PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
FEBRUARY 25, 2022

Oregon
Kate Brown, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM**

DATE: **February 25, 2022**

TIME: **8:00 a.m. – 1:30 p.m.**

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

OPEN SESSION (Via Zoom)
https://us02web.zoom.us/j/88592662509?pwd=Y1NTeEswMzY5bm9hMjUwWnRsWWYyZz09
Dial-In Phone #: 1-253-215-8782 • Meeting ID: 885 9266 2509 • Passcode: 892025

Review Agenda

1. Approval of Minutes
   - December 17, 2021 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - Dental Therapy Rules Oversight Committee Meeting #4 held 1.19.2022 Chair Martinez, RDH
   - Dental Therapy Rules Oversight Committee Meeting #5 scheduled for 2.23.2022
   - American Board of Dental Examiners Letter
   - Call for Nominations for ADA CCEPR Board of Commissioners
   - CDCA-WREB News

4. Executive Director's Report
   - Board Member and Staff Updates
   - OBD Budget Status Report
   - Customer Service Survey
   - Board and Staff Speaking Engagements
   - 2022 Dental License Renewal
   - Licensee Statistics
   - OBD Strategic Planning
   - 2022 Legislative Session
   - Affirmative Action Representatives Meeting
   - Council of State Governments - Dental Compact Dec 2021 Meetings
   - AADA & AADB 2022 Mid-Year Meetings
   - Newsletter

5. Unfinished Business and Rules
   - Recommendation from Dental Therapy Rules Oversight Committee – OAR 818-026-0080

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

6. Correspondence
   - American Board of Oral Medicine – request for specialty exam review/approval

7. Other Items & Open Public Comment
   - OBD 2022- 2025 Strategic Plan final review and ratification
   - Invitation from the OBD to the Tribal Communities to address dental therapy rules and other important issues
   - Memo - Compliance with SB 770 (2001), ORS 182.164 & ORS 182.166
     - OBD Draft Policy for discussion and approval
   - DPP #300 Meeting Materials
   - Minnesota Dental Therapy Toolkit
   - Open Comment Period – Anyone is welcome to address the Board

8. Articles & Newsletters (No Action Necessary)
   - NPDT Press Release – Model Dental Therapist Rule & Best Practices Guide
     - Model Dental Therapist Rule – National Model Dental Therapy Rule Panel
   - OHSU names Dean of Dental School
   - 2021 CODA Annual Report

EXECUTIVE SESSION **10:00 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.345(4); 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 – Break 30 minutes **12:00 p.m.**

OPEN SESSION (Via Zoom) **12:30 p.m.**

https://us02web.zoom.us/j/88592662509?pwd=Y1NTeEswMzY5bm9hMjUwWnRsWWYyZz09

Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 885 9266 2509 ● Passcode: 892025

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Request for Approval of Soft Relines Course – Lindsay Chronicle
    - Request for Approval of Soft Relines Course – Trina Lepper

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

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

APPROVAL OF MINUTES

DRAFT 1
OREGON BOARD OF DENTISTRY
MINUTES
DECEMBER 17, 2021

MEMBERS PRESENT:	Alicia Riedman, R.D.H., President Jose Javier, D.D.S., Vice President Reza Sharifi, D.M.D. Jennifer Brixey Sheena Kansal, D.D.S. Yadira Martinez, R.D.H. Chip Dunn Aarati Kalluri, D.D.S.
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop "Bernie" Carter, D.D.S., Dental Director/ Chief Investigator Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager (portion of meeting) Shane Rubio, Investigator (portion of meeting) Ingrid Nye, Investigator (portion of the meeting) Kathleen McNeal, Office Specialist (portion of meeting)
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT VIA TELECONFERENCE*:	Jen Lewis-Goff, Oregon Dental Association (ODA); Lisa Rowley, R.D.H., Oregon Dental Hygienists' Association (ODHA); Mary Harrison, Oregon Dental Assistants Association (ODAA)Jen Coyle, Peak Fleet Facilitator; Theresa Trelstad, Peak Fleet Facilitator; Pam Johnson, Northwest Portland Area Indian Health Board

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

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

President Alicia Riedman, R.D.H., welcomed everyone to the meeting and had the Board Members, Lori Lindley, and Stephen Prisby introduce themselves.

NEW BUSINESS

Approval of Minutes

Dr. Javier moved and Dr. Sharifi seconded that the Board approve the minutes from the October 22, 2021 Board Meeting as presented. The motion passed unanimously.

Ms. Martinez moved and Dr. Sharifi seconded that the Board approve the minutes from the October 23, 2021 Board Strategic Planning Session Meeting as presented. The motion passed

unanimously.

Dr. Javier moved and Dr. Sharifi seconded that the Board approve the minutes from the November 5, 2021 Special Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Lewis-Goff reported that the ODA's April conference will be a hybrid schedule. All required courses, aside from CPR, will be offered virtually. The ODA has been working with their partners on the dental assistant shortage. The ODA is pleased to see the releasing of $19 million for Medicaid Dental Plans.

Oregon Dental Hygienists' Association (ODHA)

Lisa Rowley submitted a written report ythat was included in the board meeting packet. Ms. Rowley congratulated Ms. Riedman on receiving the Lynn Ironside Access to Care award. President Alicia Riedman congratulated Ms. Rowley on receiving the Lois Whitford Outstanding Dental Hygienist Award.

Oregon Dental Assistants Association (ODAA)

Mary Harrison reported that the ODAA has been working with the ODA and OHA on the dental assistant shortage. At the ODAA planning session a decision was passed to make a professional video on four handed dentistry to share with any interested party, to help explain dental assisting. There will be a panel discussion on this issue at the 2022 Oregon Dental Conference.

COMMITTEE AND LIAISON REPORTS

CDCA-WREB Liaison Report

The annual CDCA WREB meeting will be taking place in January.

AADB Liaison Report

Ms. Riedman reported that much information was presented at the AADB meeting which was presented in the OBD latest newsletter. Ms. Lindley did an amazing update and answered many questions on measure 110 and Dental Therapy. Ms. Lindley offered copies of the presentation to anyone interested. Dr. Javier also attended and found the presentations on the new laws interesting. Mr. Prisby attended the AADB and AADA meetings and offers a report below.

ADEX Liaison Report

Ms. Riedman invited any Board Member interested in becoming an ADEX liaison to check with Mr. Prisby.

Dental Therapy Rules Oversight Committee Meeting

Ms. Martinez reported that the committee's third meeting was held on December 8, 2021. The fourth meeting is planned for January 19, 2022.

EXECUTIVE DIRECTOR'S REPORT

Board and Staff Updates

Mr. Prisby welcomed the newest staff member, Kathleen McNeal as the OBD's new Office Specialist. A University of Oregon graduate, with a BA in Asian Studies. She spent many years traveling and working in the travel industry before joining our team. She lives in Milwaukie with her partner Jason and a very large dog and very small cat. She enjoys gardening, rock hunting, reading and time with friends and family.

Mr. Prisby discussed filling the three board positions which will be open in spring of 2022 as Dr. Gary Underhill, Dr. Amy B. Fine and Yadira Martinez, RDH will have completed two terms of service on the OBD. A Board Member interest document was attached and was posted on the OBD Website to encourage and facilitate applications for board service.

OBD Budget Status Report

The latest budget report for the 2021 - 2023 Biennium was presented. This report, which is from July 1, 2021 through, October 31, 2021 shows revenue of $816,655.42 and expenditures of $539,344.79.

Customer Service Survey

The customer service surveys received from July 1, 2021 – November 30, 2021 were presented. A majority of respondents rated their experience with OBD positively.

Board and Staff Speaking Engagements

OBD President Alicia Riedman shared a brief overview of OBD activities at the Oregon Dental Hygienists' Association Annual Conference. It was held in Tigard, on November 12 -13, 2021. She was awarded the prestigious Lynn Ironside Access to Care Award at the conference.

Ingrid Nye gave a license application presentation via Zoom to the Portland Community College Dental Hygiene students on Monday, November 29, 2021.

Dental Hygiene License Renewal – Revised Data

The renewal period started on July 26th and ended September 30th. We had some revisions to previously reported data to report as final documents were updated and received.

Dental Hygienists sent renewal notices in 2021: 2163
Renewed: ~~1884~~ **revised 1888**
Retired: ~~39~~ **revised 50**
Expired: ~~238~~ **revised 223**
Resigned: 0 no change
Deceased: 2 no change

OBD Strategic Planning

The OBD held its strategic planning sessions October 22 & 23, 2021 to develop its next strategic plan. The Peak Fleet facilitators provided the Board an overview of the draft plan with

discussion at this meeting. The Board will review and approve a final draft of the strategic plan at the February 25, 2022 Board Meeting.

AADA Annual Meeting

The American Association of Dental Administrators' (AADA) annual meeting was held on October 29, 2021 as a virtual meeting. Lori Lindley presented and led the Board Attorneys' Roundtable discussion and presentation. We adapted to the virtual setting and it was an efficient meeting. Mr. Prisby was elected President of the AADA. The other AADA Officers are from Washington State, Minnesota, North Dakota and Mississippi.The AADA Mid Year Meeting date will be either April 8 or 9, 2022 in Chicago. Mr. Prisby asked that the Board approve his travel to Chicago to lead and attend this meeting and to attend the AADB Meeting which will be April 9 - 10, 2022 as well.

Dr. Javier moved and Ms. Martinez seconded that the Board approve Mr. Prisby traveling to Chicago for the meeting. The motion passed unanimously.

AADB Annual Meeting

The American Association of Dental Boards' (AADB) annual meeting was held October 30 - 31, 2021 as a virtual meeting. President Riedman, Dr. Javier and I attended. Lori Lindley presented and led the Board Attorneys' Roundtable discussion and presentation.

Pew Dental Therapy Model Rules Project

Mr. Prisby volunteered to participate and share his experience on the topic of dental therapy rulemaking. A preliminary slide deck was released to share the group's work on this project.

OBD December 2021 Newsletter

The latest newsletter was presented with a thank you to all that contributed and especially to the OBD's graphic artist, Samantha VandeBerg, who assembled the newsletter. Alicia Riedman also lent her editorial skills once again. The newsletter has been posted distributed on the OBD website.

UNFINISHED BUSINESS AND RULES

OBD Strategic Planning follow up was addressed by facilitators Jen Coyle and Theresa Trelstad recapped the process and introduces the draft of the Strategic Plan for 2022-2025. Ratification is slated for the February 25, 2022 Board Meeting.

Rule Changes effective January 1 and July 1, 2022 were presented.

Requirements for the instructor applications for Radiation Proficiency for Dental Assistants were discussed.
Ms. Martinez moved and Mr. Dunn seconded that the Board move this discussion to the Licensing Standards and Competency committee. The motion passed unanimously.

No board members were available for a site visit to Pacific University. Mr. Prisby reported this to CODA.

All of the 9 Federally Recognized Tribes were invited to review and comment on the OBD draft Tribal Relationship & Cooperation Policy. Ms. Brixey requested that Urban Indian Health Programs be added to the tribal groups identified on the draft. Pam Johnson addressed the issue and the Board and said additional information would be submitted for consideration, Mr. Prisby will bring a revised draft policy back to the Board at the February Board meeting for discussion.

The OHA Public Health Division, Oral Health Program Sealant Program Rule Changes were discussed.

Articles & Newsletters (No Action Necessary)

- HPSP October 2021 Newsletter
- PCC Need for Dental Instructors
- OAGD Staffing Update

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

OPEN SESSION: The Board returned to Open Session at 12:00 p.m.

CONSENT AGENDA

2022-0040, 2022-0051, 2022-0037, 2022-0036, 2022-0041, 2022-0039
Dr. Javier moved and Mr. Dunn seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

COMPLETED CASES

2022-0027, 2022-0007, 2021-0172, 2022-0020, 2022-0013, 2022-0043, 2022-0019, 2022-0011, 2021-0165, 2021-0134
Dr. Javier moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

BEDNARIK, WENDY, R.D.H. 2022-0035
Ms. Martinez moved and Mr. Dunn seconded that the Board move to order an issue of Notice of Proposed Disciplinary Action and offer License a Consent Order incorporating a reprimand and a $250.00 civil penalty. The motion passed unanimously.

2022-0009
Mr. Dunn moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he (1) refer patients who are exhibiting post-surgical paresthesia from implant placement surgery to OMS in a timely manner, (2) documents his implant removal techniques, and (3) he continues to learn and evolve to increase his knowledge and skills to provide acceptable implant surgery procedures for his patients throughout his professional career. The motion passed unanimously.

2021-0186
Ms. Brixey moved and Ms. Martinez seconded that for Respondent #1**:** In reference to case #2021-0186 move to close the matter with a Letter of Concern reminding licensee to assure that he (1) document informed refusal of treatment options, and (2) complete all required CE during license renewal cycles. Respondent #2: In reference to case #2021-0186 move to close the matter with a Letter of Concern reminding licensee to assure that he (1) document interpretation and diagnosis of all radiographic images, and (2) document weekly biological monitoring. The motion passed unanimously.

LARSON, JUDD, D.D.S 2021-0125
Dr. Sharifi moved and Dr. Javier seconded that the Board move to issue an Order of Dismissal, dismissing the Interim Consent Order and issuing a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order to incorporate a reprimand, a $2,000.00 civil penalty, ten hours of Board approved continuing education in proper sedation practice, a six-month sedation restriction where Licensee agrees to only use Nitrous Oxide. Moderate enteral sedation permit will be reinstated after six months. The licensee agrees that after six months he will be prohibited from providing any therapeutic injectable agents submucosal, intramuscular, intranasal, intravenous, with the exception of providing emergency medical treatment. The motion passed unanimously.

2022-0005
Dr. Kalluri moved and Mr. Dunn seconded that the Board move to close the matter with a Letter of Concern reminding licensee to assure his written emergency response protocols include communication and delegation of assigned duties during medical emergencies. The motion passed unanimously.

2021-0034
Dr. Kansal moved and Ms. Martinez seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure that caries risk assessments are accurately documented and recorded. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

HEHN, CRAIG, D.M.D. 2022-0045
Ms. Martinez moved and Mr. Dunn seconded that the Board move to issue an Order of Dismissal, Dismissing Licensees Order of Immediate Dental License Suspension and offer Licensee a Consent Order incorporating a reprimand, an agreement to resign his State of Oregon Dental License effective immediately and agree to never reapply for a State of Oregon Dental License. The motion passed unanimously.

