efforts within the dental profession that are underway, and how best to move forward. CSG covered the hotel and transportation costs of the participants through its Department of Labor Occupational Licensure Grant. The meeting was held at the offices of the National Council of State Boards of Nursing in Chicago, IL.

The participants were:
- 5 CSG staffers
- 5 ADA representatives
- 2 ADHA representatives
- 2 ADEA representatives
- 2 ASDA representatives
- 2 ADSO representatives
- 1 AADB representative
- 1 NLC representative
- 1 NC attorney for the Speech and Language Board
- 1 AADA representative – Sandra Reen.

Information on Compacts Addressed
- Some compacts are agreements to expedite state licensure (Medicine) others provide practice privileges in multiple states (Nursing)
- Compacts are tailored to each profession to reduce barriers to portability and establish uniform standards for licensure
- Compacts address some FTC concerns
- Compacts include a national database – nursys.com a good model, AADB’s voluntary database was offered
- Are critical for emergency/crisis/disaster management
- Stages for development of a compact are:
  - Convening an advisory group of approximately 20 individuals which meets two or three times over a period of several months to develop a set of recommendations as to what the final compact should look like – macro level discussion – meets 2 to 3 times over several months
  - Drafting team of 5 to 8 compact and issue experts craft language for the compact based on the advisory group’s recommendations, circulates the draft for comment and revises the draft then submits it to the advisory group for final review – meets 3 to 4 times over 10 to 14 months
  - Education of legislators, state by state technical assistance and briefings for state officials – occurs before and during state legislative sessions
  - Enactment occurs when a predetermined number of states join the compact – it was suggested that a minimum of 12 states should be committed
  - Transition includes standard startup activities, planning meetings of member states, establishing forms, rules and operational standards
- Estimated cost for starting a dental compact was about $750,000
- CSG has grant funding and can pursue additional grants

Meeting Outcomes
- Everyone in attendance agreed that formation of a dental compact for dentists and dental hygienists should be explored
- Advisory Group should include more current representatives of Boards of Dentistry:
  - Another board exec
  - A legal representative of a board, board counsel or assistant attorney general
  - Up to 3 current sitting board members – preferably experience in an independent board, a board in an umbrella agency and/or a citizen member, and
- A state legislator/dentist
ABOUT »

Founded in 1933, The Council of State Governments is our nation’s only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national and international opportunities to network, develop leaders, collaborate and create problem-solving partnerships.

CSG’s Mission

CSG champions excellence in state governments to advance the common good.

CSG’s Values

To achieve this mission, CSG will:

- Pursue the priorities of its member states
- Be nonpartisan and inclusive
- Engage leaders from all three branches of state government
- Have a regional focus, a national presence and a global reach
- Be a respected and trusted source for best practices and policy expertise
- Convene leader to leader interactions and foster leadership development
- Facilitate multistate solutions
- Zealously advocate for the states in our federal system of government
- Adhere to the highest ethical standards
- Respect diversity and act with civility
- Partner and collaborate with others

CSG Headquarters

CSG’s national headquarters is in Lexington, Ky. The address is 1778 Avenue of the States, Lexington, Ky 40511. The phone number is (859) 244-8000 and the fax number is (859) 244-8001.
The National Center for Interstate Compacts (NCIC)

NCIC is a policy program developed by CSG to assist states in developing Interstate compacts, which are contracts between states. State governments often prefer to direct themselves collaboratively when addressing problems that span boundaries, and compacts have proved to be an effective mechanism for states to jointly problem-solve, often avoiding federal intervention. NCIC serves as an information clearinghouse, a provider of training and technical assistance and a primary facilitator in assisting states in the review, revision and creation of new Interstate compacts to solve multi-state problems.

The compacts center is a program borne from CSG's more than 75 year history of promoting multi-state problem solving and advocating the role of the states in determining their respective futures. During that time, CSG began tracking the progress of more than 200 active Interstate compacts, researching innovative solutions for the states and bringing the states together to build consensus on national issues.
3. Regulatory Compacts:

- These compacts are a development of the 20th century that cover a wide range of policy topics, including:
  - Regional planning and development
  - Crime control
  - Agriculture
  - Flood control
  - Water resource management
  - Education
  - Mental health
  - Juvenile delinquency
  - Child support
- Regulatory compacts create ongoing administrative agencies that are granted rulemaking and regulatory authority by the compact.
- Many regulatory compacts require congressional consent.

CSG-Derived Best Practices for Development of Regulatory Compacts

The compact development process has evolved for more than 200 years, and maintaining the integrity of the development process remains crucial to the success of a compact.

Unlike most legislation, a compact bill should not be amended from its original form after introduction because it legally functions as the acceptance of a contractual agreement between states. Therefore, compacts face a unique hurdle. They can be easily derailed, merits aside, if the appropriate stakeholders and groundwork have not been addressed on the front end. Legislative buy-in is crucial, and in CSG's experience, the development of any interstate compact should be a state-driven and state-championed solution to a policy issue.

Outlined below are the key steps to the development process of a regulatory compact—one of the more sophisticated and common forms of modern compacts. This facilitative approach has become popular because of its flexibility. The following steps in the process should be viewed as examples and can be customized as needed.

- Advisory Group: Composed of state officials and other critical stakeholders, an advisory group examines the problem, suggests possible solutions and makes recommendations as to the structure of the Interstate compact. Typically, an advisory group is comprised of approximately 20 individuals, each representative of various groups and states. This step also represents a crucial foundation and opportunity to ensure a credible, inclusive process. An advisory group usually meets two or three times over a period of several months, with its work culminating in a set of recommendations as to what the final compact product should look like.

- Drafting Team: While the advisory group is tasked with thinking about the issue from a macro level, a drafting team pulls the thoughts, ideas and suggestions of the advisory group into a draft compact. The drafting team, comprised of five to eight compact and issue experts, crafts language based on the recommendations of the advisory group, as well as their own thoughts and expertise. The drafting team opens the document for comments from a wide array of stakeholders and the public. Following these comment periods, the drafting team revises the compact as needed and sends it back to the advisory group for final review to ensure it meets the original spirit of the group's recommendations. A drafting team meets three to four times over a period of 10 to 14 months, with significant staff work and support between sessions.

- Education: Once completed, the Interstate compact is available to states for legislative approval. During this phase of the initiative, state-by-state technical assistance and on-site education are keys to rapid success. Previous Interstate compact efforts have convened end-of-the-year legislative briefings for state officials to educate them on the solutions provided by the compact. Education occurs before and during state legislative sessions.

- Enactment: A majority of Interstate compacts do not become active right away. Rather, they typically activate when a predetermined number of states join the compact. For instance, the Interstate Compact for Adult Offender Supervision, known as the Adult Compact, required 35 state enactments before it could become active. This number was chosen for two reasons. A membership of 35 states ensures that a majority of states are in favor of the agreement and that a new compact would not create two conflicting systems. Moreover, a sense of urgency for states was created because the first 35 jurisdictions to join would meet soon thereafter and fashion the operating rules of the compact. Most Interstate compacts take up to seven years to reach critical mass. Recent efforts managed by CSG, including the Adult Compact and the Interstate Compact on Educational Opportunity for Military Children, reached 35 states in just 20 months, about two
and a half legislative sessions.

- Transition: Following enactment by the required minimum number of states, the new compact becomes operational. Depending on the administrative structure, the compact goes through standard startup activities such as state notification, planning for the first commission or state-to-state meetings, and if authorized by the compact, hiring of staff to oversee the agreement and its requirements. A critical component of the transition is the development of rules, regulations, forms, standards, etc., by which the compact operates. Typically, transition activities run between 12 and 18 months before the compact body is independently running.

These steps represent the core best practices for compact development and the developmental framework used by CSG’s National Center for Interstate Compacts (www.csg.org/compacts). The model has been used in previous compacts efforts, such as the Interstate Compact on Educational Opportunity for Military Children, the Interstate Compact for Juveniles and the Interstate Compact for Adult Offender Supervision, as well as ongoing CSG projects such as the Prescription Monitoring Program Compact and the Interstate Electric Transmission Line Siting Compact.

The development of an interstate compact should not be entered into lightly. Emphasis should be placed on the development being an inclusive process, getting stakeholder input and buy-in, and doing considerable research in advance of and during the advisory phase. Considerable effort must be made to determine if an interstate compact is feasible for a particular policy problem, and if so, what the compact needs to look like. When developed and structured correctly, interstate compacts provide states a durable solution to interstate policy challenges and a viable alternative to federal pre-emption.

Resources:

For more information, see "The Evolving use and the Changing Role of Interstate Compacts: A Practitioner’s Guide" by Caroline N. Broun, Michael L. Buenger, Michael H. McCabe, & Richard L. Masters. Additional information is also available at www.csg.org/compacts.

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Tags:
Capitol Research (/kc/category/tags/capitol-research)
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Policy Area (/kc/category/policy-area) › Interstate Compacts (/kc/category/policy-area/interstate-compacts) › National Center for Interstate Compacts (/kc/category/policy-area/interstate-compacts/national-center-compact-compacts)
Uniform Licensure Requirements for a Multistate License

Requirements:
An applicant for licensure in a state that is part of the eNLC will need to meet the following uniform licensure requirements:

1. Meets the requirements for licensure in the home state (state of residency);
2. a. Has graduated from a board-approved education program; or
   b. Has graduated from an international education program (approved by the authorized accrediting body in the applicable country and verified by an independent credentials review agency);
3. Has passed an English proficiency examination (applies to graduates of an international education program not taught in English or if English is not the individual's native language);
4. Has passed an NCLEX-RN® or NCLEX-PN® Examination or predecessor exam;
5. Is eligible for or holds an active, unencumbered license (i.e., without active discipline);
6. Has submitted to state and federal fingerprint-based criminal background checks;
7. Has no state or federal felony convictions;
8. Has no misdemeanor convictions related to the practice of nursing (determined on a case-by-case basis);
9. Is not currently a participant in an alternative program;
10. Is required to self-disclose current participation in an alternative program; and
11. Has a valid United States Social Security number.
INDICATOR 1: ADOPTION OF NURSE LICENSURE COMPACT

KEY FINDING: 31 states participated in the Nurse Licensure Compact in 2018.

Workforce shortages can impair a state’s ability to effectively manage disasters or disease outbreaks, potentially resulting in poorer health outcomes for those affected. Therefore, the capacity to quickly increase the availability of qualified medical personnel is critical.

This indicator examines whether states have adopted legislation to participate in the Nurse Licensure Compact (NLC). Launched in 2000 by the National Council of State Boards of Nursing, the NLC permits registered nurses and licensed practical nurses to practice with a single multistate license—physically or remotely—in any state that has joined the compact. The NLC provides standing reciprocity, with no requirement that an emergency be formally declared.

To help make participation in the compact more viable for states, the National Council of State Boards of Nursing enhanced its requirements in 2017–2018, adding a requirement for state and federal criminal background checks, and standardizing licensure requirements among participating states, among other changes.\(^\text{10}\)

The NLC has been crucial to response efforts after several recent disasters.\(^\text{11}\) In 2017, when Hurricane Harvey struck Texas, healthcare systems were overwhelmed, and nurses from many member states were able to immediately assist those in need. In 2018, when Hurricane Florence left severe damage in South Carolina from rain, flooding, and high winds, DaVita Renal Dialysis Centers were in dire need of nurses. Thanks to South Carolina’s membership in the compact, DaVita was able to recruit nurses from other NLC states without delay. A few weeks later, when flooding from Hurricane Michael forced at least one hospital in the state to evacuate, nurses from other member states were able to assist.

As of November 2018, 31 states had adopted the NLC.\(^\text{12}\) (See Table 4.) Five states (Florida, Georgia, Oklahoma, West Virginia, and Wyoming) began to formally implement the compact in January 2018, and two (Kansass and Louisiannas) are scheduled to do so in July 2019. In contrast, Rhode Island exited the NLC in July 2018.

<table>
<thead>
<tr>
<th>TABLE 4: 31 States Participated in the Nurse Licensure Compact</th>
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</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
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<tr>
<td>Arizona</td>
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<td>Arkansas</td>
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<td>Colorado</td>
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<td>Delaware</td>
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<td>Florida</td>
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<td>Iowa</td>
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<tr>
<td>Kansas</td>
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<tr>
<td>Kentucky</td>
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<tr>
<td>Louisiana</td>
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Note: Kansass and Louisiannas are scheduled to begin implementing the NLC in July 2019.
Source: National Council of State Boards of Nursing\(^\text{12}\)
State adoption of NLC is among the report recommendations found on page 34:

- Clarify and strengthen policies regarding disaster healthcare delivery. States have varied policies and practices governing the delivery of healthcare during emergencies, including those pertaining to contracting and hiring, licensure and credentialing, use of telehealth, liability for healthcare providers and volunteers, and adoption of crisis standards of care in the context of scarce resources. The ASPR should review barriers to healthcare response and recovery and should provide guidance for states to clarify laws and policies regarding healthcare disaster readiness and volunteer management. State policymakers should adopt best practices and policies that promote healthcare readiness, such as the Nurse Licensure Compact, the EMS Personnel Licensure Interstate CompAct, the Uniform Emergency Volunteer Health Practitioners Act, and crisis standards of care guidelines.
### Participant List

<table>
<thead>
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<th>Organization</th>
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NORTHERN KENTUCKY GREAT CINCINNATI

CSG 2018 NATIONAL CONFERENCE • DECEMBER 6-8

Nurse Licensure Compact: Nuts & Bolts
Joey Ridenour RN MN FAAN
December 7, 2018
Nurse Licensure Compact (NLC) 2000-2018

Nuts & Bolts

Most important & fundamental pieces that fasten compact parts together
1. **New** legal structure: interstate compact agencies are “supra state” and “sub federal” which necessitate different governmental structure

- Most legislators & other governmental officials are unfamiliar with compacts **quasi** governmental structure

- “Courts typically treat a compact agency like a state agency, rather than hold the compact agency is a state agency” (Jeffrey Litwak, 2018 Interstate Compact Law: Cases & Materials)

- First compact adopted 1783; 235 years and 200 compacts later, many still state “it will never work”

**What works:** Education and messaging that communicates how the an unusual agency works into the familiar governmental structure.
2. Identical “sameness”: Compact enacted by the legislature, becomes law & the “contract” may not be amended, modified or otherwise altered without the consent of all parties

- The original NLC model act was originally adopted in 1997 & enacted in 2000
- The enhanced compact language was adopted in 2015 or 18 years later & enacted January 2018
- Unlike model laws, which need not to be identical, interstate compacts between states must be adopted verbatim, thus they offer great uniformity and stability, but limited flexibility

**What works:** Vigilant legal review to ensure there are not any material differences in the proposed language when introduced. The NLC has on occasion determined that the language adopted by the state was not binding and therefore not recognized by the other party states
3. **Portability procedures** - licensees need only one multi state license which gives them a privilege to practice in other states that have implemented the NLC

- Applicants who meet the Uniform Licensure Requirements (ULR’s) and do not have any disqualifying event, are eligible for a multi state license
- In general, no additional fees, paperwork or review is needed

**What works:** Under the NLC, currently licensed nurses moving from one state to another party state may continue to work on the multi state privilege until the new license issued. Nurses do not need stop work when moving to a new primary state of residence.

One multistate license issued locally & recognized nationally
4. IT: Data system fastens together information between all states/territories

- Nursys is a national data base that is free & allows employers & public verify multistate and single state licenses and privileges to practice
- Multistate licensure privilege means the nurse has the authority to practice in any compact party state

**What works:** Nurses & Human Resource Staff need non technical explanations of the multistate compact requirements i.e. webinars, videos & educational material such as FAQ’s

Nurse leaders also need assistance & education on how to validate licenses from home state or primary state of residence.
5. IT: Nursys data system enhances sharing of applicant and licensee records & disciplinary histories among compact states when endorsing into new primary state of residence

**What works:** Nurses who declare a new primary state of residence in another party state apply for licensure when the person holds privileges only granted to citizens of the new state; i.e. drivers license, voter registration, payment of federal income taxes

*NLC does not alter the scope of practice provision of state practice acts*
6. Rulemaking: Interstate compact rules are uniquely viewed as independent & separate from state or federal rulemaking processes

- NLC has modeled the process to mirror APA’s model acts
- The intent of rulemaking is to assure due process primarily obtained through notice & comment procedures

What works: No matter how lawful, technically sound & reasonable the rule may be, the NLC will not adopt rule as law if the public or commissioners do not want it.
8. ULR’s: Harmonizing of state licensure standards- Uniform Licensure Requirements (ULR)

- Builds confidence in the qualifications of those who are practicing nursing in multiple states
- ULR’s: meet state qualifications; eligible graduate of approved pre-licensure program; foreign applicants pass English proficiency exam, successfully pass NCLEX, eligible/active unencumbered license, finger prints/biometric data for state/FBI history, no felony history, no misdemeanor related practice of nursing, not currently enrolled ATD, self disclosure if in ATD, valid SS number

**What works:** 31 states have enacted the NLC. Licensure portability benefits consumers of healthcare through access to care when more states enact the compact.
9. **Enforcement**: Authority for disciplinary action across state lines

- Multistate license provides privilege to practice in all party states. Such provisions provide for a “stronger and more efficient state board enforcement in the context of modern cross-border practice in which state lines are often blurred.” UAA, supra note 60, at 1-2

**What works**: Member states coordinate and communicate information about licensee conduct. Party states ensure disciplinary action may be taken against the license or the privilege to practice. Adverse actions are reported to Nursys within fifteen days on date action was taken.
Summary: Nine Nuts & Bolts

- The NLC journey will continue to create new ways to “fasten things together”
- Thank you!

- Joey Ridenour, Executive Director
- Arizona State Board of Nursing
- jridenour@azbn.gov
- Direct line: 60 771 7801
<table>
<thead>
<tr>
<th>Bill Name</th>
<th>Last Three Actions</th>
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</thead>
</table>
| HB 2011  | 04/09/19 - Work Session scheduled.  
            04/02/19 - Public Hearing held.  
            03/06/19 - Referred to Health Care. |
|           | Relating to cultural competency continuing education; prescribing an effective date.  
            Requires specified professional regulatory boards to require persons authorized to practice professions regulated by board to complete cultural competency continuing education.  
            Takes effect on 91st day following adjournment sine die. |
| HB 2220  | 04/02/19 - Referred to Health Care.  
            04/01/19 - First reading. Referred to President's desk.  
            03/28/19 - Third reading. Carried by Hayden, Schouten. Passed. Ayes, 58; Excused, 2--Findley, Keny-Guyer. |
|           | Relating to vaccines administered by dentists; declaring an emergency.  
            Authorizes trained and certified dentists to prescribe and administer vaccines. Directs Oregon Board of Dentistry to approve training course on prescription and administration of vaccines. Directs board to adopt rules related to prescription and administration of vaccines by dentists.  
            Declares emergency, effective on passage. |
| HB 2241  | 04/01/19 - Referred to Ways and Means by prior reference.  
            04/01/19 - Recommendation: Do pass and be referred to Ways and Means by prior reference.  
            03/25/19 - Work Session held. |
|           | Relating to state court technology fees; prescribing an effective date.  
            Authorizes Chief Justice of the Supreme Court to impose fees on public bodies for use of certain electronic court services.  
            Takes effect on 91st day following adjournment sine die. |
| HB 2257  | 02/18/19 - Referred to Ways and Means by prior reference.  
            02/18/19 - Recommendation: Do pass with amendments, be printed A-Engrossed, and be referred to Ways and Means by prior reference.  
            02/12/19 - Work Session held. |
|           | Relating to drugs; declaring an emergency.  
            Declares legislative intent to consider substance use disorder as chronic illness.  
            Directs Department of Corrections to study issues related to continuity of care for persons in department's custody. Requires department to report to interim committee of Legislative Assembly not later than July 1, 2020. Sunsets January 2, 2021.  
            Directs Oregon Health Authority to convene advisory group to make recommendations for accreditation requirements for substance use treatment providers. Requires authority to implement requirements not later than January 2, 2021. Sunsets January 2, 2022.  
            Expires as follows:  
            Directs authority to prohibit coordinated care organizations and public payers of health insurance from requiring prior authorization of payment during first 30 days of medication-assisted treatment for substance use disorders. Directs authority to implement pilot project to provide substance use disorder treatment to pregnant persons. Requires authority to report on pilot project to interim committee of Legislative Assembly not later than December 31 of each year. Sunsets January 2, 2022.  
            Directs authority to prohibit coordinated care organizations and public payers of health insurance from requiring prior authorization of payment during first 30 days of medication-assisted treatment for substance use disorders. Requires commission to report to interim committee of Legislative Assembly not later than December 31, 2019. Sunsets January 2, 2020.  
            Requires prescription monitoring program established by authority to be accessible to dental directors. Defines "dental director." Requires dispensation of gabapentin to be reported to prescription monitoring program. Allows Prescription Monitoring Program Prescribing Practices Review Subcommittee to direct authority to compare prescriptions of certain drugs between similarly situated practitioners for purposes of evaluation.  
            Declares emergency, effective on passage. |
<table>
<thead>
<tr>
<th>Bill Name</th>
<th>Last Three Actions</th>
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</thead>
<tbody>
<tr>
<td>HB 2265</td>
<td>03/27/19 - Chapter 3, (2019 Laws): Effective date January 1, 2020. 03/20/19 - Governor signed. 03/13/19 - President signed.</td>
</tr>
<tr>
<td></td>
<td>Relating to health care practitioners.  Adds optometrists to list of health care practitioners who must complete pain management education program.  Replaces Governor with Oregon Health Policy Board as appointing authority for Health Plan Quality Metrics Committee.  Permits Oregon Health Authority to provide to agencies and Legislative Assembly data from other relevant sources in addition to data from health care workforce database.</td>
</tr>
<tr>
<td>HB 2431</td>
<td>04/03/19 - Referred to Ways and Means by order of Speaker. 04/03/19 - Recommendation: Do pass with amendments, be printed A-Engrossed, and be referred to Ways and Means. 03/26/19 - Work Session held.</td>
</tr>
<tr>
<td></td>
<td>Relating to state agency accountability for public records law compliance.  Requires each state agency to report to Attorney General, Public Records Advocate and public records subcommittee of Legislative Counsel Committee on number of public records requests received during preceding year, and number of those requests still outstanding after specified periods of time. Requires each state agency to include in report specified information on fee waivers and reductions.</td>
</tr>
<tr>
<td>HB 2482</td>
<td>01/15/19 - Referred to Judiciary. 01/14/19 - First reading. Referred to Speaker's desk.</td>
</tr>
<tr>
<td></td>
<td>Relating to physician-patient privilege.  Provides exception to physician-patient privilege for examination at deposition about communications with patient's physicians about issue of patient's physical, mental or emotional condition in proceeding in which party relies on condition as element of claim.</td>
</tr>
<tr>
<td>HB 2607</td>
<td>01/15/19 - Referred to Education. 01/14/19 - First reading. Referred to Speaker's desk.</td>
</tr>
<tr>
<td></td>
<td>Relating to oral health education in public schools; prescribing an effective date.  Requires school districts to provide instruction in oral health. Takes effect July 1, 2020.</td>
</tr>
<tr>
<td>HB 2609</td>
<td>04/02/19 - Referred to Health Care. 04/01/19 - First reading. Referred to President's desk. 03/28/19 - Third reading. Carried by Hayden. Passed. Ayes, 58; Excused, 2--Findley, Keny-Guyer.</td>
</tr>
<tr>
<td></td>
<td>Relating to dental directors; declaring an emergency.  &lt;i&gt;Requires prescription monitoring system established by Oregon Health Authority to be accessible to dental director appointed by authority.&lt;/i&gt; Directs &lt;b&gt;Oregon Health&lt;/b&gt; Authority to disclose certain patient information to dental directors for specified purposes. Defines &quot;dental director.&quot; Declares emergency, effective on passage.</td>
</tr>
<tr>
<td>HB 2666</td>
<td>01/15/19 - Referred to Education. 01/14/19 - First reading. Referred to Speaker's desk.</td>
</tr>
<tr>
<td></td>
<td>Relating to oral health education in public schools; prescribing an effective date.  Requires school districts to provide instruction in oral health. Takes effect July 1, 2020.</td>
</tr>
<tr>
<td>Bill Name</td>
<td>Last Three Actions</td>
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</tbody>
</table>
| HB 2706   | 04/04/19 - Work Session held.  
|           | 03/12/19 - Public Hearing held.  
|           | 01/15/19 - Referred to Health Care with subsequent referral to Ways and Means.  |
|           | Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association.  
|           | Establishes COFA Dental Program in Oregon Health Authority to provide dental care to low-income citizens of Pacific Islands in Compact of Free Association who reside in Oregon and lack access to affordable dental coverage. Specifies eligibility requirements for program and duties of authority in administering program. |
| HB 3030   | 04/08/19 - Work Session scheduled.  
|           | 03/20/19 - Public Hearing held.  
|           | 02/25/19 - Referred to Business and Labor.  |
|           | Relating to professional authorizations; prescribing an effective date.  
|           | Allows professional licensing board to issue temporary authorization to spouse of member of Armed Forces of United States stationed in Oregon and who holds out-of-state authorization to provide occupational or professional service. Takes effect on 91st day following adjournment sine die. |
| HB 3106   | 03/04/19 - Referred to Health Care.  
|           | 02/27/19 - First reading. Referred to Speaker's desk.  |
|           | Relating to dental care provided by coordinated care organizations.  
|           | Requires coordinated care organization that manages its own dental program to have licensed dentist on site at least one day each week. |
| HB 3107   | 03/04/19 - Referred to Health Care.  
|           | 02/27/19 - First reading. Referred to Speaker's desk.  |
|           | Relating to dental programs managed by coordinated care organizations.  
|           | Requires coordinated care organization that manages its own dental program to have dental clinical advisory group. |
| HB 3108   | 03/04/19 - Referred to Health Care.  
|           | 02/27/19 - First reading. Referred to Speaker's desk.  |
|           | Relating to dental care providers.  
|           | Requires Oregon Health Authority to make available upon request specified information regarding dental care providers that contract with coordinated care organizations. |
| HB 3267   | 04/02/19 - Work Session held.  
|           | 03/11/19 - Referred to Health Care.  
|           | 03/04/19 - First reading. Referred to Speaker's desk.  |
|           | Relating to health care.  
|           | Requires Oregon Health Authority to research innovative approaches to delivery and financing of health care in other states and countries and report to interim committees of Legislative Assembly related to health on any practices that could be implemented in this state. |
| HB 3315   | 03/11/19 - Referred to Health Care with subsequent referral to Ways and Means.  
|           | 03/04/19 - First reading. Referred to Speaker's desk.  |
|           | Relating to prescription drugs; prescribing an effective date.  
<p>|           | Requires that certain prescription drugs, including those prescribed by veterinarians, must be reported to prescription monitoring program. Requires pharmacies located in institutions operated, controlled, managed and supervised by Oregon Health Authority and Department of Corrections to report specified prescriptions to prescription monitoring program. Requires Oregon Health Authority to disclose prescribing history information to practitioner for purpose of practitioner's self-evaluation and to health professional regulatory board for purpose of evaluating practitioners regulated by board. Directs health professional regulatory board to require practitioners to register with prescription monitoring program. Requires authority to meet specified objectives to increase effectiveness of prescription monitoring program and to report to interim committee of Legislative Assembly related to health care not later than December 31, 2020. Takes effect on 91st day following adjournment sine die. |</p>
<table>
<thead>
<tr>
<th>Bill Name</th>
<th>Last Three Actions</th>
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<tbody>
<tr>
<td>HB 3332</td>
<td>03/11/19 - Referred to Health Care.</td>
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<tr>
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<td>03/04/19 - First reading. Referred to Speaker's desk.</td>
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<tr>
<td>Relating to naloxone; prescribing an effective date.</td>
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<td>Requires certain pharmacies to provide notice that naloxone and necessary medical</td>
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<td>supplies to administer naloxone are available at pharmacy. Requires practitioners</td>
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<td>to prescribe naloxone and necessary medical supplies in conjunction with</td>
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<td>prescription for certain dose of opiate. Requires practitioner to prescribe and</td>
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<td></td>
<td>dispense naloxone and necessary medical supplies to patient discharged from</td>
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<td>hospital after treatment for opiate overdose.</td>
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<td>Takes effect on 91st day following adjournment sine die.</td>
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<tr>
<td>HB 3344</td>
<td>03/11/19 - Referred to Health Care.</td>
</tr>
<tr>
<td></td>
<td>03/04/19 - First reading. Referred to Speaker's desk.</td>
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<tr>
<td>Relating to health care provider billing.</td>
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<td>Requires health care providers to include CPT codes in bills sent to consumers</td>
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<td>and insurers. Requires insurers to include CPT codes in explanation of benefit</td>
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<td>notices.</td>
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<td>HB 3353</td>
<td>03/11/19 - Referred to Health Care.</td>
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<tr>
<td></td>
<td>03/04/19 - First reading. Referred to Speaker's desk.</td>
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<tr>
<td>Relating to dental services; prescribing an effective date.</td>
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<td>Allows nonprofit corporation that provides reduced-cost dental services to</td>
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<td>underserved populations, including individuals 55 years of age or older or</td>
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<td>individuals who require accessible facilities, to own, operate, conduct or</td>
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<td>maintain dental practice.</td>
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<td>Takes effect on 91st day following adjournment sine die.</td>
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<tr>
<td>HB 5013</td>
<td>04/03/19 - President signed.</td>
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<td>04/02/19 - Speaker signed.</td>
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<td>04/01/19 - Third reading. Carried by Roblan. Passed. Ayes, 23; Nays, 6--Baertschiger</td>
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<td>Jr, Bentz, Boquist, Linthicum, Thatcher, Thomsen; Excused, 1--Olsen.</td>
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<tr>
<td>Relating to the financial administration of the Oregon Board of Dentistry;</td>
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<td>declaring an emergency.</td>
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<td>Limits biennial expenditures from fees, moneys or other revenues, including</td>
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<td>Miscellaneous Receipts, but excluding lottery funds and federal funds, collected</td>
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<td>or received by Oregon Board of Dentistry.</td>
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<td>Declares emergency, effective July 1, 2019.</td>
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<td>SB 240</td>
<td>04/09/19 - Public Hearing and Possible Work Session scheduled.</td>
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<tr>
<td></td>
<td>01/15/19 - Referred to Business and General Government.</td>
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<td></td>
<td>01/14/19 - Introduction and first reading. Referred to President's desk.</td>
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<tr>
<td>Relating to electronic government records; prescribing an effective date.</td>
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<td>Directs governmental agencies of this state to use electronic records and</td>
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<td>Directs each governmental agency of this state to submit website modernization</td>
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<td>plan to State Chief Information Officer by July 1, 2020, and to update plan</td>
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<td>biennially. Directs each governmental agency of this state to submit plan for use</td>
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<td>of electronic records and electronic signatures to State Chief Information Officer</td>
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<td>by July 1, 2020, and to update plan biennially. Directs each governmental agency of</td>
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<td>this state to ensure its websites effectively render on mobile devices and are</td>
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<td>accessible for persons with disabilities by July 1, 2021.</td>
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<td>Takes effect on 91st day following adjournment sine die.</td>
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<tr>
<td>SB 592</td>
<td>01/15/19 - Referred to Judiciary.</td>
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<td>01/14/19 - Introduction and first reading. Referred to President's desk.</td>
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<tr>
<td>Relating to noneconomic damages; declaring an emergency.</td>
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<td>Repeals $500,000 limitation on awards of noneconomic damages in civil actions</td>
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<td>seeking damages for bodily injury, death or property damage.</td>
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<td>Declares emergency, effective on passage.</td>
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</tbody>
</table>
Bill Name | Last Three Actions
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SB 688 | 04/08/19 - First reading. Referred to Speaker's desk.
04/04/19 - Third reading. Carried by Olsen. Passed. Ayes, 28; Excused, 2--Roblan, Winters.
04/01/19 - Taken from 04-01 Calendar and placed on 04-04 Calendar by unanimous consent.
Relating to professional authorizations; prescribing an effective date.
   Allows professional licensing board to accept as authorization to provide occupational or professional service out-of-state authorization of spouse of member of Armed Forces of United States who is stationed in Oregon.
   Takes effect on 91st day following adjournment sine die.
SB 770 | 04/08/19 - Work Session scheduled.
04/03/19 - Work Session held.
04/01/19 - Public Hearing held.
Relating to statewide health care coverage; declaring an emergency.
   Establishes Health Care for All Oregon Board to be responsible for planning and oversight of Health Care for All Oregon Plan to be administered by Oregon Health Authority. Provides comprehensive health care coverage to all individuals residing or working in Oregon. Repeals health insurance exchange upon implementation of Health Care for All Oregon Plan.
   Supplants coverage by private insurers for health services covered by plan. Authorizes Public Employees’ Benefit Board and Oregon Educators Benefit Board to offer supplemental health benefit plans to employees. Requires public employees to be covered by Health Care for All Oregon Plan.
   Establishes Health Care for All Oregon Fund. Continuously appropriates moneys in fund to Health Care for All Oregon Board.
   Establishes office of Health Care for All Oregon Ombudsman in office of Governor.
   Requires Health Care for All Oregon Board to establish Regional Planning Boards to oversee allocation of health resources in geographic regions prescribed by Health Care for All Oregon Board. Requires submission to Regional Planning Board of plans for addition, alteration or construction of health care facility except long term care facility. Authorizes Health Care for All Oregon Board to provide public funding upon request if addition, alteration or construction approved. Transfers to Department of Human Services authority to approve certificate of need for long term care facility.
   Appropriates moneys from General Fund to Health Care for All Oregon Board for purposes of Health Care for All Oregon Plan.
   Declares emergency, effective on passage.
SB 773 | 03/25/19 - Public Hearing held.
02/14/19 - Referred to Judiciary.
02/12/19 - Introduction and first reading. Referred to President's desk.
Relating to criminal background criteria used by professional licensing boards.
   Requires each professional licensing board to study criminal background criteria and character standards for licensure, certification or other authorization to provide occupational or professional service regulated by board. Requires reports to interim committee of Legislative Assembly related to workforce.
SB 778 | 03/25/19 - Public Hearing held.
02/14/19 - Referred to Judiciary.
02/12/19 - Introduction and first reading. Referred to President's desk.
Relating to certificates of good standing.
   Expands eligibility of Certificate of Good Standing to include persons convicted of person felony or person Class A misdemeanor. Requires court to provide copy of petition for certificate to district attorney.
   Provides that, in negligence actions against landlord for renting or leasing to specific tenant, fact that tenant has valid Certificate of Good Standing creates rebuttable presumption that landlord was not negligent.
   Prohibits denial of license, permit, registration, certificate or other qualification to engage in practice of profession, occupation or business, or preclusion from volunteering in school, based solely on prior criminal conviction if person has Certificate of Good Standing.
<table>
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<th>Bill Name</th>
<th>Last Three Actions</th>
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</thead>
</table>
| **SB 808** | 04/08/19 - Work Session scheduled.  
04/03/19 - Public Hearing held.  
02/20/19 - Referred to Health Care, then Ways and Means.  
Relating to continuing education for professionals; prescribing an effective date.  
Directs Oregon Health Authority and specified professional regulatory boards to require licensees regulated by authority or board to complete continuing education related to suicide risk assessment, treatment and management and to report completion of continuing education to authority or board.  
Takes effect on 91st day following adjournment sine die. |
| **SB 824** | 04/01/19 - Work Session held.  
03/13/19 - Public Hearing held.  
02/22/19 - Referred to Health Care.  
Relating to dental licensure examinations; declaring an emergency.  
Requires Oregon Board of Dentistry to accept examination results of applicant's fitness to practice dentistry from board-recognized testing agencies. Removes requirement that board accept results from regional testing agencies.  
Declares emergency, effective on passage. |
| **SB 834** | 03/28/19 - Referred to Health Care.  
03/27/19 - First reading. Referred to Speaker's desk.  
Relating to licensees of the Oregon Board of Dentistry.  
Provides that expression of regret or apology made by or on behalf of person licensed by Oregon Board of Dentistry does not constitute admission of liability in civil action and that person who makes expression may not be examined with respect to expression. |
| **SB 835** | 04/01/19 - Work Session held.  
03/13/19 - Public Hearing held.  
02/26/19 - Referred to Health Care.  
Relating to advertising by dentists; declaring an emergency.  
Allows dentist to advertise practice in specialty area of dentistry. Authorizes Oregon Board of Dentistry to adopt rules.  
Declares emergency, effective on passage. |
| **SB 836** | 02/26/19 - Referred to Health Care.  
02/26/19 - Introduction and first reading. Referred to President's desk.  
Relating to dental pilot projects.  
Authorizes Oregon Board of Dentistry to review patient charts associated with dental pilot projects approved by Oregon Health Authority. |
| **SB 854** | 04/09/19 - Work Session scheduled.  
04/04/19 - Public Hearing held.  
02/27/19 - Referred to Business and General Government.  
Relating to acceptable identification numbers for state-issued authorizations; prescribing an effective date.  
Directs professional licensing boards, in certain circumstances, to accept individual taxpayer identification number or other federally-issued identification number in lieu of Social Security number on applications for issuance or renewal of authorization to practice occupation or profession.  
Takes effect on 91st day following adjournment sine die. |
# Bill Tracker