2021-0098
Mr. Dunn moved and Dr. Javier seconded that the Board move to issue an Order of Dismissal, Dismissing the Notice of Proposed Disciplinary Action and closing the matter with a Letter of Concern reminding Licensee to assure that he does not make any agreement with a patient to

restrict or prohibit the person's ability to file a complaint with the Board. The motion passed unanimously.

2018-0235
Ms. Brixey moved and Ms. Martinez seconded that the Board move to accept Licensee's request and release her from HPSP. The motion passed unanimously.

ZHU, LIN D.D.S. 2021-0086
Dr. Sharifi moved and Dr. Javier seconded that the Board move to accept Licensees proposal and issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $5,000.00 civil penalty to be paid within sixty days, completion of four hours of Board approved continuing education related to sedation within 60 days, completion of three hours of Board approved continuing education related to pharmacology within 60 days, and completion of three hours of Board approved continuing education related to record keeping within 60 days. The motion passed unanimously.

Compliance Audit Project
Ms. Riedman moved and Dr. Javier seconded that the Board approve the compliance audit project to audit licensees after renewal. The motion passed unanimously.

2021-0097
Dr. Kalluri moved and Ms. Martinez seconded that the Board move to release summary the requester. The motion passed unanimously.

RATIFICATION OF LICENSES

Dr. Kansal moved and Ms. Martinez seconded that the Board ratify the licenses presented. The motion passed unanimously.

ADJOURNMENT

The meeting was adjourned at 12:12 p.m. Ms. Riedman stated that the next Board Meeting would take place on February 25, 2022.

_____
Alicia Riedman, R.D.H.
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

William Pappas, D.D.S., President
Jeffery Hartsog, D.M.D., Vice-President
Conrad McVea, III, D.D.S., Secretary
Renee McCoy-Collins, D.D.S., Treasurer
Bruce Barrette, D.D.S., Past President

December 29, 2021

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

Dear Members of the Oregon Board of Dentistry:

Having just completed our 2021 Annual Meeting on August 7th, I wanted to update you regarding the appointments from your Board to the American Board of Dental Examiners, Inc, (ADEX).

ADEX House of Representative Member---Oregon
Dr. Hai Pham DMD – 2018-2021

ADEX Dental Exam Committee Member--- Oregon
Dr. Hai Pham DMD-- 2018 to 2021

ADEX Dental Exam Committee Educator—Oregon
Needing appointment

As Dr. Hai Pham is the Member Board representative for the Oregon Board of Dentistry, he retains his position if you so desire or you may identify another appointment to the above position.

If you would like to retain your representatives, you may, and no further action is needed by you at this time. I will update terms as noted accordingly to complete then in 2024 unless changed sooner by notice from your Board; or again retained at your discretion. For your convenience, please send a letter or other notification via e-mail to office@adexexams.org should you wish to make any revisions in the future.

If you have any questions, please feel free to contact me at the e-mail address above or call me at 503-724-1104.

Sincerely,

Kathy Kelly
ADEX Executive Director

cc: Hai Pahm DMD; ADEXHOR; State Member, District 2
Stephen Prisby: Executive Director

From: Borysewicz, Mary A. <borysewiczm@ada.org>
Sent: Friday, January 14, 2022 10:38 AM
To: Borysewicz, Mary A. <borysewiczm@ada.org>
Subject: Call for Nominations for ADA CCEPR Board of Commissioners

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The Commission for Continuing Education Provider Recognition (CCEPR) is seeking nominations to fill an open position on the Board of Commissioners for a member of a state dental board or other jurisdictional licensing agency.

CCEPR is an agency of the American Dental Association which oversees the ADA Continuing Education Recognition Program (ADA CERP). The state dental board member will bring the perspective of the regulatory community to the Commission's deliberations. Potential candidates may be nominated by an entity such as a dental board or may nominate themselves. Interested parties should review the CCEPR Criteria for State Licensing Board Member (PDF) and download the application form (DOCX).

CCEPR serves the public and the dental profession by developing standards that promote excellence in continuing dental education to support professional competence and continuous improvement of patient care. The primary duties of the Commission for Continuing Education Provider Recognition are to:

- Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.

- Approve providers of continuing dental education programs and activities.

The Commission appreciates your agency's assistance in identifying potential candidates for this position, or in forwarding this information to your members.

For more information, please contact Mary Borysewicz, CCEPR director, at borysewiczm@ada.org.

Mary Borysewicz borysewiczm@ada.org
Director, Commission for Continuing Education Provider Recognition
312.440.2704

American Dental Association
211 E. Chicago Ave. Chicago, IL 60611 www.ada.org/cerp

COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION

BOARD OF COMMISSIONERS
STATE DENTAL BOARD/JURISDICTIONAL LICENSING AGENCY MEMBER
NOMINATION CRITERIA

CCEPR MISSION

CCEPR serves the public, the dental profession, and other healthcare providers by developing and implementing standards that promote excellence in continuing dental education to support professional competence and continuous improvement of patient care.

CCEPR fulfills its mission by:

- Establishing standards and criteria for the recognition of continuing dental education providers
- Recognizing providers of continuing dental education through a voluntary, self-regulated, peer-review process
- Promoting quality improvement of continuing dental education standards and recognized providers.

COMPOSITION OF THE COMMISSION

The composition of the Commission for Continuing Education Provider Recognition, as established by the ADA *Governance and Organizational Manual,* the CCEPR *Rules, Policies and Procedures* is as follows:

- Four (4) members who shall be appointed by the Board of Trustees of the American Dental Association from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of members appointed shall be general dentists.

- One (1) member who is an active member of the American Dental Education Association and also, if eligible, an active, life or retired member of this Association shall be selected by the American Dental Education Association.

- One (1) dentist who is board certified in the respective discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists; and the American Society of Dentist Anesthesiologists.

- One (1) member who is also a member of a state dental board or jurisdictional dental licensing agency.

- One (1) member appointed by the American Society of Constituent Dental Executives.

- One (1) member of the public who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental education institution and who is selected by the Commission, based on established and publicized criteria.

STATE DENTAL BOARD/JURISDICTIONAL LICENSING AGENCY MEMBER

The member who is a member of a state dental board or jurisdictional licensing agency member may not (i) hold a leadership position for an entity that has a certification or accreditation program for continuing

dental education providers or courses, (ii) be involved in the administration of a certification or accreditation program for continuing dental education providers or courses, or (iii) work more than one day a week as a faculty member of any dental education program. The jurisdictional licensing agency member shall be appointed to one (1) four (4) year term.

CRITERIA FOR APPOINTMENT TO THE COMMISSION

All appointees to the Commission must meet the following criteria:

- Ability to commit to one (1) four (4) year term;
- Willingness to commit to ten (10) to twenty (20) days per year to Commission activities, including but not limited to training, comprehensive review of print and electronic materials, and participation in and travel to Commission meetings;
- Ability to evaluate a continuing dental education program objectively in terms defined by recognition standards;
- Stated willingness to comply with all Commission policies and procedures;
- Ability to conduct business through electronic means (email, Commission web sites);
- If a dentist, must be an active, life or retired member in good standing of the American Dental Association

No member of the Commission may hold a leadership position for another entity that has a certification or accreditation program for continuing dental education providers or courses, or be involved in the administration of another certification or accreditation program for continuing dental education providers or courses.

TERM OF OFFICE

The term of office of the members of the Commission shall be one four (4) year term.

Terms of Commissioners shall begin and end with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association in the appropriate year.

MEETINGS

The Commission meets twice a year to conduct the official business of the Commission, and to finalize ADA CERP recognition actions. Meetings are scheduled in March or April and in September or October. Meetings are held over a day and a half, at the ADA Headquarters in Chicago or virtually. Commissioners are compensated for travel and hotel expenses for attending meetings in Chicago.

The Commission, and any of its appointed committees, may also meet via conference call between regularly scheduled meetings.

CONTACT

For more information contact Mary Borysewicz, CCEPR director, at borysewiczm@ada.org or 312-440-2704.

CCEPR COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION

Board of Commissioners: State Dental Board/Dental Licensing Jurisdiction Agency Member Application

Form to be completed and signed by applicant.

Name:

Business Address (Check if preferred mailing address ☐**):**

Phone:

Home Address (Check if preferred mailing address ☐**):**

Phone:

Email Address:

How did you learn about this opportunity?

If an organization suggested you apply, name of organization:

All applicants must agree to the following (please check each box to confirm agreement)**:**

- ☐ Ability to commit to one (1) four (4) year term;
- ☐ Willingness to commit to ten (10) to twenty (20) days per year to Commission activities, including but not limited to training, comprehensive review of print and electronic materials, and participation in and travel to Commission meetings;
- ☐ Ability to evaluate a continuing dental education program objectively in terms defined by recognition standards;
- ☐ Stated willingness to comply with all Commission policies and procedures;
- ☐ Ability to conduct business through electronic means (email, Commission web sites).

State Dental Board/Jurisdictional Licensing Agency Member Applicant Eligibility

To be eligible for appointment to the Commission, a nominee who is a dentist must be an active, life or retired member in good standing of the American Dental Association.

To be eligible for appointment to the Commission, a nominee for the state dental board/jurisdictional licensing agency member must **NOT**:

a. Hold a leadership position for an entity that has a certification or accreditation program for continuing dental education providers or courses,
b. Be involved in the administration of a certification or accreditation program for continuing dental education providers or courses,
c. Work more than one day a week as a faculty member of any dental education program, or
d. Serve concurrently on an ADA council or another ADA commission.

☐ I attest that I meet the criteria above to serve as a state dental board/jurisdictional licensing agency member for the Commission for Continuing Education Provider Recognition.

Educational Background (beginning with most recent)

Name of School, City & State	Year of Grad.	Certificate or Degree	Area of Study

Employment Background for Past 10 Years (list current employment first)

Employer	Address/E-mail	Position	From (Year)	To (Year)

Organizational Affiliations for Past 10 Years (list current dental board/jurisdictional licensing agency affiliation first)

Name of Organization	Offices Held	From (Year)	To (Year)

Does the state dental board/jurisdictional licensing agency on which you serve maintain or oversee a certification or accreditation program for continuing dental education providers or courses? Describe your role with respect to any such continuing education recognition, approval or accreditation program.

Describe any previous experience with entities that provide continuing dental education (for example, as an organizer or administrator, a regulator, and/or a consumer)**.**

Write a short paragraph summarizing your unique qualifications and interest in serving on the Commission for Continuing Education Provider Recognition.

List Two References

Name	Address/Email	Position

Signature: **Date:**

Please return completed form to:
cousinsk@ada.org
ADA Commission for Continuing Education Provider Recognition

1304 CONCOURSE DRIVE, SUITE 100 | LINTHICUM, MD 21090
TEL: 301-563-3300 | FAX: 301-563-3307

23460 N. 19TH AVENUE, SUITE 210 | PHOENIX, AZ 85027
TEL: 623-209-5400 | FAX: 602-371-8131

January 21, 2022

Greetings from CDCA-WREB! We are pleased that so many of you could participate in our virtual Annual Meeting & Educator's Conference. We appreciate your ability to transition with us from an in-person to a virtual meeting due to health safety considerations and travel system limitations. We offer the summary below for you and your board.

We will be contacting you again periodically throughout the year, and we appreciate any pertinent updates in your state that may affect licensure candidate requirements, as well as any changes to your Board Member roster or meeting schedule you can share!

CDCA-WREB Annual Meeting Summary

The CDCA-WREB held its largest meetings ever January 6-7, 2022, with nearly 800 people virtually taking part in the General Assembly 400 participants in the ADEX-focused Educators Conference.

Chairman Dr. Harvey Weingarten welcomed all attendees to the first Annual Meeting of CDCA-WREB since the merger of the two organizations. CDCA-WREB now consists of 43 jurisdictions with the recent additions of Washington (dental), Louisiana, Idaho, and North Carolina. CDCA-WREB members unanimously approved an additional merger between the CDCA-WREB and CITA. The merger will be complete in August 2022. In 2023, CDCA-WREB-CITA will universally administer ADEX Dental and Dental Hygiene examinations simplifying licensure examination standards and processes for candidates and dental boards nationally for the oral health professions.

This means that every dental school in the US will be offering the ADEX dental licensure examination in 2023, as well as candidates in Canada, Puerto Rico, Jamaica, and Mexico. CDCA-WREB-CITA will also serve approximately 80% of dental hygiene licensure candidates and administer ADEX Dental Hygiene examinations in every region of the United States. Additionally, state-specific examination products such as Local Anesthesia, EFDA, and others will continue to be offered to schools as state boards require.

By bringing together leading dental hygiene clinicians, educators, and industry-leading manufacturers, CDCA-WREB is proud to introduce SimProDH for 2022, which includes multiple enhancements in dental hygiene clinical examination simulation. The ADEX approved and tested SimProDH™ meets all ADEX dental hygiene examination standards for the simulated patient psychomotor performance examination component. When combined with the didactic ADEX CSCE OSCE section, the non-patient ADEX Dental Hygiene Examination is currently accepted in 40 US jurisdictions.

CDCA-WREB members elected Betty Howard, RDH (Maryland), as Secretary, and Greg Waite, DDS (Arizona), as Treasurer. Attending state contingents also elected CDCA-WREB Steering Committee Members for 2021-2022.

We missed seeing everyone together in Denver this year and hope you and your colleagues are well. CDCA-WREB anticipates an in-person gathering at the Gaylord Texan Resort and Conference Center in Dallas for its next Annual Meeting in January 2023.

For your reference, schedules for 2022 ADEX and WREB exams are available here:

If you or your board would like additional information or have questions, please email me at kcobb@cdcawreb.org.

Sincerely,

Kimber Cobb, RDH
National Director for Licensure Acceptance & Portability
Director of Dental Hygiene Examinations
CDCA WREB

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
February 25, 2022

Board Member & Staff Updates

Most OBD Staff have been getting acclimated to a Hybrid Work Model effective February 1, 2022. This flexible work schedule was adopted by six of our staff and they seem to enjoy the flexibility of it. They work two days remotely and three days on-site at our downtown Portland Office.

OBD Budget Status Report

Attached is the latest budget report for the 2021 - 2023 Biennium. This report, which is from July 1, 2021 through December 31, 2021, shows revenue of $907,046.64 and expenditures of $810,854.32. As always, please let me know if you have any questions. **Attachment #1**

Customer Service Survey

The customer service surveys received from July 1, 2021 – January 31, 2022 are attached and a majority rate their experience with us positively. **Attachment #2**

Board and Staff Speaking Engagements

Ingrid Nye and Samantha VandeBerg gave a licensing application zoom presentation to the graduating dental hygiene students at OIT in Salem & Klamath Falls on Friday, February 4, 2022.