**Report Date: April 8, 2019**

<table>
<thead>
<tr>
<th>Bill Name</th>
<th>Last Three Actions</th>
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| SB 855    | 04/09/19 - Work Session scheduled.  
04/04/19 - Public Hearing held.  
02/27/19 - Referred to Business and General Government.  
**Relating to professional practice authorizations; declaring an emergency.**  
Directs professional licensing boards to develop pathways to licensure, certification or other authorization to practice occupation or profession for specified persons. Requires boards to report to Legislative Assembly not later than November 30, 2019.  
**Declares emergency, effective on passage.** |
| SB 912    | 04/08/19 - Work Session scheduled.  
04/05/19 - Public Hearing held.  
03/01/19 - Referred to Judiciary, then Ways and Means.  
**Relating to sexual conduct toward children.**  
Revises definition of terms "sexual conduct" and "substantiated report" for purposes of certain laws related to abuse and sexual conduct by school employees.  
Requires report of suspected sexual conduct be made to law enforcement agency or Department of Human Services.  
Expands reporting and investigation requirements to sexual conduct by students.  
Requires public or private official to report sexual conduct by regulated public or private official and to report student sexual conduct. Directs Department of Human Services and law enforcement to conduct investigation related to report.  
Requires department and law enforcement agency to notify regulatory board of regulated public or private official of findings related to sexual conduct. Directs regulatory board to initiate disciplinary proceedings if department or law enforcement finds reasonable cause to believe that sexual conduct occurred.  
Requires department and law enforcement agency to notify school district of findings related to student sexual conduct. |
| SB 933    | 04/05/19 - Recommendation: Do pass with amendments.  (Printed A-Eng.)  
03/28/19 - Public Hearing and Work Session held.  
03/06/19 - Referred to Business and General Government.  
**Relating to inquiries issued by public bodies about race or ethnicity.**  
Provides that form or document issued by public body asking person to identify person’s race or ethnicity must allow person to select multiple races or ethnicities  
<i>and include certain categories of race or ethnicity</i>.  
<b>Becomes operative July 1, 2023.</b> |
Hi Stephen,

As you may know, OHA must develop integration performance indicators for Year 2 (2021) of the CCO 2.0 contract. I plan to manage that project from July through December 2019. Since this is during the period when OHA will also be evaluating CCO applications, our conversations must be governed by conflict of interest agreements.

I anticipate that we may want to consult with the Board of Dentistry about some of our integration concepts to ensure that they fall within the scope of practice of dental practitioners. (I do not anticipate that we would need ongoing support from the Board.) Therefore, I want to put in place an interagency agreement (IAA) that allows us to share information with you. The document attached outlines what the IAA would say.

It would be helpful to add to this document a contact person with the authority to sign the IAA. Can you let me know who that would be?

Please be in touch if you have any questions or concerns. Thanks.

Sarah

Sarah E. Wetherson, M.A.
Transformation Analyst
OREGON HEALTH AUTHORITY
Health Policy and Analytics Division
Transformation Center
sarah.e.wetherson@state.or.us
Mobile: 503-793-1920
Pronouns: she, her, hers
http://www.transformationcenter.org
Click below to be added to our distribution list for events, resources & learning opportunities:
https://www.surveymonkey.com/r/OHATransformationCenterTA
**OREGON BOARD OF DENTISTRY MEETING DATES**

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<tr>
<th>EVALUATORS</th>
<th>BOARD</th>
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<tr>
<td>February 1, 2019</td>
<td>February 15, 2019</td>
</tr>
<tr>
<td>April 5, 2019</td>
<td>April 19, 2019</td>
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<tr>
<td>June 7, 2019</td>
<td>June 21, 2019</td>
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<td>August 9, 2019</td>
<td>August 23, 2019</td>
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<tr>
<td>October 11, 2019</td>
<td>October 25, 2019</td>
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<tr>
<td>November date TBD</td>
<td>December 13, 2019</td>
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<td>February 7, 2020</td>
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<td>April 10, 2020</td>
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<td>June 5, 2020</td>
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<td>August 7, 2020</td>
<td>August 21, 2020</td>
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<td>October 16, 2020</td>
<td>October 30, 2020</td>
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<td>December 4, 2020</td>
<td>December 18, 2020</td>
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Holidays & Observances
- Indicates office closure

- Jan 01 – New Year's Day
- Jan 20 – Martin Luther King Day
- Feb 17 – President’s Day
- Apr 12 – Easter
- May 25 – Memorial Day
- April 23 – Ramadan Begins
- Jul 03 – Staff Holiday
- Jul 04 – Independence Day
- Sep 07 – Labor Day
- Sep 18 – Rosh Hashanah
- Nov 11 – Veteran’s Day
- Nov 26 – Thanksgiving
- Nov 27 – Staff Holiday
- Dec 25 – Christmas Day

Important OBD Dates
- Evaluators’ Meeting
- Board Meeting
UNFINISHED BUSINESS & RULES
Division 23
PRESCRIPTION DRUG MONITORING PROGRAM

333-023-0825
Practitioner Registration Requirements

(1) A practitioner with an active United States Drug Enforcement Agency (DEA) registration to prescribe in Oregon must register with the Prescription Drug Monitoring Program in accordance with OAR 333-023-0820(8) in order to have access to the Program’s electronic system.

(2) A practitioner who becomes licensed on or after July 1, 2018, and who has an active DEA registration must register with the Program as specified in section (1) of this rule, within 30 calendar days of Oregon licensure or DEA registration, whichever is later.

333-023-0820(8)
Information Access

Practitioner, Pharmacist, Medical Director, Pharmacy Director, and Delegate Access. A practitioner, pharmacist, medical director, pharmacy director, or delegate who chooses to request access to the system shall apply for a user account as follows:

(a) Complete and submit an application provided by the Authority that includes identifying information and credentials; and

(b) Agree to terms and conditions of use of the system that defines the limits of access, allowable use of patient information, and penalties for misuse of the system.
AGENDA

Dental Pilot Project #100 “Oregon Tribes Dental Health Aide Therapist Pilot Project”
Quarterly Dental Pilot Project Program Advisory Committee Meeting DPP #100
March 4, 2019, 9:00 AM – 12:00 PM

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Speaker(s)</th>
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<tr>
<td>9:00 AM - 9:10 AM</td>
<td>Official Introductions Agenda Review</td>
<td>Bruce Austin, DMD</td>
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<tr>
<td>9:10 AM - 9:20 AM</td>
<td>Review of Guiding Principles &amp; Terms of Engagement for Meetings</td>
<td>Kelly Hansen</td>
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<tr>
<td>9:20 AM - 9:30 AM</td>
<td>Revised Advisory Committee Charter Call for Applications &amp; Timeline for Applications</td>
<td>Amy Umphlett, MPH</td>
</tr>
</tbody>
</table>
| 9:30 AM - 10:30 AM | Review Nitrous Oxide Modification Request & NPAIHB Response to Advisory Committee Comments
  - Nitrous subject matter expert
  - Facilitated discussion between OHA, NPAIHB and Advisory Committee | Bruce Austin, DMD
  Frank A. Catalanotto, DMD
  Fred Quarnstrom, DDS
  Mary Williard, DDS
  Gita Yitta, DMD |
| 10:30 AM - 10:45 AM | Break |                               |
| 10:45 AM - 11:45 AM | NPAIHB Presentation
Review Requirements under Stipulated Agreement for Mobility Requirements for Primary Teeth
  - Facilitated discussion between OHA, NPAIHB and Advisory Committee | Bruce Austin, DMD
  Frank A. Catalanotto, DMD
  Gita Yitta, DMD
  Mary Williard, DDS |
| 11:45 AM - 11:50 AM | Follow Up Items
Future Meeting Dates & Site Visit Closing | Bruce Austin, DMD |
| 11:50 AM - 12:00 PM | Public Comment Period - limited to 2 minutes per individual
Public comments are accepted through in-person oral testimony or submission of written comments via email at oral.health@state.or.us or US mail | |

Next Meeting: Monday, June 3, 2019, PSOB 800 NE Oregon Street, Room 1A, Portland, 9:00 AM - 4:00 PM
Memo

DATE: February 25, 2019

TO: Dental Pilot Project #100 Advisory Committee Members

FROM: Bruce Austin
Statewide Dental Director
Oregon Health Authority

RE: Nitrous Oxide Modification Request

On November 8, 2018, the Oregon Health Authority’s (OHA) Dental Pilot Project Program received a modification request from the Northwest Portland Area Indian Health Board (NPAIHB) to allow the administration of nitrous oxide to the approved scope of practice for trainees under Dental Pilot Project (DPP) #100.

Under Oregon Administrative Rules (OAR) 333-010-0800, approved dental pilot projects may submit a request to modify the scope of practice for trainees as part of an approved dental pilot project. All modifications require OHA approval.

Six different scenarios have been outlined below for review by members of the Advisory Committee. Please review the options outlined and be prepared to comment at the Advisory Committee meeting on March 4, 2019.

Definitions:

- “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.

- “Indirect supervision” means supervision requiring that a dentist authorize the procedure and that a dentist be on premises while the procedure is performed.

- “Anesthesia monitor” means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
Options Under Consideration:

1. Allow dental therapist trainees in DPP #100 to administer nitrous oxide under indirect supervision of a dentist. The dental therapist is allowed to perform all procedures in their scope of practice under indirect supervision while the patient is receiving nitrous oxide.
   a. AND require an anesthesia monitor be present at all times.
   b. OR do not require an anesthesia monitor to be present at all times.

2. Allow dental therapist trainees in DPP #100 to administer nitrous oxide under direct supervision of a dentist. The dental therapist is allowed to perform all procedures in their scope of practice under indirect supervision while the patient is receiving nitrous oxide.
   a. AND require an anesthesia monitor be present at all times.
   b. OR do not require an anesthesia monitor to be present at all times.

3. Allow dental therapist trainees in DPP #100 to administer nitrous oxide under direct supervision of a dentist and perform all procedures in their scope of practice under direct supervision while the patient is receiving nitrous oxide.

4. Require the dentist with a current permit to administer nitrous oxide. Dental therapists are then allowed to perform all procedures under their scope of practice under indirect supervision while the patient is receiving nitrous oxide.
   a. AND require an anesthesia monitor be present at all times.
   b. OR do not require an anesthesia monitor to be present at all times.

5. Require the dentist with a current permit to administer nitrous oxide. Dental therapists are then allowed to perform all procedures under their scope of practice under direct supervision while the patient is receiving nitrous oxide.

6. Prohibit dental therapist trainees from administering and working on patients under nitrous oxide.
OHA Representatives:

The Board of Dentistry would like to bring the current Oregon Dental Practice Act rules regarding nitrous oxide to your attention. The Dental Pilot Project #100 recent meetings have discussed the request for DHAT’s to administer nitrous oxide under various scenarios, but very little discussion on the facilities, protocols, drugs and emergency management plans in place to assure patient safety. I included applicable rules that the Board wishes your advisory committee take into account when considering the modification request. The Board believes that any person administering nitrous oxide in Oregon should meet and follow all the applicable rules in the Dental Practice Act. Anesthesia Rules in the Dental Practice Act are considered and reviewed by the Board’s Anesthesia Committee which is comprised of oral surgeons and general dentists. These practitioners share their deep and varied dental experience from serving in a variety of clinical settings throughout Oregon to help the Board of Dentistry regulate safe sedation practices in Oregon.

818-026-0020
Presumption of Degree of Central Nervous System Depression

(1) In any hearing where a question exists as to the degree of central nervous system depression a licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.

(2) The following drugs are conclusively presumed to produce general anesthesia and may only be used by a licensee holding a General Anesthesia Permit:

(a) Ultra short acting barbiturates including, but not limited to, sodium methohexital, thiopental, thiamylal;

(b) Alkylphenols — propofol (Diprivan) including precursors or derivatives;

(c) Neuroleptic agents;

(d) Dissociative agents — ketamine;

(e) Etomidate; and

(f) Volatile inhalational agents.

(3) No permit holder shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.

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

(5) A licensee must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide, minimal sedation, moderate sedation, deep sedation or general anesthesia.

818-026-0030  
Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.

(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.

(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:

(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or

(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or

(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.

(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or

(e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.
Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)

A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Health Care Providers certificate or its equivalent.

A licensee holding an anesthesia permit for moderate sedation, deep sedation or general anesthesia at all times maintains a current BLS for Health Care Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association’s course “Recognition and Management of Complications during Minimal and Moderate Sedation” at least every two years may be substituted for ACLS, but not for PALS.

Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Health Care Provider Basic Life Support (BLS).

When a dentist utilizes a single oral agent to achieve anxiolysis only, no anesthesia permit is required.

The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.

Permits shall be issued to coincide with the applicant's licensing period.
(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;

(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 all medications administered with dosages, time intervals and route of administration.
(7) 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.

(8) 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.

(9) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.

(10) 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.

818-026-0055
Dental Hygiene and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation

(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

(b) The permit holder, or an anesthesia monitor, monitors the patient; or

(c) if a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.

(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

(2) Under direct supervision, a dental assistant may perform those procedures for which the
dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

(b) The permit holder, or an anesthesia monitor, monitors the patient; and

(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

818-026-0110
Office Evaluations

(1) By obtaining an anesthesia permit or by using the services of a physician anesthesiologist, CRNA, an Oregon licensed dental hygienist permit holder or another dentist permit holder to administer anesthesia, a licensee consents to in-office evaluations by the Oregon Board of Dentistry, to assess competence in central nervous system anesthesia and to determine compliance with rules of the Board.

(2) The in-office evaluation may include, but is not limited to:

(a) Observation of one or more cases of anesthesia to determine the appropriateness of technique and adequacy of patient evaluation and care;

(b) Inspection of facilities, equipment, drugs and records; and

(c) Confirmation that personnel are adequately trained, hold a current BLS for Healthcare Providers certificate, or its equivalent, and are competent to respond to reasonable emergencies that may occur during the administration of anesthesia or during the recovery period.

(3) The evaluation shall be performed by a team appointed by the Board and shall include:

(a) A permit holder who has the same type of license as the licensee to be evaluated and who holds a current anesthesia permit in the same class or in a higher class than that held by the licensee being evaluated.

(b) A member of the Board's Anesthesia Committee; and

(c) Any licensed dentist, deemed appropriate by the Board President, may serve as team leader and shall be responsible for organizing and conducting the evaluation and reporting to the Board.

(4) The Board shall give written notice of its intent to conduct an office evaluation to the licensee to be evaluated. Licensee shall cooperate with the evaluation team leader in scheduling the evaluation which shall be held no sooner than 30 days after the date of the notice or later than 90 days after the date of the notice.

Regards,

Stephen
Stephen Prisby  
Executive Director  
Oregon Board of Dentistry  
1500 SW 1st Ave., Suite #770  
Portland, Or 97201  
p 971-673-3200  
f 971-673-3202  
www.Oregon.gov/Dentistry

Your opinion matters. Please complete our Customer Satisfaction Survey at https://www.surveymonkey.com/r/OBDSurveyLink

"The Mission of the Oregon Board of Dentistry is to promote high quality oral health care in the State of Oregon by equitably regulating dental professionals."

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DRAFT Dental Pilot Project Program
Advisory Committee Charter

I. Description of the Dental Pilot Project Program

Senate Bill 738 was passed by the Oregon State Legislature in 2011. This bill allows the Oregon Health Authority (OHA) to administer and evaluate a Dental Pilot Project once an application has been approved. The goal of the dental pilot projects is to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care.

Dental Pilot Projects are intended to evaluate the quality of care, access, cost, workforce, and efficacy of teaching new skills to existing categories of dental personnel; developing new categories of dental personnel; accelerating the training of existing categories of dental personnel; or teaching new oral health care roles to previously untrained persons. OHA may approve a dental pilot project that is designed to operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project and evaluate the quality of care, access, cost, workforce and efficacy.

II. Oregon Health Authority Dental Pilot Project Program Responsibilities

OHA is responsible for monitoring approved pilot projects to ensure patient safety and to ascertain the progress of each project in meeting its stated objectives and complying with program statutes and rules. Monitoring and evaluation includes, but is not limited to, reviewing progress reports and conducting site visits.

III. Role of the Dental Pilot Project Program Advisory Committee

If OHA convenes an Advisory Committee (Committee) for an approved dental pilot project, the Committee will serve to provide OHA with the collective knowledge, experience, expertise, and insight of the Committee members to assist the OHA in meeting its responsibilities. Committee Members will be asked to review and provide advice on:

- The efficacies of training, competencies and data collection;
- Project protocols related to the ongoing assurance of patient safety;
- Evaluation of project progress reports as needed; and
- Other project issues as needed throughout the duration of the pilot project.

Although the Committee provides advice to the agency, OHA makes all final decisions.
IV. Committee Details and Membership

To be considered for committee membership or to remain on the Committee, individuals may not be involved in any way with the specific dental pilot project applicant or approved project they wish to participate on the Committee.

A. Environment. The Committee will operate under an email intensive environment utilizing Dropbox to organize project and meeting material.

B. Committee Size. The Committee shall not consist of more than 15 members, except that additional members may be added by OHA.

C. Process for Membership. Prospective members are required to complete an application. The process for soliciting members and eligibility of members is described in Oregon Administrative Rule (OAR) 333-010-0790(2). OHA makes the final determination on Committee membership selection.

D. Term of Office. The term of office for each member is two years. The term begins on the date OHA notifies an individual in writing that the individual has been selected for the Committee. Individuals who wish to serve additional term(s) must reapply. A Committee member cannot serve more than six consecutive years. If a member resigns or is removed from the Committee before the end of his or her term, OHA will accept applications for a new member.

E. Payment/Reimbursement. Committee members are non-paid, but travel expenses may be reimbursed according to State of Oregon policies. Members are not allowed to accept gifts, meals, lodging, etc. provided by the sponsor of a pilot project or provided on behalf of the sponsor.

F. Removal of Committee Members. OHA may remove a Committee member who is unable to meet the responsibilities of a member including abiding by the terms of this Charter and abiding by OAR 333-010-0790(2)(e).

V. Meetings

Dental Pilot Projects operate under two distinct phases, the training/education phase and the utilization/employment phase. OHA will determine committee meeting frequency depending on which phase a project is currently operating under. OHA staff will facilitate all meetings.

- OHA will call meetings during the training phase as dictated by project and committee member needs;
- Meeting frequency during the utilization/employment phase will be quarterly unless the OHA and the Committee agrees to a different frequency;
- Meetings will be held at times that are agreed upon by OHA and a majority of the committee members. Meetings will only be held during State of Oregon normal operating business hours;
- Additional meetings may be called as dictated by project needs; and
- Members are required to attend all Committee meetings unless excused by OHA.
VI. Site Visits

Each Committee member is expected to participate in and volunteer to attend at least one site visit of a dental pilot project during each year of the pilot project.

- Dentists are required to participate in the chart review process at a minimum of once per year.
- All chart reviewers are required to attend calibration and chart review trainings as part of the site visit process.

VII. Code of Conduct for Members

When acting in the capacity of a Committee member, each member is expected to comply with OAR 333-010-0790(2)(e) and conduct themselves in the following manner:

- Maintain confidentiality of any sensitive information or protected health information (PHI) acquired as a Committee member.
- Use best-practices, evidence-based and data-driven science in providing advice to OHA.
- Recuse oneself if there is a conflict of interest or perceived conflict of interest.
- Treat all people fairly regardless of race, color, gender and ethnic origin.
- Respect other points of view brought before the Committee.
- Review materials ahead of each meeting and come prepared to discuss and participate.
- Respond as requested to any deadlines set by OHA.
- Do not volunteer for any activity or assignment that you are not qualified for.
- Do not claim to represent, speak, or write opinions of the Oregon Health Authority without prior written permission.

VIII. Oregon Public Meetings Law

Committee meetings shall be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the DPP website: www.healthoregon.org/dpp.

A public notice will be provided to the public and media at least 10 days in advance of each regular meeting and at least five days in advance of any special meeting. Written minutes will be taken at all regular and special meetings.

IX. Oregon Public Records Law

Committee materials and communications are subject to the Oregon Public Records Law, ORS 192.311 to 192.478, even if such materials or communications are located on the personal devices of Committee members.

X. Review of Charter

This charter will be periodically reviewed and updated at OHA’s discretion. Last updated on February 15, 2019.
CORRESPONDENCE
We would like to propose the attached Division 42 rule changes for dental assistants.

Please move these proposed changes to the Oregon Board of Dentistry Licensing, Standards and Competency Committee for review.

Thank you.

Sincerely,

Ginny Jorgensen, CDA, EFDA, EFODA
Mary Harrison, CDA, EFDA, EFODA
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 (818-042-0070 and 818-042-0090) or Expanded Orthodontic Function duty (818-042-0100) without holding the appropriate certification.
4. Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818042-0100.
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 fluoride, topical anesthetic, desensitizing agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0030(6), OAR 818-026-0050(5)(a) OAR 818-026-0060(11), 818-026-0065(11), 818-026-0070(11) and as provided in 818-042-0070, 818-042-0090 and 818-042-0115.
7. Prescribe any drug.
8. Place periodontal packs.
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.
14. Use air abrasion or air polishing.
15. Remove teeth or parts of tooth structure.
16. Preliminarily fit crowns to check contacts, cement or bond any fixed prosthetic prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in 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) Take jaw registrations or oral impressions for supplying artificial teeth as substitutes for natural teeth, except diagnostic or opposing models or for the fabrication of temporary or provisional restorations or appliances.

(20) Apply denture relines except as provided in OAR 818-042-0090(2).

(21) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (818-042-0050 and 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.

(22) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.

(23) Perform periodontal probing.

(24) Place or remove healing caps or healing abutments, except under direct supervision.

(25) Place implant impression copings, except under direct supervision.

(26) Any act in violation of Board statute or rules. No licensee may authorize any dental assistant to perform the following acts:

818-042-0050
Taking of X-Rays — Exposing of Radiographs

(1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.

(2) A dentist or dental hygienist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency
Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist or dental hygienist that the assistant is proficient to take radiographs.

**818-042-0060**
**Certification — Radiologic Proficiency**

(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:

(2) Submits an application on a form approved by the Board, pays the application fee and:

(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;

(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and

(c) Certification by an Oregon licensed dentist or dental hygienist that the assistant is proficient to take radiographs.

**818-042-0070**
**Expanded Function Dental Assistants (EFDA)**

The following are direct patient care duties and are considered Expanded Functions 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 (i.e., zinc oxide eugenol based 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 alloy and composite restorations any direct restoration;

(6) Polish amalgam or composite surfaces with a slow speed hand piece;

(7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;
Fabricate temporary crowns or bridges, and temporarily cement the temporary crown or bridge. The cemented crown or bridge must be examined and approved by the dentist prior to the patient being released; and

Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate; and

Perform all aspects of teeth whitening procedures.

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 Basic Infection Control Examination (ICE) or 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 within six months of being authorized to perform all expanded function duties, certification by an Oregon licensed dentist that the applicant has successfully polished 12 amalgam or composite surfaces, removed supra-gingival excess cement from six (6) crowns or bridges with hand instruments; placed temporary restorative material (i.e., zinc oxide eugenol based material) in six (6) teeth; preliminarily fitted six (6) crowns to check contacts or to adjust occlusion outside the mouth; removed six (6) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated six (6) temporary crowns and temporarily cemented the crowns; polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; placed two matrix bands in each quadrant on teeth prepared for Class II restorations; and complete six (6) teeth whitening or bleach procedures is proficient in all expanded function duties. If no expanded function certificate is issued within the six months of being authorized to perform the duties, the assistant is no longer able to continue performing expanded function duties until EFDA certification is achieved.
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;

(i) Cut arch wires; and

(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.

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

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

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

818-042-0110
Certification — Expanded Function Orthodontic Assistant

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 **Infection Control Examination (ICE)** Basic, CDA or 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 **within six months of being authorized to perform all expanded orthodontic function duties**, 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 hand piece from teeth on four (4) patients is proficient to perform all expanded function orthodontic duties. If no expanded functions orthodontic certificate is issued within the six months of being authorized to perform the duties, the assistant is no longer able to continue performing 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 Infection Control Examination (ICE)** or the **Certified Preventive Functions Dental Assistant (CPFDA)** examination, and or the **Expanded Function Dental Assistant** 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 **within six months of being authorized to perform coronal polishing**, certification by an Oregon licensed dentist that the applicant is proficient to has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six patients. If no expanded functions preventive certificate is issued within the six months of being authorized to perform coronal polishing, the assistant is no longer able to continue performing coronal polishing until EFPDA certification is achieved.
Good Morning Teresa,

Here is our proposal for the Board at their meeting April 19th. Can you provide me with an address and time? Thank you, Rod

To the Oregon Board of Dentistry:

Greetings,

My name is Roderick Rowan and I am a Director for The Resuscitation Group, a Licensed Washington State Vocation and Post-Secondary School and an American Heart Association National Training Center based in Vancouver, Washington. Our Vancouver, Washington headquarters serves over 4,000 healthcare providers annually in the Portland metropolitan area that seek quality training in critical care and resuscitation programs. We also serve an international client base with similar training and consulting services.

Recently, the Oregon Board of Dentistry granted approval of our Anesthesia Dental Assistant program’s IV cannulation segment for Anesthesia Dental Assistants that seek to initiate vascular access. We’re grateful to the Board for this approval.

Humbly, I present to the Board a request for the review of our complete Anesthesia Dental Assistant program with the intention of its’ recognition as a substantive training alternative to the existing programs as listed in OAR 818-042-0116.

The Resuscitation Group has offered advanced critical care training in various capacities for over 2 decades and has served as a Licensed School for the last 5 years. We have offered individual elements of this program applicable to Anesthesia Dental Assistants for several years by way of our Paramedic and Critical Skills programs. However, to better serve our clients in the Dental industry, we formulated our program to meet the comprehensive regulatory criteria as outlined in the Dental Boards of Washington and Oregon. We have attained approval in Washington by the Washington State Dental Board, as a substantive training program for Anesthesia Dental Assistant training that qualifies for licensure in Washington State. Again, we humbly ask the Board to review our program with the intended goal of approving The Resuscitation Group’s Anesthesia Dental Assistant program as an approved training alternative to currently approved programs.

We believe this comprehensive program offers an all-inclusive, instructor led, training experience that allows students to additionally build solid practical skills through a series of manipulative ongoing tasks. The didactic portion is presented with the most current science and assessed through a series of exams and culminates with a written assessment.

For your convenience, I have attached several documents for your review:

1. The Resuscitation Group’s complete program curriculum,

Attachments:

2. A comprehensive independent crosswalk of TRG to DAANCE and CALAOMS,
4. Washington State regulatory structure,
5. Approval letter from Washington State.

We were advised there are no other likened programs in Washington State and are not aware of such programs in Oregon. We believe we are uniquely qualified to offer this service and stand ready to work with the Oregon Board of Dentistry to provide a structured pathway to train Dental Anesthesia Assistants to successfully meet the Oregon standard while building confidence for Assistants and offering the Providers a well-prepared Assistant; with the stated intentions of reducing risks to patients and supporting positive training tools for the dental surgical community

Most Sincerely,

Rod Rowan

Roderick Rowan
Co-Director
The Resuscitation Group
(a Washington State Licensed Vocational Technical Post-Secondary School and American Heart Association National Training Center)
901 West Evergreen Blvd.
Suite 100
Vancouver, Washington, 98660 USA
(855) 739-2257 Main Line
(360) 910-5126 Direct Line
rrowan@resuscitationgroup.com
www.resuscitationgroup.com
<table>
<thead>
<tr>
<th>DAANCE</th>
<th>CALAOMS</th>
<th>The Resuscitation Group</th>
</tr>
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<tbody>
<tr>
<td>36 hour – Self-study (with OMS or GA permit holder designated) - 6 months to complete</td>
<td>3 three month online self-study– with chat and forum technology</td>
<td>Dental Anesthesia Assistant Training Program 40 hour course – instructor led/Physician oversight - Integrative lectures, practical skills lab, and supervised practice</td>
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<tr>
<td>• Basic sciences</td>
<td>• Cardiovascular System</td>
<td>• Prerequisite – Washington State KNOW HIV Prevention Education – 7 hours</td>
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<td>• Evaluation and preparation of patients with systemic diseases</td>
<td>• Conducting System of the Heart</td>
<td>• Prerequisite – ACLS Provider certification</td>
</tr>
<tr>
<td>• Anesthetic drugs and techniques</td>
<td>• Respiratory System</td>
<td>Pre-Course Review</td>
</tr>
<tr>
<td>• Anesthesia equipment and monitoring</td>
<td>• Endocrine System</td>
<td>Conscious Sedation for Minor Procedures in Adults NEJM</td>
</tr>
<tr>
<td>• Office anesthesia emergencies</td>
<td>• Immune and Other Body Systems</td>
<td>Understanding IV Conscious Sedation Gina L. Salatino DMD, FAGD</td>
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<tr>
<td>• Intravenous Therapy</td>
<td>• Principles of Capnography Lesson 1</td>
<td><a href="https://youtu.be/KLRPlvbw3M8">https://youtu.be/KLRPlvbw3M8</a></td>
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<tr>
<td>• Pharmacology</td>
<td>• Principles of Capnography Lesson 2: Basic principles</td>
<td><a href="https://youtu.be/rsd5C7FLXXo">https://youtu.be/rsd5C7FLXXo</a></td>
</tr>
<tr>
<td>• Outpatient Anesthesia</td>
<td>• Principles of Capnography Lesson 3: Capnography waveforms</td>
<td><a href="https://youtu.be/GUV7BTIGLeM">https://youtu.be/GUV7BTIGLeM</a></td>
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<tr>
<td>• Office Anesthetic Emergencies</td>
<td>• Nitrous Oxide Oxygen Sedation</td>
<td><a href="https://youtu.be/1o35MoG3cc8">https://youtu.be/1o35MoG3cc8</a></td>
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<tr>
<td>• Intravenous line insertion, IV starting techniques, How to start an IV. Eyad Ahmed MD.</td>
<td>• Intravenous line insertion, IV starting techniques, How to start an IV. Eyad Ahmed MD.</td>
<td><a href="https://youtu.be/sGKZbKL5QM">https://youtu.be/sGKZbKL5QM</a></td>
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<tr>
<td>Practical quiz after each completed module.</td>
<td>On-line Pre-Test to ensure understand material presented</td>
<td>Reasons Why People Miss Veins When Starting an IV or Drawing Blood. RegisteredNurseRN.com; <a href="https://youtu.be/jNf-8DwW224">https://youtu.be/jNf-8DwW224</a></td>
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**DENTAL ANESTHESIA ASSISTANT – EDUCATION COMPARISON – PROGRAM REQUEST**

<table>
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<tr>
<td>• Review of material learned in on-line self-study curriculum.</td>
<td>Day 1 – 8 hours • Course Introduction and Registration • Continuum of Sedation • Pharmacology • Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 1 • Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 2 • Emergency Response Protocols for anesthesia emergencies</td>
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<tr>
<td></td>
<td>Day 2 – 8 hours • Intravenous Therapy Didactic • Intravenous Therapy and Pharmacology Lab • Participants orientation to provider supervised activities</td>
</tr>
<tr>
<td></td>
<td>Day 3 – 8 hours • Immersive Simulation – Anesthesia Emergencies</td>
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<td>Day 4 – 8 hours • Anesthesia Lab</td>
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<td></td>
<td>Day 5 – 8 hours • Immersive Simulation – Anesthesia Emergencies</td>
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<td>2 hour computerized exam at designated testing center (115 questions)</td>
<td>• Final Examination</td>
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<td>• Successfully manage three anesthesia emergencies in an immersive simulation environment, under the observation of instructor staff and scored against the NREMT scenario skills sheet.</td>
</tr>
</tbody>
</table>
Successfully complete five (5) intravenous catheter placements under the observation of the instructor staff, using the NREMT IV Access Skills Sheet Standard.

Successfully complete ten (10) intravenous catheter placements under the supervision of their Dental or Medical Provider.

WAC 246-817-205

Dental anesthesia assistant certification requirements.

An applicant for certification as a dental anesthesia assistant must submit to the department:

1. A completed application on forms provided by the secretary;
2. Applicable fees as defined in WAC 246-817-99005;
3. Evidence of:
   a. Completion of a commission approved dental anesthesia assistant education and training. Approved education and training includes:
      i. Completion of the "Dental Anesthesia Assistant National Certification Examination (DAANCE)" or predecessor program, provided by the American Association of Oral and Maxillofacial Surgeons (AAOMS); or
      ii. Completion of the "Oral and Maxillofacial Surgery Assistants Course" course provided by the California Association of Oral and Maxillofacial Surgeons (CALAOMS); or
      iii. Completion of substantially equivalent education and training approved by the commission.
   b. Completion of training in intravenous access or phlebotomy. Training must include:
      i. Eight hours of didactic training that must include:
         A. Intravenous access;
         B. Anatomy;
         C. Technique;
         D. Risks and complications; and
(ii) Hands on experience starting and maintaining intravenous lines with at least ten successful intravenous starts on a human or simulator/manikin; or

(iii) Completion of substantially equivalent education and training approved by the commission;

(c) A current and valid certification for health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS);

(d) A valid Washington state general anesthesia permit of the oral and maxillofacial surgeon or dental anesthesiologist where the dental anesthesia assistant will be performing his or her services;

(e) Completion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC, Part 8; and

(4) Any other information determined by the commission.
Washington Dental Anesthesia Assistant Program Catalog

The Resuscitation Group
901 West Evergreen Boulevard
Vancouver, Washington USA 98660
+1-855-739-2257
http://resuscitationgroup.com/
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Admission Requirements

All documentation must be submitted to the office staff at the time of admissions and final payment.

Pre-requisites:
1. 18 years or older by start date of program.
2. High School diploma or GED
3. Copy of USA State Driver’s License or Copy of Current Passport Photo Page.
4. Must have the following current certifications to be awarded a certificate:
   a. American Heart Association Basic Life Support (BLS)
   b. American Heart Association Advanced Cardiac Life Support (ACLS)

Insurance Requirements:
None required

Immunizations Required:
1. MMR immunization at least twice during lifetime, or within the last ten years;
2. Hepatitis B immunization
3. Current influenza vaccine shot
4. Tetanus/Diphtheria
5. Polio

Tests Required:
1. Tuberculosis test within the past six months.
INTRODUCTION

OVERVIEW OF ANESTHESIA ASSISTANT PROGRAM

The 40 hour Anesthesia Assistant Certificate Program is approved by the Washington State Dental Commission specifically for Dental Anesthesia Assistants who assist a Dentist, Oral Surgeon, Maxillofacial Surgeon, or other provider with anesthesia during procedural or surgical events.

An anesthesiologist assistant is a non-physician qualified to assist a licensed provider with preoperative, operative, and postoperative anesthesia, monitoring, and interventional care. The anesthesia assistant works under the direct medical direction of a licensed provider as an assistant in the care team. Anesthesia assistants obtain pre-anesthetic health history, perform vascular access, establish non-invasive monitors, assist with the preparation and administration of medications, assist in the treatment of life-threatening situations, and execute techniques, as directed by licensed provider.

OUR VISION

The Resuscitation Group seeks to showcase the exceptional healthcare system in Washington State, improve healthcare systems in the region, increase the effectiveness of the healthcare system, enhance the education of healthcare practitioners, and provide a model for other regions and countries.

OUR PHILOSOPHY

The Resuscitation Group (TRG) is committed to a philosophy of educational excellence and attention to detail both in our programs and in our students. We accept responsibility for preparing students who are knowledgeable in the field, responsive to service in the community and dedicated to continued expansion of human understanding through study.

To this end, we hold to the following philosophy:

- To promote high ethical codes of conduct and professional standards and foster participation in professional organizations and activities.
- To prepare students to assume responsibility for management of critical care patients in a wide range of environments, utilizing the principles of critical care medicine.
- Academically educating students for successful completion of international, national, and state certification examinations.
- Assuring student competencies in critical care medicine prior to allowing patient contact and then assuring high standards of compliance with competencies during patient care.

GOALS AND PROGRAM OBJECTIVES

TRG holds that learning is a lifelong process through which an individual modifies his/her behavior in order to accommodate changing healthcare needs. We also believe that learning is
facilitated when student participation is actively encouraged, instructional and educational goals are well defined and communicated, and student goals and objectives are clear and supported by the faculty.

It is understood that, ultimately, the full responsibility for learning rests with the student and his/her commitment to the learning process.

The 40 hour, Anesthesia Assistant Program has the distinction of being among the highest level of training programs in the world today and incorporates the 2017 International Liaison Committee on Resuscitation (ILCOR) Education and Science Recommendations, The 2013 IHCA AHA Conesus Recommendations, The Emergency Cardiovascular Care Update Anesthesia Assistant objectives; while blending in the objectives required for the unique environment and challenges of the Pacific Northwest and Pacific Rim environments, with additional objectives incorporated to meet the highest level of clinical expectation under the current United States CMMS guidelines.

Specific Program Objectives can be found at the start of each learning module in the program curriculum (Appendix 1).

**CONTACT TELEPHONE NUMBERS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rod Rowen</td>
<td>Director of School Operations</td>
<td>+1-855-739-2257</td>
</tr>
<tr>
<td>Michael Christie</td>
<td>Critical Care Program Director</td>
<td>+1-855-739-2257</td>
</tr>
<tr>
<td>Dr. Bernie Sperley</td>
<td>Medical Director</td>
<td>+1-855-739-2257</td>
</tr>
<tr>
<td>Shaleesh Gregg</td>
<td>Office Manager</td>
<td>+1-855-739-2257</td>
</tr>
</tbody>
</table>

**PROGRAM STAFF & DUTIES**

Rod Rowen - Director of School Operations:
The DOSO manages the day to day operations of the entire school environment, as well as assures compliance with equipment, support services, and legal documents.

Michael Christie - CC Program Director
The CCPD will review and approve the educational content of the program curriculum to certify its ongoing appropriateness and medical accuracy against current regional, national, and international guidelines. The CCPD will review and approve the quality of medical instruction, supervision, and evaluation of the students in all area of the program. The CCPD will assure and attest to the competence of each graduate in the cognitive, psychomotor, and affective domains.

Dr. Bernie Sperley - Medical Director
The Medical Director is responsible for all adherence to medical science in the curriculum, supervision of the CCPD, issuance of medical privileges, and final approval of all patient contact protocols and treatment processes.

Office Manager
The Office Manager is responsible for operating The Resuscitation Group front office, interfacing with students for registration and scheduling, and manages the collection of fees and tuitions.

**FACULTY**

The TRG faculty is comprised of a numerous healthcare practitioners at a variety of levels from Critical Care Paramedic to Physician.

The Resuscitation Group practices non-discriminatory faculty recruitment with regard to disability, race, color, creed, gender, sexual preference, affectional preference, veteran status, and national origin; but The Resuscitation Group does seek the highest qualified educational staff in the United States and abroad.

**ACCREDITATION**

There is no accreditation process for the educational component of critical care medicine at the non-physician level in the United States; the process in the United States as revolved around outcome testing through third party boards or registry.

**FACILITIES**

We are located in Southwest Washington in the Portland Metro area at 901 West Evergreen Boulevard, Suite 100, in Vancouver, Washington. Business hours are from 9:00am until 5:00pm Monday through Friday and we can be reached at 855-739-2257 or by email at info@resuscitationgroup.com

**STUDENT/TEACHER RATIO**

While no standard exists for this type of educational process, The Resuscitation Group intends to hold to the international standard of not more than 24:1 ratio during didactic sessions, a student/teacher ratio of not greater than 8:1 in the laboratory setting, and a ratio not to exceed 8:1 in the clinical setting under an assigned educator.

**ACADEMIC CALENDAR AND HOURS OF OPERATION**

The Resuscitation Group will observe the following holidays and classes will not be held on the following United States Holidays:

- New Year’s Day
- Martin Luther King Day
- Memorial Day
• Independence Day
• Labor Day
• Thanksgiving Day
• Christmas Eve
• Christmas Day

Enrollment is ongoing throughout the year. The Program runs 600 hours in duration over a 3-6 month period. Class hours are scheduled for ease of the student population in the program cohort.

TUITION, FEES AND DEPOSITS

Tuitions, fees, and deposits are paid to The Resuscitation Group.

1. Tuition and Fees for domestic or international students:
   Application Fee: $100
   Tuition: $550
   Lab Fee: $100

   Total Charges: $750 usd

Notation as to Textbooks:
Students are required to obtain textbooks for the course per the course syllabus.
REFUND POLICY

All refunds will be made within thirty (30) calendar days from the time of cancelation from the program; provided cancellation was made at least 30 days prior to program start date.

The official date of termination or withdrawal for a student shall be determined in the following manner:
1. The date on which the school recorded the student's last day of attendance; or,
2. The date on which the student is terminated for a violation of a published school policy which provides for termination.

No student shall be continued on an inactive status in violation of school policy without written consent of the student. Inactive students must be terminated within thirty days of the next available start date and refunded appropriate prepaid tuition and fees at that time.

Refunds must be calculated using the official date of termination or withdrawal and the date designated on the current enrollment agreement executed with the student. Refunds must be paid within thirty calendar days of the student's official date of withdrawal or termination.

Application/registration fees may be collected in advance of a student signing an enrollment agreement; however, all monies paid by the student shall be refunded if the student does not sign an enrollment agreement and does not commence participation in the program.

The school must refund all money paid if the applicant is not accepted; this includes instances where a starting class is canceled by the school.

The school must refund all money paid if the applicant cancels within five business days (excluding Sundays and holidays) after the day the contract is signed or an initial payment is made, as long as the applicant has not begun training; the applicant may request cancellation in any manner, in the event of a dispute over timely notice. The burden of proof rests on the applicant.

The school may retain an established registration fee equal to ten percent of the total tuition cost, or one hundred dollars, whichever is less, if the applicant cancels after the fifth business day after signing the contract or making an initial payment. A "registration fee" is any fee charged by a school to process student applications and establish a student records system.

If training is terminated after the student enters classes, the school may retain the registration fee established under (c) of this subsection, plus a percentage of the total tuition as described in the following table:

<table>
<thead>
<tr>
<th>If the student completes this amount of training:</th>
<th>The school may keep this % of the tuition cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>One week or up to 10%, whichever is less</td>
<td>10%</td>
</tr>
</tbody>
</table>
If the student completes this amount of training: | The school may keep this % of the tuition cost:
---|---
More than one week or 10% whichever is less but less than 25% | 35%
25% through 50% | 50%
More than 50% | 100%

Should The Resuscitation Group (TRG) cancel the program after a student has paid the full tuition, TRG will refund all monies paid by the student, including the application fee.

COURSES AND PROGRAMS OFFERED AT TRG

- Advanced Cardiac Life Support (ACLS)
- Advanced Cardiac Life Support – Experienced Provider (ACLS EP)
- Pediatric Advanced Life Support (PALS)
- Cardiopulmonary Resuscitation (CPR)
- AHA Blended learning programs (All disciplines)
- Trauma Life Support courses
- 12 Lead ECG and Capnography workshops
- Advanced Airway management workshops
- Advanced scope of practice, transport, wilderness, and SAR medicine courses
- Emergency Medical Responder (EMR) – NREMT and Washington State
- Emergency Medical Technician (EMT) Program – NREMT and Washington State
- Anesthesia Assistant Programs
  - Anesthesia Assistant (CCP)
  - Critical Care Transport (CCT)
  - Flight Paramedic and Flight Nurse
- Ultrasound Program
  - Basic Ultrasound
  - Emergency Ultrasound
  - Ultrasonography
- Tactical Medicine Program
- Search and Rescue (SAR) Medicine Program
- Disaster Medicine Program
- Crew Resource Management (CRM)
- Immersive simulation for healthcare staff drills
- Safety and disaster response drills
- Managing large scale events
- All terrain discipline rescue programs
POLICIES & PROCEDURES

ATTENDANCE

The education program is a rigorous program of study where any absences are detrimental to a student’s chances of passing all required phases. Attendance is required for all classes. Excused absences will be granted for emergency situations only. Students are required to attest to attendance for each day of class. Absences, tardiness and/or early exits, and operational policies are as follows:

Absences:
A student will be allowed only three (3) absences with notification. Absences above this limit may result in expulsion from the program with any reimbursement provided in accordance with TRG scheduled refund policy.
An absence with prior notification means that the student has contacted the TRG staff more than one hour prior to the scheduled start of class.
After one (1) absence without prior notification or two (2) absences with notification, the student shall meet with the Program Director to create a remediation plan and the student will be placed on probation.
In addition, if a student is absent for three (3) or more consecutive days, he or she will be expelled from the program with no reimbursement for tuition already paid.

During the clinical phase of a program, absence without prior notification to the educator or preceptor in charge is not acceptable and is cause for dismissal from the program.

Tardiness and Early Exits:
A student will be allowed only three (3) unexcused tardy or early exits. A tardy is defined as arriving to class more than 5 minutes after the scheduled start time. An early exit is defined as leaving class more than 30 minutes prior to the end of scheduled class time. Tardy arrivals or early exits above this limit will be cause for expulsion from the program with any reimbursement provided in accordance with TRG scheduled refund policy.

During the clinical phase of a program, tardiness without prior notification to the educator or preceptor in charge is not acceptable and is cause for dismissal from the program.

Make-up Work:
Students who miss assignments, exams, or any other work due to absences, tardiness, or early exits must make-up any missed assignments. Missed exams must be taken before the next day class can be attended.

During the clinical phase of a program, make up sessions or shifts are at the discretion of the educator or preceptor in charge.
Inclement Weather:
During inclement weather, TRG will hold class according to the Vancouver School District weather condition policy. Students should use added discretion when traveling from more rural areas. If class is in session, and the student deems it unsafe to travel to class, the Program Director should be contacted immediately.

Cell Phones and Pagers:
All cell phones, pagers, or other such electronic communication devices will be turned to vibrate during class and will not be utilized except for emergency or clinical contact during class.

Dress Code:
During didactic and laboratory sessions, students may wear any form of clothing they feel is appropriate, keeping in mind that The Resuscitation Group does not, under any circumstances, take responsibility for clothing which becomes soiled, stained, torn, or ruined during didactic or laboratory sessions.

Clinical Phase Behavior
All students are expected to follow the instructions of his or her educator/preceptor exactly and present a professional attitude/presence at all times.

CONFIDENTIALITY OF STUDENT RECORDS (FERPA)

Student records are released only for legitimate educational reasons or pursuant to a student’s express written consent. Students may provide written consent to the TRG staff by filling out and submitting the Consent to Release Student Information form.

A copy of this document is available at the back of this handbook, the form may not be sent electronically.

TRG adheres to the guidelines set forth in the federal Family Educational Rights and Privacy Act (FERPA).

Family Educational Rights and Privacy Act (FERPA)
The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S Department of Education.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1-800-877-8339. Or you may contact the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington D.C. 20202-5920
STUDENT EVALUATIONS
Students will be evaluated relative to the cognitive, psychomotor, and affective educational domains. Evaluation of students shall be conducted on a recurring basis and with sufficient frequency to provide both the student and program faculty with valid and timely indicators of the student’s progress toward and achievement of entry level competencies stated in the curriculum.

STUDENT CONDUCT

Representation of the TRG Education Program:
Through their professional conduct, students represent TRG. The quality of medical care, abilities to explain and/or justify the care provided and even personal appearance all reflects the educational and professional philosophies of TRG.

We have an excellent reputation in the healthcare community because our faculty and students take pride in the TRG Education Program. Students should not make statements on behalf of TRG, or represent TRG in administrative, financial, educational, or policy matters without the express written authorization of TRG staff.

Honor Code:
Students are responsible for conducting themselves in a manner that is above reproach at all times. The TRG staff maintains that above all, ethical conduct, especially honesty, is one of the most important attributes of a competent healthcare professional. Having adopted the high ethical standard of the healthcare profession, the student is charged with the responsibility for the behavior of his or her colleagues as well as his/her own.

Violations of this honor code can be cause for dismissal from the program. Students with knowledge of an infraction of this honor code are obligated to provide this information to the TRG staff immediately. If a student fails to notify TRG staff immediately, the student could face disciplinary action up to and including expulsion.
Prohibited Conduct:
The following is a list of prohibited conduct. This list is not meant to be exhaustive, nor should it be inferred that items not expressly listed are acceptable. Students are required to abide by all rules, policies, and procedures dictated by TRG staff, whether indicated herein or communicated at a later date.

- Submitting material in assignments, examinations, or other academic work which is based upon sources prohibited by the instructor or the furnishing of materials to another person for the purposes of aiding another person to cheat
- Submitting material in assignments, examinations, and other academic work which is not the work of the student in question
- Knowingly producing false evidence or false statements, making charges in bad faith against any other person, or making false statements about one’s own behavior related to educational or professional matters
- Falsification or misuse of TRG records, permits, or documents.
- Exhibiting behavior which is disruptive to the learning process or to the academic or community environment.
- Conviction of a crime, either:
  - Before becoming a student under circumstances bearing on the suitability of a student to practice a health or related profession, or
  - While a student at the program.
- Disregard for the ethical standards appropriate to the practice of a health or related profession while a student
- Attending any TRG Program while under the influence of alcohol, drugs, or medication that may impair one’s ability to perform required functions is prohibited. It is inappropriate to be under the influence or have consumed within the last eight (8) hours any substance that would alter your state of mind, or jeopardize patient care (e.g. alcohol, drugs, or medications). Students should be aware that tolerances may vary and the eight (8) hour minimum may not be sufficient time for some individuals.
- If a student is suspected of being under the influence of alcohol, drugs, or impairing medication, he/she will be dismissed immediately from class, lab, or clinical placement. In such an instance, the student will fall under the procedures outlined in the Academic Discipline/Dismissal Procedure.
- Obstruction or disruption of teaching, research, administration, disciplinary procedures, or other institutional activities including the TRG public service functions or other authorized activities on institutionally owned or controlled property.
- Obstruction, disruption, and/or interfering with freedom of movement, either pedestrian or vehicular, on TRG owned or controlled property.
- Possession or use of firearms, explosives, dangerous chemicals, or other dangerous weapons or instruments on institutionally owned, TRG controlled property, or Clinical placement, unless the student is a law enforcement officer or active duty military personnel on specific assignment requiring armed capability.
- Detention or physical abuse of any person or conduct intended to threaten imminent bodily harm or endanger the health of any person on any TRG owned, TRG controlled property, or Clinical site.
• Malicious damage, misuse, or theft of TRG property, or the property of any other person where such property is located on TRG owned or controlled property or regardless of location, is in the care, custody, or control of TRG or a clinical site.
• Refusal by any person while on TRG owned or controlled property (or clinical site) to comply with TRG staff orders or an appropriate authorized official to leave such premises because of conduct proscribed by this rule when such conduct constitutes a danger to personal safety, property, or educational or other appropriate institutional activities on such premises.
• Unauthorized entry to or use of TRG facilities, including buildings and grounds.
• Use of TRG or clinical site computers for any activities involving (a) buying or selling of items not required for program use, (b) downloading programs off the Internet, including music or video files, (c) accessing Internet sites containing pornography or gambling.
• Inciting others to engage in any of the conduct or to perform any of the acts prohibited herein. Inciting means that advocacy of prescribed conduct which calls upon a person or persons addressed for imminent action and is coupled with a reasonable apprehension of imminent danger to the functions and purposes of the TRG including the safety of persons and the protection of its property.

Knowledge of Misconduct:
Any person who witnesses or has firsthand knowledge of misconduct as described in the section above is obligated to send a written report of the infraction to TRG Staff. Failure to do so may result in disciplinary action up to and including dismissal from the program.

DRUG AND ALCOHOL AWARENESS

TRG recognizes the obligation of the administration, faculty, staff, and students to support and maintain a community atmosphere that emphasizes the development of healthy lifestyles and the making of responsible, informed decisions concerning drug and alcohol use. Efforts to provide this atmosphere will include: education through curriculum infusion, intervention, treatment referral, and especially the support of healthy lifestyle alternatives.

The goal of these efforts is to provide factual information about use and abuse and to increase awareness of indicators of harmful involvement; to educate students, faculty, and staff concerning options for dealing with excessive consumption by self and/or others; and to educate concerning possible interventions to prevent further abuse.

Whenever a person is concerned about another’s abuse of chemicals. The concerned individual is encouraged to speak privately with the abuser. Students needing assistance should consult with TRG staff for counseling and/or referral.
DISCIPLINE PROCEDURE

Academic Discipline/Dismissal Procedure:
Any student for whom a recommendation for discipline/dismissal is considered will have received ample notification of unsatisfactory work. The student will be notified in writing, either by email, personal delivery or posted letter, of the following:
1. Factors the TRG Program intends to consider in the discipline/dismissal proceedings.
2. The time and place for a meeting with members of the program staff.

From the time of written notification to the time in which the proceeding is held and a final decision rendered, the student loses all attendance privileges. This time period will not exceed three (3) business days.

A meeting will be convened, attended by members of the program staff and the student. During this meeting, the following will be reviewed:
- Policies and Procedures relevant to the disciplinary proceeding.
- Student’s signed statement, agreeing to be bound by the TRG Education Program policies.
- TRG Education Program documentation regarding student’s deficient performance.
- Student rebuttal.

Within five (5) business days of this meeting TRG Staff shall provide the student with a written decision. The student has the right to appeal the Instructors decision based on the Appeal Process outlined below.

APPEAL PROCESS
A student who has been dismissed from TRG program or disciplined in any way that the student feels is unfair may appeal the decision of the staff.

- **Step 1:**
  Within five (5) working days of receiving the Instructor’s decision, the student shall provide to the Director staff (or his or her designee) a written request for an appeals hearing. The request should outline the alleged behavior that led to discipline and why the student does not believe this is a fair outcome.

- **Step 2:**
  Within five (5) working days of receiving the request for an appeals hearing, the Director staff (or his or her designee) shall meet with the student. During this meeting the student will present his or her case as to why he or she believes the discipline to be unfair.

- **Step 3:**
  Within five (5) working days of this meeting, the Director staff (or his or her designee) shall provide a written response to the student regarding this matter. The decision of the Director staff (or his or her designee) is final and may not be appealed.
DISCRIMINATION AND HARASSMENT

In addition to the prohibited behaviors listed above, TRG prohibits any type of discrimination or harassment against any person based on the following:

- Race
- National Origin
- Sex
- Age
- Creed
- Presence of physical, sensory, or mental disability
- Religion
- Color
- Disabled veteran status
- Sexual Orientation
- Affectional Preference
- U.S. Military Veteran status
- Marital Status

The responsibility for, and the protection of this commitment extends to students, faculty, administration, staff, contractors, and those who develop or participate in TRG programs. It encompasses every aspect of employment and every student and community.

Trainees are seeking to assume a vital position of trust in the community and taking on the responsibility of serving everyone in need of their services, regardless of gender, race, age, national origin, sexual orientation, economic or educational background, religion, or any other factor. This is the responsibility that goes with having access to people’s private homes and lives in times of their great stress. It is your obligation to treat every patient and their families with equal respect. Everyone in the community must be approached and served with equal respect, care, and professionalism.

Persons who believe they have been discriminated against or harassed by TRG or its employee(s) or agent(s) on the basis of any status listed above, may request informal assistance and/or lodge a formal complaint.
COMPLAINT PROCESS

The process for filing a complaint for alleged discrimination or harassment is as follows:

- **Step 1:**
  The student shall provide TRG with a written summary of the alleged behavior which led to the complaint. If the complaint involves the Instructor, the student shall provide the complaint to the Director staff.

- **Step 2:**
  Having received the complaint, TRG shall review the facts with the Director staff and determine the appropriate course of action. Many situations can be resolved by the Instructor mediating a meeting between the complainant and the alleged offender. If that is not a viable option, or if it is not successful in resolving the matter, TRG shall initiate an investigation.

- **Step 3:**
  The investigation shall include interviews with the complainant and the alleged offender(s). This investigation may be conducted by TRG staff or outside investigators. This investigation will be completed within 45 days of the original complaint. Once the investigation is complete, the Instructor shall provide the complainant with a written summary of the findings and the action to be taken by TRG
  - No one shall be singled out, penalized, or retaliated against in any way by a member of the agency for initiating or participating in the complaint process. Retaliation may be grounds for disciplinary action.

If desired, inquiries or appeals beyond TRG level may be directed to:

**Equal Employment Opportunity Commission**
909 First Avenue, Suite 400
Seattle, WA 98104
(206) 220-6883

**Washington State Human Rights Commission**
711 South Capitol Way, Suite 402
PO BOX 42490
Olympia, WA 98504
(360) 753-6770

**Workforce Training and Education Coordinating Board**
128 10th Avenue, SW
PO BOX 43105
Olympia, WA 98504-3105
(360) 753-5673
**BLOODBORNE/AIRBORNE PRECAUTIONS**

In the laboratory and clinical settings students are at risk for exposure to blood borne pathogens and infectious diseases. All bodily substances should be considered potentially infectious. Personal protective equipment (PPE) is readily available in the laboratory, clinical, and field internship settings and should be used at any time where there is a possibility of exposure to blood borne pathogens. The minimum recommended PPE includes:

- **Gloves:** Disposable gloves should be worn BEFORE initiating patient care when there is any risk of exposure to bodily substances.
- **Masks and Protective Eyewear:** Masks and protective eyewear should be worn when there is any risk of blood or other bodily fluids splashing or spattering.
- **Gowns:** Gowns should be worn when there is any risk of blood or other bodily fluids splashing or spattering.
- **Hand Washing:** Hand washing is mandatory before and after any patient contact. All students must wash their hands after eating or using the restroom facilities.
- **Any student who is exposed to a patient’s bodily fluids should immediately decontaminate themselves and report the incident to their instructor or preceptor. Failure to adhere to precautions will result in disciplinary action.**

**PATIENT CARE & CONFIDENTIALITY**

Students should expect to participate in the care of patients with infectious diseases during their educational activities. Students will follow Bloodborne/Airborne Precautions to avoid transmission of or infection from infectious diseases. The procedures deemed necessary should be those recommended by the Centers for Disease Control (CDC).

1) It shall be the responsibility of TRG or clinical placement site to provide adequate protective materials (e.g. disposable gloves, masks, eye protection), or to ensure that the student is not put in a position where unprotected exposure is likely. Some facilities may require the student to supply his/her own HEPA-filter masks as protection against airborne pathogens.

2) It shall be the responsibility of TRG or clinical site to instruct the student about accepted infection control procedures applicable to the student’s activities.

3) It shall be the responsibility of the student to use the protective barriers provided, and to follow the instructions given, to minimize the risk of being infected by or transmitting any infectious diseases.

**Student Illness or Injury:**

Students are expected to exercise prudence in attending mandatory class or clinical sessions when ill. Healthcare professionals at clinical sites are empowered to restrict the activities of, or prohibit a student from completing a clinical shift.
Patient Confidentiality:
The following guidelines should be followed to protect the patient’s right to privacy:
1. Students, staff, and faculty of TRG will comply with the patient confidentiality guidelines established in the Health Insurance Portability & Accountability Act (HIPAA) of 1996.
2. TRG Patient Charting Forms and the clinical logs submitted for review should not have patients name, social security number, address, phone number, hospital identification number, or any other uniquely distinguishing information noted on them.
3. Patient condition and/or therapy will not be discussed with anyone not directly involved in that patient’s care. Cases may be discussed as part of the educational process of the TRG Program. During these case presentations, every effort will be made to protect the patient’s confidentiality. Any discussion regarding patient condition or care will be undertaken in an area and under circumstances which prevent dissemination of information to others not directly involved in the patient care conference.
4. If patient care assessment or management problems are perceived, or questions arise regarding the care, the case may be discussed in private with the Program Director.

Students should understand that when at international clinical placements, the standards of patient confidentiality and behavioral values may differ from the United States. Students must show respect for and compliance with local customs and regulations.

RECORD KEEPING

The TRG maintains all training records in electronic format. All records will be made available to students and to authorized agencies upon request. All hard copy format student files, during the program instruction, are maintained in a locked office within TRG, only the Instructor, Executive Assistant, and the Director staff are permitted access to these records. Each student shall be permitted to review their file upon request. In addition, TRG conforms with all laws under the Family Education Rights and Privacy Act (FERPA) regarding any records released to outside sources. Student records will be maintained for a minimum of ten (10) years.

TRG Program Files:
TRG Program files will contain for each course: summary of student attendance, summary of all written exams and all practical exams, copies of all written exams with answer keys, copy of practical exam plan to include evaluators utilized. Also included for each course is a detailed syllabus, copy of applicable handbook(s), and records pertaining to clinical and field internship experiences.

Student Files:
Student files will contain the student application and any applicable documentation for prerequisites, waivers, signed code of conduct agreements, attendance record, skill competency record, exams, counseling forms, clinical evaluations, incident reports (as needed), clinical and field internship records, and copies of certifications earned.

Access to Student Files:
Any student shall have access to their personal class records upon request. This request should be made to the Instructor or the Director staff. The Instructor and student issuing the request will then review the student’s file.

**GRADING**

The program is a preparatory program for exam process, such as the BCCTPC, BCEN, AREMT, HSI, and PHECC, as well as preparation to care for patients. It is important for all students to know at least 85% of the course content to successfully complete the program. This is ensured through homework, skills competency examination, authentic assessment, and exams.

**Self-Paced Student Assignments:**
Assignments are graded as pass/fail; and are due according to the course syllabus. Any assignments not turned in on time will be entered into the grade book as failed and successful completion of the course will not occur.

**Exams:**
Each student must pass exams to successfully complete the program. A minimum score of 85% on all exams is required. If an exam is failed, the student will be allowed one retest, after meeting with the director of the program. The exam must be retested within five (5) days of failing the exam. If the exam is not tested within five (5) days the student will be dismissed from the program.

If the student fails, the retest they will be dismissed from the program. If a second exam is failed, the student will meet with the director to discuss continuing in the program. It is the responsibility of the student to arrange to meet with the director and schedule a retest.

If a student misses an exam due to an absence, they must take the exam before their next class day.

If a retest is passed the maximum score the student will receive for that exam will be 85%.