OBD Staff will be presenting at the ODA's Oregon Dental Conference in early April. One presentation will be virtual and one in person. All details can be found on the ODA's website. We appreciate the invitation and opportunity to provide information and updates at this well attended forum.

2022 Dental License Renewal

The dental license renewal is progressing and will conclude March 31. A friendly reminder that audits will be conducted after the renewal closes this year for both dentists and dental hygienists (this fall) renewing their licenses. The Board is adopting a new audit scheme to monitor CE compliance, safe practices and also to align staff resources with work load.

License Statistics

Attached is a snapshot of licensee data as of January 1, 2022.The initial preparation for the 2023 -2025 OBD Budget will start in March 2022. Licensee data will be used to help make revenue projections, estimates and plans for the next 2- year budget. **Attachment #3**

OBD Strategic Planning

At this meeting the Board will review the final draft of the OBD's 2022 – 2025 Strategic Plan. Thank you to the Board Members, staff and our attorney for their work and on this important endeavor. The feedback from our Licensees and others helped inform us on the strategic priorities outlined in the new plan which is included in Tab 7 of this meeting packet.

2022 Legislative Session
The short session began Feb 1 and can run no longer than 35 days. I attached a report on legislation I am tracking on behalf of the OBD. **Attachment #4**

Affirmative Action Representative Meeting
I attended the December Affirmative Action Representative Meeting on behalf of the OBD. This Office has had some staff turnover and transitions, but is now back on track. These meetings are scheduled every other month going forward. **Attachment #5**

Council of State Governments - Dental Compact Dec 2021 Meetings
The Council provided some excellent information and resources to give you an overview of the work they are undertaking. **Attachment #6**

AADA & AADB 2022 Mid-Year Meetings
Both the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) mid-year meetings will be held virtually. The AADA's will be on April 7. The AADB's will be on April 8 & 9.

Newsletter
The OBD published a December 2021 Newsletter which can be accessed with past newsletters on the OBD website. We intend to publish a summer OBD Newsletter capturing the 2022 legislative session bills impacting the OBD, dental therapy information, new board member biographies and other fun facts.

Appn Year 2023

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

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4425	LEASE PAYMENTS & TAXES	0.00	0.00	0.00	0.00	0.00
		0.00	**0.00**	**0.00**	**0.00**	**0.00**

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0505	FINES AND FORFEITS	218,326.70	32,500.00	250,826.70	250,000.00	-826.70
0205	OTHER BUSINESS LICENSES	617,534.00	21,185.00	638,719.00	3,100,001.00	2,461,282.00
0210	OTHER NONBUSINESS LICENSES AND FEES	4,150.00	0.00	4,150.00	10,000.00	5,850.00
0410	CHARGES FOR SERVICES	6,655.00	0.00	6,655.00	18,000.00	11,345.00
0605	INTEREST AND INVESTMENTS	3,604.61	585.73	4,190.34	60,000.00	55,809.66
0975	OTHER REVENUE	2,375.60	130.00	2,505.60	13,999.00	11,493.40
		852,645.91	**54,400.73**	**907,046.64**	**3,452,000.00**	**2,544,953.36**

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	1,305.00	0.00	1,305.00	226,800.00	225,495.00
		1,305.00	**0.00**	**1,305.00**	**226,800.00**	**225,495.00**

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3260	MASS TRANSIT	1,546.11	334.34	1,880.45	8,268.00	6,387.55
3110	CLASS/UNCLASS SALARY & PER DIEM	269,693.98	59,754.78	329,448.76	1,327,438.00	997,989.24
3190	ALL OTHER DIFFERENTIAL	0.00	0.00	0.00	39,836.00	39,836.00
3170	OVERTIME PAYMENTS	103.13	0.00	103.13	6,400.00	6,296.87
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	4,400.00	4,400.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	39,888.98	9,566.91	49,455.89	220,730.00	171,274.11
3221	PENSION BOND CONTRIBUTION	12,144.93	2,939.88	15,084.81	79,458.00	64,373.19
3230	SOCIAL SECURITY TAX	20,472.78	4,532.99	25,005.77	104,164.00	79,158.23
3270	FLEXIBLE BENEFITS	45,766.97	10,369.61	56,136.58	305,856.00	249,719.42
3210	ERB ASSESSMENT	74.40	16.80	91.20	464.00	372.80
3250	WORKERS' COMPENSATION ASSESSMENT	61.72	12.72	74.44	368.00	293.56
		389,753.00	**87,528.03**	**477,281.03**	**2,097,382.00**	**1,620,100.97**

SERVICES and SUPPLIES

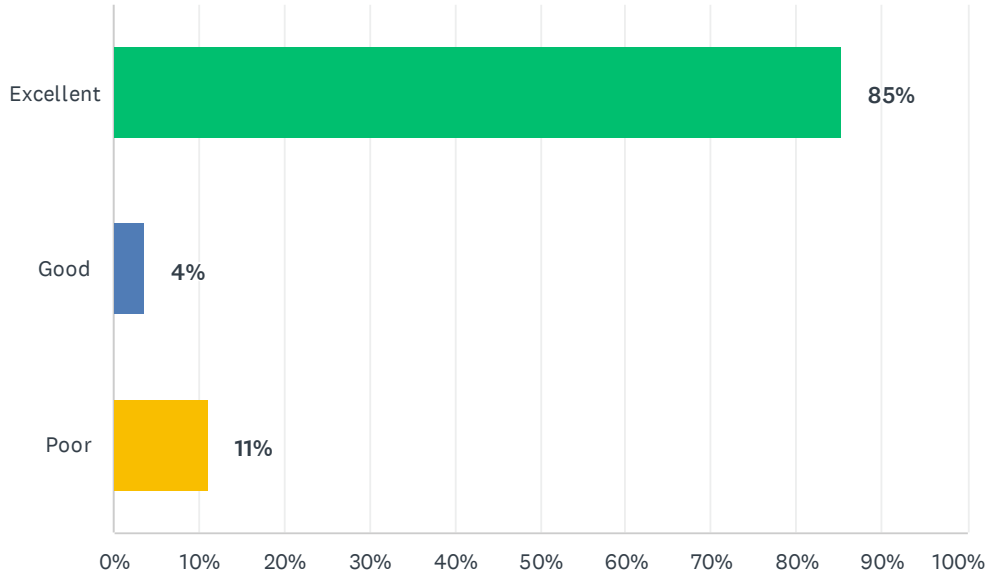
Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4150	EMPLOYEE TRAINING	4,260.54	480.00	4,740.54	56,553.00	51,812.46
4275	PUBLICITY & PUBLICATIONS	350.06	0.00	350.06	15,494.00	15,143.94
4715	IT EXPENDABLE PROPERTY	7,261.32	279.99	7,541.31	24,492.00	16,950.69
4200	TELECOMM/TECH SVC AND SUPPLIES	4,747.67	1,144.83	5,892.50	25,997.00	20,104.50
4650	OTHER SERVICES AND SUPPLIES	12,442.66	1,921.98	14,364.64	95,453.00	81,088.36
4300	PROFESSIONAL SERVICES	86,018.16	13,619.50	99,637.66	270,498.00	170,860.34
4175	OFFICE EXPENSES	15,336.60	2,193.05	17,529.65	95,153.00	77,623.35
4400	DUES AND SUBSCRIPTIONS	4,498.95	248.99	4,747.94	10,874.00	6,126.06
4100	INSTATE TRAVEL	7,851.40	0.00	7,851.40	52,968.00	45,116.60
4250	DATA PROCESSING	22,583.70	2,998.56	25,582.26	186,234.00	160,651.74
4225	STATE GOVERNMENT SERVICE CHARGES	33,442.56	41.00	33,483.56	73,273.00	39,789.44
4425	LEASE PAYMENTS & TAXES	26,599.89	0.00	26,599.89	186,798.00	160,198.11
4575	AGENCY PROGRAM RELATED SVCS & SUPP	11,329.39	141.04	11,470.43	107,494.00	96,023.57
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	7,888.00	7,888.00
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	0.00	6,087.00	6,087.00
4325	ATTORNEY GENERAL LEGAL FEES	58,281.93	15,499.52	73,781.45	306,725.00	232,943.55
4315	IT PROFESSIONAL SERVICES	0.00	0.00	0.00	148,013.00	148,013.00
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	735.00	735.00
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	608.00	608.00
		295,004.83	**38,568.46**	**333,573.29**	**1,671,337.00**	**1,337,763.71**

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
TRANSFER OUT	TRANSFER OUT	0	1,305	226,800.00
	Total	0	1,305	226,800.00
PERSONAL SERVICES	PERSONAL SERVICES	87,528.03	477,281.03	2,097,382.00
	Total	87,528.03	477,281.03	2,097,382.00
REVENUES	REVENUE	54,400.73	907,046.64	3,452,000.00
	Total	54,400.73	907,046.64	3,452,000.00
		0	0	0.00
	Total	0	0	0.00
EXPENDITURES	SERVICES AND SUPPLIES	38,568.46	333,573.29	1,671,337.00
	Total	38,568.46	333,573.29	1,671,337.00

Attachment #1

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

Answered: 27 Skipped: 0

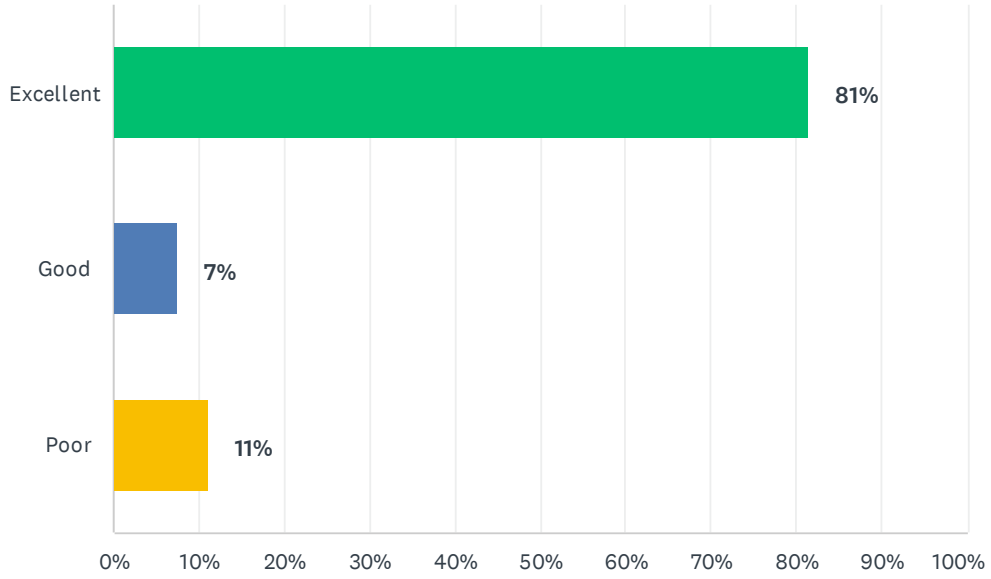


ANSWER CHOICES	RESPONSES	
Excellent	85%	23
Good	4%	1
Poor	11%	3
TOTAL		27

Attachment #2

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

Answered: 27 Skipped: 0

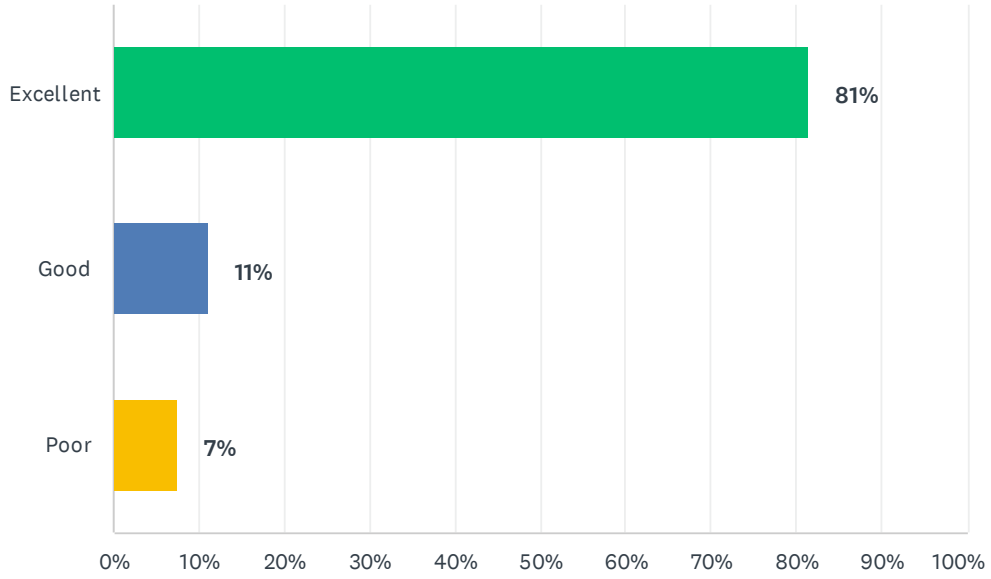


ANSWER CHOICES	RESPONSES	
Excellent	81%	22
Good	7%	2
Poor	11%	3
TOTAL		27

Attachment #2

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

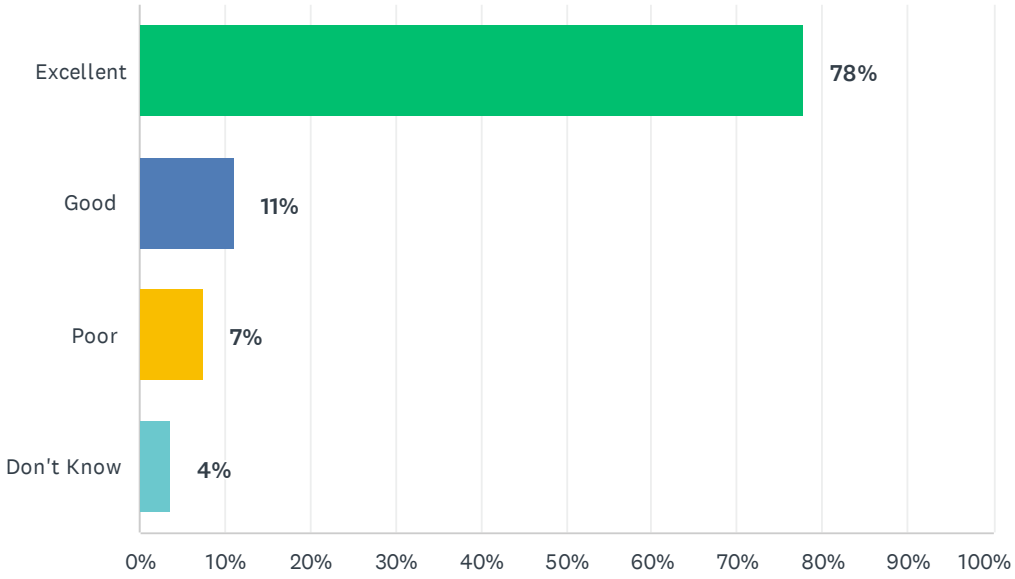
Answered: 27 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	81%	22
Good	11%	3
Poor	7%	2
TOTAL		27