**Exam Grading Scale:**
Grades during the didactic phase will be determined on the basis of the following:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>95% - 100%</td>
<td>Exceeds Expectations</td>
</tr>
<tr>
<td>B</td>
<td>86% - 94%</td>
<td>Exceeds Standard</td>
</tr>
<tr>
<td>C</td>
<td>85%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>F</td>
<td>0% - 84%</td>
<td>Failing</td>
</tr>
</tbody>
</table>

**Method to report Student Grades:**
Student’s grades will be posted and accessible via electronic record.
**Academic Probation / Remediation:**

Failure of a student to meet academic or skill performance standards will result in remedial action to address educational strategies. Such corrective action may include additional course work in the form of oral presentations, written assignments, additional examinations, and/or one-on-one coaching by peers or staff. Remediation may be initiated by the student or the Director staff. All remedial sessions will be documented and recorded in the student’s personal file. Inability to resolve academic or skill performance deficiencies with remedial course work is grounds for dismissal. A student may discuss academic or skill performance difficulties at any time by making an appointment directly with the Director staff.
GRADUATION

REQUIREMENTS
1. Payment in full of all TRG Program tuition and fees.
2. Meet minimum attendance requirements.
3. Satisfactory completion of all didactic requirements with grade scores of at least 85%.
4. Satisfactory completion of all skills competency examinations with a “meets standard” rating.
5. Satisfactory completion of clinical placement and submission of supporting documentation.
6. Submission of all assigned writing assignments

CERTIFICATE AND PERMANENT RECORD
Students successfully completing the program will receive a certificate in Resuscitation Officer. An example of the certificate is below:

[Image of certificate]

The student’s academic records will be kept on file at TRG for a minimum of fifty (50) +1 years using secured cloud capabilities as required per state law WAC 490-105-200.
PLACEMENT SERVICES

None

EDUCATIONAL CREDENTIAL UPON GRADUATING

Upon graduation from the program student will be prepared to potentially successfully complete national or international exams.
Consent to Release Student Information

The TRG philosophy regarding student information is that students are adults and we generally will not share their academic and/or financial records with third parties, including parents, without consent. At the same time, we will share a student’s education records where the student has given consent and in other cases permitted by federal law. The Family Educational Rights and Privacy Act of 1974 (FERPA) and the TRG policy on the confidentiality of student records protect the privacy of student education records and generally limit access to the information contained in those records by third parties. FERPA and TRG policy, however, do provide for situations in which TRG may, at its discretion, and sometimes must, disclose information without a student’s consent. For example, we may disclose education records to a parent without the consent of the student of the student is listed as a financial dependent on the parent’s federal tax submission (financial aid applicants) when we determine such disclosure is merited. **You may choose to grant TRG the right to disclose education records to certain individuals in accordance with FERPA and TRG policy by filling out and signing this consent form.**

You have the right to revoke the permissions granted here at any time by submitting your written revocation to the office maintaining this consent form. Such revocation will not affect disclosure made by the TRG relying on your consent prior to receipt of such notice of revocation. **Note: this form does not pertain to Medical inquiries.**

Student’s Name: ____________________________________________

Last four digits of your SSN: _______

I have listed below the individual(s) to whom TRG may release information from my education records:

Name: ____________________________________________
Relationship to Student: _________________________________
Address & Telephone #: _________________________________

Name: ____________________________________________
Relationship to Student: _________________________________
Address & Telephone #: _________________________________

The above named individual(s) may have access to the following information (examples: all academic information, all financial information):

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

Student Signature ___________________________ Date ________________
ACADEMIC GUIDELINES

1. Reading assignments are to be completed prior to class.
2. Attendance is required for all classes. Excused absences will be granted for emergency situations only.
3. You will be responsible and accountable for all equipment assigned to you during skill stations and patient care scenarios. You are expected to assist in the cleaning and proper storage of equipment after each class.
4. Tests will include the material from the resource texts, online resources, and classroom work.
5. Any student may withdraw from the program at any time; refunds will be made according to the policy.
6. Any student may be dismissed if they do not meet the course standards; this will include skills, clinical rotation, and written grades (after review by the Director staff and the individual).
7. Passing score for this program is 85% or greater on exams and “meets standard” on skills competencies and clinical evaluations.
8. If the student does not successfully pass any practical portion of the class, they will not receive a passing grade or a course completion certificate.
GENERAL RELEASE

I understand that the education and work of a Resuscitation Officer, including lab work and clinical rotations within hospitals or other healthcare facilities with which I may be associated, are inherently dangerous and could expose me to accident and injury, including but not limited to blood borne and airborne pathogens, needle sticks, and many other dangerous and hazardous situations and environments, and I hereby release and hold harmless The Resuscitation Group and any other their employees, instructors and volunteers from any liability associated with these risks.

All students have the understanding that taking and successfully completing the required written and practical material does not guarantee the student will obtain certification and/or practice as a Anesthesia Assistant in the state of Washington or any other state.

I, (Print Student Name)______________________________________, understand the Student Code of Conduct from this handbook and agree to follow these policies and procedures of TRG.

I, (Print Student Name)______________________________________, understand this activity will fundamentally place me in an environment that has risks, dangerous situations, and exposure to potentially deadly diseases and accept this potential risk as my own, holding all organizations and staff associated with this program harmless from liability.

____________________________________  __________
Student Signature               Date
NOTICE OF LICENSURE

This school is licensed under Chapter 28C.10RCW.

Inquiries or complaints regarding this private vocational school may be made to the:

Workforce Board, 128 – 10th Ave., SW, Box 43105, Olympia, Washington 98504
Web: wtb.wa.gov
Phone: (360) 709-4600
E-Mail Address: pvsa@wtb.wa.gov
APPENDIX 1

Anesthesia Assistant Curriculum
Anesthesia Assistant Training Program

Course Description: This 40-hour course, instructor led and Physician oversighted, designed to provide the Anesthesia Assistant a program of learning to enhance the knowledge and skills of the

Course Contact: The Resuscitation Group
+1-855-739-2257
info@resuscitationgroup.com
www.resuscitationgroup.com

Course Location: The Resuscitation Group
901 West Evergreen Blvd, Vancouver, WA 98660

Prerequisites:
1. Washington State KNOW HIV Prevention Education for Health Care Facility Employees (7 hour course certificate)
2. Current AHA ACLS Provider Certification

Pre-Course Review Media:
Conscious Sedation for Minor Procedures in Adults NEJM
https://youtu.be/BSYYq01Y9xQ

Understanding IV Conscious Sedation
Gina L. Salatino DMD, FAGD
https://youtu.be/bZHqQsgovy8

Principles of Capnography Lesson 1
https://youtu.be/KLRPlvw3M8

Principles of Capnography Lesson 2: Basic principles
https://youtu.be/rsd5C7FLXXo

Principles of Capnography Lesson 3: Capnography waveforms
https://youtu.be/GUV7BTIGeM

Nitrous Oxide Oxygen Sedation
Royal College
https://youtu.be/lo35MoG3cc8

Intravenous line insertion, IV starting techniques, How to start an IV.
Eyad Ahmed MD. https://youtu.be/sGZbKlSdQSM

Reasons Why People Miss Veins When Starting an IV or Drawing Blood.
RegisteredNurseRN.com: https://youtu.be/jNf-8DwW224
How to start an IV: Antecubital Fossa. Med School Made Easy Inc. 
https://youtu.be/IxhXahrXLbQ

**Instructional Format:** Integrative lectures, practical skills lab, and supervised practice.

**Participation Expectations:** In order to successfully complete this course of instruction, a registered participant must be present for all scheduled hours and be engaged in the interactive discussions, case reviews and knowledge evaluation.

Participants will successfully:
1. Complete a comprehensive written examination with a score of 86% or better.
2. Successfully manage three anesthesia emergencies in an immersive simulation environment, under the observation of instructor staff and scored against the NREMT scenario skills sheet.
3. Successfully complete five (5) intravenous catheter placements under the observation of the instructor staff, using the NREMT IV Access Skills Sheet Standard.
4. Successfully complete ten (10) intravenous catheter placements under the supervision of their Dental or Medical Provider.

**Course completion:** Having met the Participation Expectations listed above, a participant will receive a Course Completion indicating the respective course or module hours completed. It is recommended that the participant also retain this Syllabus and the attached module descriptions as further documentation to professional certification/licensure agencies or employers of content, objectives, outcomes, and assessments.

**Course Certification:** Having successfully completed the program of instruction and 10 independent vascular access initiations, the student will receive a *Certificate in Anesthesia Assistant* from the Resuscitation Group with approval from the Washington State Workforce Training - Vocational Education Board.

**Objectives:** Educational content covered in this course includes a review of current science and best practices, with the following objectives:
1. Orientation to the continuum of sedation.
2. Demonstration of pre-procedure patient evaluation and monitoring.
3. Recognition of respiratory and/or circulatory compromise.
4. Ability to describe patient safe monitoring procedures.
5. Recognize the role of pulse oximetry and quantitative waveform capnography in sedation.
6. Demonstrate the ability to interpret common waveform capnography waveforms.
7. Demonstrate familiarity with common anesthesia pharmacological agents; including, but not limited to: Ketamine, Midazolam, Lorazepam, Fentanyl, and Propofol.
8. Demonstrate the ability to respond with a systematic resuscitative approach to the following common anesthesia emergencies; including: hypoxia, hypotension, hypertension, bradycardia, cardiac arrest, respiratory conditions, angina, syncope, stroke, allergy, and hypoglycemia.

9. Recognize the role of IV Therapy and medication infusion.

10. List factors that affect flow rates of IV solutions.

11. Describe proper use of specific IV therapy equipment.

12. Initiate IV therapy utilizing nursing precautions or patient safety by:
   a. Preparing the patient psychologically
   b. Explaining the rationale for venipunctures
   c. Differentiating between the types of skin puncture, venipunctures and arterial devices and their appropriate uses
   d. Differentiating between skin puncture, arterial puncture, and venipunctures
   e. Distinguishing between types of intravenous solutions and their appropriateness
   f. Preparing equipment properly and aseptically
   g. Selecting and correctly preparing the most appropriate vein for venipuncture
   h. Preparing the site in a manner which reduces the chance of infection
   i. Performing venipuncture utilizing direct or indirect method
   j. Dressing site according to policy
   k. Securing and immobilizing device appropriately and safely
   l. Regulating flow rate and fluid accurately
   m. Documenting on medical record

13. Recognize complications related to venipunctures.

14. Recognize local and systemic reactions related to intravenous therapy and medications.

15. List the measures taken to reduce local and systemic reactions

16. List three reasons to discontinue and restart IV access.

17. List the cause and differentiate clinical symptoms of electrolyte imbalances.

18. Identify the role of IV therapy and pH balance.

19. Differentiate actions, dosages, side effects, and implications of specified intravenous solutions.

20. Correlate the IV fluid container label with the name of the solution as commonly ordered.

21. Examine the differences between techniques used in adult and pediatric IV therapy.

22. Discuss situations related to IV therapy and legal implications.

23. Describe appropriate ways of minimizing legal risks in IV therapy and blood withdrawal practice.

24. Identify the safety precautions in regards to administering IV fluids.

25. Properly calculate, draw up, and administer IV medications.

Outcomes: Participants who successful complete this course will be able to:
- Discuss the continuum of sedation.
- Explain the perimeters for patient safe monitoring during conscious sedation.
- Describe pharmacological agents for conscious sedation.
- Demonstrate proper administration of pharmacological agents.
- Discuss proper pre-procedure evaluation and physical exam processes.
- Demonstrate proper response to anesthesia emergencies in a simulation environment.
- Discuss the structure and function of veins.
- Identify the names and the locations of the veins most suitable for phlebotomy and cannulation/venipuncture.
- Assemble equipment and supplies needed to collect blood and for cannulation/venipuncture and discuss the correct use of each.
- Demonstrate the steps in performing blood collection and cannulation/venipuncture procedure.
- Assess techniques and equipment used to minimize biohazard exposure in blood collection and cannulation/venipuncture.
- Evaluate procedural errors in blood collection and cannulation/venipuncture and discuss remedies for each.
- Differentiate complications associated with blood collection and cannulation/venipuncture and their effect on the quality of laboratory results.

Assessments: Knowledge Evaluation Tool completion and skills testing completion.

Course Outline:
Day 1:
0800-0815 Course Introduction and Registration
0815-0900 Continuum of Sedation
0900-1030 Pharmacology
1030-1200 Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 1
1200-1300 Lunch
1300-1400 Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 2
1400-1700 Emergency Response Protocols for anesthesia emergencies

Day 2:
0800-1200 Intravenous Therapy Didactic
1200-1300 Lunch
1300-1700 Intravenous Therapy and Pharmacology Lab
1700-1715 Participants orientation to provider supervised activities

Day 3:
0800-1200 Immersive Simulation – Anesthesia Emergencies
1200-1300 Lunch
1300-1700 Immersive Simulation – Anesthesia Emergencies
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 4:</td>
<td></td>
</tr>
<tr>
<td>0800-1700</td>
<td>Anesthesia Lab</td>
</tr>
<tr>
<td>Day 5:</td>
<td></td>
</tr>
<tr>
<td>0800-1200</td>
<td>Immersive Simulation – Anesthesia Emergencies</td>
</tr>
<tr>
<td>1200-1300</td>
<td>Lunch</td>
</tr>
<tr>
<td>1300-1700</td>
<td>Immersive Simulation – Anesthesia Emergencies</td>
</tr>
</tbody>
</table>
APPENDIX 2

Education, Competency Assurance, Privileges to Practice Considerations
Education, Competency Assurance, Privileges to Practice Considerations

What is the best way to determine if a provider is competent? This question is increasingly being asked by employers, regulators, certifying agencies, insurance companies, and professional associations. Currently in the majority of jurisdictions and courts, a practitioner is determined to be competent when initially licensed, able to show proof of skills competencies, and has the approval of medical oversight; thereafter unless proven otherwise, the issue of competency has been through this pathway, yet in the past decade, legal actions and media investigations have thrown a poor light on this pathway.

As a result, the simple fiscal impacts to the major carriers has resulted in a standard determination that the standard must change. Many organizations and regulatory authorities are exploring alternative approaches to assure continuing competence in today’s environment where technology and practice are continually changing, new health care systems are evolving and consumers are pressing for providers who are competent, both privately, through legal action, and through social media processes.

The purpose of this discussion is to explore various approaches and views related to continuing competency and examine the difficult policy, development and implementation issues related to continuing competency.

Both the American Medical Association (AMA) and the American Nurses Association (ANA) have been asked this question by their membership, regulators, consumers and the public. Since competence of the provider has become a primary concern of the profession, Both the AMA and ANA have embarked on the development of policy addressing the continuing competence of practicing providers.

The American College of Emergency Physicians (ACEP) believes that:
1. The exercise of clinical privileges in the emergency department is governed by the rules and regulations of the department;
2. The medical director (or their designee) is responsible for periodic assessment of clinical privileges of emergency physicians against the national competency guidelines;
3. When a physician applies for reappointment to the medical staff and for clinical privileges, including renewal, addition, or rescission of privileges, the reappraisal process must include assessment of current competence by the medical director (or their designee);
4. The medical director (or their designee) will determine the means by which each emergency physician will maintain competence and skills and the mechanism by which the proficiency of each physician will be monitored.

(Revised and approved by the ACEP Board of Directors October 2014, June 2006 and June 2004)

Mechanisms for continuing competence include regulatory and private sector approaches, as well as approaches by national organizations, certifying entities, and state boards.
Regulatory Approaches to Continuing Competence:
Health care practitioners are regulated by state regulatory boards with the purpose of protecting the health, safety and welfare of the public. When a practitioner is initially licensed, they are deemed by the state to have met minimal competency standards. The challenge of licensure boards is to assure practitioners are competent throughout their practice career not just with initial licensure. As well as address the issues of post licensure inexperience during the first licensure period.

The ongoing demonstration of continuing competence is not a new regulatory issue.

According to a national commission on health manpower sponsored by the U.S. Department of Health, Education and Welfare recommended physicians undergo periodic reexaminations (Schmitt Shimberg 1996). In 1971, a similar report recommended that requirements to ensure continued competence should be developed by professional associations and states. The alternative to periodic reexamination was deemed to be continuing education (CE) and states began requiring mandatory CE as a condition of licensure renewal for a variety of professions. The National Registry of Emergency Medical Technicians (NREMT) required both continuing medical education and skills competency evaluation in its very first year of establishment.

Continuing Education and Clinical Competence:
This approach to continuing competence proved to be controversial. Given the broad parameters of what continuing education consists of and the lack of formal research to support the correlation between participation in continuing education and continuing competence related to improved practice outcomes, this method has been called into question. However, several investigators are working to make this link by designing a longitudinal descriptive research study to determine the relationship between education sessions and practice.

The 2006 study, National Reregistration and the Continuing Competence of Paramedics, by Keith Holtermann and colleagues, found that NREMT Paramedics who reregistered 4 and 6 years after initial registration were twice as likely to pass the exam as their State-certified cohort counterparts who did not reregister with the NREMT. The registered group, compared to the nonregistered group, had significantly more Continuing Medical Education. The findings suggest that Paramedics who reregister with the NREMT are more knowledgeable than those who do not reregister.

In a 2011 study (The Association Between Emergency Medical Services Field Performance Assessed by High-fidelity Simulation and the Cognitive Knowledge of Practicing Paramedics; Jonathan R. Studnek PhD, NREMT-P, Antonio R. Fernandez PhD, NREMT-P, Brian Shimberg NREMT-P, et Al), investigators simultaneously assessed cognitive knowledge and simulated field performance. Utilization of these measurement techniques allowed for the assessment and comparison of field performance and cognitive knowledge. Results demonstrated an association between a practicing paramedic’s performance on a cognitive examination and field performance, assessed by a simulated EMS response.

Substantial research demonstrates that the stressors accompanying the profession of paramedicine can lead to mental health concerns. In contrast, little is known about the effects of stress on paramedics’ ability to care for patients during stressful events. In this study, investigators examined paramedics’ acute stress responses and performance during simulated high-stress scenarios. Advanced care paramedics participated in simulated low-stress and high-stress clinical scenarios. The paramedics
provided salivary cortisol samples and completed an anxiety questionnaire at baseline and following each scenario. Clinical performance was videotaped and scored on a checklist of specific actions and a global rating of performance. The paramedics also completed patient care documentation following each scenario. Results showed that clinical performance and documentation both appeared vulnerable to the impact of acute stress. Developing systems and training interventions aimed at supporting and preparing emergency workers who face acute stressors as part of their everyday work responsibilities is a vital avenue to successful patient outcomes. (LeBlanc VR, Regehr C, Tavares W, Scott AK, MacDonald R, King K. The impact of stress on paramedic performance during simulated critical events. Prehosp Disaster Med. 2012)

In a randomized controlled trial, simulation based learning was superior to problem based learning for the acquisition of critical assessment and management skills (Simulation-based training is superior to problem-based learning for the acquisition of critical assessment and management skills; Steadman, Randolph H. MD; Coates, Wendy C. MD; et Al; Critical Care Medicine; January 2006 - Volume 34)

The link between exposure to patients and improvement in performance has been established many times in literature, but perhaps most compelling of recent studies is from Australia, where patient survival after OHCA significantly increases with the number of OHCAs that paramedics have previously treated (Paramedic Exposure to Out-of-Hospital Cardiac Arrest Resuscitation Is Associated With Patient Survival; Kylie Dyson, Janet E. Bray, et Al; Circulation: Cardiovascular Quality and Outcomes; January 26, 2016)

In the past twenty years, state legislative action related to continuing competency has increased. In 1999, legislation was passed in Tennessee requiring the development of continuing competence requirements of providers. In the same year, legislation was passed in Vermont mandating continuing competency evaluations of physicians, chiropractors, and podiatrists. Currently, twenty-four states have introduced legislation relative to continuing competence of health professions. Most legislation would require licensees to demonstrate continuing competence to a licensure board upon re-licensure while some bills would require a provider to demonstrate competency in the workplace setting.

A bill in Massachusetts that would authorize the Board of Registration (Board of Nursing) to require periodic competency testing of all licensed and registered nursing including testing of current nursing practice and procedures. Failure to pass this test would result in automatic suspension of a nurses’ license until competency was established. A bill introduced in Hawaii would require nurses in hospitals to demonstrate competence in providing care in order to be assigned to a nursing unit. Other continuing competence bills apply to chiropractors, podiatrists, dentists, dietitians, physicians, paramedics, pharmacists and speech-language pathologists.

As states regulate advanced practice, they are turning to certification as an indicator of entry-level competence. Certification in these instances is therefore not a voluntary process, but instead constitutes a regulatory requirement to ensure public safety and enhance public health. As a result, certifying bodies are expected to demonstrate that their initial certification exams truly reflect entry level and that their recertification process reflects continuing competence.

The underlying assumptions regarding the use of certification to ensure competence and its inherent value have been increasingly questioned since the late 1970's. There is a dearth of empirical data which substantiate the predictive power of certification and recertification exams, which has led to the assertion that certification does not have an impact on patient outcomes.
Private Sector Approaches to Continuing Competence:
The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requires hospitals to assess the competency of employees when hired and then regularly throughout employment. The competence assessment is defined as "the systematic collection of practitioner-specific data to determine an individual’s capability to perform up to defined expectations." (Joint Commission on Accreditation of Healthcare Organizations, 1998).

Pew Commission Reports on health professions licensure issues have been a catalyst in bringing the issue of continued competence to the public’s attention. In its 1995 report, Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century, one of the proposed recommendations is: "States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals." Accompanying the recommendation was a series of policy options. In formal responses to the report from the public, this recommendation received the highest score for level of concern and one of the highest scores for level of support. There were 76 formal responses to the report; 45% were from the nursing community which included state and national organizations as well as nursing boards; 26% of the responses were from individuals; and 29% from other health care professions including occupational therapy, physical therapy, medicine, pharmacy and dentistry (Gragnola, Stone, 1997). Identified barriers to reform included the complexity of the health care environment and the vast differences in practice. These differences make testing for competence difficult as areas of expertise may not fit into standardized testing.

A second Pew Report, Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation was released in October of 1998. One of the three priority issues included in the report was continuing competence. The report recommended that state regulatory boards should be held responsible to require health care practitioners to demonstrate competence throughout their careers. However, the report added that the "actual assessment of competence may best be left to the professional associations, private testing companies and specialty boards" (Pew Health Professions Commission, 1998).

The Interprofessional Workgroup on Health Professions Regulation, which represents 17 health professions, received a Pew Foundation grant to sponsor a continuing competence Summit entitled, "Assessing the Issues, Methods and Realities for Health Care Professions," July 25 - 26, 1997 in Chicago, Illinois. The objective of the Summit was for participants to recognize the significance of ensuring continued competence for health care professionals. The Summit focused on analyzing the issues related to continuing competence and promoted discussion of various methods of assessing continuing competence.

Other measures to promote competence have been indirectly aimed at the prevention of potential problems through accreditation of educational institutions, background checks on licensees and the threat of disciplinary action if the licensee is reported to the board.

Whose role is it to assure continuing competence? Is it the role of the individual provider, professional association, employer, regulatory board, or certifying agency to assure continued competence? Should all of the stakeholders be involved, or just one or two?
Dennis Wentz, American Medical Association, points out that 90% of physicians take specialty board examinations and pass. There are continuing medical education requirements for recertification. Fourteen programs are now operational and moving toward maintenance of competence rather than testing at intervals.

The ANA sponsored Expert Panel appointed in 1999 has formulated the following assumptions regarding continuing competence:
1. The purpose of ensuring continuing competence is the protection of the public and advancement of the profession through the professional development of providers.
2. The public has a right to expect competence throughout provider’s careers.
3. Any process of competency assurance must be shaped and guided by the profession of the provider.
4. Assurance of continuing competence is the shared responsibility of the profession, regulatory bodies, organizations/workplaces and individual providers.
5. Providers are individually responsible for maintaining continuing competence.
6. The employer’s responsibility is to provide an environment conducive to competent practice.
7. Continuing competence is definable, measurable and can be evaluated.
8. Competence is considered in the context of level of expertise, responsibility, and domains of practice.

Building on existing regulatory models and the mission of its organizations, the National Council of State Boards of Nursing (NCSBN) has explored various approaches to determine continued competence. NCSBN has investigated the use of computer simulated testing (CST) for assessing nursing competence, reviewed and utilized mandated continuing education, and is now focusing on the licensee’s responsibility for individual competence. NCSBN has also explored through the Continuing Competence Accountability Profile (CCAP), a self-assessment tool, which "provides a framework for nurses to track and document a synthesis of professional growth activities across a nurse’s career." NCSBN recognizes that continued competence is a multifaceted issue that compels the profession, consumers and other to assist in comprehensive development of options to best assure ongoing nursing education and skill levels. (National Council of State Boards of Nursing, 1998).

In addition to competency assessment, the issue of clinical privileges is significant.

In its Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine, the American College of Emergency Physicians (ACEP) states the medical director (or designee) is responsible for setting competence criteria. The medical director is also ultimately responsible for determining the competence of individual department members.

The medical director must also be in compliance with established department proficiency and competence criteria. In the event of question or dispute over the medical director's competency, the matter may be referred to the medical staff's credentials committee or to the medical executive committee.

Establishing criteria for proficiency and the evaluation of proficiency may be problematic. For those medical specialties that perform major procedures (i.e.: surgery, emergency medicine, etc..), establishing numerical thresholds may be a valid methodology (ie, requiring that a minimal number of procedures be
performed during the privileging period under review). Lack of numerical compliance requires stress inoculation simulation performance appraisal.

However, for those specialties that are primarily "cognitive" in nature, which employ a wide armamentarium of "minor" procedural skills, establishing numerical thresholds for numerous procedures may be very difficult to track. Further, it is not clear whether such tracking of "minor" procedural skills is a valid component of proficiency assessment.

Many departments will choose to establish clinical privileges assessment methodologies that utilize a combination of procedure tracking (frequency), plus assessment based on sentinel events, training, assessment, and information forthcoming from the department's overall quality improvement plan.

Establishing frequency thresholds in emergency medicine may be problematic. Certain procedures may be performed very rarely (eg, cricothyrotomy). Yet, all emergency physicians must be capable of performing this and several other rarely-performed emergency procedures. In the event that a member does not meet or exceed numerical thresholds for procedures when such thresholds have been set, an option is to extend a provider's procedure privileges through a "skills lab" (eg, educational review, demonstration, simulation and testing) is a recommended process.

In their work, Defining and Assessing Professional Competence, Epstein and Hundert (JAMA 2002;287(2):226-235) stated that in addition to assessments of basic skills, new formats that assess clinical reasoning, expert judgment, management of ambiguity, professionalism, time management, learning strategies, and teamwork promise a multidimensional assessment while maintaining adequate reliability and validity. Institutional support, reflection, and mentoring must accompany the development of assessment programs.

Summary:

Clinical competency, defined as, “The capability to perform acceptably those duties directly related to patient care, competence in professional activities directly related to patient care”, has been an issue for decades in healthcare. As early as 1967, a national commission on health manpower sponsored by the U.S. Department of Health, Education and Welfare recommended licensed physicians be re-examined periodically; this commission later recommended CE as an alternative to re-licensure. State legislatures continue to address continuing competence, as do the courts and private accreditation and certification agencies.

The reality of critical care medicine, especially as applied in the prehospital environment, requires that each and every provider have base licensure, recognized educational processes, regular competency assessment, and a formal process for clinical privilege granting.

Failure to have a defendable program that does not include skills demonstration, simulation, and supervised clinical practice as components of the process will not lead to improved patient outcomes, and most certainly will lead to professional or legal complications.
APPENDIX 4

Course Participant Assessment Documents and Tools
### INTRAVENOUS THERAPY

<table>
<thead>
<tr>
<th>Actual Time Started</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checks selected IV fluid for:</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>- Proper fluid (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clarity (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Expiration date (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selects appropriate catheter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selects proper administration set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connects IV tubing to the IV bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares administration set [lis drip chamber and flushes tubing]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuts or tears tape [at any time before venipuncture]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes or verbalizes body substance isolation precautions [prior to venipuncture]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applies tourniquet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts suit case venipuncture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infuses site appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs venipuncture</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>- Inserts stylet (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Notes or verbalizes flashback (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Occludes vein proximal to catheter (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Removes stylet (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Connects IV tubing to catheter (1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposes/verbalizes proper disposal of needle in proper container</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Releases tourniquet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runs IV for a brief period to assure patien flow rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secures catheter [tape securely or verbalizes]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusts flow rate as appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
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### INTRAVENOUS BOLUS MEDICATIONS

<table>
<thead>
<tr>
<th>Actual Time Started</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asks patient for known allergies</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Selects correct medication</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Assures correct concentration of medication</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Assembles prefilled syringe correctly and dispels air</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Continues to take or verbalize body substance isolation precautions</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Identifies and cleanses injection site closest to the patient [Y-port or hub]</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Neatly delivers medication</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Stops IV flow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers correct dose at proper push rate</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Disposes/verbalizes proper disposal of syringe and needle in proper container</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Turns IV on and adjusts drip rate to TGD/VCO</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Verbalizes need to observe patient for desired effect and adverse side effects</td>
<td>1</td>
<td></td>
</tr>
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**Total:** 22
<table>
<thead>
<tr>
<th>Scenario Management</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoroughly assessed and took deliberate actions to control the scene</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Assessed the scene, identified potential hazards, did not put anyone in danger</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Incompletely assessed or managed the scene</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Did not assess or manage the scene</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Assessment</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed an organized assessment and integrated findings to expand further assessment</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Completed primary survey and secondary assessment</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Performed an incomplete or disorganized assessment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Did not complete a primary survey</td>
<td>0</td>
<td></td>
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<table>
<thead>
<tr>
<th>Patient Management</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed all aspects of the patient’s condition and anticipated further needs</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Appropriately managed the patient’s presenting condition</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Performed an incomplete or disorganized management</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Did not manage life-threatening conditions</td>
<td>0</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Interpersonal relations</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established rapport and interacted in an organized, therapeutic manner</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Interacted and responded appropriately with patient, crew, and bystanders</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Used inappropriate communication techniques</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Demonstrated intolerance for patient, bystanders, and crew</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integration (verbal report, field impression, and transport decision)</th>
<th>Possible Points</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stated correct field impression and pathophysiological basis, provided succinct and accurate verbal report including social/psychological concerns, and considered alternate transport destinations</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Stated correct field impression, provided succinct and accurate verbal report, and appropriately stated transport decision</td>
<td>2</td>
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<tr>
<td>Stated correct field impression, provided inappropriate verbal report or transport decision</td>
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</tr>
<tr>
<td>Stated incorrect field impression or did not provide verbal report</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Actual Time Started: ________  
Actual Time Ended: ________  
Total: 15

Critical Criteria:  
- Failure to appropriately address any of the scenario’s “Mandatory Actions”  
- Failure to manage the patient as a competent EMT  
- Exhibits unacceptable affect with patient or other personnel  
- Uses or orders a dangerous or inappropriate intervention  

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.  

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WAC 246-817-205

Dental anesthesia assistant certification requirements.

An applicant for certification as a dental anesthesia assistant must submit to the department:

(1) A completed application on forms provided by the secretary;
(2) Applicable fees as defined in WAC 246-817-99005;
(3) Evidence of:
   (a) Completion of a commission approved dental anesthesia assistant education and training. Approved education and training includes:
      (i) Completion of the "Dental Anesthesia Assistant National Certification Examination (DAANCE)" or predecessor program, provided by the American Association of Oral and Maxillofacial Surgeons (AAOMS); or
      (ii) Completion of the "Oral and Maxillofacial Surgery Assistants Course" course provided by the California Association of Oral and Maxillofacial Surgeons (CALAOMS); or
      (iii) Completion of substantially equivalent education and training approved by the commission.
   (b) Completion of training in intravenous access or phlebotomy. Training must include:
      (i) Eight hours of didactic training that must include:
         (A) Intravenous access;
         (B) Anatomy;
         (C) Technique;
         (D) Risks and complications; and
      (ii) Hands on experience starting and maintaining intravenous lines with at least ten successful intravenous starts on a human or simulator/manikin; or
      (iii) Completion of substantially equivalent education and training approved by the commission;
   (c) A current and valid certification for health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS);
   (d) A valid Washington state general anesthesia permit of the oral and maxillofacial surgeon or dental anesthesiologist where the dental anesthesia assistant will be performing his or her services;
   (e) Completion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC, Part 8; and
(4) Any other information determined by the commission.
WAC 246-817-771

Dental anesthesia assistant.

(1) A dental anesthesia assistant must be certified under chapter 18.350 RCW and WAC 246-817-205.

(2) A dental anesthesia assistant may only accept delegation from an oral and maxillofacial surgeon or dental anesthesiologist who holds a valid Washington state general anesthesia permit.

(3) Under close supervision, the dental anesthesia assistant may:
(a) Initiate and discontinue an intravenous line for a patient being prepared to receive intravenous medications, sedation, or general anesthesia; and
(b) Adjust the rate of intravenous fluids infusion only to maintain or keep the line patent or open.

(4) Under direct visual supervision, the dental anesthesia assistant may:
(a) Draw up and prepare medications;
(b) Follow instructions to deliver medications into an intravenous line upon verbal command;
(c) Adjust the rate of intravenous fluids infusion beyond a keep open rate;
(d) Adjust an electronic device to provide medications, such as an infusion pump;
(e) Administer emergency medications to a patient in order to assist the oral and maxillofacial surgeon or dental anesthesiologist in an emergency.

(5) The responsibility for monitoring a patient and determining the selection of the drug, dosage, and timing of all anesthetic medications rests solely with the supervising oral and maxillofacial surgeon or dental anesthesiologist.

(6) A certified dental anesthesia assistant shall notify the commission in writing, on a form provided by the department, of any changes in his or her supervisor.
(a) The commission must be notified of the change prior to the certified dental anesthesia assistant accepting delegation from another supervisor. The certified dental anesthesia assistant may not practice under the authority of this chapter unless he or she has on file with the commission such form listing the current supervisor.

(b) A supervisor must be an oral and maxillofacial surgeon or dental anesthesiologist who holds a valid Washington state general anesthesia permit.
(c) For the purposes of this subsection "any change" means the addition, substitution, or deletion of supervisor from whom the certified dental anesthesia assistant is authorized to accept delegation.
WAC 246-817-445

Dental anesthesia assistant continuing education requirements.

(1) To renew a certification a certified dental anesthesia assistant must complete a minimum of twelve hours of continuing education every three years and follow the requirements of chapter 246-12 WAC, Part 7.

(2) Continuing education must involve direct application of dental anesthesia assistant knowledge and skills in one or more of the following categories:
   (a) General anesthesia;
   (b) Moderate sedation;
   (c) Physical evaluation;
   (d) Medical emergencies;
   (e) Health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS);
   (f) Monitoring and use of monitoring equipment;
   (g) Pharmacology of drugs; and agents used in sedation and anesthesia.

(3) Continuing education is defined as any of the following activities:
   (a) Attendance at local, state, national, or international continuing education courses;
   (b) Health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS), or emergency related classes;
   (c) Self-study through the use of multimedia devices or the study of books, research materials, or other publications.
      (i) Multimedia devices. The required documentation for this activity is a letter or other documentation from the organization. A maximum of two hours is allowed per reporting period.
      (ii) Books, research materials, or other publications. The required documentation for this activity is a two-page synopsis of what was learned written by the credential holder. A maximum of two hours is allowed per reporting period.
   (d) Distance learning. Distance learning includes, but is not limited to, correspondence course, webinar, print, audio/video broadcasting, audio/video teleconferencing, computer aided instruction, e-learning/on-line-learning, or computer broadcasting/webcasting. A maximum of four hours of distance learning is allowed per reporting period.
6. **Request for Board Approval for a Course in Intravenous Access or Phlebotomy**

OAR 818-042-0117 states “Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.”

Dr. Brett Sullivan has submitted a letter to the Board requesting that the Board approve Oquirrh Mountain Phlebotomy School's IV Certification Course. (Attached)
March 29, 2019

RE: Request for Board approval of additional IV introduction course

To the Members of the Oregon Board of Dentistry,

My name is Brett M. Sullivan, DMD, MD. I am a board-certified, oral surgeon and owner of Clackamas Implant & Oral Surgery Center. The purpose of this letter is to request consideration by the OBD to add the Intravenous Introduction course currently offered by Oquirrh Mountain Phlebotomy School, LLC. (OMPS), to the list of approved courses for the AnA-IV certification.

Of the seven surgery assistants that I employ: one holds her Oregon AnA-IV certificate from DANB, three have their AnA certificate, one is scheduled to sit for the DAANCE test in May, and the other two are next in line. My goal is to have all the Assistants I employ, certified as AnA-IV Dental Assistants.

As you know, the OBD has five, approved programs for this purpose (listed below).

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Program</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intro to IV Therapy</td>
<td>Portland Community College</td>
<td>8/22/2002</td>
</tr>
<tr>
<td>Phlebotomy Skills</td>
<td>Portland Community College</td>
<td>10/10/2006</td>
</tr>
<tr>
<td>Phlebotomy*</td>
<td>MedTexx-Medical-Corp</td>
<td>10/10/2008</td>
</tr>
<tr>
<td>IV Therapy*</td>
<td>MedTexx-Medical-Corp</td>
<td>10/10/2008</td>
</tr>
<tr>
<td>Anesthesia Assistant Training Program</td>
<td>Resuscitation Group Vancouver, WA</td>
<td>2/15/2019</td>
</tr>
</tbody>
</table>

* MedTexx Medical Corporation no longer offers courses in Oregon or Washington.
* The Anesthesia Assistant Program offered through the Resuscitation Group in Vancouver WA, is a 40-hour program; they do not provide IV training on its own.
* Portland Community College no longer offers a Phlebotomy Skills course.

I believe that it’s important for my staff that work full-time, have access to a course that is located within their community, does not conflict with their work, and is affordable. For these reasons, I hope you will consider the course offered by OMPS.

I am not affiliated with OMPS in any way. I make this request out of the need I see for my staff. In review of the school and the course description, I believe that the information taught is adequate for the purpose of educating an AnA in how to introduce a intravenous access lines in patients, under my supervision.

I hold the Board, and the decisions you make, in high-regard. I also respect your time and greatly appreciate you taking a portion of it to consider this request. I’ve included with this letter, information regarding QMP School, to assist you in this purpose.

Respectfully,

Brett M. Sullivan, DMD, MD
Oquirrh Mountain Phlebotomy School, LLC
Located: 12725 SW Millikan Way Suite 300 Beaverton, OR 97005
Phone: (971)231-8600
Email: office@ommps.com
Website: https://oregonphlebotomyschool.com

Name of Course: IV Certification Course

Instructor: Emma Ross

Description: 1-day, 4-hour, IV certification course. 5-10 hands-on, IV placements. This course instruction is focused on how to place IV catheters. This is great for nurses or anyone that wants to further their medical career. Participants receive a certificate of completion at the end of the course.

OVERVIEW:

During intravenous therapy, some patients can experience complications—either local, at the I.V. site, or systemic. Updated with the latest venipuncture practices, this program will focus on the identification of complications, their causes, and appropriate interventions to take to support the patient and restore safe and effective therapy.

Over 90% of hospital patients receive intravenous therapy, including medication, nutrition, electrolytes, and blood. These life-giving fluids are administered through an I.V. This program describes the basics of intravenous therapy and demonstrates the correct technique for performing a venipuncture to initiate intravenous therapy.

OBJECTIVES:

After completing this course, the learner should be able to:

- Describe the uses of IV therapy
- Identify appropriate sites for venipuncture
- Identify equipment used to provide IV therapy
- Perform venipuncture
- infiltration
- extravasation
- occlusions
- vein irritation/pain at the venipuncture site
- a severed catheter
- hematoma
- venous spasm
- thrombosis/thrombophlebitis
- nerve, tendon or ligament damage
- circulatory overload
- septicemia
- air embolism
- allergic reaction
6. **Board Approval of Restorative Dental Hygiene and Dental Assisting Course – Oregon Health & Science University**

Ms. Alexandria Dewey, CDE Program Director for Oregon Health and Science University (OHSU) School of Dentistry is requesting the Board approve the OHSU School of Dentistry restorative course for dental assistants who wish to obtain a Restorative Functions Certificate, and for dental hygienists who wish to obtain a Restorative Functions Endorsement.

**Applicable Rules**

**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 the Western Regional Examining Board’s 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 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)
History:
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13
OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07

**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 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 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)
History:
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13
OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08
OBD 3-2007, f. & cert. ef. 11-30-07
OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE 770
PORTLAND, OR 97201
(971) 673-3200

Request for Approval of Dental Assistant Restorative Curriculum

<table>
<thead>
<tr>
<th>Name of Institution/Program:</th>
<th>OHSU School of Dentistry Continuing Dental Education Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Program Director:</td>
<td>Alexandria Dewey</td>
</tr>
<tr>
<td>Address:</td>
<td>2730 SW 123rd Ave</td>
</tr>
<tr>
<td>City:</td>
<td>Portland</td>
</tr>
<tr>
<td>State:</td>
<td>OR</td>
</tr>
<tr>
<td>Zip code:</td>
<td>97201</td>
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<tr>
<td>Telephone:</td>
<td>503-494-8857</td>
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</table>

Date Institution/Program adopted/revised current Curriculum: December 6, 2018

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Program Director's Signature: [Signature]
Date: 2/19/2019
Dental Hygiene
Request for Approval of Restorative Curriculum

☐ Dental Hygiene Program  ☒ Dental Hygiene CE Course

Name of Institution/Program: OHSU Dental School Continuing Dental Education Department

Name of Program Director: Alexandria Dewey

Address: 2730 SW Moody Ave


Date Institution/Program adopted/revised current Curriculum: December 6, 2018

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Program Director’s Signature: ___________________________  Date: 2/19/2019
LESSON PLAN; BASIC RESTORATIVE COURSE FOR EFDA’S/RDH’S

RESTORATIVE FUNCTIONS FOR THE EFDA OR RDH

18 hours didactic
22 hours lab (minimum 22)
27 hours patient care (minimum of 24)

Sample schedule:

**Week one:** Mon, Tues, Wednesday 8:30-4:30, didactic and laboratory (didactic could be 2 hours in the morning and one in the afternoon.) = 9 didactic and 12 hours lab

**Week two:** Wednesday, Thursday, Friday 8:30-4:30 didactic and laboratory (didactic could be 2 hours in the morning and one in the afternoon.) = 9 didactic and 12 hours lab

Saturday: 8:30-3:30 patient care (Occlusals and smaller class II’s)

**Week three:** Thurs, Fri, Sat 8:30-4:30 patient care with a 10 minute huddle at the beginning of each patient session.

Lesson Plan:

**Week 1, Lesson 1.1:** G.V. Black Classification of caries and restorations,

1.2: Matrix and Wedge,

1.3: Gingival Retraction

Lesson 2.1: Material and Equipment Safety

2.2: Cavity sealers, liners, bases

2.3: Amalgam Material

Lesson 3.1: Composite Material,

3.2: Adhesives

3.3: Operative Instruments

**Week 2, Lesson 4.1:** Overview: Anatomy and Terminology

4.2: Amalgam Restorations and Instrument Review

4.3: Anatomy, Mandibular molars

Lesson 5.1: Anatomy, Maxillary molars

5.2: Composite Restorations and Instrument Review

5.3: Anatomy

Lesson 6.1: Anatomy, anterior teeth

6.2 Class III, IV, and V restorations and review of gingival retraction

6.3 Selection of dental materials: Introduction to Doctor.

Week 3 Patient care, 10 minute huddle before each patient session (at the beginning of each a.m. and p.m. session)
At Home: Safety and Asepsis with Quiz on Day 2
- Location of MSDS as well as EMERGENCY EXIT PROTOCOL
- Other safety measures, as identified by OHSU CE department
- Mercury, Curing Lights (Board mandated)
- Handpiece Safety

All EFDA certification and other evidence of qualification to take this course and payment for this course, will be collected BEFORE the first lesson.

LESSON PLAN, DAY 1
Clinic: Set up for G.V. Black Classification Exercise, (Review Materials needed.)

8:30- 9:30 Introduction and Overview of Schedule, Clinic tour, Review of Clinical Procedures, MSDS, Safety, PPE, etc.; Operatory Assignments.
9:30-10:30 Didactic G.V. Black Classification of Caries and Restorations
   Power Points, Handouts
10:30-10:45 Questions and Clarification, Review
10:30-11:30 G.V. Black Classification Exercise
   Handouts, Typodonts (Kilgore), Prepped Kilgore typodont teeth, Photographs, Diagrams
11:30-12:00 Quiz G.V. Black Classification of Carious Lesions, Preps, Restorations
   Multiple Choice quiz
12:00-1:00 Lunch
1:00-3:00 Didactic (2 hr.) Lab (1hr); Toffelmeier Matrix and Wedge, Gingival Retraction Chord, Tabletop Formatives
   Power Points, video, typodonts on tabletop, Restorative instruments, Toffelmeirs and wedges, retraction chord, plastic dappen dishes with water
3:00-4:30 Lab Toffelmeier Matrix and Wedge Competencies, Retraction Chord Competency; Clean-up

5.5 hours didactic
2 hours lab
Lesson Plan, Day 2

8:30-9:00 Quiz: Safety and Asepsis; Material and Equipment Safety
9:00-10:00 Didactic (1hr) Dental Materials and Restorative Applications: Cavity sealers, liners, and bases
    - Power Points, Handouts
10:00-11:00 Didactic (1hr) Dental Materials: Amalgam
    - Power Point
11:00-12:00 Lab Formative Application of Sealers, liners, bases
12:00-1:00 Lunch
1:00-2:00 Dental Materials: Composite and Adhesives
2:00-2:30 Lab Operative Instruments; Review
2:30-3:00 Quiz: Sealers, liners, bases
3:00-4:30 Lab Competencies: Application of Sealers, liners, bases

4.5 didactic
3 hours lab

Lesson Plan Day 3

8:30-11:00 Overview: Anatomy and Terminology
    - Amalgam Restorations and Instrumentation
    - Anatomy, Mandibular molars
    - Power Points, Diagrams, Typodonts on tabletop, extracted teeth
11:00-12:00 Lab Occlusal amalgams, #30, #31
12:00-1:00 Lunch
1:00-2:30 Didactic: Review and discussion of marginal ridge development
2:30-4:30 Lab Class II Amalgams #30,19

4 hours didactic
3 hours lab

Lesson Plan Day 4

8:30- 9:30 Anatomy: Maxillary Molars
    - Power Points, Diagrams, Extracted teeth
9:30-10:30 Composite Instrumentation of Class II
    - Power Points, videos, Typodonts on tabletop
10:30-12:30 Lab Composite Instrumentation #3,#14
12:30-1:30 Lunch
1:30-4:30 Lab Composite Instrumentation #2,#15,#30,#31, #19, #18

2 hours didactic
5 hours lab
Lesson Plan Day 5
8:30-12:00 Lab Amalgam and Composite, all WREB preps
12:00-1:00 Lunch
1:00-2:00 Didactic Amalgam Finishing and Polishing
2:00-4:30 Lab Amalgam Finishing and Polishing, Amalgam and Composite Restorations, all Class II WREB preps

1 hr. didactic
6 hours lab

Lesson Plan Day 6
8:30-10:00 Didactic Anterior Class III, IV composites, Anterior and Posterior class V composites
10:00-12:30 Lab Anterior Class III, IV composites, Anterior and Posterior Class V composites with gingival retraction (review)
12:30-1:00 Lunch
1:00-3:30 Lab
3:30-4:30 Clinic overview and preparation with Q&A
2.5 hours didactic
4.5 hours lab

19.5 total didactic/42 total = 19.5 didactic and 22.5 lab

Lesson Plan Day 7-Day 10, Patient Care
8:00-8:15 Set-up
8:15-8:30 huddle
8:30-12:00 Patient Care
12:00-1:00 Lunch
1:00-4:30 Patient Care

Each clinic day provides 7 hours of patient care, 3.5 hours in the a.m. session and 3.5 hours in the p.m. session. There will be 6 operators during each clinic session, with 2 students acting as assistants; each student will rotate through a single 3-hour clinic session as an assistant, so each student will accomplish 24.5 hours as clinic operator.
Course Objectives;
Basic Restorative for the EFDA or RDH
OHSU Dental CE
Christina Tselnik, BSDH, RDH

BACKGROUND KNOWLEDGE:

ANATOMY
1. The student will be able to identify and differentiate individual characteristics of all permanent and primary dentition, including lobes, grooves, cusps and fossae.
2. The student will be able to define the following terms: marginal ridge, triangular ridge, transverse ridge, oblique ridge, fossa, developmental groove, embrasure and contacts.

CLASSIFICATION OF CARIES AND PREPARATIONS
1. The student will be able to define and classify carious lesions and cavity preparations (Class I, II, III, IV, V, VI).
2. The student will be able to identify the following components of prepared cavity walls; axial, distal, facial, gingival, lingual, mesial and pulpal wall.
3. The student will be able to identify and define the walls, line angles and point angles of all types of cavity preparation.
4. The student will be able to describe the steps involved in removing caries and creating a quality cavity preparation for restoration.

ISOLATION TECHNIQUES:

RUBBER DAM
1. The student will be able to identify the advantages, indications, and contraindications for rubber dam placement.
2. The student will be able to properly choose, apply, and remove the clamp and rubber dam to effectively isolate any area with minimal tissue trauma.

MATRIX AND WEDGE
1. The student will be able to list the purposes for using a matrix and wedge.
2. The student will be able to identify the armamentarium required and demonstrate the proper band, retainer and wedge selection, placement and removal.

TISSUE RETRACTION
1. The student will be able to explain gingival deflection.
2. The student will be able to identify methods of and armamentarium for retraction.
3. The student will be able to discuss reasons to use retraction.
4. The student will be able to describe the materials and chemicals used in retraction.
5. The student will be able to state the contraindications to hemostatic agents.
6. The student will be able to demonstrate the proper steps in tissue retraction.
SAFETY AND ASEPSIS:
MATERIAL AND EQUIPMENT SAFETY
1. The student will be able handling of mercury.
2. The student will be able
3. The student will be able
4. The student will be able
5. The student will be able
exposure.
to discuss proper office and personal safety in the
to discuss proper treatment of mercury exposure.
to discuss proper techniques and safety when using restorative curing lights.

DENTAL MATERIALS:

AMALGAM
1. The student will be able to name and identify the unique characteristics of at least
four types of amalgam particle shapes.
2. The student will be able to discuss alloy components and their properties, including
silver, tin, copper, zinc, palladium, indium, and mercury.
3. The student will be able to identify and differentiate the three different Gamma
phases.
4. The student will be able to explain the trituration process and identify characteristics
of improper trituration.
5. The student will be able to list the benefits of amalgam restorations.

COMPOSITE (RESIN) AND GLASS IONOMERS
1. The student will be able to define the following terms: polymers, monomer, oligomer,
Bis CMS, UDMA, TEGDMA and Free Radical.
2. The student will be able to discuss the properties of various resins and composites.
3. The student will be able to differentiate between properties of unfilled acrylic resins,
nanofilled composites, microfilled composites, macrofilled composites, hybrid
composites, small particle composites, resin-modified glass ionomers, and plain glass
ionomers.

CAVITY SEALERS, LINERS AND BASES
1. The student will be able to define the term sealer, liner, and base as they relate to
cavity preparations.
2. The student will be able to list indications for placement of cavity sealers, liners and
bases.
3. The student will be able to list trade names, uses, properties, and manipulation of
varnishes.
4. The student will be able to list the trade names, uses, properties, and manipulations
of Calcium Hydroxide.
5. The student will be able to list the trade names, uses, properties, and manipulation of Glass Ionomers.
6. The student will be able to identify the trade names, uses, properties and manipulation of the following dental cements: zinc oxide-eugenol, zinc phosphate, glass ionomer luting cements, resin luting cements.

ADHESIVE SYSTEMS
1. The student will be able to discuss the properties of enamel and dentin.
2. The student will be able to discuss the benefits and uses of adhesive systems.
3. The student will be able to distinguish between etch-and-rinse, self-etch adhesives, and glass ionomer adhesives.
4. The student will be able to list the components of adhesive systems.
5. The student will be able to discuss the properties and proper manipulation of acid etchants.
6. The student will be able to discuss the properties and proper manipulation of primers.
7. The student will be able to list trade names, uses, properties, and manipulation of adhesive bonding systems.
8. The student will be able to discuss the properties and proper manipulation of adhesive resins.
9. The student will be able to discuss and identify characteristics and components of the smear layer.
10. The student will be able to discuss the hybrid layer or zone.
11. The student will be able to discuss adhesive properties with amalgam bonding.
12. The student will be able to discuss adhesive properties and resin composites.

OPERATIVE INSTRUMENTS:

1. The student will be able to identify and describe the use of the following cutting instruments: hatchets, chisels, hoes, gingival margin trimmers, angle formers, and excavators.
2. The student will be able to identify and describe the use of the following condensing and carving instruments: Amalgam carrier, amalgam condensers, interproximal carvers, T-3 carvers, small and large carvers, greg 4/5 and burnishers.

AMALGAM RESTORATIONS:

1. The student will be able to state the reasons that amalgam restorations fail.
2. The student will be able to properly prepare the instruments required on a tray set up for amalgam condensing and carving.
3. The student will be able to evaluate the cavity prep for outline form, resistance form and retention form.
4. The student will be able to mix, load amalgam carriers and properly condense amalgam into the cavity preparation.
5. The student will be able to carve all surfaces with appropriate instrumentation to recreate proper anatomy.
6. The student will be able to properly evaluate the occlusion of the restored surface(s).
7. The student will be able to discuss the indications and contraindications of pin retained or supported restorations and buildups.

**COMPOSITE (RESIN) RESTORATIONS:**

1. The student will be able to evaluate the cavity preparation and understand the selection of the appropriate restorative material.
2. The student will be able to discuss and describe factors affecting the etching, bonding, and curing processes for resin restorations.
3. The student will be able to demonstrate the steps for placing composite restorations.
4. The student will be able to list common problems, causes and potential solutions of placing composite restorations.

**FINISHING AND POLISHING:**

1. The student will be able to define the following terms: finishing, polishing, recontouring.
2. The student will be able to list the benefits of finishing and polishing amalgam and resin restorations.
3. The student will be able to list and discuss precautions and contraindications for finishing and polishing amalgam and resin restorations.
4. The student will be able to identify armamentarium of rotary and hand instruments used in finishing and polishing.
5. The student will be able to identify polishing agents.
6. The student will be able to list the procedure steps for amalgam finishing and Polishing.
7. The student will be able to identify and properly utilize composite finishing and polishing instruments to establish appropriate contour and occlusion.
OTHER ISSUES
Oregon’s Nine Federally Recognized Tribes
Indian Health Delivery System

Indian Health Programs can be grouped into 3 categories:

• Indian Health Service (IHS) Directly Operated - Warm Springs, Western Oregon Service Unit – Chemawa Indian School
• Tribally Operated (P.L. 93-638 Indian Self-Determination Act) 8 Oregon Tribes
• Urban Indian Health Care Program - NARA

Types of Health Services that may be provided

• Ambulatory Primary Care (outpatient care)
• Inpatient care - Hospitals
• Medical specialties
• Traditional healing practices
• Dental and Vision Care
• Behavioral Health Services
• Specialty Care Services (CHS)
A note on Service Areas

Each tribe’s area of interest may extend far beyond its tribal governmental center or reservation location. The federal government acknowledges that many tribal members do not live on tribal lands and, therefore, allows for tribes to provide governmental programs in specified service areas.

For example, the Confederated Tribes of Siletz service area includes 11 Oregon counties: Benton, Clackamas, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington and Yamhill.
Oregon Indian Tribes

Tribal governments are separate sovereign nations with powers to protect the **health, safety and welfare** of their members and to govern their lands. This tribal sovereignty predates the existence of the U.S. government and the state of Oregon. The members residing in Oregon are citizens of their tribes, of Oregon and, since 1924, of the United States of America.

All Oregon tribal governments have reservation or trust lands created by treaties or federal acts.
Oregon Tribal Governments

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grand Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes
Termination & Relocation

The Klamath Termination Act (PL 587) enacted in 1954 and terminated Federal supervision over land and members

The Western Oregon Indian Termination Act (PL 588) was passed in August 1954 as part of the United States Indian termination policy and affected ~60 Oregon Tribes (Siletz, Grand Ronde, Coquille, Coos, Lower Umpqua, Siuslaw, and other Oregon tribes) effective immediately

The Indian Relocation Act of 1956 encouraged Native Americans to leave Indian reservations, acquire vocational skills, and assimilate into the general population
Historical Trauma

Historical trauma refers to cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences.

- Loss of Land
- Loss of Culture
- Loss of Language
- Boarding Schools
- Relocation Act

How do these things continue to affect Native people and where they live, work and play?
Restoration 1977-1989

1977, the Siletz Tribe was recognized and restored
1982, the Cow Creek Band of the Umpqua Tribe was restored
1984, Coos, Lower Umpqua, and Siuslaw had trust status restored
1986, Klamath had their trust status restored
1989, Coquille Restoration Act to restore federal trust relationship

WE ARE STILL HERE! WE ARE STRONG! WE ARE RESILIENT!
Oregon Indian Population

129,579 AI/AN (alone or in combination, ACS 2015)

15,314 AI/AN in Portland (alone or in combination, ACS 2015)

Portland is 9th largest Native American population in USA

<table>
<thead>
<tr>
<th>Total HNA Enrollment</th>
<th>Total Enrollment</th>
<th>% of Total</th>
</tr>
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<tbody>
<tr>
<td>33,919</td>
<td>945,619</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Fee For Service/Managed Care

17,742, 52%

16,177, 48%
SB 770  (ORS 182.162 to 182.168)

Oregon 1st state to adopt formal legal government-to-government relations through legislation

Directs state agencies in government-to-government relationships with Oregon tribes

- State agencies to develop and implement policy on relationship with tribes; cooperation with tribes.

- Training of state agency managers and employees who communicate with tribes; annual meetings of representative of agencies and tribes; annual reports by state agencies.
Oral Health Disparities

FINDING # 2 (CONT.): AI/AN CHILDREN HAVE MORE TOOTH DECAY THAN OTHER POPULATIONS

Percent with Untreated Decay Among Children 3-5 Years of Age

- **AI/AN, 2014**: 43.2%
- **Hispanic**: 19.8%
- **Black**: 19.3%
- **White**: 11.3%

AI/AN children have 4 times more untreated decay than white children

* Data Source: NHANES 2009-2010
KEY FINDING #2: AI/AN ADULT DENTAL PATIENTS ARE MORE LIKELY TO HAVE SEVERE PERIODONTAL DISEASE THAN THE GENERAL U.S. POPULATION.

Periodontal disease is an inflammatory disease that affects the soft and hard tissues that support the teeth. As the disease progresses, the supporting tissues are destroyed, bone can be lost, and the teeth may loosen or eventually fall out. Severe periodontal disease can adversely affect glycemic control in adults with diabetes and there is a direct relationship between periodontal disease severity and diabetes complications.

About 10% of U.S. adults (30+ years of age) have severe periodontal disease compared to about 17% of AI/AN dental patients aged 35+ years (Figure 3). Smoking is a risk factor for periodontal disease and the prevalence of severe periodontal disease is higher among AI/AN adults who smoke than among non-smokers (28% vs. 15% respectively).

Figure 2: Percent of Adults with Untreated Tooth Decay by Age Group
AI/AN Dental Patients (IHS 2015) Compared to HP 2020 Objectives

Figure 3: Percent of Adults with Severe Periodontal Disease
U.S. Overall (NHANES 2009-2012) vs. AI/AN Dental Patients (IHS 2015)

+ 35+ year olds with periodontal pockets > 5.5mm
* 30+ year olds with periodontal pockets > 6.0 mm
What are the barriers to care?

- Shortage and high turnover rate of dentists in tribal communities
- Lack of resources—IHS chronically underfunded
- Cost of care
- Historical trauma
- Lack of culturally competent providers
- Geographic isolation
An oral health care solution: 
Dental Health Aide Therapists

- Model began in the 1920s, brought to US by Alaska Natives 2006 as part of Community Health Aide Program.

- Dental therapists practice in 54 countries, and in the US authorized in AK, MN, ME, VT, WA, AZ, MI, NM, ID and OR pilots.

- Alaska DHAT Education Program is a partnership between Alaska Native Tribal Health Consortium and Ilisagvik Tribal College. It uses a 2-calendar-year curriculum and students graduate with a AAS degree.
Increased Dental Therapist treatment days significantly associated with:

- More children and adults who receive preventive care
- Fewer children under age of 3 with extractions of the front four teeth
- Fewer adults ages 18 and older with permanent tooth extractions
- Fewer children OR visits for full mouth restorations.

**Dental Utilization for Communities Served by Dental Therapists in AK’s Yukon Kuskokwim Delta.**

*University of Washington, August 2017.*

*Principal Investigator Donald Chi, DDS, PhD*
Oregon Dental Pilot Projects were authorized by state legislation in 2011 to evaluate access and improved quality to oral health care by:

- Teaching new skills to existing categories of dental personnel
- Developing new categories of dental personnel
- Accelerating the training of existing categories of dental personnel
- Teaching new oral health care roles to previously untrained persons
Pilot Project #100: 
Tribal Dental Health Aide Therapist Project

Purpose: Develop a new category of dental personnel in Oregon and teach new oral health care roles to previously untrained individuals. We will be recruiting, training and employing Dental Health Aide Therapists, primary care oral health providers, to work in underserved tribal communities to achieve pilot objectives.

Short term objectives:
Increase the efficiency of the dental clinic and dental team;
Increase the ability of tribal health programs to meet unmet need;
Increase provider job satisfaction and patient satisfaction.

Long term objectives:
Increase the number of Native providers serving Native communities;
Increase patient education at the community level;
Increase treatment of decay and decrease decay rates in pilot populations;
Improve overall understanding of oral health in relation to overall health, and:
Improve oral care behaviors in pilot communities.
Measurable Outcomes

What evidence is there that the pilot has expanded access to dental services and education to targeted Tribal communities?

How has the pilot improved clinic productivity, ensured patient safety and quality dental care, and influenced patient satisfaction with services?

How has the pilot impacted the productivity of the oral health team and the costs of dental care in the tribal communities?
NPAIHB Partner Sites:
Tribal Dental Health Aide Therapist Project
Key Pilot Project #100 staff and consultants

Project Dental Director: Gita Yitta, DMD
Consulting Dentist: Dane Lenaker, DMD
NARA Supervising Dentist: Azma Ahmed, DDS
CTCLUSI Supervising Dentist: Sarah Rodgers, DMD
External Evaluating Dentist: Cheryl Sixkiller, DDS

NPAIHB (project sponsor) Staff: Joe Finkbonner, RPh, MHA; Christina Peters; Miranda Davis, DDS, MPH; Pam Johnson

Evaluators: Joan LaFrance, EdD; Janet Gordon, PhD, Mekinak Consulting

Site Health Directors: Allyson Lecatsas, NARA; Kelle Little, RDN, Coquille; Vicki Faciane, CTCLUSI

Site DHAT coordinators: April Geisler, NARA; Dennita Antonellis-John, MPH, Coquille; Jamie Meyers, CTCLUSI
Trainees: Naomi Petrie and Marissa Gardner, Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians

Naomi Petrie

Marissa Gardner
# Pilot Project #100 Internal Advisory Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher G. Halliday</td>
<td>Deputy Director, Division Of Oral Health, Indian Health Service HQ</td>
</tr>
<tr>
<td>Victoria Warren-Mears</td>
<td>Director, Northwest Tribal Epidemiology Center</td>
</tr>
<tr>
<td>Mary Williard</td>
<td>Director, Alaska Dental Therapy Education Program</td>
</tr>
<tr>
<td>Kelle Little</td>
<td>Health and Human Services Administrator</td>
</tr>
<tr>
<td>Vicki Faciane</td>
<td>Health and Human Services Administrator, CTCLUSI</td>
</tr>
<tr>
<td>Allyson Lacatsas</td>
<td>Director of Health Services, NARA</td>
</tr>
<tr>
<td>Chief Warren Brainard</td>
<td>CTCLUSI</td>
</tr>
<tr>
<td>Rachael Hogan</td>
<td>Dental Director, Swinomish Indian Tribal Community</td>
</tr>
<tr>
<td>Frank Catalanotto</td>
<td>Professor, Department of Community Dentistry and Behavioral Science, University of Florida College of Dentistry</td>
</tr>
</tbody>
</table>
Before students return to employment sites:

- Graduate from Alaska Dental Therapy Education Program (ADTEP). Cannot graduate without showing competency in every procedure, and have a full year’s worth of clinic work as part of the program.

- Supervising dentists undergo training provided by ADTEP and Pilot Dental Director.

- Director and staff of ADTEP visit employment sites and do a thorough clinic assessment to ensure graduates will be returning to a clinic that meets IHS standards.

- The project passed our first OHA site visit which evaluated the curriculum, educators and student’s progress at ADTEP.
Monitoring Safety and Quality

Preceptorship:

- Preceptorship for trainees is 400+ hours of direct supervision and includes a checklist of 4-8 of every procedure in scope. As trainees complete procedures in checklist they can be moved into a practice plan under the level of supervision deemed appropriate by supervising dentist, or required by OHA.

- Supervising dentists evaluate and make comments as necessary on every procedure through an online patient encounter form, and that information is submitted to OHA every quarter.

- Consent forms to see a DHAT are currently being collected for every patient encounter.
Monitoring Safety and Quality

Post Preceptorship:

• Practice Agreement includes all procedures allowed by supervising dentist, including any restrictions on supervision and additional documentation required.

• If in the event a new supervising dentist is assigned, each procedure listed in the Practice Agreement must be successfully demonstrated once to the new supervising dentist under direct supervision for a minimum of 80 hours.

• Every two years the Practice Agreement must be reviewed, and each procedure listed in the practice agreement successfully demonstrated at least once to supervising dentist for a minimum of 80 hours.

• Weekly chart review by supervising dentist of irreversible procedures submitted to OHA every quarter.

• External Dentist reviews random sample of 10 charts and required images of irreversible procedures, submitted to OHA quarterly.
Monitoring Safety and Quality

Throughout employment phase trainees will be trained and comply with Standard Operating Procedures including:

- **Protocols for radiography and intraoral photography** per procedure are in Appendix C and will be used to help the evaluating dentists assess the quality of the DHAT’s work.

- **Infection Control Guidelines** must be followed according to OARs 818-012-0400.

- **HIPAA (Health Insurance Accountability and Portability Act):** Transmission of protected health information must follow the Department of Health and Human Service Guidelines.
SOP continued:

- **Consent forms**: In compliance with OAR 333-010-0440, informed consent is required for each visit. The patient must sign and date the general DHAT treatment administration paper consent form indicating they understand the DHAT role. Before proceeding with treatment, the DHAT must obtain and document PARQ verbal consent which includes possible complications of treatment. For other procedures such as extractions and silver diamine fluoride procedures, a digital consent format is acceptable.

- **Photos**: Procedures requiring tooth preparation and final restoration require pre-op, mid-op, and post-op intraoral photos when appropriate. Images must be of high quality with no debris, blood, or excess restorative material present. Extractions: A recent radiograph of the tooth to be extracted is required including a pre-op intraoral photo. A post-op photo of the removed tooth must be taken including all residual coronal or root tip remnants. A post-op PA is not required.
SOP continued:

Defining and Tracking Potential Outcomes of Irreversible Procedures:

- A new code will be created in Dentrix, and charted for unscheduled returns to a clinic following an irreversible procedure where the DHAT was the provider. This new code will track all return visits for a complication related to the original procedure, regardless of whether scheduled or not.

- Charts with those codes will be added to those pulled weekly for review by the supervising dentist, will be included in the random sample of charts pulled by the external supervising dentist, and will be made available for review by OHA.

- All reviews of charts should confirm appropriate care given to the returning patient, and note if the return visit was unrelated to the original procedure.
Monitoring Safety and Quality

External/OHA Review and Monitoring

• Original Application reviewed by OHA Technical Review Board comprised of members of dental professional associations, Board of Dentistry, individual oral health providers.

• Adverse events required to be reported within 24 hours and included in quarterly report.

• Reports submitted quarterly on all aspects of project, including evaluation data and monitoring and demographic data collected per procedure.

• OHA site visits to training and utilization sites, including interviews with pilot participants, tour of facilities and chart reviews drawn from random sample of all DHAT charts.

• OHA Advisory Committee reviews and offers opinions on modifications, documents, protocols, and participates in site visits and chart reviews.
Oregon Pilot Study

Mekinak Consulting - Seattle, Washington
Northwest Portland Area Indian Health Board
The Oregon DHAT Pilot Study Evaluation Questions

• What evidence is there that the DHAT program expanded access to dental services and education?
  • Number of patients seen quarterly
  • Changes in wait time for appointments
  • Changes in educational outreach

• How has the DHAT program improved clinic productivity?
  • Numbers of and changes in procedures performed by providers organized by IHS’s six Levels of Care and IHS relative value units for procedures
  • Numbers of and changes in more complex procedures (Levels 4, 5, 9) completed by dentists
  • Number of and changes in treatment plans completed
  • Number of new patients seeking treatment and a self-reported survey of their oral health
Evaluation Questions

• How do the supervising dentists and outside dentists assess the quality and safety of the DHATs’ work?
  • Successful completion of preceptorship
  • Weekly chart reviews by the supervising dentist
  • Quarterly review of a sample of charts by an outside dentist

• How does patient satisfaction with the quality of care change over a baseline measure and during the DHAT program?