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

Answered: 27 Skipped: 0

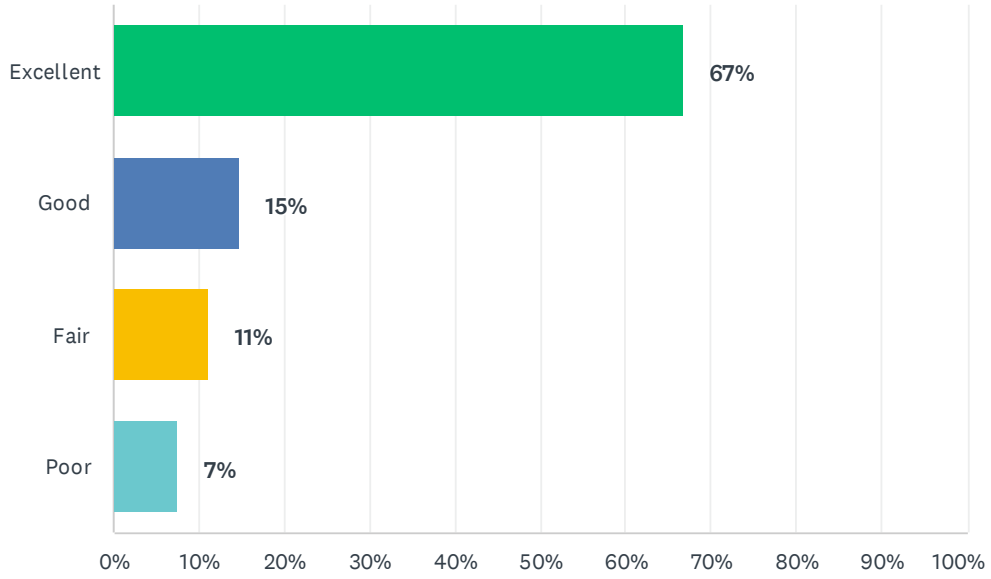


ANSWER CHOICES	RESPONSES	
Excellent	78%	21
Good	11%	3
Poor	7%	2
Don't Know	4%	1
TOTAL		27

Attachment #2

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

Answered: 27 Skipped: 0

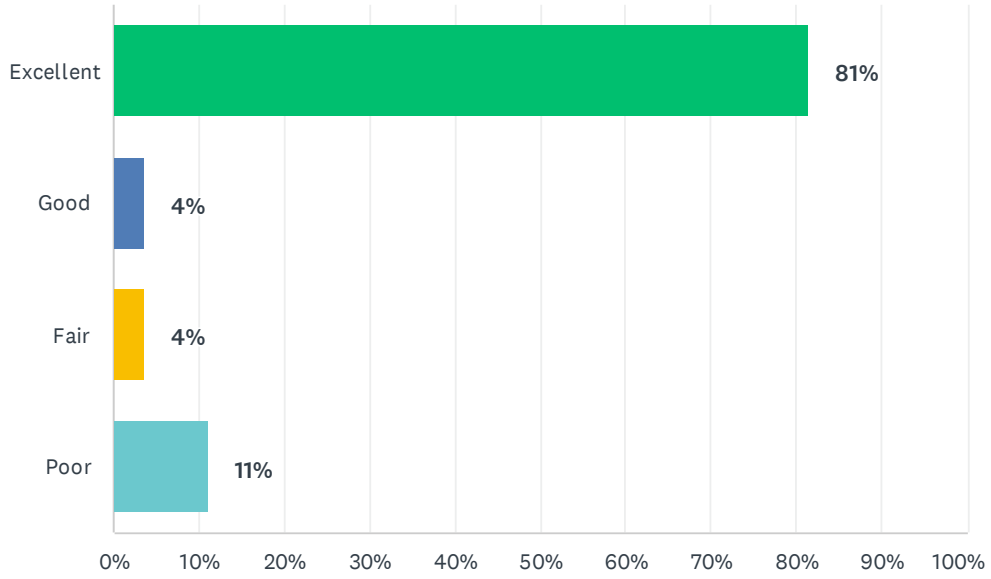


ANSWER CHOICES	RESPONSES	
Excellent	67%	18
Good	15%	4
Fair	11%	3
Poor	7%	2
TOTAL		27

Attachment #2

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

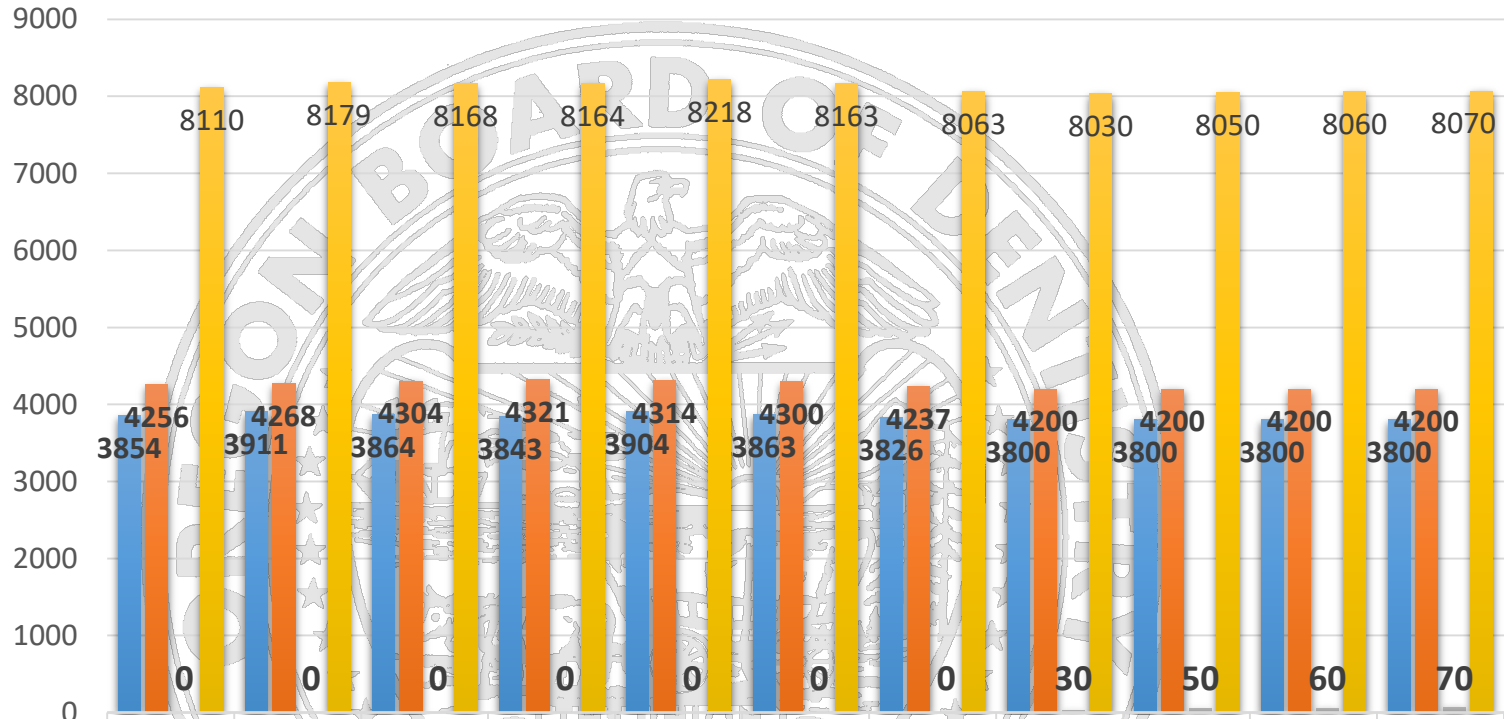
Answered: 27 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	81%	22
Good	4%	1
Fair	4%	1
Poor	11%	3
TOTAL		27

Attachment #2

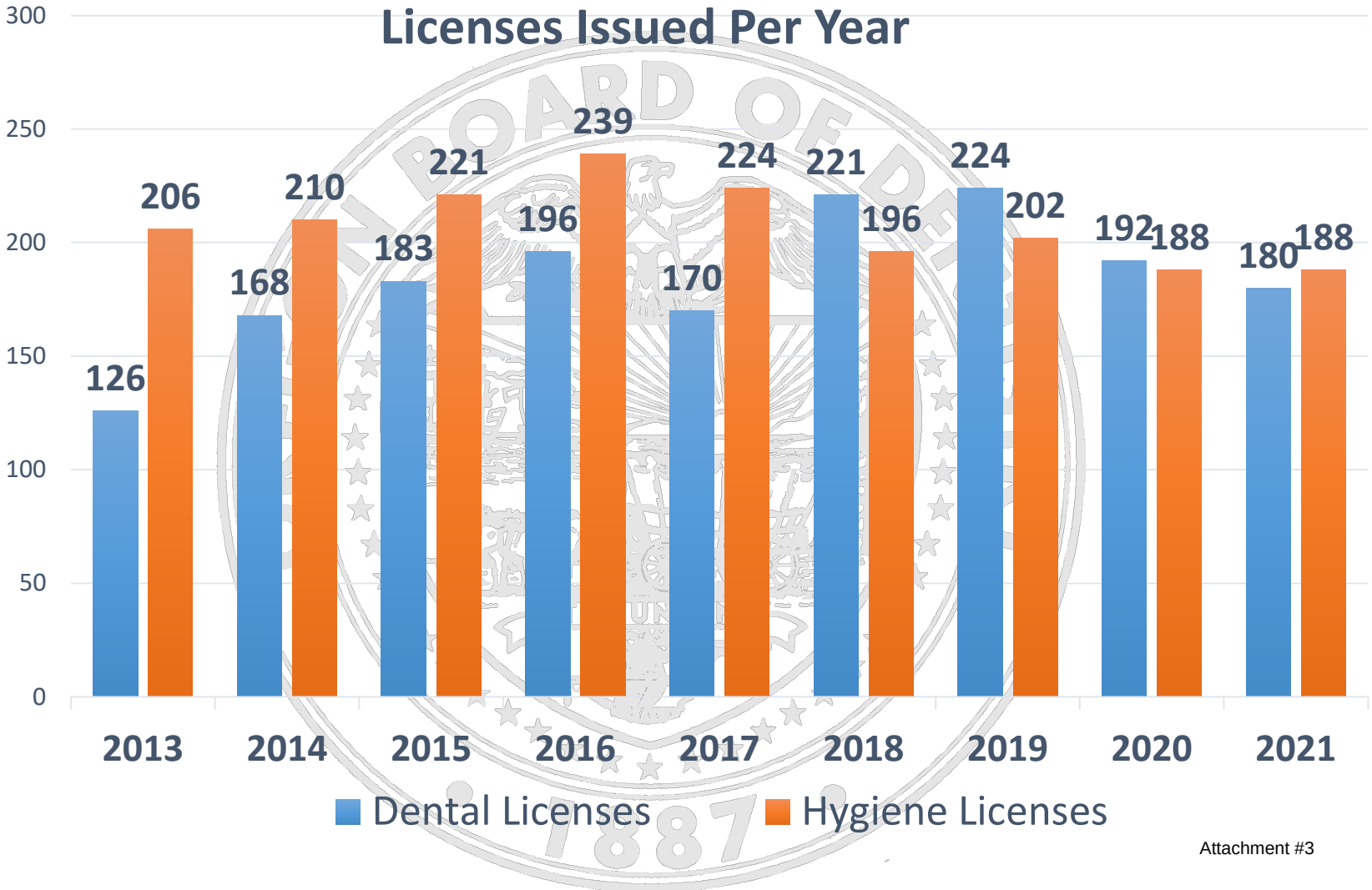
OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



	2015	2016	2017	2018	2019	2020	2021	est 2022	est 2023	est 2024	est 2025
Dental Licenses	3854	3911	3864	3843	3904	3863	3826	3800	3800	3800	3800
Hygiene Licenses	4256	4268	4304	4321	4314	4300	4237	4200	4200	4200	4200
Dental Therapy	0	0	0	0	0	0	0	30	50	60	70
Total Licenses	8110	8179	8168	8164	8218	8163	8063	8030	8050	8060	8070