• How do patients view the DHAT’s services?
  • Semi-annual telephone interviews with a random sample of patients who received care from a DHAT

• How do the clinic staff, tribal health administrators, and tribal leaders view the progress and outcomes of the DHAT program?
Evaluation Questions

• How has the introduction of DHATs into the clinic practice influenced the following?
  • Personnel costs for providers in relation to costs of clinic production considering staffing changes and physical expansion on the levels of production and costs
  • Penetration of clinic’s provision of care to tribal/community members (expansion of clinic locations, provision of care at tribal or organizational programs, etc.)
  • Numbers of referrals to outside dental providers
Evaluation Assumptions

- Access increases as DHAT’s provide basic care
- DHAT’s provide high quality and safe services
- Dentists can do more of the Level 4, 5, and 9 procedures
- Patients are satisfied with DHAT services
- Educational outreach increases
- Productivity of clinic improved in relation to costs of care
Methodology

• Comparison of baseline year to treatment years (addition of DHATs)
  • Access - number of patients seen, patient demographics, wait time for appointments, referrals to outside providers
  • Production -- number of and changes in procedures by IHS Levels, relative value units, and costs of production

• Patient Satisfaction Surveys - baseline sample/compared to annual summaries of treatment years

• New patient surveys

• Qualitative interviews with providers, tribal administrators, and sample of patients

• Qualitative description of DHAT educational outreach
NARA Baseline Year and Year 1 Treatment

• NARA is a Federal Qualified Health Center (FQHC) and an Urban Indian Health Center
• The Baseline year was June 1, 2016 to May 31, 2017 (first year at current site)
• The DHAT was hired on September 7, 2017
• The first year of comparison data was collected for September 7, 2017 to September 6, 2018
Native Americans Are Majority of NARA Patients

Race was not routinely entered for Dentrix records when clinic first opened, so sample group illustrated race as recorded in patients’ charts.

<table>
<thead>
<tr>
<th>Race</th>
<th>Baseline Sample</th>
<th>Year 1 Sample</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>136</td>
<td>58%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>White (not Hispanic or Latino)</td>
<td>35</td>
<td>15%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
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<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>17%</td>
</tr>
<tr>
<td>Declined to Answer</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
<td>100%</td>
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## Most of NARA’s Patients Qualify for Medicaid

<table>
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<tr>
<th>Primary Production Source</th>
<th>Baseline Billings</th>
<th>Year1 Billings</th>
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<tbody>
<tr>
<td></td>
<td>Amount</td>
<td>Percent</td>
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<tr>
<td>Oregon Health Plan (Medicaid)</td>
<td>$653,171.44</td>
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<tr>
<td>HRSA</td>
<td>249,919.96</td>
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<tr>
<td>Private Insurance</td>
<td>82,435.96</td>
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<tr>
<td>Total</td>
<td>985,420.36</td>
<td>100%</td>
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Access to Care Improved at the NARA Clinic

- In the baseline year the clinic served 1460 patients
- During the treatment year 2,294 patients were served
- A 57% increase in the number of patients seen in the treatment year compared to the baseline
- There was an increase in the number of younger patients seen during the year (percent change was 105%)
- The DHAT’s practice focused on younger patients
• The DHAT contributed to the increase in service levels
• The supervising dentist’s production went down owing to more responsibility for administration of the pilot study and clinic
• Early results from telephone interview (13) indicate high level of satisfaction with the DHAT’s services
• Too soon to see increases in higher levels of care (also owing to clinic administrative issue)
Baseline is representative of patient populations

- The similarities in demographic information in both sites indicates that the Baseline year is representative of the patient population in terms of age, gender, race, and sources of funding for dental care.
CTCLUSI CLINIC

• A Tribally controlled clinic
• Receives IHS funding to support services to eligible Native Americans
• Clinic serves members of the Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians, the Coquille Indian Tribe, and members of other tribes living in southwest Oregon
• One third of its patients qualify for Medicaid
CTCLUSI Baseline Year and Year 1 Treatment

• The Baseline year was January 1 to December 31, 2016
• The DHAT was hired on July 17, 2017
• The first year of comparison data was collected for July 17, 2017 to June 30, 2018.
• The DHAT’s was involved in completing her preceptorship during the year
• A second DHAT began her preceptorship in the third quarter of 2018
CTCLUSI Early Findings

Baseline to Year 1
• Small increase in the number of patients seen (7%)
• Increase in the numbers of procedures performed by DHAT and the dentist (12%)
• Dentist did more complicated procedures
  • Increase in production at Level 4
  • Higher RVU value for Level 5

First 2 qtrs. Year 2
• Large increase in numbers of patients seen with DHAT in practice, and one in preceptorship
• 915 patients compared to 700 in Yr. 1
• Percentage of Level 5 procedures by dentist increased over the two quarters
• Early results from phone interviews (15) indicate high level of satisfaction with the DHAT’s services
Approximately two thirds of patients say that CTCLUSI Clinic is better than private clinics. One third say it is the same. Only 8% of the sample group say it not at good.

Comments as to why it is better include:

- The care at CTCLUSI is more personal. The staff is friendly and show genuine care for the patient and knowledge when it comes to ancestry.
- Respectful and just feel better being here ... they don’t make me feel bad.
- It’s great to know the people who work on you! It was great to have [a DHAT provider] who was a young person going though a program to become an awesome adult.
- CTCLUSI has always been great with my children. They are patient and understand the difference with youth and native teeth.
Comments from Patients at NARA

• As at CTCLUSI, approximately two thirds of patients say that CTCLUSI Clinic is better than private clinics. One third say it is the same. Only 8% of the sample group say it not at good.

• Comments as to why it is better include:
  • Because I feel comfortable that the workers are familiar with Native Americans and not prejudiced.
  • I like that I am able to communicate better and that I’m seen as person in need, not “needy.”
  • I love NARA dental. They listen to me and try to help me to best of their ability. Other places wanted to pull all my teeth, but NARA dentists are fixing my teeth.
  • I felt my concerns were heard. I was treated like family, not a credit card.
March 28, 2019

To: Denture Technology Stakeholders

From: Samie Patnode, Policy Analyst

Subject: Proposed Administrative Rules, Chapter 331

Proposed rules for the Board of Denture Technology were filed with the Secretary of State’s Office for publication in the April 2019 Oregon Bulletin. You are invited to review the proposed rules and provide written comments from, Monday, April 1 through April 28, 2019 at noon. Administrative rules are scheduled to become permanent and effective on June 1, 2019.

Proposed changes are as follows and are scheduled to become effective June 1, 2019:

1) The temporary license is good for one year and may be renewed one time with no additional renewals or applications.

2) Individuals holding a temporary license before June 1, 2019 may renew one additional time and may not reapply.

3) All examination scores, both passed and failed, must be sent by the testing service directly to the Health Licensing Office.

4) All examinations must be passed within two years of the date of application.

5) Clarify and specify which examinations are Board approved.

6) Specify that prior to taking a Board approved examination verification from the Office must be sent and received by the testing service.

7) Simplify written rationale examination requirements.

8) Provide fee reduction of $150 if licensee is renewing online.

Please submit all comments to Samie Patnode at:
E-mail – samie.patnode@state.or.us
Postal – Health Licensing Office, 1430 Tandem Ave NE, Suite 180, Salem OR 97301-0380

For complete information including draft proposed rules please visit the board Web site at: https://www.oregon.gov/OHA/PH/HLO/Pages/Board-Denture-Technology-Laws-Rules.aspx
For alternative formats please contact Samantha Patnode at (503) 373-1917 or Samie.patnode@state.or.us
written examination three times must wait until the next scheduled board meeting to have the Board determine additional education and training.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

There are approximately 120 licensed denturists in Oregon, many of which may be small business owners. If a denturist is a small business owner and they renew online, they will see a $150 fee discount to their annual renewal expense. There is not expected to be any additional reporting requirements due to this rule change. There is not expected to be any increased administration for compliance with this rule change.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):
There are seven members on the Board of Denture Technology - three members are small business owners who helped develop the proposed rule.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO  IF NOT, WHY NOT?
The rule changes are clarifying and administrative; the discount offered for online renewals is not controversial.

RULES PROPOSED:

AMEND: 331-410-0015

RULE SUMMARY: Align requirements for temporary licensure with current practice.

CHANGES TO RULE:

331-410-0015
Denture Technology Temporary License ¶

(1) A denture technology temporary license authorizes the holder to temporarily practice denture technology while waiting to take a Board-approved written and practical examination pursuant to OAR 331-410-0045 including qualifying retake examinations listed under OAR 331-410-0055 and 331-410-0060. ¶
(2) A denture technology temporary license is valid for one year and may be renewed one time. ¶
(3) A denture technology temporary licensee may work under indirect supervision as defined under OAR 331-405-0020. ¶
(4) A denture technology temporary license holder must notify the Office within 10 calendar days of changes in employment status or changes in supervisor status. ¶
(5) A denture technology temporary license is invalid after passage of the written and practical examination. ¶
(6) A denture technology temporary license holder who changes supervisors more than three times must receive approval from the Board prior to making a fourth or subsequent change. ¶
(7) A denture technology temporary license holder must adhere to all practice standards listed in OAR 331. Division 420. ¶
(8) A denture technology temporary license holder licensed prior to June 1, 2019 may renew one additional time and may not reapply. ¶
(9) A denture technology temporary license holder may not reapply for additional temporary licenses.
ANRED: 331-410-0020

RULE SUMMARY: Align rule with current examination requirements.

CHANGES TO RULE:

331-410-0020
Application Requirements for Denture Technology Temporary License

An applicant for a denture technology temporary license must:
(1) Meet the requirements of OAR chapter 331 Division 30;
(2) Provide documentation of completing a qualifying pathway;
(a) License Pathway 1: Qualification through an associate’s degree program or equivalent education with 1,000 hours supervised clinical practice in denture technology within the education program. The applicant must submit:
(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Office-approved associate’s degree program in denture technology or equivalent education listed under OAR 331-407-0000. The official transcript must document completion of 1,000 hours of supervised clinical practice as defined under OAR 331-405-0020(9);
(B) Proof of having completed and passed a Board-approved written examination within two years before the date of application; and
(C) Supervisor information on a form prescribed by the Office;
(b) License Pathway 2: Qualification through an associate’s degree program or equivalent education with 1,000 hours supervised clinical practice in denture technology under an approved supervisor. The applicant must submit:
(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Office-approved associate’s degree program in denture technology or equivalent education listed under OAR 331-407-0000;
(B) Documentation of 1,000 hours supervised clinical practice as defined under OAR 331-410-0020(9) under an approved supervisor pursuant to OAR 331-410-0012 on a form prescribed by the Office;
(C) Proof of having completed and passed a Board-approved written examination within two years before the date of application; and
(D) Supervisor information on a form prescribed by the Office;
(3) All applicant examination scores must be submitted by the testing service directly to the Office including passed and failed examinations.

Statutory/Other Authority: ORS 680.515, ORS 680.565, ORS 676.615, ORS 676.592
Statutes/Other Implemented: ORS 680.515, ORS 680.565
another state, the District of Columbia, a United States Territory, or Canada, and that jurisdiction's denturist licensing standards must be substantially equivalent to those of Oregon, as determined by the Office; (C) Documentation of having successfully passed both written and practical denturist examinations, which are both substantially equivalent to those required for licensure in Oregon, as determined by the Office; and (D) Documentation of having engaged in full-time denturist practice in the applicant's reciprocal licensure jurisdiction for at least two years immediately before the date of application for licensure in Oregon, on a form prescribed by the Office.

(4) All applicant examination scores must be submitted by the testing service directly to the Office including passed and failed examination scores.

(5) An applicant under subsection (a) or (b) of this rule is not required to provide official transcript, documentation of 1,000 hours supervised clinical practice under an approved supervisor or proof of having completed and passed a Board-approved written examination if the applicant obtained a denture technology temporary license within two years from the date of application for a full denture technology license.

Statutory/Other Authority: ORS 680.527, ORS 680.565, ORS 680.520, ORS 676.615
Statutes/Other Implemented: ORS 680.527, ORS 680.565, ORS 680.520
AMEND: 331-410-0050

RULE SUMMARY: Align practical examination requirements with current practice.

CHANGES TO RULE:

331-410-0050
Qualification and Requirements for Practical Examination ¶

(1) To be qualified to take the Board-approved practical examination, the individual must submit an official transcript and documentation of 1,000 hours of supervised clinical practice, the completed application form prescribed by the Office, which must contain the information listed in OAR 331-440-30-00 25(2)(a); or ¶

(2) To be scheduled to take the Board-approved practical examination, applicants must submit a form prescribed by the Office and pay $50, and be accompanied by payment of all required fees, at least 60 calendar days prior to the examination date, and meet ¶

(3a) A practical examination candidate must provide the following at the time of practical examination:

(a) Temporary licensing requirements in OAR 331-410-0020(a); or ¶

(b) Government-issued photographic identification listed under temporary licensing requirements in OAR 331-410-0000 proving that the practical examination candidate is the individual scheduled to take the practical examination; 20(b); or ¶

(c) Permanent licensing requirements in OAR 331-410-0035 (3)(a)(A); or ¶

(d) Government-issued identification proving the patient is at least 18 years of age. See identification options under ORS permanent licensing requirements in OAR 331-4410-0000; 35 (3)(b)(B); ¶

(e) An oral health certificate for the patient signed by a dentist, physician, nurse practitioner, naturopathic physician or a licensed denturist with the oral pathology endorsement, within 30 days of the practical examination, stating the patient’s oral cavity is substantially free from disease and mechanically sufficient to receive a denture; and ¶

(f) Office-prescribed practical examination candidate and patient forms. ¶

(4) The candidate must be completely edentulous (lacking teeth); ¶

(5) If a patient does not speak English, the candidate for individual must receive verification to take the Board-approved practical examination, including practical examination retakes. All documentation must be received and verified prior to sitting for the practical examination, including practical examination must ensure an interpreter is available for retakes; ¶

(3) All applicant examination proctors to communicate with patient. The interpreter is prohibited from being the practical examination candidate. Any costs incurred for interpreter must be submitted by the testing services are the responsibility of the practical examination candidate. ¶

(6) A practical examination candidate may be disqualified from taking the practical examination if any requirements of this rule are not met directly to the Office including passed and failed examination.

Statutory/Other Authority: ORS 676.615, Chapter 356, Section 88 2017 Laws, ORS 680.545
Statutes/Other Implemented: Chapter 356, Section 88 2017 Laws, ORS 680.545
AMEND: 331-410-0060

RULE SUMMARY: Align practical retake requirements with current practice.

CHANGES TO RULE:

331-410-0060

Practical Examination Retake Requirements

(1) Pursuant to ORS 680.515(1)(c) an applicant failing specific portions of the practical examination must obtain the following additional clinical and laboratory training hours within two years from the date of the failed practical examination:

(a) Final impression and model: 50 hours of direct patient care and laboratory training consisting of production of 10 removable dentures;

(b) Trial denture centric relation: 150 hours in direct patient care and laboratory training consisting of production of 16 removable dentures;

(c) Trial dentures vertical relation: 150 hours in direct patient care laboratory training consisting of production of 16 removable dentures;

NOTE: Each removable denture will be counted as one denture; an upper and a lower removable denture counts as two removable dentures.

(2) An applicant failing any portion of the practical examination must apply and qualify for a temporary denture technology license under OAR 331-410-0015 and 331-410-0020 before commencing direct patient care.

(3) An applicant must submit documentation approved by the Office upon completion of additional clinical and laboratory training hours pursuant to ORS 680.515(1)(c). Upon Office approval of additional training, an applicant may be scheduled to take the practical examination at a date and time approved by the Board.

(4) An applicant applying to retake the practical examination must meet the requirements of OAR 331-410-0050.

(5) For the purpose of this rule each removable denture will be counted as one denture; an upper and a lower removable denture counts as two removable dentures.

(6) All applicant examination scores must be submitted by the testing service directly to the Office including passed and failed examination scores.

Statutory/Other Authority: ORS 676.615, ORS 680.515, ORS 680.520, ORS 680.565, ORS 680.500

Statutes/Other Implemented: ORS 680.515, ORS 680.520, ORS 680.565, ORS 680.500
7. **Proposed change to OAR 818-021-0017 regarding limited specialty practice requirements.**

Since the Board began approving specialty examinations other than the CDCA specialty examination, a gap in our rules for limited specialty licensure has opened up. Previously, all applicants for a limited specialty license would have to sit for a specialty exam conducted by Oregon immediately prior to obtaining licensure here. When the rules changed to require “a Board approved specialty examination”, and the CDCA examination was the only Board-approved examination, very little changed, since the CDCA specialty examination is fairly new, and none of the applicants for limited specialty licensure had taken that particular exam. Thus, these applicants would also take the exam (thus proving their competency in their specialty) shortly before they would be issued a limited specialty license to practice in Oregon.

However, now that the Board has begun to approve other specialty exams (which an applicant may have completed a very long time prior to applying for a license in Oregon) it might now prove to be much easier for an applicant for a specialty license to meet the requirements for a limited specialty license than it would be for an applicant for a general dental license. In particular, applicants for specialty licensure are not required to have completed any CE or a certain number of clinical practice hours within the years immediately prior to applying for licensure in Oregon. In order to assure that applicants for specialty licensure are required to meet the same high standards as applicants for general dental licenses, the following proposed changes to OAR 818-021-0017 “Application to Practice as a Specialist” are recommended for review by the Licensing Standards Committee:

**818-021-0017**

**Application to Practice as a Specialist**

(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;

(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and

(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.

(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:
(a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language, and evidence of active licensure as a general dentist in another state obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency; or

(b) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language and certification of having successfully passed the clinical examination administered by any state or regional testing agency within the five years immediately preceding application; and

(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and

(3) An applicant who meets the above requirements shall be issued a specialty license upon:

(a) Passing a specialty examination approved by the Board within the five years immediately preceding application, or;

(b) Passing a specialty examination approved by the Board greater than five years prior to application, and;

(A) Having conducted licensed clinical practice in the applicant's dental specialty in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching the applicant's chosen dental specialty by dentists employed by a dental education program in a CODA-accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions; and;

(B) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application, and;

(b) (c) Passing the Board's jurisprudence examination.
Any applicant who does not pass the first examination for a specialty license may apply for a second and third regularly scheduled specialty examination. The applicable fee and application for the reexamination shall be submitted to the Board at least 45 days before the scheduled examination. If the applicant fails to pass the third examination for the practice of a recognized specialty, the applicant will not be permitted to retake the particular specialty examination until he/she has attended and successfully passed a remedial program prescribed by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(5) Licenses issued under this rule shall be limited to the practice of the specialty only.

Statutory/Other Authority: ORS 679
History:
OBD 4-2011, f. & cert. ef. 11-15-11
DE 4-1997, f. & cert. ef. 12-31-97; OBD 2-1999(Temp), f. 3-10-99, cert. ef. 3-15-99 thru 9-10-99;
OBD 5-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 11-2001, f. & cert. ef. 1-8-01; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11
7. **Proposed change to OAR 818-021-0088 regarding volunteer license renewal requirements.**

Licensees with volunteer dental and dental hygiene licenses have experienced some confusion regarding the number and distribution of volunteer hours required for renewal of a volunteer dental or dental hygiene license. On occasion, a lack of understanding regarding the requirements has resulted in a volunteer licensee choosing to retire their license, thus removing the valuable skills provided to Oregon’s citizens by a volunteer dentist or dental hygienist. In particular, licensees are mistakenly assuming that “40 hours [of pro bono dental/dental hygiene services] per calendar year” translates to 80 hours per renewal cycle. Additionally, it is unclear from the wording of the rule that the required hours must be completed in Oregon. To simplify the renewal process and clarify exactly what is required of volunteer licensees, the following changes to the rules are proposed for review by the Licensing Standards Committee:

**818-021-0088 - Volunteer License**

(1) An Oregon licensed dentist or dental hygienist who will be practicing for a supervised volunteer dental clinic, as defined in ORS 679.020(3)(f) and (g), may be granted a volunteer license provided licensee completes the following:

(a) Licensee must register with the Board as a health care professional and provide a statement as required by ORS 676.345.

(b) Licensee will be responsible to meet all the requirements set forth in ORS 676.345.

(c) Licensee must provide the health care service without compensation.

(d) Licensee shall not practice dentistry or dental hygiene for remuneration in any capacity under the volunteer license.

(e) Licensee must comply with all continuing education requirements for active licensed dentist or dental hygienist.

(f) Licensee must agree to volunteer for provide a minimum of 40 hours per calendar year **80 hours per renewal cycle**.

(2) Licensee may surrender the volunteer license designation at anytime and request a return to an active license. The Board will grant an active license as long as all active license requirements have been met.

Statutory/Other Authority: ORS 679 & 680
History:

OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05
NEWSLETTERS & ARTICLES OF INTEREST
Thank you to all of those who participated in the January 2019 Health Professionals’ Services Program (HPSP) Satisfaction Survey. This was our seventeenth consecutive biannual survey since January 2011. For this survey, 24% of active participants who had been enrolled for at least four months responded. The survey serves as an ongoing quality improvement tool and provides a feedback loop for participants. Survey results are reviewed by the internal HPSP Policy Advisory Committee (PAC) comprised of the HPSP Medical Director, Consulting Psychiatrist, Program Director, and two Agreement Monitors.

Highlights from this period:

• 100% of treatment providers rate their experience working with HPSP as “excellent” or “above average”
• 93% of licensees and 91% of workplace monitors rate their experience with HPSP positively
• 96% of licensees indicate they understood the program’s statutory monitoring requirements
• 89% of licensees felt program requirements are clearly explained
• 95% of licensees stated the program provides more than “some” accountability
• 91% of licensees believed their Agreement Monitor is knowledgeable of their case
• 89% of licensees reported information is communicated clearly, professionally, and within one business day
• 82% of licensees feel the program treats them with dignity
• 84.5% of licensees feel the program treats them with respect

In addition to the Likert scale responses, nine open-ended comments were received this period. Two comments were positive, five were negative, and two were suggestions for program improvement.

The two positive comments:

• Thank you for this program!
• This is a great program for anyone willing to better themselves.

The negative comments can be summarized as follows:

• A participant respondent who feels that the program is punitive
• A participant “resents everything about the program”
• A participant does not feel they should be required to follow program guidelines
• A participant who feels that the program is inflexible and changes the rules without notice
• A participant who questions the program’s ability to legitimately advocate for participants in reflection of the program’s contractual obligation to the HPSP participating boards

In response to all of these comments, please be reminded that HPSP allows participants to continue practicing in their chosen medical field. The program is grounded in Oregon Revised Statute and is consistent in terms of what is required of participants. The program is required to follow guidelines that have been developed and approved by the HPSP participating health professional boards. The legislature and the boards have a statutory responsibility to protect the public from impaired health professionals. To that end, toxicology as outlined in the monitoring agreement may come from urine, blood, hair, or other sample types. Additionally, participants in the toxicology program should not be able to count or otherwise predict when their next test will come.
To address the notion that the program will not advocate or be the champion for participants: HPSP representatives are always willing, with licensee approval, to depict a participant’s program compliance. We do, when invited, speak on behalf of participants to coordinated care organizations, credentialing agencies, and other health systems. Additionally, it is a board-referred licensee’s participation history that is reported back to the board that provides the track history that s/he has been abstinent (in cases of licensees with substance use disorders), has met their requirements as outlined in their monitoring agreement and program guidelines, and has practiced safely while in monitoring. Thus, it is the same hard work that participants put into the program that HPSP will stand behind and be happy to report.

The notion that one participant should be treated differently than other participants is one of the factors that brought the legislature to develop HPSP; HPSP must and will always follow Oregon Revised Statutes, Oregon Administrative Rules, and the HPSP Guidelines. Program components including on demand toxicology for licensees with substance use disorders and weekly group requirements for Oregon Medical Board licensees are not requirements that are up for change negotiation.

The last two comments concerned the layout of the biannual satisfaction survey and request for more collection sites including Saturday collection sites. Thank you for the input on the survey layout for licensees who are not participating in toxicology. As for collection sites, we continuously look for new sites and try to negotiate Saturday hours. If you know of a collection site in your community, please share the site information with RBH’s Mark Stotts (mstotts@reliantbh.com; (503) 802-9816).

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

**Be Healthy and Safe in the Garden**

Enjoy the benefits of gardening, and stay safe.

Whether you are a beginner or expert gardener heading out to your garden, vegetable plot, or grassy lawn, health and safety are important. Gardening can be a great way to get physical activity, beautify the community, and go green. However, it also can expose you to potentially harmful elements, such as the sun, insects, lawn and garden equipment, and chemicals. Below are some health and safety tips for gardeners to follow while enjoying the beauty and bounty gardening can bring:

- **Dress to protect.** Prevent exposure to chemicals, insects, and the sun.
- **Put safety first.** Limit distractions, use chemicals and equipment properly, and be aware of possible hazards to lower your risk for injury.
- **Watch out for heat-related illness.** Even being out in short periods of time in high temperatures can cause serious health problems. Monitor your activities and time in the sun to lower your risk for heat-related illness.
- **Know your limits.** Talk to your health care provider if you have concerns that may impair your ability to work in the garden safely.
- **Enjoy the benefits of physical activity.** Gardening is an excellent way to get physical activity. Active people are less likely than inactive people to be obese or have high blood pressure, type 2 diabetes, osteoporosis, coronary artery disease, stroke, depression, colon cancer, and premature death.
- **Get vaccinated.** Vaccinations can prevent many diseases and save lives. All adults should get a tetanus vaccination every 10 years.
- **Go green.** Conserve water, reuse containers, recycle, and share your bounty.

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**PRN Annual Conference**

The 2019 Oregon Professionals Recovery Network (PRN) Conference will be Saturday, April 13, 2019 in Salem at the Chemeketa Eola Center (215 Doaks Ferry Road NW). Speakers will include Serenity Lane’s Jerry Gjesvold, Shabbir Imber Safdar, Kassi Lamert, Rob Bovett, and HPSP’s Christopher Hamilton and Scott McBeth. Pharmacists will receive continuing education units. Visit www.prnoforegon.org for more information and to register!

**HPSP Outreach**

The HPSP Team is scheduling informational sessions on HPSP. If the administrators of your health care workplace are interested in learning more about HPSP, please ask them to contact Christopher Hamilton, Ph.D. (503-802-9813; chamilton@reliantbh.com) for more information, or to schedule a meeting. Visit www.prnoforegon.org for more information and to register!
RBH’s New Name and Logo

Over the next few months you will see references to Reliant Behavioral Health (RBH) and the RBH logo changing to Integrated Behavioral Health (IBH). RBH has been part of IBH family for nearly six years. There are no other changes for HPSP participants besides the new IBH name and logo. You will soon see this logo on the newsletter, signature blocks, and the website.

Over-the-Counter Allergy Relief

Allergies will soon be in full force. As a reminder, several over-the-counter medications may have sedating or stimulating effects. These include centrally acting antihistamines, such as diphenhydramine (Benadryl), and hydroxyzine (Vistaril or Atarax). Like prescriptions with addictive potential and/or psychotropic medication be sure to have your primary care physician populate a Medication Management Form before a non-negative test. The Medication Management Form (MMF) and other useful forms are available at www.RBHMonitoring.com.

Travel

Spring is here and summer on its way, please remember that travel requests need to be made two weeks in advance in order to guarantee appropriate site allocation and chain of custody form distribution. The Guideline for Toxicology Testing Exemptions and all other HPSP Guidelines are available at www.RBHMonitoring.com.

Spring Sunshine Brightens Mood

After months of low temperatures and dark skies, isn’t it delightful to celebrate spring again?

For many people, this wonderful season of new life is a real morale booster. One reason: a brain chemical known as serotonin that soothes and balances the nervous system. For most people, serotonin production is linked closely to the amount of sunlight that strikes the retina of the eye.

When people are deprived of light, as usually happens during the winter months, the production of serotonin is slowed, and that could be a factor that produces a bad case of the winter blues. Conversely, the arrival of spring means more light, and for most of us, possibly a more cheerful mood. Here are a few suggestions on ways to take advantage of spring sunshine.

• Adjust your schedule, whenever possible, to spend time with the sun. When the weather is bright outside, why not grab a sandwich and a bottle of water and carry them to your favorite outdoor bench? If you can get 30-40 minutes of exposure to bright sunlight periodically, your serotonin level will rise and the winter blahs will begin to fade.
• Get serious about exercise. If you're like most of us, you added a few pounds during the winter. Try committing to three or four half-hour workouts per week to shed that weight. (Consult your family physician before beginning any new exercise program.) About 30 minutes of brisk walking, every other day, is enough to improve cardiovascular fitness, while also elevating your mood.

• Change your diet to match the more active, outdoor lifestyle that begins with spring. Instead of fats, sweets and heavy starches, enjoy seasonal fruits and vegetables. You'll feel lighter and quicker on your feet.

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Do You Have $5.9 Trillion for Health Care?
The Centers for Medicare & Medicaid Services (CMS) released its annual study, which predicts that national health expenditures will increase by 5.5% on average each year between 2018 and 2027, rising to $5.96 trillion in 2027. Medicaid spending growth is then projected to average 6.0% for 2020 through 2027. The study highlights the larger debate about the Affordable Care Act's (ACA) viability and growing health care costs. Health care costs are expected to make up 19.4% of the gross domestic product in 2027, as compared with 17.9% in 2017. Members of Congress continue to look at ways to address both costs and coverage through legislation. Whether it is shoring up the ACA, Medicare for All Act or the Competitive Health Insurance Reform Act, no one seems to want to foot a $5.9 trillion bill.

Increased FDA Oversight of Dental Devices Isn’t Slowing Industry Growth
Technology is driving a lot of innovation in dentistry, especially the use of computer-aided design (CAD) and computer-aided manufacturing (CAM) in restorative dentistry. When manufacturing operations are used to produce medical devices and those devices are marketed for sale, the Food & Drug Administration (FDA) is obligated to ensure device manufacturers are following appropriate protocols in the design and manufacture of their devices. As more dental laboratories adopt automated technology and more dental restorations are produced via CAD/CAM, the FDA has increased its oversight as an industry regulator. Typically, increased oversight hurts the industry it’s regulating; however, recent analysis of the dental CAD/CAM market shows 8.1% growth between 2017-2027, with the United States dominating the global dental CAD/CAM market.
The Member of Congress Most Focused on Dental Care Isn’t a Dentist

In the 116th Congress, 19 pieces of legislation touch on dental care and coverage. However, there is one Member of Congress who has introduced two bills to address dental benefits and dental loan repayment assistance—Senator Ben Cardin of Maryland. Sen. Cardin has been a long-time supporter of the dental community. In September 2018, he led his colleagues in a bipartisan letter to the Department of Health and Human Services urging Secretary Azar to use existing authorities to improve Medicare coverage for adult oral health, which would improve oral health and overall wellness and potentially reduce costs to the Medicare program. Sen. Cardin was also responsible for guaranteeing pediatric coverage for dental care through the Children’s Health Insurance Program (CHIP) and the Affordable Care Act (ACA).

Wisconsin Governor Tony Evers Proposes Expanded Access to Dental Care

Earlier this month, Wisconsin Governor Tony Evers announced that his soon-to-be-released state budget will include $43 million to expand access to dental care and support for dental therapist licensure. The funding would be used to expand the number of dental clinics eligible to receive grant funding to provide services to Medicaid and uninsured patients and would also expand the Seal-A-Smile program, which provides preventive services to children through the state’s K-12 school system. The Governor also plans to unveil a plan to create a pathway to licensure for dental therapists that would include funding for Wisconsin colleges and universities willing to implement a dental therapist program.

Public Student Loan Forgiveness Program Gets a Boost in Court

On Feb. 22, U.S. District Judge Timothy J. Kelly found that the Department of Education (Department) “acted arbitrarily and capriciously” when it changed its interpretation of regulations governing the Public Service Loan Forgiveness (PSLF) program. The American Bar Association brought five claims against the Department, essentially challenging its reversal of certain determinations under the PSLF program.

The PSLF program was established in 2007. It offers federal student loan forgiveness to those who make 10 years, or 120 months, of monthly loan payments while employed in public service. The Department determines whether the borrower’s loan payments were made while employed at
a qualifying public service organization (such as a nonprofit, including academic dental institutions).

The district judge ordered the Department to reconsider the denial letters sent to three of the four individual plaintiffs named in the lawsuit. The judge also struck down two of the standards used to determine whether a borrower’s job qualifies as “public service” under the program. One requires an employer to have public service as its “primary purpose.” The other examines whether an organization that offers public education services does so in a “school-like setting.”

ADEA has consistently supported PSLF as one of the many ways to support dental and allied dental professionals as they seek careers in public health. An assortment of repayment and loan forgiveness options have been created to help those who qualify. If you are concerned about student loan debt, visit ADEA’s Financing Dental Education webpage.

Patients First Act Would Allow Georgia to Seek Waivers Under the ACA

Georgia Governor Brian Kemp recently unveiled legislation that would grant his administration the authority to seek waivers from the Centers for Medicare & Medicaid Services to provisions under the Affordable Care Act (ACA). The bill, which recently passed a Senate Committee vote, would allow the Governor’s office to request a waiver allowing the state to expand Medicaid to individuals earning up to 100% of the federal poverty level, instead of 138% as currently allowed under the ACA. The legislation would also allow the Governor to seek waivers to provisions of the ACA governing health insurance coverage and health insurance products.