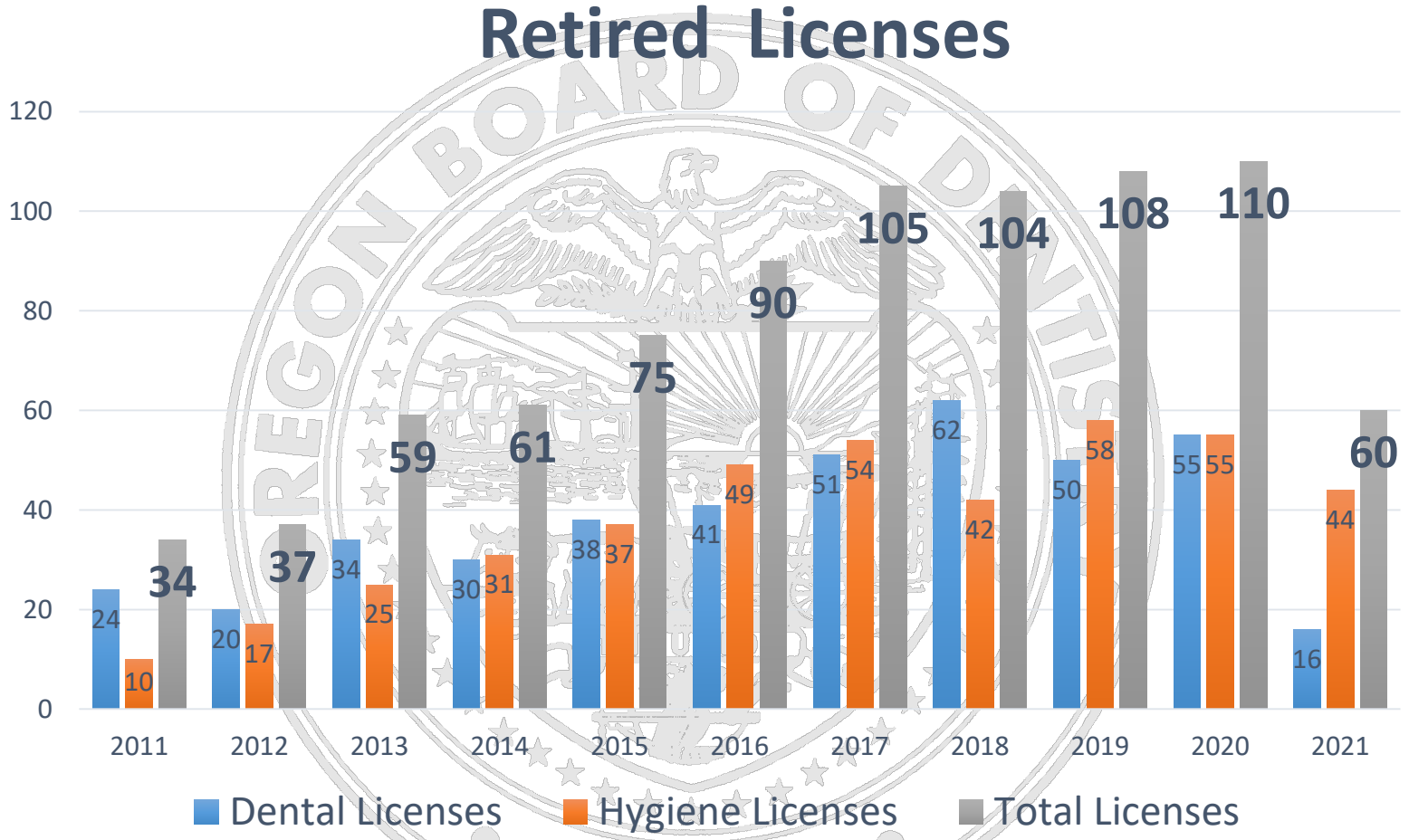
Attachment #3

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



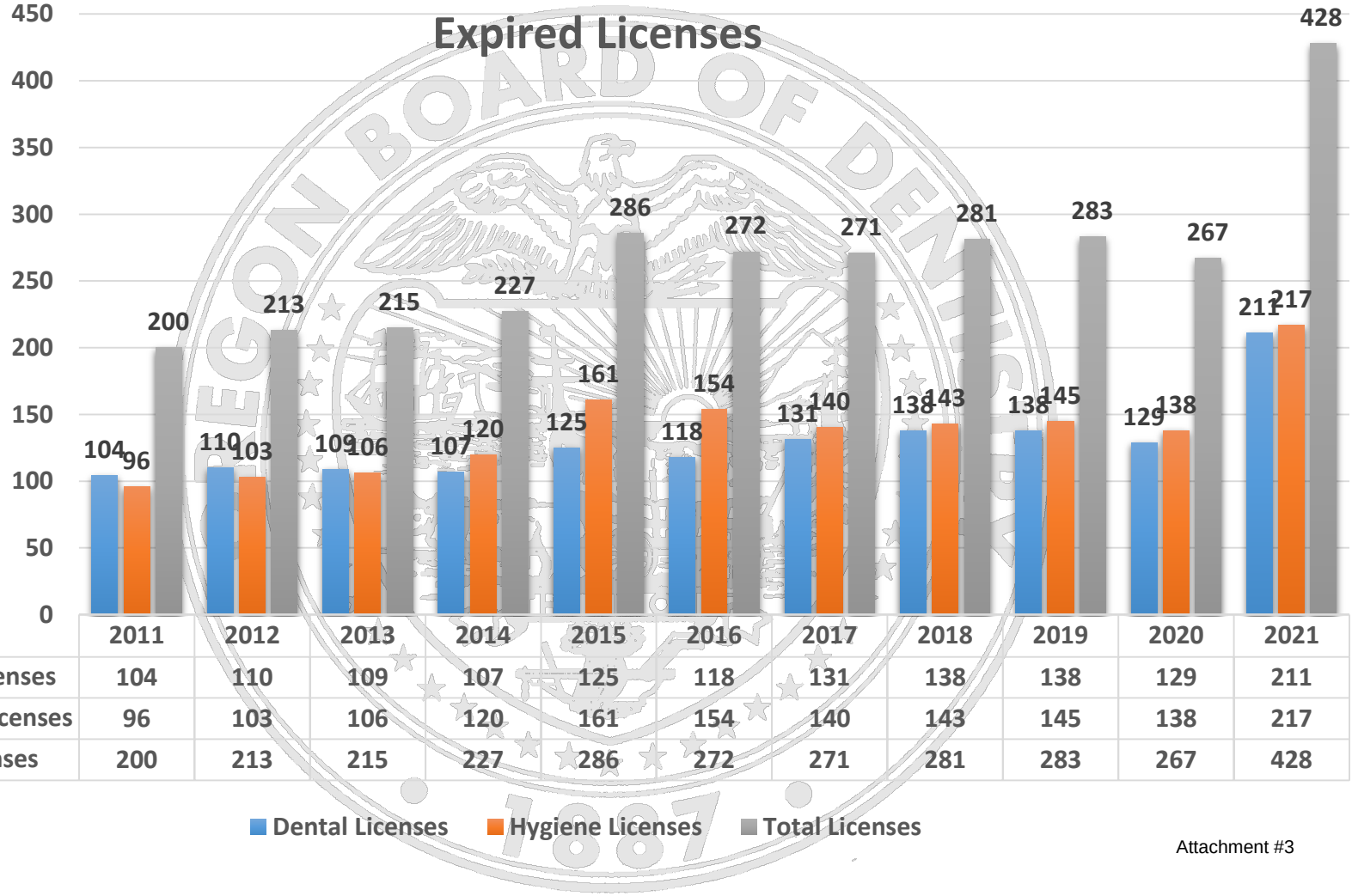
Attachment #3

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



Attachment #3

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Dental Licenses	104	110	109	107	125	118	131	138	138	129	211
Hygiene Licenses	96	103	106	120	161	154	140	143	145	138	217
Total Licenses	200	213	215	227	286	272	271	281	283	267	428

Attachment #3

BillTracker

Custom Report

Report Date: February 14, 2022

Bill Number	Bill Number	Bill Sponsor	Last Action
HB 4034	HB 4034 INTRO	Presession filed (at the request of House Interim Committee on Health Care for Representative Rachel Prusak)	02/14/22 - Work Session scheduled.

Relating to health care; declaring an emergency.

Deletes requirement that coordinated care organization collect specified data from members and submit data to Oregon Health Authority.

Relating to health care; creating new provisions; amending ORS 413.163, 413.164, 435.205, 442.015, 475.230, 689.522, 689.700 and 743A.067 and section 4, chapter 92, Oregon Laws 2021; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Last Action
HB 4096	HB 4096 INTRO	Rep Hayden; Rep Moore-Green; Rep Prusak; Rep Smith DB; Sen Steiner Hayward (Presession filed)	02/14/22 - Work Session scheduled.

Relating to volunteer health care practitioners; prescribing an effective date.

Authorizes health care practitioner authorized in another state or United States territory to practice in this state without compensation for specified number of days without obtaining licensure in this state.

Relating to volunteer health care practitioners; creating new provisions; amending ORS 677.137, 678.031, 679.025, 680.020, 683.030, 685.030 and 689.225; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Last Action
SB 1512	SB 1512 INTRO	Presession filed (at the request of Senate Interim Committee on Judiciary and Ballot Measure 110 Implementation)	02/14/22 - Work Session scheduled.

Relating to the effects on adjudicated persons of adjudications for criminal acts.

Specifies conditions under which licensing board, commission or agency may suspend or deny occupational or professional license on basis of applicant's or licensee's criminal history, moral character or similar qualification.

Relating to the effects on adjudicated persons of adjudications for criminal acts; amending ORS 419A.255, 419C.400, 670.280 and 670.290.

Bill Number	Bill Number	Bill Sponsor	Last Action
SB 1560	SB 1560 INTRO	Rep Alonso Leon; Rep Bynum; Rep Campos; Rep Dexter; Rep Evans; Rep Fahey; Rep Grayber; Rep Helm; Rep Hoy; Rep Hudson; Rep Kropf; Rep Marsh; Rep McLain; Rep Meek; Rep Neron; Rep Nosse; Rep Pham; Rep Power; Rep Prusak; Rep Reardon; Rep Reynolds; Rep Ruiz; Rep Sanchez; Rep Schouten; Rep Valderrama; Rep Wilde; Rep Williams; Sen Anderson; Sen Armitage; Sen Dembrow; Sen Frederick; Sen Gelser Blouin; Sen Golden; Sen Gorsek; Sen Hansell; Sen Jama; Sen Kennemer; Sen Lawrence Spence; Sen Lieber; Sen Manning Jr; Sen Patterson; Sen Prozanski; Sen Sollman; Sen Steiner Hayward; Sen Taylor; Sen Wagner (Presession filed)	02/14/22 - Work Session scheduled.

Relating to noncitizens.

Updates statutory references to individual who is not citizen or national of United States to replace "alien" with "noncitizen."

Directs state agencies to use "noncitizen" in rules and regulations to reference individual who is not citizen or national of United States and to update rules and regulations that use "alien" to use "noncitizen."

Makes nonsubstantive changes.

Relating to noncitizens; creating new provisions; and amending ORS 12.200, 165.800, 166.291, 238.015, 316.027, 316.567, 316.695, 408.010, 411.139, 497.006, 656.005, 656.232, 657.045, 657.184 and 658.440.

MEETING AGENDA – AFFIRMATIVE ACTION REPRESENTATIVE

MEETING INFORMATION

Date: Dec. 7, 2021

Time: 10:00 – 12:00 p.m.

Location: Virtual Meeting via Zoom | Click here to join the meeting

Audioconference: +12532158782, 6936033154#, *725039# United States, Portland
Meeting ID: 693 603 3154

	AGENDA ITEM	PRESENTER	TIME
*	**Welcome & Introductions**	Serena Stoudamire Wesley	10:00 a.m.
*	**Office of Cultural Change & Recruitment Updates**	Serena Stoudamire Wesley	10:20 a.m.
*	**OCC Affirmative Action Plans (i.e., training, speakers, Affirmative Action submissions, etc.)**	Serena Stoudamire Wesley	10:40 a.m.
*	**Affirmative Action Rep Meeting Occurrence – Bi-monthly**	Serena Stoudamire Wesley	11:00 a.m.
*	**OCC Cultural Committee – Events & Calendar**	Serena Stoudamire Wesley	11:10 a.m.
*	**Partners in Diversity**	Serena Stoudamire Wesley	11:30 a.m.
*	**Roundtable**	All	11:40 a.m.
*	**Adjourn**	All	12:00 p.m.

NEXT MEETING:

February 2022

Interstate Occupational Licensure Compacts – *Discipline and Governance*

The Council of State Governments

Dentistry and Dental Hygiene Compact
Technical Assistance Group
December 8, 2021

Attachment #6

Overview

- Compact Governance
- Licensee Discipline and Reporting
- Admission of Member States
- Member State Compliance

Compact Governance

Compact Commission

- Has ultimate legal responsibility
- Comprised of one delegate (or "commissioner") from each state
  - Appointee is typically chosen by the state licensing board
  - This creates dual duties, i.e., to the delegate's employer, and as a fiduciary to the Commission

Executive Board

- Usually comprised of the elected officers of the Commission
- May also include “at large” member(s)
- May also include *ex officio* members (non-voting)
  - Executive Director/Compact Administrator
  - National organization representative

Executive Board

- Delegation of Commission authority to Executive Board
  - EB usually meets more frequently than full Commission
  - May be more efficient for handling routine business

Open Meetings

- Both full Commission and Executive Board meetings are ordinarily conducted as public meetings
  - The model compact legislation identifies specific reasons why a meeting, or portion of a meeting, may be closed

Commission Duties

- Meet at least once annually
- Adopt bylaws
- Adopt rules
- Manage its finances
- Hire staff
- Establish an office
- Accept grants/ donations
- Perform other appropriate functions

Legal Aspects of Governance

- “Layers” of guidance
- Jurisdiction/Venue
- Liability and Qualified Immunity
- Indemnification

"Layers" of Guidance

- Main sources of guidance for a Commission:
  - The model compact legislation
  - Duly promulgated commission rules
  - Commission bylaws
    - *Robert's Rules of Order* often designated as the "gap filler"
  - Commission policies

Jurisdiction/Venue

- Compacts generally provide for jurisdiction and venue in the state where the compact maintains its principal office
  - This may be a source of lobbying by interest groups during the legislative process

Jurisdiction/Venue

- But, it is vital to note that these provisions do not affect where individual practitioners can be sued
  - For example, will *not* limit where a plaintiff's attorney can file a malpractice action against a licensed healthcare provider

Jurisdiction/Venue

- These provisions are vital to ensure consistency and uniformity in case law involving the interstate commission

Liability and Immunity

- Compact legislation typically includes a form of qualified or limited immunity for:
  - Commission members
  - Officers
  - Staff
  - Representatives

Liability and Immunity

- Limitations of official immunity:
  - Must be within scope of Commission duties
  - No protection for intentional, willful or wanton misconduct

Liability and Immunity

- Important note:
  - Just as with the venue provisions, the Compact does *not* provide any level of immunity for licensed practitioners in the provision of healthcare
  - This is often misunderstood by trial lawyers' groups in the legislative process

Indemnification

- Compact legislation typically covers any settlement or judgment against Commission officials
  - Again, limited to official acts in the course of Commission business
  - Does *not* include indemnification for intentional, willful or wanton misconduct

Licensee Discipline and Reporting

Disciplinary Authority

- It is important to distinguish types of practice:
  - Practice under a ***state license***
  - Practice pursuant to an ***interstate privilege***

License vs. Privilege

- **License**
  - Discipline by the issuing state
  - A remote state may not impose discipline against a home state license
- **Privilege**
  - Discipline by the remote state where the individual is practicing
  - Discipline limited to the privilege to practice

Effect of Discipline

- **License**
  - Discipline by an issuing state against a *license* typically results in ***both:***
    - Loss or restrictions within the issuing state, and
    - Loss of the interstate privilege to practice, ***but…***
- **Privilege**
  - Discipline by a remote state against a *practice privilege* typically results in:
    - Loss of the privilege to practice in that remote state
    - In some compacts, this may also trigger an automatic loss of privileges in *all* other compact states, ***and…***

Effect of Discipline

- **License**
  - …a remote practice privilege *might* still be permitted if *written authorization* is given by *both* the home state and the remote state
- **Privilege**
  - …may *also* be a basis for a *home state* to take action against the ***license*** it issued

Disciplinary Jurisdiction

- Compact architecture can vary on which state has jurisdiction in investigating potential disciplinary matters

Disciplinary Jurisdiction

- In some compacts
  - The remote state where the alleged violation occurred under a practice privilege will be the primary investigating state
  - The remote state would then report its finding to the home state which issued the license

Disciplinary Jurisdiction

- In other compacts
  - The remote state where an alleged violation occurred under a practice privilege would refer the matter to the home state where the license was issued
  - That home state would then have primary disciplinary authority

Disciplinary Scenario 1

Nursing

Scenario 1 (Nursing)

- Mary is a resident of Texas (a compact state) and holds a Texas multistate license
- Mary accepts a temporary travel nurse assignment in Louisiana (a compact state)
- While practicing in LA, she violates the LA nurse practice act
- The hospital reports Mary to the LA Board
- LA Board receives the complaint and after a preliminary inquiry, decides that an investigation is warranted.
- LA Board conducts the investigation because that is where the violation occurred
- LA Board turns on the Nurse Alert in the licensee's Nursys file, as appropriate
- LA Board staff notifies TX that one of their multistate license holders is under investigation
- LA Board treats the licensee as if the licensee were a resident of LA, applying its state laws to the case when disciplining the compact privilege
- At the conclusion of the investigation, LA Board sends the licensee investigative file to TX Board
- TX Board takes action on the multistate license as if the violation occurred in TX, applying its own state laws (no repeat investigation.)
- TX Board converts the multistate license to single state, as appropriate

Disciplinary Scenario 2

Physical Therapy

Scenario 2 (PT)

- Mary is a resident of TX (a compact state) and holds a Louisiana compact privilege.
- While practicing in LA, she violates the LA PT practice act
- Someone reports Mary to the LA PT Board
- LA PT Board receives the complaint and decides that an investigation is warranted
- LA PT Board conducts the investigation because that is where the violation occurred
- LA PT Board flags Mary's record in the Federation of State Boards of Physical Therapy Exam Licensure and Disciplinary Database (ELDD) as under investigation once probable cause is met
- The investigation flag is displayed in the party state investigations queue for all other member state PT boards that are a party to that individual
- LA PT Board treats the compact privilege holder as if they held a regular licensee in LA, applying its state laws to the case when disciplining the compact privilege
- At the conclusion of the investigation, LA Board either enters the disciplinary action into the ELDD
  - Or removes the flag if no action is taken
- If disciplinary action is taken, *all* compact privileges for that individual are terminated immediately
  - Ineligible for compact privileges for at least 2 years
  - Doesn't affect any regular licenses held by the individual.
- Any state where the individual is licensed may choose to take its own actions

Disciplinary Scenario 3

EMS

Scenario 3 (EMS)

- In 2015, at the age of 18, Paul was arrested, charged and pled guilty to one count of burglary in the State of Colorado
- Paul was sentenced to 2 years of probation, which he completed successfully
- Paul has had no criminal record since then
- Paul completes paramedic school in 2021 and applies for a license from the Colorado Department of Public Health (compact state)
- Paul's 2015 conviction constitutes grounds for denial of a paramedic license
- However, CO DPH believes Paul does not pose a threat to public health or safety and issues a probationary license to Paul
- As part of the decision to issue the license, DPH and Paul enter into a stipulation agreement
- The agreement indicates that Paul may practice in a remote state under the EMS Compact interstate practice privilege, but only if any remote state in which he intends to practice provides such authorization in writing

Reporting

- Healthcare-related interstate commissions typically maintain centralized/coordinated database
- This is *essential* to permit member states to keep their promises to all other member states
  - Remember, a Compact is both a state law *and* an agreement between the member states!

Reporting

- Members states typically have the obligation to report to the Commission:
  - Any adverse actions by a home (licensing) state
    - Typically includes any findings of a violation of statute or regulation that results in discipline against a license
  - Any privilege to practice restrictions by a remote/distant state

Reporting

- Investigatory information
  - Some compacts require the reporting of active open, investigations prior to adjudication
  - Typically requires a finding of probable cause of a violation that could result in disciplinary action
    - Reportable even if the allegations have not yet been conclusively proven

Reporting

- Some variation in compact requirements on reporting investigatory information
  - Some may require reporting *only* that there is investigatory information available
  - Instead of reporting the substantive information to the commission, the onus may be on a state to inquire directly to another

Nonpublic Information

- Compact may permit the withholding of information specifically designated under state law as confidential or non-public

Alternative Programs

- Under a compact, a state typically reserves sole authority to determine if a licensee is eligible to participate in an alternative program
  - Substance abuse, addiction, etc.
  - Impaired professional programs

Alternative Programs

- The compact may establish rules regarding admission into such a program
  - May result in temporary loss of practice privileges during the duration of the program
  - May require specific approval to continue to practice under the privilege

Alternative Programs

- Again, key to this is the reporting of the alternative program participation by the licensee
- Reporting such participation to the commission does *not* mean:
  - The report must become public
  - The underlying details are disclosed to the commission

Admission of Member States

New States

- One issue that comes up is a state enacting legislation with some deviations from the model compact legislation
  - This creates potential legal problems
  - Can also impair proper administration of the compact
  - Should be discouraged whenever possible

Model Compact Deviations

- However, some deviations are purely cosmetic
  - Some states may have numbering conventions or codifying rules that require specific language be added to the statute
  - Other states may have drafting requirements
    - Example: no “whereas” or purpose clauses in legislation

Model Compact Deviations

- Some states may enact the compact law with substantive changes to the legislation
  - This may be due to:
    - Political pressure
    - State constitutional limitations

The Challenge

- The challenge for an interstate commission is to have a process in place to determine which changes are cosmetic or ***non-substantive***, and which are ***material***

The Challenge

- Since an interstate compact is an agreement between states, the terms enacted by all states must be consistent or a court could find no such agreement exists

Example: PSYPACT

Process for Review of New State Laws or Amendments to Compacts

10.5 Process for Review of New State Laws or Amendments to Compacts:

A. Upon enactment by a state of a law intended as that state's adoption of the Compact, the Executive Board shall review the enacted law to determine whether it contains any provisions which materially conflict with the Compact model legislation.

1. To the extent possible and practicable, this determination shall be made by the Executive Board after the date of enactment but before the effective date of such law. If the timeframe between enactment and effective date is insufficient to allow for this determination to be made by the Executive Board prior to the law's effective date, the Executive Board shall make the determination required by this paragraph as soon as practicable after the law's effective date. The fact that such a review may occur subsequent to the law's effective date shall not impair or prevent the application of the process set forth in this Section 10.5.

2. If the Executive Board determines that the enacted law contains no provision which materially conflicts with the Compact model legislation, the state shall be admitted as a party to the Compact and to membership in the Commission pursuant to Article X of the Compact upon the effective date of the state's law and thereafter be subject to all rights, privileges, benefits and obligations of the Compact, these Rules and the bylaws.

3. In the event the enacted law contains one or more provisions which the Executive Board determines materially conflicts with the Compact model legislation, the state shall be ineligible for membership in the Commission or to become a party to the Compact, and the state shall be so notified within fifteen (15) days of the Executive Board's decision.

4. A state deemed ineligible for Compact membership and Commission participation pursuant to this Section 10.5 shall not be entitled to any of the rights, privileges or benefits of a Compact State as set forth in the Compact, these Rules and/or the bylaws. Without limiting the foregoing, a state deemed ineligible for membership and participation shall not be entitled to appoint a Commissioner, to submit to and/or receive data from the Coordinated Licensure Information System and/or to avail itself of the default and technical assistance provisions of the Compact. Psychologists licensed in a state deemed ineligible for membership and participation hereunder shall be ineligible for the Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice set forth in the Compact and

Examples of Deviations That Might Disqualify a State

- Materially altering the rights or obligations of member states
- Eliminating qualified immunity for the Commission or its officials
- Enlarging choice of venue
- Imposing undue restrictions on privileges to practice compared to the model legislation
- Allowing state to negate Commission rules
- Eliminating fees applicable to the state

Member State Compliance

Member State Compliance

- After a state is admitted to the commission, its legislature could enact subsequent laws
  - Some might directly amend the previously-enacted compact
  - Some might be other, non-compact laws that nevertheless conflict with or limit the operation of the compact in that state

Example: Telehealth Laws

- As a result of the pandemic, some states have enacted or updated their telehealth/telemedicine laws
- In some cases, those laws have posed conflicts with interstate practice privileges

Other Compliance Issues

- Member states may also come into non-compliance with their compact obligations in other ways
  - Non-payment of fees or assessments
  - Failure to report required data to the commission
  - Failure to enforce disciplinary or adverse action obligations

Member State Compliance

- Model compact typically includes provisions to deal with non-compliance by a member state
- This is different than a state attempting to gain initial entry into the compact
- As a member state, there are additional due process considerations

Member State Compliance

- For existing member states found to be out of compliance, the model compact legislation will typically include a process for:
  - Notice and opportunity to be heard
  - Time for implementation of remedial measures
  - Technical advice or assistance to the state

Withdrawal

- For withdrawal, a compact typically requires:
  - Enactment of a statute repealing the compact
    - May specify a time period (i.e., “one year after enactment”)
  - Mechanism for a state to be expelled for non-compliance

Questions?

The Council of State Governments

Welcome

Dentistry and Dental Hygiene Compact
TA Group Meeting
December 7-8, 2021

Attachment #6

Benefits and Challenges of a Dental/Dental Hygiene Compact

I hope the compact achieves…

I have concerns/ am confused about…

The Council of State Governments

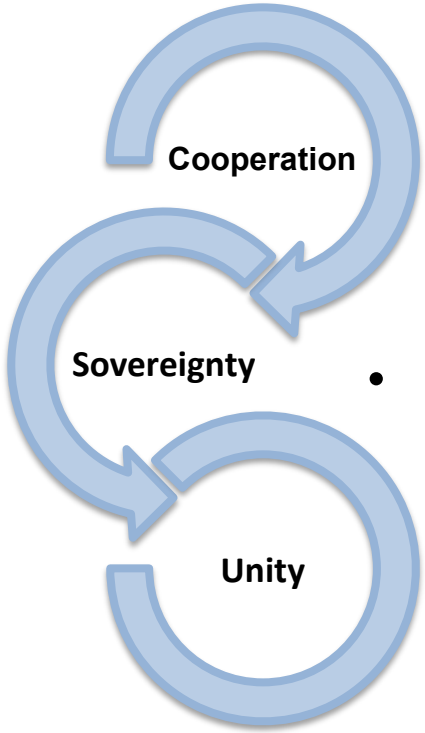
Compacts 101

Dentistry and Dental Hygiene Compact
TA Group Meeting
December 7, 2021

Attachment #6

What is an Interstate Compact?

*A **legal**, **legislatively enacted contract** between **two or more states** that allows states to:*



- Cooperatively address shared problems
- Maintain sovereignty over state issues
- Respond to national priorities with one voice

Three Primary Uses of Interstate Compacts

Resolve boundary disputes

Manage shared natural resources

Create administrative agencies with jurisdiction over state concerns

Compacts in the U.S. Constitution

Constitutional Authorization

The Compact Clause

"No State shall, without the Consent of Congress . . . enter into any Agreement or Compact with another State . . ."
(U.S. Const. Art. I, §10, cl. 3)

The Supreme Court

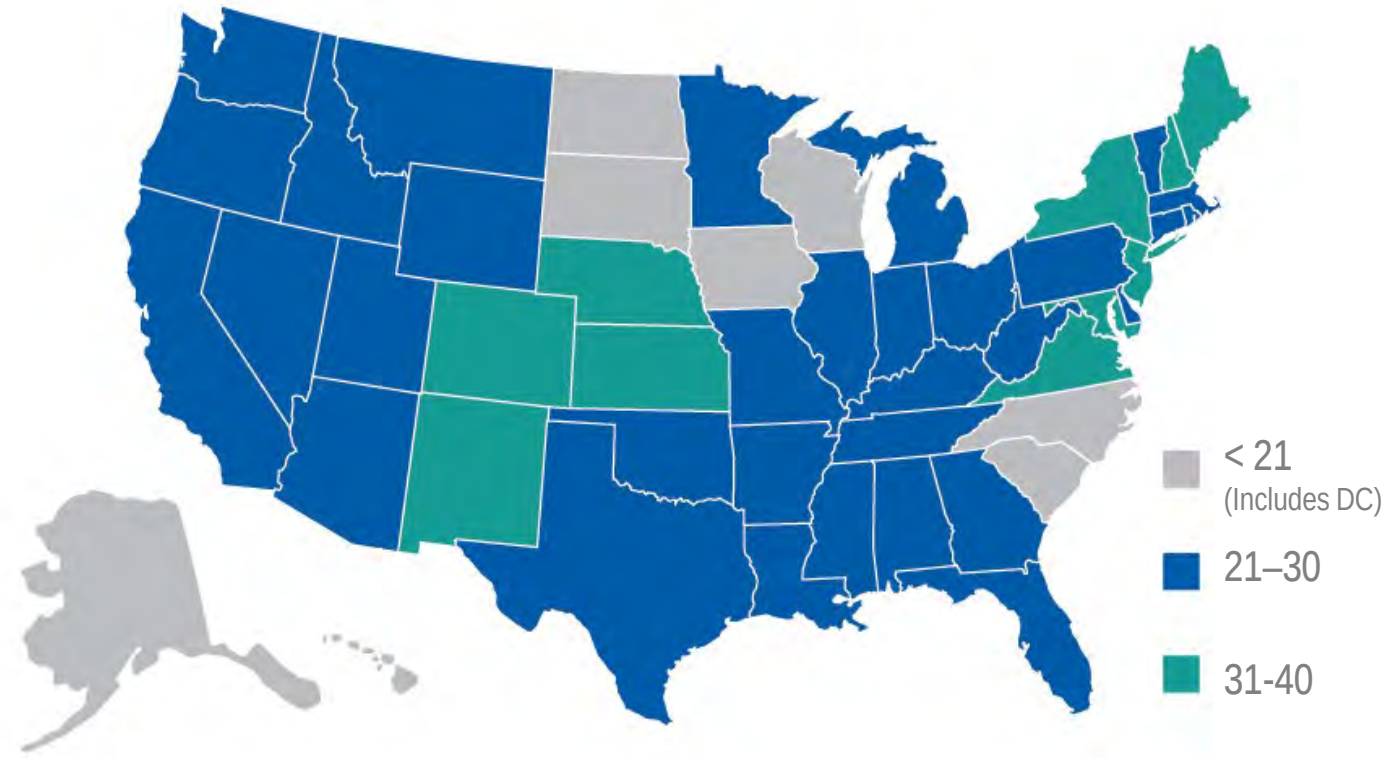
"Any" does not mean "all" and consent is not required unless the compact infringes on federal supremacy.
[Va. v. Tn 148 U.S. 503 (1893); U.S. Steel Corp. v. Multistate Tax Comm'n 434 U.S. 452 (1978)]

Compacts Today

Wide Acceptance in the States

There are approximately **250** active compacts

On average, states are members of about **25** compacts



Occupational Licensing Interstate Compacts

Facilitate Multistate Practice

Maintain or Improve Public Health and Safety

Preserve State Authority Over Professional Licensing

44 states have adopted at least one compact.
28 states have adopted at least three compacts.