Iowa Supreme Court Rules State Must Hear Medicaid Denials

The Iowa Supreme Court recently ruled that the state must hear an appeal from a dentist seeking to dispute denial of coverage rulings from one of the state’s Medicaid managed care providers. The state Department of Human Services (DHS) argued it was not required to hear the appeal because it was a dispute between a provider and a private company, and state law only required DHS to review appeals presented by patients. The court’s decision, however, found that DHS must grant the dentist a hearing based on the state’s administrative rules.

2019 ADEA Capitol Hill Day Is April 11

Join us on Thursday, April 11 in Washington, DC for the 2019 ADEA Capitol Hill Day. On Hill Day, dental, allied dental and advanced dental education faculty, students, residents, fellows and researchers speak directly with Members of Congress and their staffs to articulate key issues that impact the dental education community—and share how the federal government can help address
these issues. Interested faculty and students can [register online](#) to join us in person on Capitol Hill for this event.
Why Does ADEA Advocate for Oral Health Training Programs on Capitol Hill?

Each year, ADEA hosts a Capitol Hill Day. This year we will gather in Washington, DC on April 11 to advocate for dental education. One issue ADEA prioritizes is the funding of Title VII, Section 748 of the Public Health Service Act, Oral Health Training Programs. The Health Resources and Services Administration administers the Title VII programs, which support predoctoral dental and dental hygiene programs, advanced dental education (postdoctoral dental residencies), faculty development, and dental faculty loan repayment for general, pediatric and public health dentistry.

Through loans, loan guarantees, scholarships to students and grants and contracts to academic institutions and nonprofit organizations, the Title VII health professions programs are the only federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce.

ADEA is increasingly concerned that the oral health research community is not growing and the pipeline of new researchers is inadequate to address future needs. ADEA is also part of an informal alliance of over 60 organizations focused on funding recruiting, retaining and growing the health care workforce. As part of the Health Professions and Nursing Education Coalition (HPNEC), ADEA fights to ensure the oral health care workforce of tomorrow has the training and resources needed to adequately serve the country’s needs, including those in the most underserved communities.
Update to Work Requirements

Late last week, New Hampshire became the third state to implement community engagement and work requirements for able-bodied Medicaid recipients. The work requirements, which went into effect March 1, are some of the toughest in the nation. Under the law, able-bodied Medicaid recipients will be required to complete 100 hours per month of work, study, job training or volunteering. Individuals who fail to meet the requirement for one month are suspended until they can demonstrate the requirement has been met. Arkansas and Indiana, the only other states to have implemented a work requirement, only require 80 hours per month of community engagement. New Hampshire won’t begin enforcing the work requirement until 75 days after implementation, and Indiana won’t begin enforcement until 2020. In Arkansas, however, individuals who fail to meet the requirement for three months are disenrolled until the next calendar year—more than 18,000 people were disenrolled in 2018.

Work requirements have been approved but not implemented in seven states, and eight additional states have applied to the Centers for Medicare & Medicaid Services for waivers to implement the requirements. While most of the approved states are proceeding with implementing their requirements as planned, some states that recently experienced change in party leadership may make changes before implementation.

Sen. Manchin Says Physicians Are Giving out Prescription Opioids “Like M&Ms”

On Feb. 28, the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies held a hearing on the opioid epidemic. Subcommittee Chairman Roy Blunt (R-MO) noted that while funding has increased about 300% since four years ago, more needs to be done to address the epidemic. Current funding is about $3.7 billion, but advocates have long argued for increased funding to states and local governments as the death toll from opioids continues to climb.

Sen. Lamar Alexander, (R-TN) who serves as Chairman of the Subcommittee as well as on the Senate Health, Education, Labor and Pensions Committee, said there needed to be a greater focus on pain management and opioids. He questioned Dr. Charissa Fotinos, Deputy Chief Medical Officer for Washington State Health Care Authority, about the Centers for Disease Control and Prevention (CDC) opioid guidance and whether it should be revised or made into law. Dr. Fotinos said CDC opioid guidance should not be made into law, but the issue is complicated so revisions to the guidance may be necessary.

Sen. Joe Manchin, III (D-WV) questioned witnesses about how Medicaid expansion efforts have helped stem the tide of the opioid epidemic. He spoke further about his bill that would establish a stewardship fee on the production and importation of opioid pain relievers to increase funding. The senator said his next push would be a bill to change the labeling of prescription opioids to
discourage overuse by physicians since “... because the doctors haven’t done that themselves, they’re just giving them out like M&Ms.”

Dental Therapy Bill Passes New Mexico House
Legislation to license dental therapists passed the New Mexico House of Representatives early last week. The bill defines the scope of practice for dental therapists and limits the places dental therapists are permitted to work to facilities that serve Native populations and other traditionally underserved populations. Similar legislation passed the House in 2017 but failed to pass the Senate.

Dental therapy legislation has been introduced in at least seven other states and may also begin moving in Massachusetts after compromise legislation recently passed a committee vote. This legislation and others can be found on the ADEA U.S. Interactive Legislative and Regulatory Tracking Map by selecting scope of practice.

Some States May Expand Dental Coverage to Pregnant Women
Legislation that would expand dental coverage to pregnant women covered under public health programs is moving in at least two states. A bill in Arizona that would ensure comprehensive dental benefits to pregnant women covered by Medicaid recently passed the state Senate, while a bill in Colorado that recently passed the state House would grant dental coverage to pregnant women enrolled in the state’s Child Health Plan Plus program. Arizona’s legislation appears to have considerable support and Colorado’s passed the House on a 62-1 vote. Similar legislation has been introduced in Oklahoma.

Canada Increases Dental Care Benefit for 2019
Effective Jan. 1, participants and their eligible dependents will have improved coverage under the Canadian Public Service Dental Care Plan (PSDCP). The yearly maximum for dental services will steadily increase over the next three years. The PSDCP is a mandatory dental services plan for federal public service employees and their eligible dependents for specific dental services and supplies not covered under a provincial/territorial health or dental care plan.

Canada’s health care system is a group of socialized health insurance plans that provides coverage to all Canadian citizens. It is publicly funded and administered on a provincial or territorial basis within guidelines set by the federal government. Even with the advent of the Affordable Care Act, the United States does not have a system that provides coverage to all citizens. According to the National Association of Dental Plans, nearly 74 million Americans had no dental coverage in 2016. Given the connection between oral and overall health, dental coverage is essential whether you live in Canada, the United States or any other country.
OSAP-DANB-DALE Foundation Launch Website
For Dental Infection Control Education and Certification

The Organization for Safety, Asepsis and Prevention (OSAP), the Dental Assisting National Board (DANB) and the DALE Foundation are collaborating on a comprehensive infection control education and certification initiative. The initiative will establish a standardized infection control educational program, two professional certification programs and online continuing education. These collaborative initiatives advance the organizations' missions, which relate to enhancing patient and practitioner safety.

On February 22, OSAP, DANB and the DALE Foundation launched a new website that will serve as a hub of information to both the profession and the dental trade on dental infection control education and certification.

The Dental Infection Control Education & Certification website, [dentalinfectioncontrol.org](http://dentalinfectioncontrol.org), is now available for all dental professionals, including clinicians, educators, consultants, state dental board investigators and inspectors, and dental sales representatives. The easy-to-navigate site offers specific steps on how to enhance current infection control knowledge and demonstrate real commitment to patient safety.

Those who pursue the comprehensive education and certification programs can boost their credibility and potential job prospects. Other benefits include:

- Increased performance and job satisfaction
- Deeper level of connection and credibility with patients
- Potential new career growth opportunities
- Demonstrated commitment to patient and dental team safety
- Verification of knowledge-based competence in dental infection prevention and control
- And more!

"The multi-faceted dental infection prevention education and certification initiative is a game-changing outcome of a unique collaboration of experts," said Michelle Lee, CPC, executive director of OSAP. "After several infection control breaches in dental settings made national headlines, OSAP combined its expertise in infection control with DANB for its certification and credentialing expertise and the DALE Foundation, a research and online education developer and official DANB affiliate. The new website highlights the elements of the collaboration for the profession."

Cynthia Durley, M.Ed., MBA, executive director of DANB and the DALE Foundation, added: "The website offers numerous resources including the educational framework of seven national dental..."
associations and the Centers for Disease Control and Prevention, a background article on the initiative, training needs analysis, brochures, FAQs and much more.

"The new education and certification initiative will raise the bar on the quality and reliability of infection control information," Durley continued. "And the two OSAP-DANB professional certification programs can help protect the public by measuring knowledge and experience based on a formal job analysis, not a specific curriculum, through a standardized comprehensive exam."

###

About OSAP
The Organization for Safety, Asepsis and Prevention (OSAP) focuses on strategies to improve compliance with safe practices and on building a strong network of recognized infection control experts. OSAP offers an extensive online collection of resources, publications, FAQs, checklists and toolkits that help dental professionals deliver the safest dental visit possible for their patients. Plus, online and live courses help advance the level of knowledge and skill for every member of the dental team. The organization's Annual Conference is May 30-June 2 in Tucson, AZ. For additional information, visit www.OSAP.org.

About DANB
The Dental Assisting National Board, Inc. (DANB) is recognized by the American Dental Association as the national certifying board for dental assistants. DANB's mission is to promote the public good by providing credentialing services to the dental community. DANB exams and certifications are recognized or required by 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs. For more information, visit www.danb.org.

About the DALE Foundation
The DALE Foundation, the official DANB affiliate, benefits the public by providing quality continuing education and conducting sound research to promote oral health. The DALE Foundation offers interactive e-learning courses and study aids to help dental assistants and other dental auxiliaries expand their knowledge and grow their careers. To learn more, visit www.dalefoundation.org.
Introduction

The American Dental Education Association (ADEA) is The Voice of Dental Education. Its members include all 76 U.S. and Canadian dental schools, more than 1,000 allied and advanced dental education programs, over 60 corporations and more than 20,000 individuals.

The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

ADEA is committed to conducting research into contemporary and emerging issues that are likely to impact decisions in the dental education and policy-making communities.

Each year, ADEA collects data on topics of particular interest to dental school deans, program directors, faculty, students, residents and fellows.

The resulting ADEA Snapshot of Dental Education presents findings on discrete subject areas to help the ADEA membership and other stakeholders better understand the academic dental profession and its role in health and health care.

The information in this report is taken from data compiled by ADEA, the American Dental Association and other sources.

The associated online resources are updated regularly and are available for download at: adea.org/snapshot.

ORDERS

Additional copies are available from:
American Dental Education Association
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<tr>
<td>State/Province</td>
<td>Dental School</td>
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<tr>
<td>MO</td>
<td>University of Missouri School of Dentistry</td>
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<tr>
<td>MS</td>
<td>University of Mississippi Medical Center School of Dentistry</td>
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<tr>
<td>MT</td>
<td>University of Montana School of Dentistry</td>
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<td>NE</td>
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<tr>
<td>NV</td>
<td>University of Nevada, Las Vegas, School of Dental Medicine</td>
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<tr>
<td>NY</td>
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<td>New York University College of Dentistry</td>
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<td>Stony Brook University School of Dental Medicine</td>
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<tr>
<td>OH</td>
<td>Case Western Reserve University School of Dental Medicine</td>
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<tr>
<td></td>
<td>The Ohio State University College of Dentistry</td>
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<tr>
<td>OK</td>
<td>University of Oklahoma College of Dentistry</td>
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<tr>
<td>OR</td>
<td>Oregon Health &amp; Science University School of Dentistry</td>
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<tr>
<td>PA</td>
<td>The Maurice H. Kornberg School of Dentistry, Temple University</td>
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<tr>
<td></td>
<td>University of Pennsylvania School of Dental Medicine</td>
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<td></td>
<td>University of Pittsburgh School of Dental Medicine</td>
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<tr>
<td>PR</td>
<td>University of Puerto Rico School of Dental Medicine</td>
</tr>
<tr>
<td>SC</td>
<td>Medical University of South Carolina James B. Edwards College of Dental Medicine</td>
</tr>
<tr>
<td>TN</td>
<td>Meharry Medical College School of Dentistry</td>
</tr>
<tr>
<td>TX</td>
<td>University of Texas Southwestern Medical School</td>
</tr>
<tr>
<td></td>
<td>University of Texas Dental Branch at Houston</td>
</tr>
<tr>
<td>UT</td>
<td>University of Texas School of Dentistry at Houston</td>
</tr>
<tr>
<td>UT</td>
<td>University of Utah School of Dental Medicine</td>
</tr>
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<td>VA</td>
<td>Virginia Commonwealth University School of Dentistry</td>
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<td>WA</td>
<td>University of Washington School of Dentistry</td>
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<td>WV</td>
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<tr>
<td>WI</td>
<td>Marquette University School of Dentistry</td>
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<tr>
<td>AB</td>
<td>University of Alberta School of Dentistry</td>
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<tr>
<td>BC</td>
<td>University of British Columbia Faculty of Dentistry</td>
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<tr>
<td>MB</td>
<td>University of Manitoba Dr. Gerald Niznick College of Dentistry</td>
</tr>
<tr>
<td>NS</td>
<td>Dalhousie University Faculty of Dentistry</td>
</tr>
<tr>
<td>ON</td>
<td>University of Toronto Faculty of Dentistry</td>
</tr>
<tr>
<td>QC</td>
<td>McGill University Faculty of Dentistry</td>
</tr>
<tr>
<td>SK</td>
<td>University of Saskatchewan College of Dentistry</td>
</tr>
</tbody>
</table>

Source: American Dental Education Association, 2018
Over Half of 2018 Dental School Graduates Report Total Educational Debt Under $300,000

For 2018 dental school graduates with educational debt, the average self-reported educational debt was under $300,000. Total educational debt is the sum of educational debt incurred before and during dental school.

AVERAGE 2018 EDUCATIONAL DEBT

Students With Debt $285,184
All Students, Including Those With No Debt $237,791

Sample monthly payment* $2,558
Less than $200,000 20%
No Debt 17%
$200,000 to $300,000 23%
More than $300,000 40%
Sample monthly payment* $3,907

*Standard 10 year (120 level payments)
Assumptions for sample monthly payments: Sample payments based on amounts of $300,000, $250,000 and $200,000 on a Standard 10 year repayment plan (120 level payments) • $162,000 direct unsubsidized, remainder direct PLUS (Grad PLUS) • Six-month “window” period (grace period for direct unsubsidized loans, post-enrollment deferment for direct PLUS) after graduation • No voluntary or aggressive payments, and loans “held to term” (entire repayment period used) • Appropriate interest rates based on academic year loans disbursed for Class of 2018 • Repayment numbers run with AAMC/ADEA Dental Loan Organizer and Calculator

Note: The repayment amounts under this basic repayment plan are not based on income, they are straight amortization schedules based solely on amount borrowed, interest rate and repayment term. Interest rates are fixed on each loan for the life of the loan. There are a number of income-driven repayment plans designed to help borrowers who cannot initially afford repayment under this and other time-driven plans, and whose repayment amounts are based on income and family size.

Source: American Dental Education Association, Survey of Dental School Seniors, 2018 Graduating Class
Note: Percentages may add up to more than 100% due to rounding.
Are There Enough Dental Graduates?

In 1977, the U.S. population was 220 million, and there were 5,177 dental school graduates (or 2.4 dental school graduates per 100,000 people). In 2017, the U.S. population grew to 325.7 million, with 6,238 dental school graduates (or 1.9 dental school graduates per 100,000 people). At the same time, there have been fluctuations in the number of graduates from other allied dental professions.

Fifty-seven degree completion programs and 21 graduate programs are available for dental hygienists to advance their degrees. More states are reducing restrictions for patients to access dental hygienists directly and are allowing prescriptive authority and direct reimbursement by Medicaid.

The majority of dentists and dental office managers believe an effective dental assistant contributes to practice productivity and patient retention. State regulation of dental assistants is evolving, with some states not requiring formal education or certification.

Only 15 CODA-accredited dental laboratory technology programs exist in the United States. Because of this profession's "behind the scenes" work, recruiting students is difficult.

Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Surveys of Dental Laboratory Technology Education Programs, and Surveys of Dental Education. "The DALE Foundation, The Value of Dental Assistants to the Dental Practice, November 2016; Dental Assisting National Board, 2018 State Fact Booklet; ada.org/en/coda/find-a-program; adha.org/dental-hygiene-programs; adha.org/resources-docs/75118_Facts_About_the_Dental_Hygiene_Workforce.pdf; Oral Health Workforce Research Center, Dental Hygiene Scope of Practice, 2016."
The Dental Student Population Includes More Women and Is More Diverse Over Time

In the past five years, dental school enrollment disaggregated by race, ethnicity and gender includes more women enrollees, nearly 50% (49.8%), and an overall rise in diversity, with observable rises in Asian, Hispanic or Latino, Nonresident Alien, Two or More Races and Native Hawaiian or other Pacific Islander enrollees.

2012 Enrollees by Race and Ethnicity and Gender

- White: 55.7%
- Asian: 21.5%
- Hispanic or Latino: 7.8%
- Black or African American: 5.1%
- Nonresident Alien: 3.4%
- Two or More Races: 3.4%
- Native Hawaiian or Other Pacific Islander: 0.1%
- Do Not Wish to Report: 0.7%
- Men: 52.3%
- Women: 47%

2017 Enrollees by Race and Ethnicity and Gender

- White: 50.4%
- Asian: 24.2%
- Hispanic or Latino: 9.4%
- Black or African American: 5.1%
- Nonresident Alien: 3.8%
- Two or More Races: 3.9%
- Native Hawaiian or Other Pacific Islander: 2.8%
- Do Not Wish to Report: 0.1%
- Men: 50.2%
- Women: 49.8%

Note: ADEA adheres to the revised federal guidelines for collecting and reporting race and ethnicity. Percentages may add up to more than 100% due to rounding.

*The "Other" gender category includes students who prefer not to report gender, do not identify as either male or female or whose gender is not available.

Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2012 and 2017 Entering Classes
Dental Schools and CODA Play Key Roles in Assessing Dental Student Competencies

CODA Standards specify that academic dental institutions must use student evaluation methods that measure their defined competencies. "The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills, but also assess the process and procedures which will be necessary for entry-level practice." (CODA Standard 2-5)

Methods Dental Schools Use to Assess Student Competencies

- Self-assessment (65 Schools)
- Simulation (66 Schools)
- Faculty assessment by observation (66 Schools)
- Simulation (66 Schools)
- Written assessment (65 Schools)
- CATS/PICO (50 Schools)
- OSCE (62 Schools)
- Work samples (59 Schools)
- Independent assessment (53 Schools)

CODA Standard 2 Educational Program

Critical Thinking (Standard 2-9)
Self-assessment (Standard 2-10)
Biomedical Sciences (Standards 2-11, 2-12, 2-13, 2-14)
Behavioral Sciences (Standards 2-15, 2-16)
Practice Management and Health Care Systems (Standards 2-17, 2-18, 2-19)
Ethics and Professionalism (Standard 2-20)
Clinical Sciences (Standards 2-21, 2-22, 2-23, 2-24, 2-25)

Source: American Dental Association, Health Policy Institute, 2016-17 Survey of Dental Education: Group IV - Curriculum
What Career Paths Do They Seek?

Intended Primary Professional Activity for New Dental School Graduates

### Percent

- **Private Practice Dentist**
  - 2015: 49.4%
  - 2018: 47.9%

- Dental Graduate Student/Resident/Intern
  - 2015: 34.3%
  - 2018: 35.9%

- Uniformed Services Dentist
  - 2015: 5.2%
  - 2018: 4.7%

- Unsure
  - 2015: 2.2%
  - 2018: 3.1%

- Federally Qualified Health Center
  - 2015: 3.0%

- Other Position Related to Dentistry
  - 2015: 2.5%
  - 2018: 2.5%

- Other Federal Service (e.g., VA)
  - 2015: 1.3%
  - 2018: 0.8%

- Other Nonprofit Clinic
  - 2015: 0.6%

- Other Type of Student
  - 2015: 0.9%
  - 2018: 0.4%

- State or Local Government Employee
  - 2015: 0.8%
  - 2018: 0.4%

- Faculty/Staff Member at a Dental School
  - 2015: 0.5%
  - 2018: 0.3%

- USPHS Commissioned Corps
  - 2015: 2.7%

- Other Position Not Related to Dentistry
  - 2015: 0.1%

*In 2015, the question structure regarding employment in a corporate-owned group practice changed from "Select All That Apply" to "Select Only One." As such, results prior to 2015 cannot be compared with results in 2015 and later.

Note: Percentages may not add up to 100% due to rounding.

Source: American Dental Education Association, Surveys of Dental School Seniors, 2015 and 2018 Graduating Classes
## Number of Applications and First-Year Enrollment for Advanced Dental Education Programs

2016-17 ACADEMIC YEAR. APPLICATION FIGURES REPRESENT THE TOTAL NUMBER OF APPLICATIONS SUBMITTED TO ALL PROGRAMS, AND COUNTS APPLICANTS MORE THAN ONCE IF THEY APPLIED TO MULTIPLE PROGRAMS.

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Number of Programs</th>
<th>Applications</th>
<th>First-Year Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015</td>
<td>2017</td>
<td>2015</td>
</tr>
<tr>
<td>All General Dentistry*</td>
<td>301</td>
<td>297</td>
<td>17,813</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>67</td>
<td>68</td>
<td>10,748</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>11,237</td>
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<tr>
<td>Pediatric Dentistry</td>
<td>77</td>
<td>80</td>
<td>10,716</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9,597</td>
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<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>101</td>
<td>102</td>
<td>10,246</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>11,340</td>
</tr>
<tr>
<td>Endodontics</td>
<td>56</td>
<td>56</td>
<td>3,570</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>4,430</td>
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<tr>
<td>Periodontics</td>
<td>57</td>
<td>58</td>
<td>2,457</td>
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<td></td>
<td>2,607</td>
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<tr>
<td>Prosthodontics</td>
<td>47</td>
<td>48</td>
<td>2,222</td>
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<td>2,260</td>
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<td>Dental Public Health</td>
<td>15</td>
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<tr>
<td>Oral and Maxillofacial Radiology</td>
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<tr>
<td>Oral and Maxillofacial Pathology</td>
<td>16</td>
<td>14</td>
<td>96</td>
</tr>
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<td></td>
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<td>96</td>
</tr>
</tbody>
</table>

*All General Dentistry includes General Practice Residency, Advanced Education in General Dentistry, Dental Anesthesiology, Oral Medicine, and Orofacial Pain.
Source: American Dental Association, Health Policy Institute, 2016-17 Survey of Advanced Dental Education
Age of Full-time and Part-time Dental School Faculty

Full-time and part-time faculty by age, 2006-07 and 2016-17 academic years

Note: Voluntary faculty are not included.
Source: American Dental Education Association, Survey of Dental School Faculty, 2016-17; ADEA Survey of Dental Educators, 2006-2007.
For dental students, residents and fellows who opt to pursue a rewarding career as dental school faculty, a variety of resources—financial and experiential—help support the pathway to an academic career.

**Faculty Loan Repayment and Grant Programs**
Federal agencies and other organizations offer programs that provide loan repayment assistance for dental graduates pursuing careers in academia.
[adea.org/facultyloanprograms](http://adea.org/facultyloanprograms)

**ADEA Chapters**
Promote dental students’ interest in academic careers.
[adea.org/DEAChapters](http://adea.org/DEAChapters)

**The ADEA Academic Dental Careers Fellowship Program**
Creates a pathway for dental students and residents who may be considering academic careers.
[adea.org/ADCFP](http://adea.org/ADCFP)

**The ADEA Council of Students, Residents and Fellows**
Promotes knowledge of and interest in academic careers.
[adea.org/COSRF](http://adea.org/COSRF)

**The ADEA Student Diversity Leadership Program**
Dental students create goals and assess resources to help them develop their leadership skills and styles.
[adea.org/SDLP](http://adea.org/SDLP)

**Student experiences that could lead to academic careers**
- Teaching assistant
- Lecturer
- Tutor
- Lab assistant
- Research assistant
A Statewide Call-to-Action: Alternate Pathways Toward Licensure and Licensure Portability

Similar to the climate change issue, after years, if not decades, of discussion but little change, we are at a point where the reality of the need to address the issue of portability of initial licensure and licensure by credentials has hit.

To view the specific exams accepted by each U.S. state or territory, see American Dental Association "State Licensure Tables," https://bit.ly/2xjNtOw.

Source: ADA Council on Dental Education and Licensure.
A statewide call-to-action centering on states’ paths forward regarding licensure and licensure portability is of great significance to the dental profession and the public it serves.

The path forward calls upon states to eliminate the use of single encounter, procedure-based examinations on patients as part of the licensure examination and remove restrictions on portability of dental licensure. States’ acceptance of a wider array of clinical exams and other pathways to licensure protect public safety while also increasing dentists’ professional mobility.

As dentists in modern society become more mobile the issue of portability of licensure takes on increased importance.

**Consider this:** between 2011-16, about 1 in 18 dentists moved to a different state, and about 1 in 8 dentists ages 40 and younger moved across state lines.

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Carnegie Classifications of U.S. Dental Schools’ Parent Institutions

**Doctoral Universities**
- **64% (42 institutions)**
  - Includes institutions that awarded at least 20 research doctoral degrees during the academic year.

**Special Focus Institutions**
- **29% (19 institutions)**
  - Institutions awarding the baccalaureate or higher-level degree where a high concentration of degrees (above 75%) is in a single field or set of related fields.

**Master’s Colleges & Universities**
- **7% (5 institutions)**
  - Generally includes institutions that awarded at least 50 master’s degrees and fewer than 20 research doctoral degrees during the academic year.

**Highest research activity**
- **33 institutions**
  - Doctoral universities that awarded at least 20 research/scholarship doctorates in 2013-14 were assigned to one of three categories based on aggregate and per-capita indices of research activity.

**Higher research activity**
- **8 institutions**

**Moderate research activity**
- **1 institution**

**Doctoral universities that awarded at least 20 research/scholarship doctorates in 2013-14 were assigned to one of three categories based on aggregate and per-capita indices of research activity.**

**Institutions that were very high on either index were assigned to the “highest research activity” group, while institutions that were high on at least one (but very high on neither) were assigned to the “higher research activity” group.**

**Remaining institutions and those not represented in the National Science Foundation data collections were assigned to the “moderate research activity” category.**

ADEA Advocacy and Government Relations: Members’ Voices Informing Policymakers

Whether advocating on behalf of the National Institute of Dental and Craniofacial Research or safeguarding dental education program funding, ADEA’s Advocacy and Government Relations team is the Voice of Dental Education on an array of federal and state issues pertinent to academic dentistry—higher education, faculty and student loan repayment, licensure portability, immigration, health care and more. In 2017 and 2018, ADEA AGR worked daily to achieve the following results:

**ANALYZE**
- Monitor and assess thousands of pieces of state legislation and proposed regulations impacting academic dentistry.
- Track hundreds of bills in Congress dealing with health care reform.
- Examine over 100 pieces of federal legislation that stand to directly impact dental care and access.
- Review and report on multiple news sources daily.

**EDUCATE**
- Publish state and federal newsletters to educate members on the latest federal and state legislation and regulations.
- Send thousands of tweets on key issues impacting dental education.
- Educate ADEA Leadership Institute Fellows on how to advocate for dental education before state and federal legislatures.
- Hold monthly conference calls to answer ADEA member questions on legislation.

**ADVOCATE**
- Support ADEA priorities by signing individual and coalition letters sent to the Administration and Congress.
- Support amicus briefs filed with the U.S. Supreme Court.
- Hold congressional briefings on Capitol Hill in support of oral health training funding.
- Hold annual ADEA Capitol Hill Day, where ADEA members engage virtually and in-person with their Members of Congress.

Meetings held with Members of Congress and their staffs to achieve higher funding levels for:
- Oral health training programs $40.7M
- National Institute of Dental and Craniofacial Research $461.8 million (+$14M)
- Health Careers Opportunity Program $14.2M
- Ryan White Part F—Dental Reimbursement Program $13.1M
Poor Oral Health Affects Our Military’s Readiness and National Security

“Dental disease and non-battle injury data from July 2009 to June 2011 for Operation Iraqi Freedom show that on average, a soldier is lost for three days each time they seek dental care. This does not include the soldiers lost to the unit to transport the soldier who needs dental treatment.”
—Col. Georgia Rogers, D.M.D., M.P.H., 2018*

Sources:
*Gourley, G. Dental health and readiness: keeping soldiers deployable and in the fight. DefenseMediaNetwork, June 11, 2018

DID YOU KNOW?

1. 4-F is a classification given to a new U.S. military registrant indicating he or she is “not acceptable for service in the Armed Forces” due to medical, dental or other reasons. The term originated in the Civil War to disqualify recruits who did not have four front teeth with which to tear open gunpowder packages.

2. In 2008, nearly all (95.8%) Department of Defense recruits required some type of dental care and over half were considered to be Dental Readiness Class 3 (non-deployable, not medically/dentally ready).

3. The most common disqualifier for military service in the 20th century was not flat feet, but military personnel dental health and complications, such as acute necrotizing ulcerative gingivitis (trench mouth).

4. The rampant dental problems of soldiers during World War II led to the National Dental Research Act in 1948. The Act established the National Institutes of Health’s third institute, known today as the National Institute of Dental and Craniofacial Research.

If you can’t eat, you can’t fight.
The American Dental Education Association (ADEA) has 20,000 members and represents all 76 dental schools in the United States and Canada. ADEA also represents more than 1,000 allied and advanced dental education programs and over 60 corporate members. With headquarters in Washington, DC, ADEA’s staff of 70 works to represent and serve the needs of academic dentistry in many key areas:

ADEA Value Proposition

ADEA’s four centralized application services—
process over 180,000 applications annually on behalf of our members.

Critical policy information and initiatives—
to support academic dental institutions in planning and decision-making.

Educational research and analysis—
findings from surveys and applicant data.

Federal advocacy efforts—
address legislation and regulations that impact dental education.

Guidance, training and tools—
foster inclusive excellence in dental education.

Professional and leadership development programming—
for deans, program directors and dental and dental hygiene faculty.

Real-time state policy monitoring—
with online access for members.

Recruitment activities—
ensure the continued quality and diversity of applicants to the dental professions.

Representation by the ADEA President and CEO—
on national higher education and health professions leadership bodies.

Unique profession-centric publications—
including the peer-reviewed Journal of Dental Education.

adea.org/valueproposition
National, Regional, and Specialized Accreditors and State Boards of Dentistry:

In accordance with established policy of the Commission on Dental Accreditation and regulations of the United States Department of Education, please consider this notification that as a result of action taken by the Commission at its February 7-8, 2019 meeting, the following education programs have been notified of the Commission's “intent to withdraw accreditation” at its next regularly scheduled meeting on August 1-2, 2019 if these programs do not achieve compliance with accreditation standards or policy by that date:

Advanced Education in Pediatric Dentistry
Howard University, Washington, DC

Advanced Education in General Practice Residency
The Queen’s Medical Center, Honolulu, HI

Advanced Education in Endodontics
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in Periodontics
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in Maxillofacial Prosthetics
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in Oral and Maxillofacial Pathology
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in Orofacial Pain
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in Prosthodontics
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in General Dentistry (24 month)
Navy Medicine Professional Development Center, Bethesda, MD

Advanced Education in General Dentistry (12 month)
Navy Medicine Professional Development Center, Bethesda, MD

Dental Assisting
Orange Coast College, Costa Mesa, CA
Lindsey Hopkins Technical Education Center, Miami, FL
Pinellas Technical College, St. Petersburg, FL
Iowa Western Community College, Council Bluffs, IA
In addition, the Commission recognized that the following programs have voluntarily discontinued their participation in the Commission's accreditation program:

**Dental Assisting**
- Rio Salado College, Tempe, AZ
- Bradford School, Pittsburgh, PA
- Fortis College, Cuyahoga Falls, OH
- Concorde Career College Center Memphis, Memphis, TN
- Lincoln College of New England, Southington, CT (via Mail Ballot 11/12/2018)

**Periodontics**
- NYU Langone Hospitals, New York, NY

The following new programs have been granted accreditation:

**Dental Assisting**
- Cape Coral Technical College, Cape Coral, FL
- Bradford School-Columbus, Columbus, OH
- South College, Nashville, TX

**Dental Hygiene**
- Hocking College, Nelsonville, OH
- South College, Nashville, TX

**Dental Anesthesiology**
- Advocate Illinois Masonic Medical Center, Chicago, IL

**Advanced Education in General Dentistry (12-month)**
- University of Nebraska Medical Center, Omaha, NE
- Fort Bliss Dental Health Activity, Fort Bliss, TX

The accreditation statuses of programs reviewed by the Commission on Dental Accreditation at its Winter 2019 meeting can be found at [http://www.ada.org/en/coda/accreditation/accreditation-news/accreditation-notices](http://www.ada.org/en/coda/accreditation/accreditation-news/accreditation-notices)

The accreditation statuses of all programs accredited by the Commission on Dental Accreditation can be found at [http://www.ada.org/en/coda/find-a-program/search-dental-programs](http://www.ada.org/en/coda/find-a-program/search-dental-programs)

You can also access the CODA-accredited program annual survey results at: [http://www.ada.org/en/coda/find-a-program/program-surveys/](http://www.ada.org/en/coda/find-a-program/program-surveys/)

If you have further questions regarding this information, please contact the Commission on Dental Accreditation. Thank you.
Dental anesthesiology becomes the 10th dental specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards.

The recognition comes after the National Commission on March 11 adopted a resolution based on an application from the American Society of Dentist Anesthesiologists to recognize dental anesthesiology as a dental specialty.

“This historic vote by the National Commission certainly reflects the ADA’s ongoing efforts towards improved patient care and safety in the areas of dental sedation, dental anesthesiology and access for those with special health care needs,” said Dr. James Tom, president of the American Society of Dentist Anesthesiologists.

Dental anesthesiology now joins the following dental specialties: dental public health; endodontics; oral and maxillofacial pathology; oral and maxillofacial radiology; oral and maxillofacial surgery; orthodontics and dentofacial orthopedics; pediatric dentistry; periodontics; and prosthodontics.

Dental specialties are recognized "to protect the public, nurture the art and science of dentistry and improve the quality of care," according to the National Commission website.

A sponsoring organization seeking specialty recognition for discipline of dentistry must document that the discipline satisfies six requirements, as outlined in the "Requirements for Recognition of Dental Specialties." The sponsoring organization of the proposed specialty must provide documentation to show that it is a distinct and well-defined field that requires unique knowledge and skills beyond those commonly possessed by dental school graduates; that it requires advanced knowledge and skills; and that it scientifically contributes new knowledge, education and research in both the field, and the profession.

The American Society of Dentist Anesthesiologists submitted its application to the National Commission in September 2018. Following a review by the National Commission's Review Committee on Specialty Recognition in November 2018, the National Commission invited public comment for a 60-day period.

At its February 2019 meeting, the review committee considered all the comments received that directly related to whether the application met all the requirements for specialty recognition and made a recommendation to the National Commission to grant specialty status. At its March 11 meeting, the National Commission determined that the application did indeed meet the "Requirements for Recognition of Dental Specialties" and adopted a resolution recognizing dental anesthesiology as a dental specialty. A resolution needs a two-thirds majority vote to be approved.

Following approval by the National Commission, the sponsoring organization must establish a national board for certifying diplomats in accordance with the "Requirements for Recognition of Dental Certifying Boards."
The National Commission on Recognition of Dental Specialties and Certifying Boards is comprised of nine general dentists, appointed by the ADA Board of Trustees and approved by the House of Delegates; one specialist from each of the nine recognized specialties, appointed by the sponsoring organization; and a public/consumer member appointed by the National Commission.

“Being the 10th ADA-recognized specialty in 20 years validates to the public and the profession that organized dentistry is willing to challenge the status quo and explore new collaborative efforts with our counterparts in medicine and nursing,” said Dr. Tom. “We look forward to widely promulgating sedation and anesthesia awareness and education in all facets of oral health care, and as dentist anesthesiologists working alongside all other dental professionals, we hope to drive the profession forward cooperatively.”

The recognition comes nearly 175 years after a Hartford, Connecticut, dentist extracted one of his third molars to test the analgesic properties of nitrous oxide. It was Dr. Horace Well’s introduction of nitrous oxide, and the demonstration of anesthetic properties of ether by Dr. William Morton, a student of Dr. Wells’, that gave the gift of anesthesia to medicine and dentistry.

- ADA News
- Current Issue
- ADA News Archive
WREB Candidates Assessed with Fewer Patients in 2018!

WREB is committed to evaluating the competence of dental candidates with the fewest patients needed, without sacrificing validity, reliability, fidelity or fairness. In 2018, the Operative section of the WREB Dental Exam allowed candidates who demonstrated competence on their first completed Class II restoration the option to pass the Operative section, without the need to complete a second procedure. Candidates could still complete a second procedure if they chose to, e.g., if they planned to apply for licensure in a state that specifically requires two procedures. As a result, 42% fewer patient-based procedures were needed to evaluate candidates in 2018.

How did this option come about? Below are a few factors that support WREB’s decision to rely on fewer patient-based procedures on the Operative section.

- Years of examination data have confirmed that virtually all candidates that perform well on their first procedure, will perform well on their second procedure and either pass the section or score well enough to attain a result within the margin of error around the cutoff score (and so they are the most likely to pass upon retake).

- Past data provided evidence that there would be no difference in pass/fail outcomes for the Operative section with this change – in other words, that the exam would not be any less challenging. Outcomes for 2018 indicate no significant difference in the percentage of candidates passing the Operative section by the end of the season between this year and previous years.

- Past data has also provided evidence that candidates perform very similarly on composite and amalgam Class II restorations. Class III restorations are also very similar, but slightly less challenging on specific criteria, which is why a Class II restoration is required. If competence in performing a Class II restoration has already been determined by multiple independent, calibrated, anonymous examiners, requiring additional similar or less challenging procedures becomes an unnecessary burden for candidates.

Know Your Exam Requirements

The following pages contain a summary of the WREB requirements for each section of the exam. It is very important to note that state boards may have additional requirements. It is your responsibility to determine what those requirements are for the state in which you plan to seek licensure. Knowing these requirements in advance will help eliminate uncertainty so you can have a more organized, positive exam experience. When you are done with the exam you should be able to celebrate with confidence the completion of this important milestone!
REQUIRED SECTIONS

The Comprehensive Treatment Planning, Endodontic, and Operative sections are required to successfully complete the WREB Dental Exam.

Comprehensive Treatment Planning (CTP)

A three (3) hour computer-based exam using case materials provided by WREB. The exam is administered through Prometric Testing Centers. The exam consists of three (3) patient cases of varying complexity, one of which is a pediatric patient. For each case, Candidates assess patient history, photographs, radiographs, and clinical information, create and submit a treatment plan, and then answer questions related to each case.

Endodontics

A three (3) hour exam consisting of two (2) procedures:

- Anterior Tooth Procedure: Treat one maxillary anterior simulated tooth, including access, instrumentation, and obturation.
- Posterior Tooth Procedure: Access one mandibular first molar simulated tooth. Access on the posterior tooth must allow Grading Examiners to identify all canal orifices.
Operative

Up to two restorative procedures on patients to demonstrate competence.

A Class II restoration must be completed to pass the WREB Exam. The restoration can be one (1) of the following:
- Direct Posterior Class II Composite Restoration (MO, DO, or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO, or MOD)
- Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)

A second procedure, if required, may be any of the following:
- Direct Posterior Class II Composite Restoration (MO, DO, or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO, or MOD)
- Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)
- A Direct Anterior Class III Composite Restoration (ML, DL, MF, DF)

ELECTIVE SECTIONS

You may also elect to complete the following, if the state(s) to which you are applying for licensure requires them: Periodontal Treatment and Prosthodontics. Please note that results for all attempted sections, required or elective, will be reported to state boards.

Periodontal Treatment

Scaling and root planning on a patient with a minimum of eight (8) surfaces of readily demonstrable sub-gingival calculus.
**Prosthodontics**

A three and one-half (3.5) hour exam consisting of two (2) procedures on simulated teeth:

- Preparation of two abutments to support a posterior three-unit fixed partial denture prosthesis.
- Preparation of an anterior tooth for a full-coverage crown.

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**Onsite Retakes**

One of the exciting changes made in 2018 was the availability of onsite retakes in Endodontics, Periodontal Treatment, and Prosthodontics. In 2018, 85% of candidates who failed one of these sections took advantage of the onsite retake opportunity. This opportunity will continue to be available for 2019. Candidates who are unsuccessful on one of these sections may have the opportunity to complete a second attempt at no additional fee, time permitting. Detailed results for any completed sections will be posted to Candidate profiles on www.wreb.org at the end of each exam day. These results will allow you to make decisions about your procedures for the remaining exam days. For example, if you receive a failing result in Endodontics, Prosthodontics, or Periodontal Treatment, you may have the opportunity to retake the failed section at the same exam site. This option may or may not be available to you depending on your other scheduled sections and individual time constraints. Additionally, if you are found to have a validated critical error, or are dismissed from the exam, you will not be eligible for an onsite retake. Onsite retakes are not available for Operative. Additional details about critical errors and onsite retake eligibility will be available in the 2019 Dental Candidate Guide that will be posted at wreb.org in November.

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**Provisional Acceptance — Use it!**

The provisional acceptance process allows Candidates to have Operative patients radiographically accepted by Grading Examiners prior to the exam. 67% of Candidates at participating sites took advantage of provisional acceptance for one or both operative submissions. Of those who participated, 99% responding to a post exam survey said they would recommend the provisional acceptance process to future Candidates. Comments received were overwhelmingly positive:

“Best. Thing. Ever.”
“Great process!! Takes away a lot of stress.”
“YES!!! This was huge. I 100% would recommend using provisionally accepted patients.”
“This saved at least 20 minutes of time and anxiety on the testing date!”
Shorter patient lines, peace of mind, and time savings are all benefits of the process. Candidates at participating sites submitted their operative preparations almost 30 minutes earlier, on average, then at sites without provisional acceptance.

Some important reminders about the process:

✓ Candidates should be aware of the provisional acceptance window for their site and ensure submission during the window. Once the window closes, additional submissions are not allowed. A listing of participating sites and their windows can be found at www.wreb.org.
✓ Patients rejected during provisional acceptance can be resubmitted at the exam for the same diagnosis. If resubmitted at the site, these patients will go through the traditional acceptance process that requires two (2) Examiners to reject. They will therefore be subject to the rejection penalty if not accepted.
✓ If you use a different patient other than one that was provisionally accepted, there is no penalty for a new patient at the exam site. If you are submitting a new patient in the place of a provisionally accepted patient, please note this on the worksheet as instructed.
✓ Starting at 7:30 a.m., Floor Examiners will be available to review Patient Medical History forms and approve provisionally accepted patients who meet clinical acceptance criteria.

Additional details can be found in the 2019 Dental Candidate Guide which will be posted at www.wreb.org in November.

WREB Really Listens!

Getting ready to take the WREB dental competency exam is an exciting and somewhat stressful time in the life of a dental Candidate. One recent Candidate suggests: “Read the Candidate Guide several times. Exam day was unbelievably smooth and stress-free since I knew the scoring criteria, penalties, and form procedures.”

After each exam, Candidates and patients are asked to share their opinions by completing questionnaires. The anonymous responses are read and analyzed by the Chief Examiner and other designated WREB staff. Feedback from these questionnaires has provided valuable suggestions for future exams. Dr. Bruce Horn, Director of Dental Examinations, can attest to this, stating, "Many of the changes made to the exam, including the Candidate Orientation Presentation and open question session, are a direct result of Candidate input on the questionnaires." This is a great opportunity to gather information directly from those participating in the WREB dental exam.

WREB is constantly striving to provide helpful, accurate information to Candidates through our published materials. One publication that is by far the most recommended by Candidates who have taken the exam is the Dental Candidate Guide. When asked whether the Candidate Guide explained the exam procedures adequately, 97.5% of Candidates said yes. One Candidate said, "I thought the guide was concise and to the point. Reading over the guide several times provided ample preparation for the exam."

Another helpful tool is wreb.org! There are various new online Candidate Preparation Tutorials covering a variety of exam topics. Over 90% of exam takers said it was helpful. Be sure to check out the CTP Candidate Tutorial too! For helpful information closer to your exam date, don’t forget to attend Candidate Orientation. Nearly 96% of Candidates surveyed said that Candidate Orientation helped clarify exam procedures. One Candidate commented, "This was extremely helpful and also served to relieve stress because of how pleasant the examiners were." Meeting the Floor Examiners and Chief Examiner before your exam
not only allows you to ask questions not addressed in other materials, but allows you to get to know the people who will be helping you on the clinic floor. “This was particularly helpful in establishing a tone of success, and to build rapport with the floor examiners,” said one Candidate of Candidate Orientation. Most importantly, trust your skills and knowledge, and know that you have received a great education.

More helpful advice for future WREB exam takers from past WREB exam takers:

“Stay calm, even when something goes wrong. Don’t dwell on it, because there is still time to redeem yourself!”

“Get organized if you aren’t already and stay organized throughout the exam. It will save you a lot of time and prevent a lot of frustration!”

“The WREB exam is executed with great organization. There is so much stress in preparing and completing the exam, that any other stresses would be detrimental. WREB does a great job of having staff and examiners that are reasonable and calming, which helps with the whole process.”

“Be patient and calm. When there are questions always talk to the floor examiners they are very helpful.”

Watch the Dental Candidate Tutorials Online

Be sure to review the Candidate Preparation Tutorials online at www.wreb.org! These presentations provide valuable information about the various components of the dental exam. You are advised to first read through the Candidate Guide and then view the tutorials:

1. General Information & Exam Schedule
2. Clinical Exam Preparation
3. Provisional Acceptance
4. Orientation Day
5. Patient Acceptance
6. Operative
7. Modification Requests (+ video)
8. Endodontics
9. Periodontal Treatment
10. Prosthodontics (+ video)
11. End of Exam & Results

Pre-Candidate Orientation

As an additional aid to prepare Candidates, WREB makes available a representative to speak to Dental Candidates at their schools in the fall/winter prior to the clinical exam. The dates and times for these presentations will be posted on the website. Students will also be notified via email 4-6 weeks before the presentation. The presentation is highly recommended for both 4th and 3rd year students.
Examination Integrity
by Sharon Osborn Popp, Ph.D., Testing Specialist/Psychometrician

The line between appropriate and inappropriate test preparation practices seems to have gotten blurrier in recent years. The best test preparation approach is to have a strong command of the knowledge, skills, and abilities required to be successful on the examination and enter professional practice. Unfortunately, the pressures associated with high-stakes tests can lead some people to be tempted by short-cut preparation approaches that they may not even realize are unethical or unlawful, including memorizing or sharing confidential, unreleased test questions. Here a few reasons why you should avoid inappropriate test preparation practices:

Reason #1: Examination Outcome
If the examining agency obtains evidence that a Candidate may have engaged in unethical test preparation activity, it can invalidate that Candidate’s score and prohibit the Candidate from taking the examination again. All WREB Candidates must agree to not disclose test questions or other examination-related materials. Any evidence that suggests a violation of this agreement can lead to score invalidation.

Reason #2: The Profession
Evidence of unethical test preparation can lead to review by the licensing entity in the state(s) in which a Candidate hopes to practice. Professional licensing entities protect the public and the profession by determining that individuals are qualified and ready to enter practice. Unethical test preparation undermines the validity of the examination and the licensure process.

Reason #3: The Law
Sharing or using unreleased questions and asking others to share unreleased questions is against federal copyright law, which protects examinations and related intellectual property. If someone tries to sell or share “real” test questions with you, they have either obtained them illegally or they may not actually have “real” questions. If the questions are authentic, you risk becoming a party to criminal activity. If the questions are not authentic, you may be wasting time and money reviewing test preparation materials of dubious quality. If someone asks you to share information from an examination, you should not agree to reveal the specific content or context of confidential test questions.

You may share whether you felt the exam was challenging or not, whether you felt prepared or not, or how you felt about general topic areas from the exam.

Engaging in inappropriate test preparation can jeopardize your test results, your professional status, and your legal status. Test preparation that focuses on knowing the test content, not memorizing specific test questions, is always the best way to prepare.

Which Exam Should I Take?
Many graduating seniors struggle with this question because there are several board exams to choose from. Since the content of all the licensing exams offered is designed to test the competency of an entry-level practitioner, the actual administration of the exam can make the experience between exams quite different. WREB prides itself on candidate-friendliness, consistency in the Candidate experience from site to site, and providing an easily understood set of preparation materials for your success.
There are no "secrets" to successfully completing the WREB exam. If you carefully review printed materials, view the online tutorials, and attend the Candidate Orientation at the exam site, you will be well prepared to take the exam. Questions that arise about the examination prior to your examination date can be answered by courteous and professional dental staff at the WREB office. If you find yourself with questions or concerns at the exam, you will be able to work with an experienced Floor Examiner. They are very approachable, patient, and specifically trained to attend to Candidate concerns and unforeseen problems that may occur. Clinical examinations can be stressful. Floor Examiners can make this experience less daunting. They are assigned to your exam site specifically to help you answer any questions or resolve any unusual circumstances which may arise with a procedure or a patient.

In addition, and perhaps most importantly, the WREB exam is organized somewhat differently than other exams. Essentially, you have 2½ days to complete your WREB examination. Except for an assigned time to complete your endodontic and optional prosthodontic section, the remainder of the examination is yours to manage as you deem appropriate. This leaves ample time available for you to schedule and complete an elective periodontal and up to two operative procedures at your discretion. Clinical procedures can be scheduled in a sequence that best suits you and your patient’s availability. There are no narrow treatment times for patient treatment. Two clinical days are provided by WREB to give you the advantage of sufficient stress-free flexibility to manage any unforeseen circumstances that you will certainly encounter in your practice. These include delayed patient commitments for their appointments and extended treatment time required with procedures. WREB understands that, like the actual practice of dentistry, exams don’t always go according to plan.

Consider these important points when you make your decision. It’s the little things that often make the biggest differences.

Let Someone Else Choose Your Patient?

Not only is finding a patient the most important part of your exam, it can also be the most frustrating. Patient selection is one of the most troubling aspects of any clinical examination. Start reviewing your patient needs early, making sure you have diagnostically clear radiographs that accurately detail the lesions you plan on submitting for treatment. Lesions should be to and/or through the DEJ. Do not submit if you have a question. Remember, if you would not normally diagnose this lesion for treatment, you should not submit it for the examination.

WREB has heard over and over from Candidates who were unsuccessful comments like, "But my instructor checked my patient and said he was perfect!" or, "I paid big bucks for this patient and they guaranteed she would qualify" or, "My father is a dentist and he said this was a great patient."

This may be perhaps just a lapse in self-confidence or not being prepared in time. The Candidate Guide clearly states the criteria for patient acceptance. Often, those you consult do not have this information or have only a cursory understanding of it. Regardless of outside reassurances, you will be the one to suffer the consequences if your patient does not qualify.
One related issue is the presence of patient procurement agencies. These hire-for-profit organizations claim to have patients pre-screened and acceptable for board exams. They hawk their wares at exam sites for those who are frantically searching for a patient. They may imply that they have a relationship with WREB or special knowledge of WREB requirements. They do not. WREB does not endorse these companies, nor does it want them on the premises during any of our board exams. They will charge you a premium price for a patient who may not even be acceptable. They don’t issue refunds. Each year there are Candidates who encounter serious issues with “procured” patients who make unreasonable financial or other demands. WREB criteria are designed so that students should be able to use patients of record that they would see in a normal treatment sequence. It is generally not necessary to search outside your own patient pool. If you are taking an exam in another city, it may be necessary to obtain an outside patient. If so, Candidates have been finding patients through friends, school clinics, homeless shelters, and occasionally, an employee at a school! Work in groups to secure patients - it may be the answer to providing secondary patients, if needed.

The key is that you are the one to screen the patient after thoroughly studying the WREB Dental Candidate Guide. You are the best person to choose the best patient. Do not relinquish your clinical judgment to someone who has no stake in passing the exam. It is your future, so make these critical decisions for yourself.

Prometric Enforces Security

Prometric enforces stringent inspections of questionable items and accessories, such as eyeglasses and jewelry. This preventative measure seeks to eliminate the potential for devices that could capture exam content in compromising the integrity of the examination. Candidates are encouraged to leave any questionable items at home or in a secure locker onsite to avoid entry delays or risk forfeiture of their WREB Comprehensive Treatment Planning examination attempt. The following items will be inspected more thoroughly prior to admission and re-entry into the secure testing area:

<table>
<thead>
<tr>
<th>Items subject to close visual inspection:</th>
<th>Items to LEAVE at Home or in Locker provided:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Eyeglasses (removed for inspection)</td>
<td>• Sunglasses</td>
</tr>
<tr>
<td>• Wedding and engagement rings</td>
<td>• Ornate hair accessories (i.e. clips, combs, barrettes, headbands)</td>
</tr>
<tr>
<td>• Earrings</td>
<td>• Watch or wearable technology</td>
</tr>
<tr>
<td>• Facial piercing jewelry (i.e. labret studs)</td>
<td>• Cell phone</td>
</tr>
<tr>
<td>• Hair accessories (i.e. clips, barrettes)</td>
<td></td>
</tr>
</tbody>
</table>

If a candidate is caught with a camera or other capture device in their possession...
- Prior to entering the testing room, the item will be confiscated and the test attempt forfeited.
- While in the testing room, the item will be confiscated and the exam terminated.

Prometric strives to provide all test takers the “opportunity to demonstrate their knowledge, skills, and abilities” by ensuring “a fair and professional testing environment.” Refer to the Testing Center Regulations page of the Frequently Asked Questions section of the Prometric website for more information.
ASK THE EXAMINER...Most Frequently Asked Questions!

Q. May I use a foreign trained dentist as my dental assistant?
   A. Operative assistants may not be dentists (including graduates of foreign dental schools) or be in their final year of dental school. For purposes of the exam, WREB considers the final year of dental school as beginning on September 1. Operative assistants may be dental assistants or dental hygienists, if they do not hold a permit to place and finish restorative materials.

Q. What is the minimum age a patient can be? If my patient is under 18, does the parent or guardian need to stay during the procedure?
   A. The minimum patient age for the periodontal treatment procedure is 18 years. There is no minimum age for operative procedures. A parent or guardian does not have to remain during the procedure.

Q. When are my assistant and my patient allowed on the clinic floor to start the exam? When can I put my patient in line for acceptance or grading?
   A. Assistants and patients may enter the clinic with you at 7:00 am on clinic days 1, 2 and 3. For patient comfort, patients should not be sent to the grading area any earlier than 15 or 20 minutes before the exam begins. The exam officially begins at 8:00 am. The patient line will not move until the exam begins.

Q. Do I have to have my patient in line for grading by 10:30 am on the last day of the exam?
   A. You have until 11:00 am to have your patient in line for grading on the last day. The first two days of the exam, your patient must be in line for grading by 4:00 pm.

Q. Are translators allowed on the clinic floor?
   A. Translators will be allowed on the clinic floor or in the grading area only as needed. Translators will be asked to remain in the patient waiting area and will be called if their services are required.

Q. What are Floor Examiners?
   A. Floor Examiners assist Candidates on the clinic floor:
      • Answer questions, clarify exam procedures
      • Act as liaisons between Candidates and Grading Examiners
      • Have extra forms for Candidates such as Patient Medical History and Follow-Up Care Agreements
      • Sign Patient Medical History forms
      • Distribute forms from Examiners that affect Candidates and procedures
      • Check on modifications (see Operative-Modification Procedure)
      • Manage pulp exposures
      • Check and initial steps in the processes involved on worksheets

Q. May I anesthetize my patient before I send him/her to the grading area for approval to start?
   A. The administration of local anesthetic may not occur prior to 7:30 am each clinic day and AFTER the patient’s medical history has been reviewed by a Floor Examiner. For periodontal treatment patients, you should anesthetize the quadrant(s) submitted for approval to facilitate Examiner evaluation and for comfort. For operative patient check-in for acceptance, you may anesthetize patients at your discretion.

Q. May I submit two operative restorations for approval at the same time?
   A. If the procedures are on the same patient but not on adjacent teeth they may be submitted for approval at the same time. You may not submit patients with adjacent (consecutive tooth numbers) for acceptance.

Q. If I have both operative restorations approved to start, do I have to do both preps that day?
   A. You may do only one preparation if you choose. For the procedure that has been approved but not started, bring your worksheet to a Floor Examiner for the proper paperwork.
Q. Do I have to work with a rubber dam?
   A. You do not have to work with a rubber dam, but a rubber dam is required when submitting a patient for the preparation grade or when requesting a modification request for your patient on the Candidate clinic floor.

Q. When do I call a Floor Examiner to check for a modification of outline or internal form?
   A. When removal of caries, affected dentin, unsound demineralized enamel, or remaining restorative material will extend the outline and/or internal form of the preparation beyond the criteria for a “5”.

Q. How do I write a modification request?
   A. Write the type, location, extent, and reason (i.e., caries, affected dentin, unsound demineralized enamel, or remaining restorative material) for the “Modification Request(s)” in the spaces provided on the procedure worksheet. The space on the worksheet is limited; therefore, you are encouraged to write the total extent required to remove the lesion on your initial modification request(s) in 0.5 mm increments (i.e., 0.5 mm, 1.0 mm, 1.5 mm). A Floor Examiner will be available to answer any questions you may have.

Q. When do I need original radiographs? And, when do I not?
   A. The Operative procedures require original radiographs of the tooth taken within the prior six months. The radiographs must show the current condition of the tooth. Duplicates are not acceptable. Separate radiographs or images are needed for each procedure. The Periodontal Treatment procedure requires complete mouth periapical radiographs, including bitewings. The radiographs must have been taken within the past three years. Original radiographs are preferred, but duplicates are acceptable if they are of diagnostic quality.

Q. If WREB considers all exposures avoidable, how do I deal with an exposure or near exposure?
   A. The preferred procedure is to leave a small amount of caries or affected dentin (0.5 mm) over the pulp to avoid an exposure. Write in the “Note to Examiners” on the worksheet your intentions. All other caries in the preparation must be removed. If an exposure does occur, write in the “Note to Examiners” on the worksheet your intentions regarding the exposure and how it will be managed, place a rubber dam (if not already in place) and call a Floor Examiner. Upon verification of the exposure, a Floor Examiner will instruct you to place a pulp capping material over the exposure as soon as possible.

Q. Can my Assistant dismiss my patient while I’m in the Endodontics or Prosthodontics exam?
   A. Yes, if there is no follow up required when your patient returns from the grading area. Remember, a Floor Examiner’s initials are required on worksheets for patient release from the exam.

Q. How many initials from Examiners do I need on my worksheet?
   A. It depends on what portion of the restoration you are doing. One initial is required at Acceptance, at least two initials if you have sent a note with a modification procedure and three initials are required if you have sent a patient for grading.

Q. When do I take the Comprehensive Treatment Planning (CTP) computerized exam?
   A. The CTP computerized exam can be taken at a Prometric Testing Center. Once you are enrolled in an exam, information will be emailed to you. This will include the time frame to take the exam, Prometrics contact information to schedule your appointment, and your eligibility number.

Q. When do I have to go to the Simulation lab to do my Endodontics/Prosthodontics section?
   A. All Candidates will be assigned a specific time block for the Endodontics exam and a separate time block for the Prosthodontics exam. Your specific schedule will be posted to your wreb.org Candidate profile about four weeks prior to the exam. You may go to the simulation lab any time during your assigned block for each exam, however, it is recommended you be in the lab in the first 30 minutes to avoid any delay getting your “Setup Check.” Candidates arriving later will be admitted, but will not receive time extensions. You must turn in all required materials at the end of the time block or you will receive a late penalty. There are no exceptions.
Q. Can I change my assigned time for the Endodontics or Prosthodontics section?
   A. Schedules are posted about four weeks before the clinical exam. Once schedules are posted, they cannot be changed. Schedules are arranged in advance and in the best interest of all Candidates, taking into consideration space availability, supplies, and exam materials. Schedules are made to give Candidates the optimum open block time and to maintain patient flow in the grading area.

Q. What identification do I need to provide at the exam?
   A. Candidates MUST present acceptable and valid identification to be admitted to the WREB dental exam. At the exam, you shall appear in person and provide two (2) valid, non-expired forms of identification to receive your exam packet with materials.

Q. My patient was provisionally accepted for my operative procedure. Can I begin treatment at 8:00 am?
   A. Yes, if ALL the following have been completed:
      1) the patient’s medical history has been reviewed and initialed by a Floor Examiner
      2) your provisionally accepted patient has been clinically examined by a Floor Examiner for acceptance criteria (starting a preparation without Floor Examiner approval results in failure of the operative section)
      3) the operative worksheet has been initialed for acceptance by the Floor Examiner

“What happens after I take my exam and how do I get my scores?” is a question that most Candidates have after taking the WREB dental exam.

Onsite Provisional Results

Provisional results will be posted at the end of each exam day, usually in the evening. You will not receive an email notification when results are posted for onsite results – you will need to check your profile at wreb.org periodically for the information. It is important that you save your login and password as they are needed to access your results. Staff at the exam site will not have that information available for you. Detailed results for any completed sections will be posted to Candidate profiles online. These results will allow you to make decisions for the remaining exam days. i.e. Whether you need to complete a second Operative procedure, or attempt a retake in Prosth, Endo, or Perio.

After the Exam - Final Exam Results

Once the exam is over and exam materials are received at the WREB office, (usually two days following the last clinic day), WREB staff reviews exam information and double-checks all scores. Various measures are taken to ensure scores are thoroughly verified and accurately reported. Like provisional results, final results are also posted to your profile at wreb.org. Results will be posted from one to three weeks after an exam. These final exam results will be reported to state boards for all sections attempted, including elective procedures.
FAQs about Score Requests

How do I get my scores after the exam?
Candidates are sent an email from WREB to the Candidate profile email address provided at the time of application. It is important to notify WREB of any email, address or name change update. The email will provide notification to log into their profile to review their results.

What does my state board want me to send them?
This is a question for the state board where you plan to apply for licensure. Since every state board has their own set of criteria, it is best for you to check with them before ordering scores from WREB.

How do I request that my scores be sent to a state board?
We suggest that prior to ordering a report, that you contact the State Board(s) to determine what type of report they require. Using Google Chrome as your browser – navigate to wreb.org (home page) and click on the “Request Your Exam Score” button in the middle of the page. Complete the information requested. Fill in the information where you would like the score report sent. You may request the report be sent directly to you or to a state board. WREB does not track mailings; therefore, if you want assurance the report is received, have the report sent to you first. You can put the sealed WREB score report envelope in a USPS Priority envelope to track the delivery.

How much does it cost to get a copy of my scores?
Prices for reports vary.

What forms of payment do you accept for score requests?
WREB accepts Visa or Master Card credit and debit cards. Requests must be ordered online.

What is an Individual Performance Report?
The Individual Performance Report is the most detailed information we can provide. Individual Performance Reports prior to 2004 are in letter form, providing a breakdown of scores received in each section of your exam. Beginning 2004, the Individual Performance Report breaks down the score received for each procedure, in each section of the exam. Unsuccessful Candidates automatically receive this report with their results. Individual Performance Reports are in hardcopy and have a WREB raised seal.

How long does it take to process my request for scores?
Once our office receives your request, it is date stamped and processed in the order it was received. There is no faster expedited method to speed up the process, other than expedited shipping. The turn-around time for requests can be up to ten (10) days depending on the volume of the requests received. Once your request has been processed, it is sent to the destination you specify by USPS or expedited shipping, if requested.
The WREB Dental Department
It’s always helpful to put a face to a name. When you receive correspondence from WREB, there’s a real person behind it. Denise Diaz oversees all dental exam operations, assisted by Edna Reyes. Exams are assigned to one of the dental coordinators (Hollie, Evonne, Sue and Cheri) who expertly prepare all exam materials and correspond with Schools, Examiners, and Candidates.
October 4, 2018

Dear CITA Family,

I wanted to update you on a recent development in CITA. I am excited to say that SRTA has decided to join with CITA. We are in the initial phase of this union but I wanted to share this news with my CITA Family. CITA and SRTA have agreed to administer the 2019 examination cycle under the CITA/ADEX name. SRTA will continue to administer their exam until all existing students that need to complete all components of the SRTA exam to receive their SRTA certification. In 2020, SRTA and CITA will become one organization to administer the ADEX Exam. The schools we currently share are grateful for this merger because now they will only have to host one testing agency.

I am excited about the union of these two organizations because we will have some of the most experienced and knowledgeable examiners here at CITA. Most of the SRTA Examiners are already signing up with CITA to help administer the CITA/ADEX exam next year. I hope we will welcome all of these new examiners into our family and help them to become a part of CITA.

Thank you for your time, support and friendships you have all brought to the CITA family and I cannot wait to see what new changes and exciting times are ahead.

Sincerely,

Dr. “Buddy” Wester
LICENSE
RATIFICATION
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**

H7795  BRENDA ANDREW LAING, R.D.H.  2/21/2019  
H7796  KRISTENE HEINTZMAN, R.D.H.  2/21/2019  
H7797  LINDSEY KATE THOMPSON, R.D.H.  2/25/2019  
H7798  YEKATERINA DEGTYAREVA, R.D.H.  2/25/2019  
H7799  AUDREY BARRETT, R.D.H.  3/1/2019  
H7800  KAYLIE ANN KONING, R.D.H.  3/14/2019  
H7801  SARAH ELIZABETH MARIE BOOTHE, R.D.H.  3/14/2019  
H7803  STACEY LYNN MCDANIELS, R.D.H.  4/3/2019  

**DENTISTS**

D11000  NIDHI TANEJA, D.D.S.  2/8/2019  
D11001  ERIC L ELTZROTH, D.D.S.  2/8/2019  
D11002  JAMES A BURNESON, D.D.S.  2/21/2019  
D11003  JOSHUA MATTHEW SMITH, D.D.S.  2/21/2019  
D11004  MINH PHAN, D.M.D.  2/21/2019  
D11005  DANIEL JORDAN DECILLIS, D.D.S.  3/1/2019  
D11006  SAMI BAHIJ KAWAS, D.D.S.  3/1/2019  
D11007  NOELLE M GEORGE, D.M.D.  3/1/2019  
D11008  KARIN HERZOG, D.D.S.  3/1/2019  
D11009  JEFFERSON B GOURLEY, D.D.S.  3/1/2019  
D11010  BRAD N STRONG, D.D.S.  3/1/2019  
D11011  LYUDMYLA ALDER, D.M.D.  3/1/2019  
D11012  SCOTT ROBERT YEAMAN, D.D.S.  3/1/2019  
D11013  CRAIG DAVID KOZELUH, D.D.S.  3/14/2019  
D11014  DEAN ROY GRETZINGER, D.D.S.  3/14/2019  
D11015  THERESE NGOC PHAM, D.M.D.  3/14/2019  
D11016  TARIM S SONG, D.D.S.  3/18/2019  
D11017  MONIKA CZEKALSKA, D.D.S.  3/18/2019  
D11018  CHRISTIAN ANTON BADER, D.D.S.  3/19/2019  
D11019  MINDY CHEN KNOX, D.D.S.  3/22/2019  
D11020  INDERRAJ DHILLON, D.D.S.  4/3/2019  
D11021  MONTE CURTIS JUNKER, D.D.S.  4/3/2019  
D11022  ANNA MARIE L MESSENGER, D.D.S.  4/3/2019  
D11023  JACOB DEAN HUTCHINGS, D.M.D.  4/3/2019
LICENSE, PERMIT & CERTIFICATION
Nothing to report under this tab