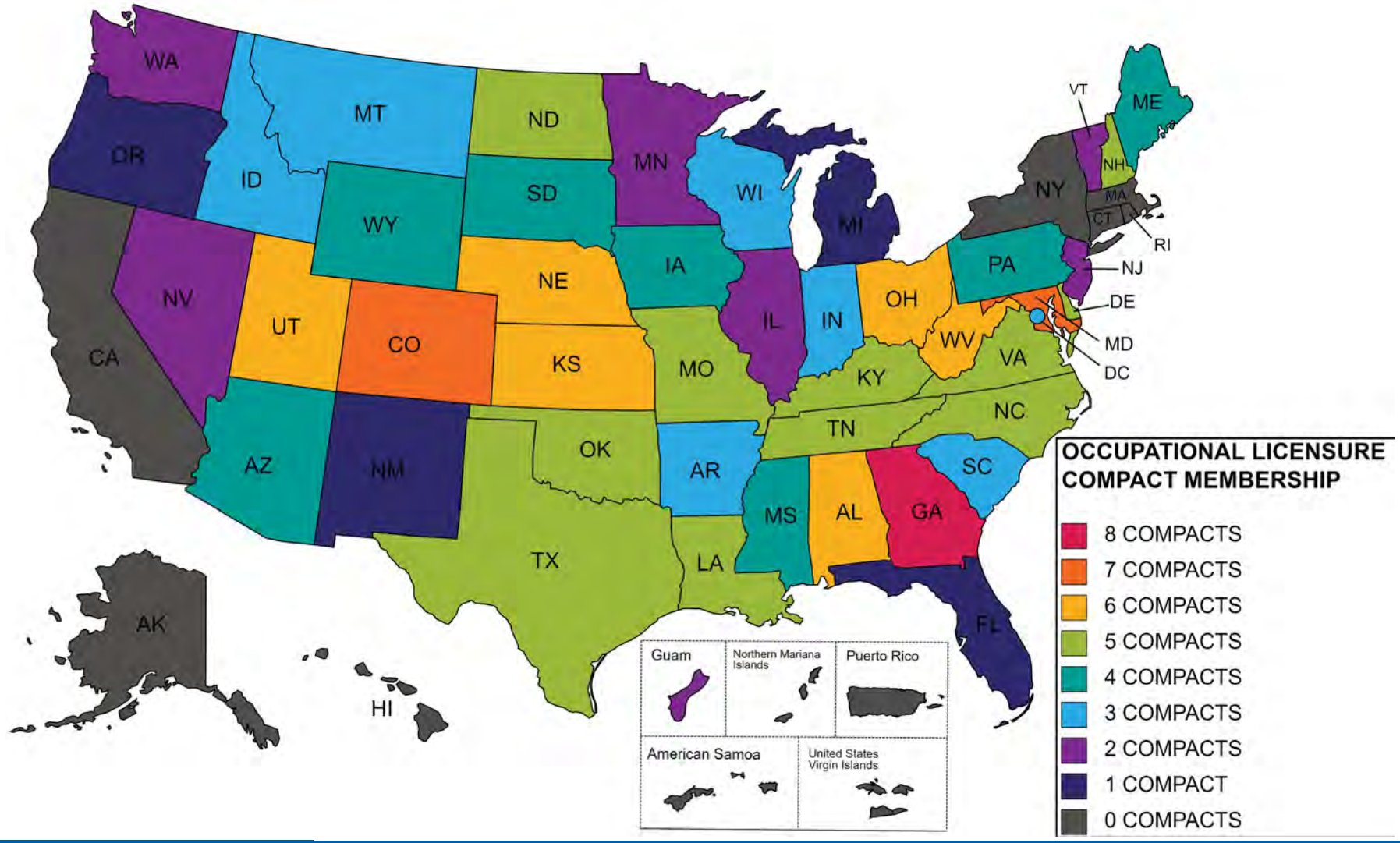
182 pieces of compact legislation have been enacted since 2016.

9 professions have active interstate compacts for occupational licensing.

Active Occupational Licensing Interstate Compacts

- Nurse Licensure Compact – 38 States
- Psychology Interjurisdictional Compact – 26 States
- Occupational Therapy Compact – 9 States
- Medical Licensure Compact – 35 States
- EMS Compact – 22 States
- Counseling Compact – 2 States
- Physical Therapy Compact – 34 States
- Audiology and Speech Language Pathology Compact – 15 States
- Advanced Practice Nursing Compact – 2 States

Occupational Licensing Interstate Compacts



Occupational Licensing Interstate Compacts Under Development

- Massage Therapy
- Social Work
- Cosmetology & Barbering
- K-12 Teaching
- Dentistry & Dental Hygiene
- Physician Assistant

Multistate Practice vs. License Transfer

Multistate Practice

I can practice in other member state(s) *without obtaining a license.*

License Transfer

If I move from one state to another, I can seamlessly obtain a *license* in the new state.

Historically, healthcare licensure compacts have been designed to facilitate multistate practice based on a valid home-state license.

Variation of Interstate Compact Models

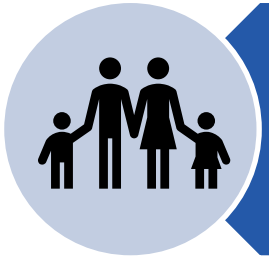
Mutual Recognition: Multistate License	Expedited Licensure	Mutual Recognition: Privilege to Practice	Telepsychology and Temporary in-person Practice

Benefits of an Interstate Compact

Benefits to Practitioners of Occupational Licensure Compacts

Increases Mobility

Leverages Advancing Technology: Tele-practice



Supports relocating families (military families)

Benefits to State Boards of Occupational Licensure Compacts

Facilitates delivering emergency assistance in times of state or national disaster/crisis

Secures agreement on uniform licensure requirements

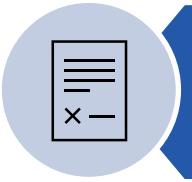
Creates shared data system

Enhances cooperation among state boards

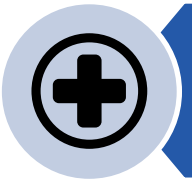
Expands ability to protect public health/safety

Benefits to States of Occupational Licensure Compacts

Facilitates flexibility and autonomy in comparison to federal policy



Strengthens state sovereignty



Increases access to highly qualified practitioners

Strengthens labor markets

Compacts vs. Universal Recognition

	Universal Recognition	Interstate Compacts
Requires practitioners to abide by the scope of practice of the state in which they are practicing	☑	☑
Allows for expeditious interstate movement of practitioners during emergencies	☑	☑
Reduces barriers for out-of-state practitioners aiming to practice within your state	☑	☑
Reduces barriers for in-state practitioners aiming to practice in multiple states	✗	☑
Allows military spouses to maintain a single home-state license for the duration of the service member's active duty, regardless of relocations, without submitting a separate application to each state's licensure board	✗	☑
Allows practitioners to work in multiple states, both in person and via telehealth/telework, without submitting a separate application to each state's licensure board, requiring verification of the current license, or obtaining a new background check	✗	☑
Brings together a coalition of states to establish uniform and enforceable interstate licensure standards that are narrowly tailored to the public protection requirements of a specific profession	✗	☑
Enhances public protection by creating a multi-state database of licensure information to facilitate collaboration on license verification and investigations of potential misconduct	✗	☑
Allows multistate practice without requiring the practitioner to change state of residence	✗	☑

Developing an Interstate Compact

Phase I
Development

TECHNICAL ASSISTANCE GROUP

- Composed of approximately 20 state officials, stakeholders and issue experts
- Examines issues, current policy, best practices and alternative structures
- Establishes recommendations as to the content of an interstate compact

DOCUMENT TEAM

- Composed of 5-8 state officials, stakeholders and issue experts
- Crafts Compact based on recommendations
- Circulates draft Compact to states and stakeholder groups for comment

FINAL PRODUCT

- Drafting team considers comments and incorporates into Compact
- Final product sent to TA Group
- Released to states for consideration

Phase II
Education and Enactment

EDUCATION

- Develop comprehensive legislative resource kit
- Develop informational website with state-by-state tracking and supporting documents
- Convene “National Briefing” to educate legislators and key state officials

STATE SUPPORT

- Develop network of “champions”
- Provide on-site technical support and assistance
- Provide informational testimony to legislative committees

STATE ENACTMENTS

- Track and support state enactments
- Prepare for transition and implementation of Compact
- Provide requested support, as needed

Phase III
Transition and Operation

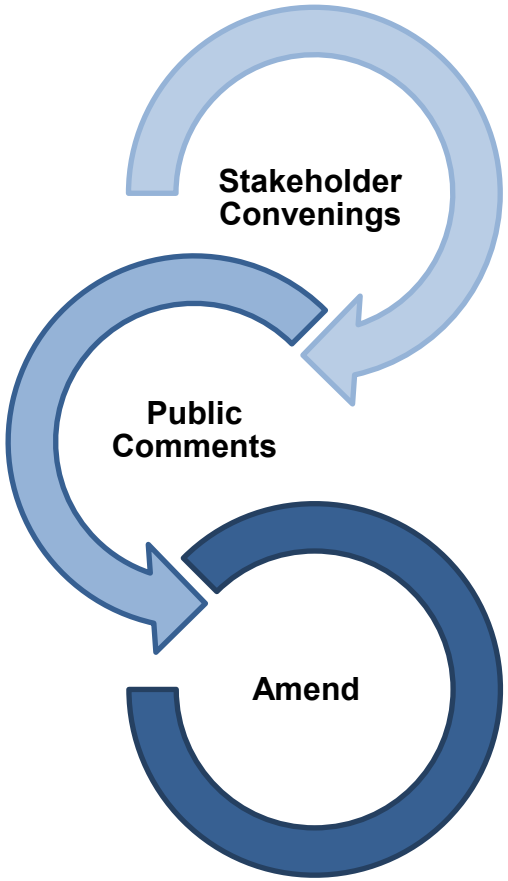
TRANSITION

- Enactment threshold met
- State notification
- Interim Executive Board appointed
- Interim committees established
- Convene first Compact meeting
- Information system development (standards, security, vendors)

OPERATION

- Ongoing state control and governance
- Staff support
- Annual assessment, if necessary
- Annual business meeting
- Information system oversight (maintenance, security, training, etc.)
- Long-term enhancements/up-grades

Licensure Compact Development Process



Throughout the entire process seek to ensure **transparency** and take the time necessary to ensure things get **done right the first time**. Compacts are difficult to revise once enacted.

Interstate Compact Governance

Key Attributes of the Compact Commission

- Commission is “stood up” when the threshold of jurisdictions pass compact legislation
- Supra-state, sub-federal nature
- Statutorily created governmental entity (authority to issue binding rules)
- Composed of member state regulatory officials (not a private entity)
- Instrumentality of the member states

Key Attributes of the Compact Commission

Composition and Responsibility

- Comprised of voting representatives from each member state
- Responsible for key decisions with respect to the Compact
- Has legal status of an interstate administrative agency with rulemaking authority

Formation of Committees

- Can form committees, including an executive committee that is responsible for making day-to-day decisions

Authority

- Created by statute with delegation of rulemaking authority within the **limitations** of the Compact statute
- Frequently granted the authority to form committees, hire staff, manage the data system and provide financial management and is responsible for implementing the policies and procedures established by the Commission

Duties

- Serve agencies of the member states and act on their behalf
- Required to administer and enforce the Compact provisions and rules
- Commission does not act on behalf of any particular group or organization

Questions?

The Council of State Governments

Elements of an Occupational Licensing Interstate Compact

Dentistry and Dental Hygiene Compact
Technical Assistance Group
December 7, 2021

Attachment #6

Principles of Licensure Compacts

- The purpose of an occupational licensure compact is to facilitate the practice of licensed professionals in other compact member states without the requirement to be licensed in those states.
    1. The licensed professional is only required to hold a license in their home state (primary state of residence).
    2. The license must be free from encumbrances or sanctions – some compacts have a “look back period”

All occupational licensure compacts are different and distinct; however, they are all essentially the same.

What follows are the common elements for occupational licensure compacts:

Purpose Statement

The Purpose Statement of the model legislation is an important exercise for the project team to complete.

- The purpose statement is sometimes cut by legislative drafters and is not essential to the functioning of the compact, but it can be helpful for those advocating the enactment of the compact and may be beneficial for interpretation in the courts.

The Document Team will write the purpose of the compact, however the TA Group can make recommendations.

- Here is the first paragraph of the purpose statement from the Occupational Therapy Compact:
  The purpose of this Compact is to facilitate interstate practice of Occupational Therapy with the goal of improving public access to Occupational Therapy services. The Practice of Occupational Therapy occurs in the State where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of States to protect public health and safety through the current system of State licensure.

Purpose Statement

- A general statement about the intent of the compact is typically followed by specific bullet points that address the following:
    - Access to care
    - Public protection
    - Preserving state jurisdiction and state sovereignty
    - Streamlining regulation
    - Supporting military spouses
    - Promoting state cooperation
    - Modernizing practice and regulation (i.e. telehealth, using technology to identify licensure fraud, digital licensing record keeping)

Definitions

Definitions are the most important section of the compact.

1. Precise definitions ease the burdens of implementing the compact
2. Narrow definitions can limit the longevity of the compact

   Examples:

   - State Board
   - Compact Privilege

The Document Team will define what is necessary and leave the rest to the member states in the compact commission rules.

- The TA Group doesn't generally make recommendations about definitions, but you may do so
- The TA Group will review the definitions and provide feedback to the Document Team

State Participation

Describes the requirements for compact membership for states.

Details the obligations of membership in the compact for member states.

- These sections typically include, but are not limited to:
  - List requirements for states to join the compact (depends on the licensure uniformity among the states)
  - FBI Criminal Background Check
  - Statement that all member states must recognize the license issued by other compact member states and that this recognition authorizes practice in their jurisdiction
  - Requirement to comply with compact commission rules
  - Ability to charge a fee

The contents of this section will be driven, in part, by the presentation on current state licensure requirements.

Practitioner Participation

- The Nurse Licensure Compact (NLC) is structured a little differently – it deals with some of these issues in Section III of the NLC entitled “General Provisions and Jurisdiction”
- Section IV of the NLC “Applications for Licensure in a Party State” describes processing an application for a multistate license and residency issues for applicants
- The other mutual recognition compacts use this section to describe in detail the eligibility requirements for practitioners:
  - Hold a valid HOME STATE license
  - Identifying number
  - Obligation to pay fees
  - Jurisprudence requirements
  - Completion of CE in home state only
  - Supervision
  - Statement that a practitioner who is utilizing the compact to practice in a compact member state must follow the laws and regulations of that member state related to practice

Active Duty Military Personnel or their Spouses

Congratulations!!

This section has been completed!!!!

Adverse Actions

The project team must walk a fine line with the Adverse Action Section.

- The provisions in the compact about adverse actions must be broad enough that the members states can adopt rules and address specific circumstances.
- Conversely, the compact can not be so broad as to be absurd.

The project team must build a solid foundation for the member states.

- General elements are:
  - Powers of the member states and the home state
  - Obligations of the member states
  - Joint investigations
  - Alternative programs

Boilerplate Language

CSG had developed boilerplate language that most of the licensure compacts use for the following compact sections:

- Interstate Commission (Member State Commission)
- Rulemaking
- Data System
- Oversight, Dispute Resolution and Enforcement
- Effective Date, Withdrawal and Amendment
- Construction and Severability
- Binding Effect of Compacts

The project team isn't obligated to use this language, but CSG strongly suggests you use this language.

- The boilerplate language must be adapted to this profession
- Recommend changes to some of the boilerplate language

Member State Commission

- Appointing Authority
- Commissioners
- Code of Ethics
- Voting
- Meetings
- Term? Number of Terms?
- Executive Committee
- Non-voting members
- Financing

Rulemaking

- Scope of commission rules
- Process for adoption
- Notice of Proposed Rulemaking
- Requirements for a public hearing
- Emergency rulemaking

Data System

Nurse Licensure Compact:

- Identifying Information
- Licensure Data
- Information related to alternative program participation
- Other Information as determined by the commission

Other compacts have been more specific:

- Adverse Actions
- Denial of licensure
- Current Significant Investigative Information
- Non-confidential information related to alternative programs

Oversight, Dispute Resolution and Enforcement

Like the language for “construction and severability” there is not much for work for the TA Group with this section

- The Oversight, Dispute Resolution, and Enforcement section:
  - Details the rights of the commission in a judicial proceeding and states that the provisions of the compact and rules promulgated by the member states have the standing of “statutory law” in the member states.
  - Describes the process for determining if a state is out of compliance with the provisions of the compact and rules, termination of membership and appeal
  - Provides for dispute resolution among the party states
  - Empowers the commission to enforce the compact provisions and rules – this is important

Effective Date, Withdrawal and Amendment

- The TA Group will make a recommendation as to the number of states required for the compact to begin operation.
- Describes how a member state can withdraw from the compact.
- Describes the process for amending the compact – not recommended.

Construction and Severability

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence, or provision of this Compact is declared to be contrary to the constitution of any Member State or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any Member State, the Compact shall remain in full force and effect as to the remaining Member States and in full force and effect as to the Member State affected as to all severable matters.

Binding Effect of Compact and Other Laws

- Repeats that practitioners operating under the compact in member states are required to follows the laws and regulations related to practice.

  "Any laws in a Member State in conflict with the Compact are superseded to the extent of the conflict."

- Repeats that compact rules are binding on member states.
- Notes again that lawful rules of the compact are binding upon the member states
- Restates primacy of state constitutions

The Council of State Governments

State Licensure Requirements in the Dentistry and Dental Hygiene Professions

Kaitlyn Bison

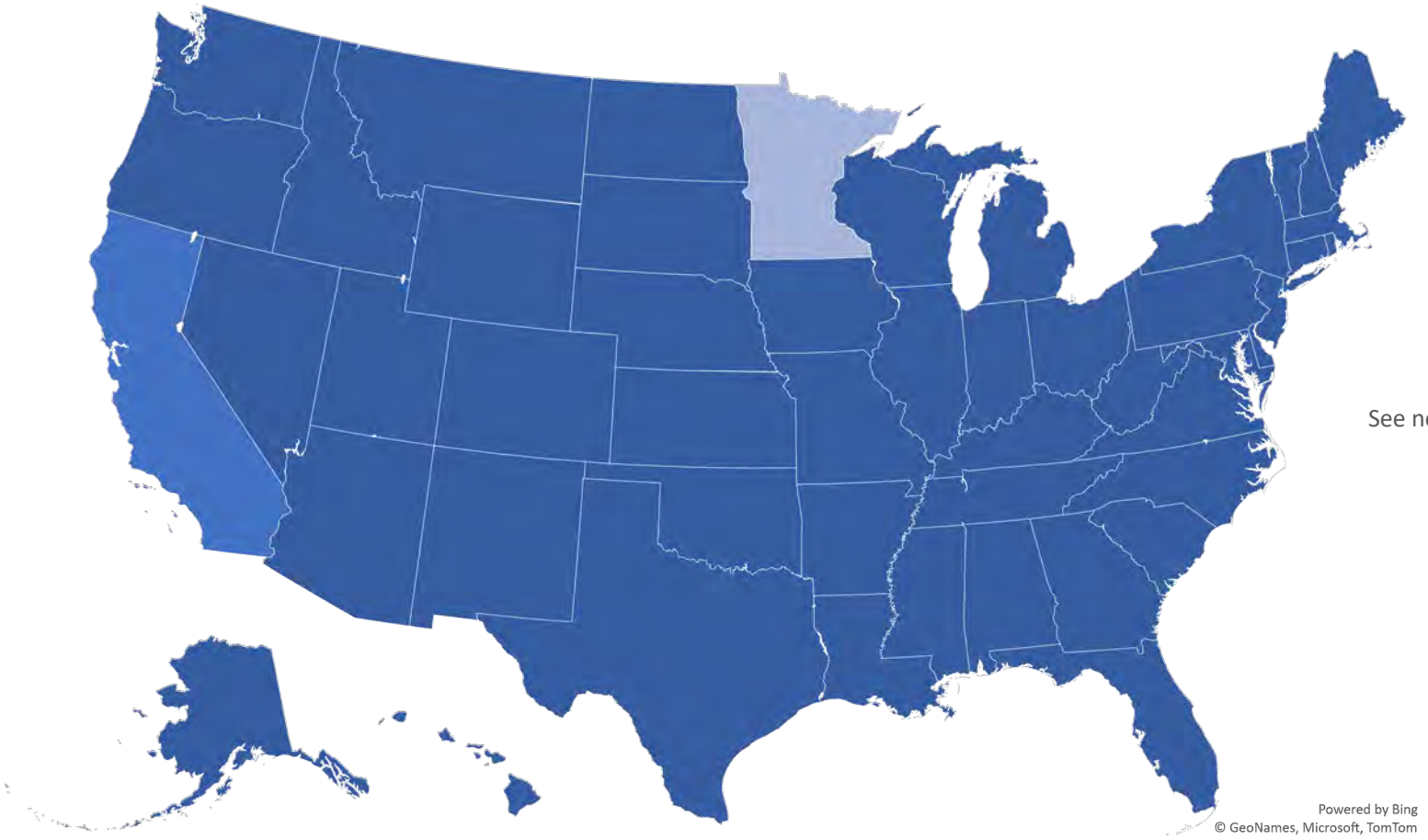
Dentistry and Dental Hygiene Compact
TA Group Meeting
December 7, 2021

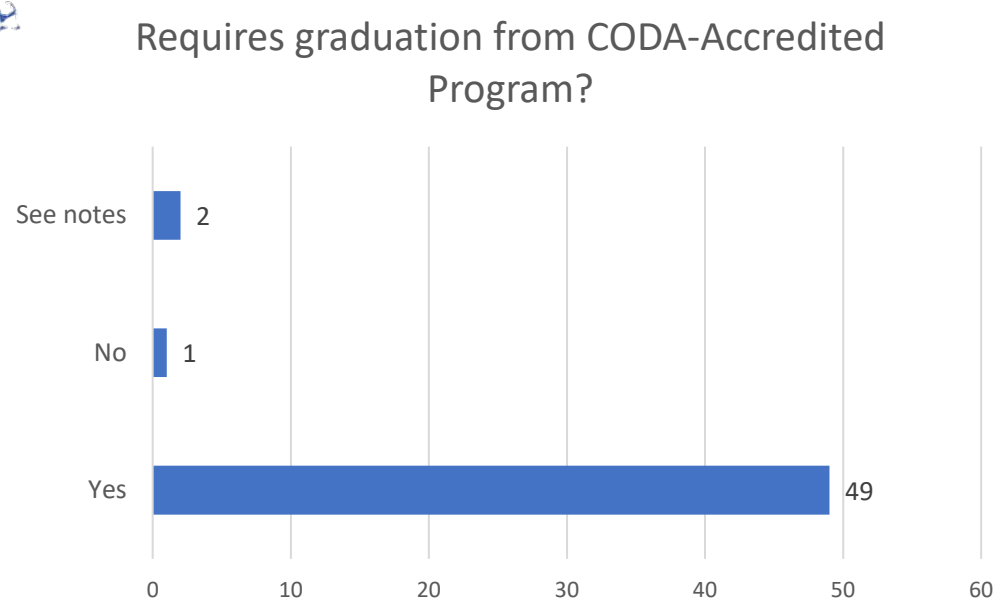
Attachment #6

Licensure Requirements in Dentistry

- **Overview:**
  - Dentists are licensed in all 50 states and Washington D.C.
  - Licensure requirements for dentistry include *Education Requirements, Written Exam (NBDE), Clinical Exam, Jurisprudence, Background Check, (and CPR Certification)*
- **Challenges:**
  - Clinical exams vary greatly by state
    - CDCA, CITA, CRDTS, SRTA, WREB, OSCE/DLOSCE, PGY-1, NDEB, PGY-2, State, NDEB of Canada
  - Background checks

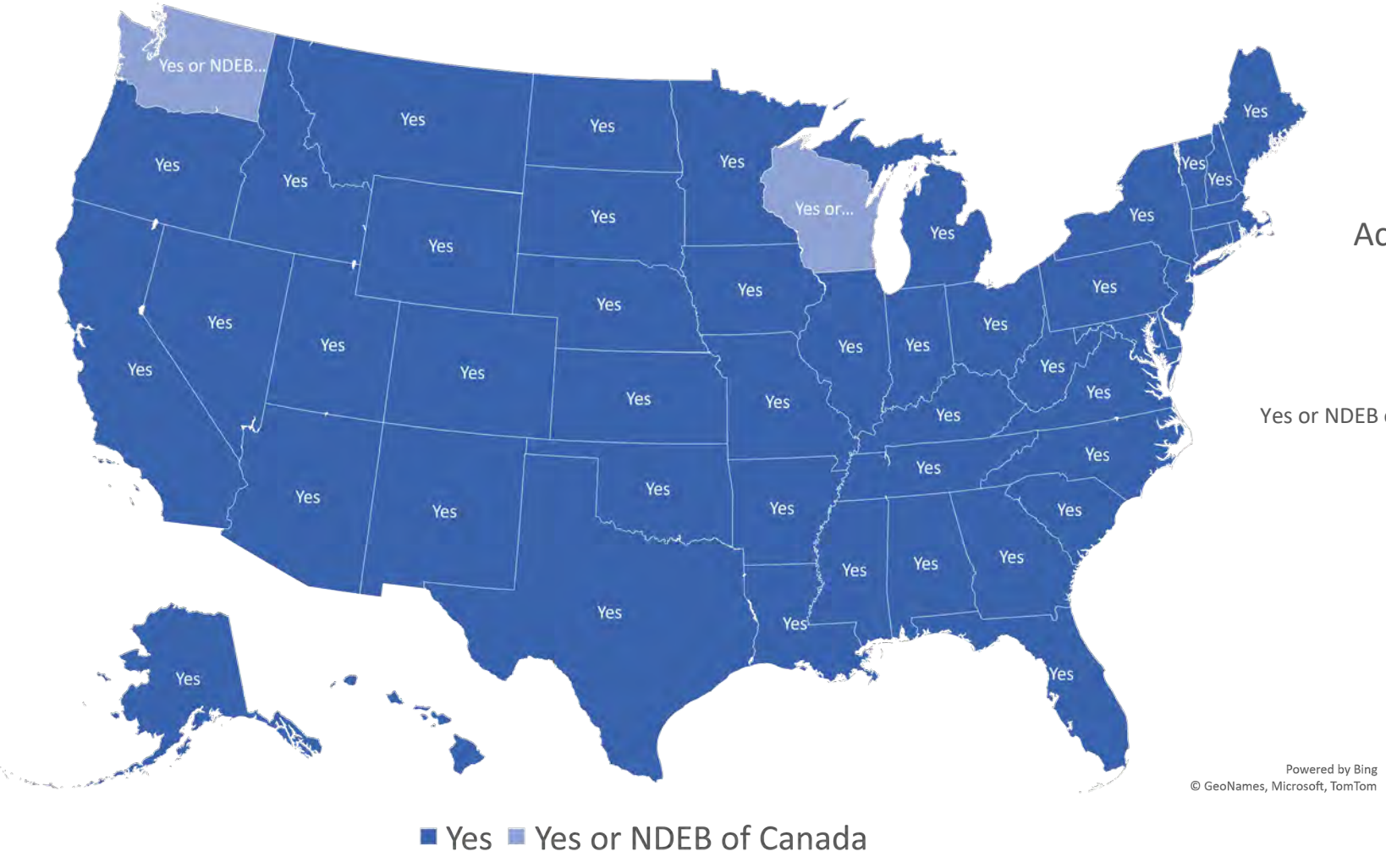
Education Requirement

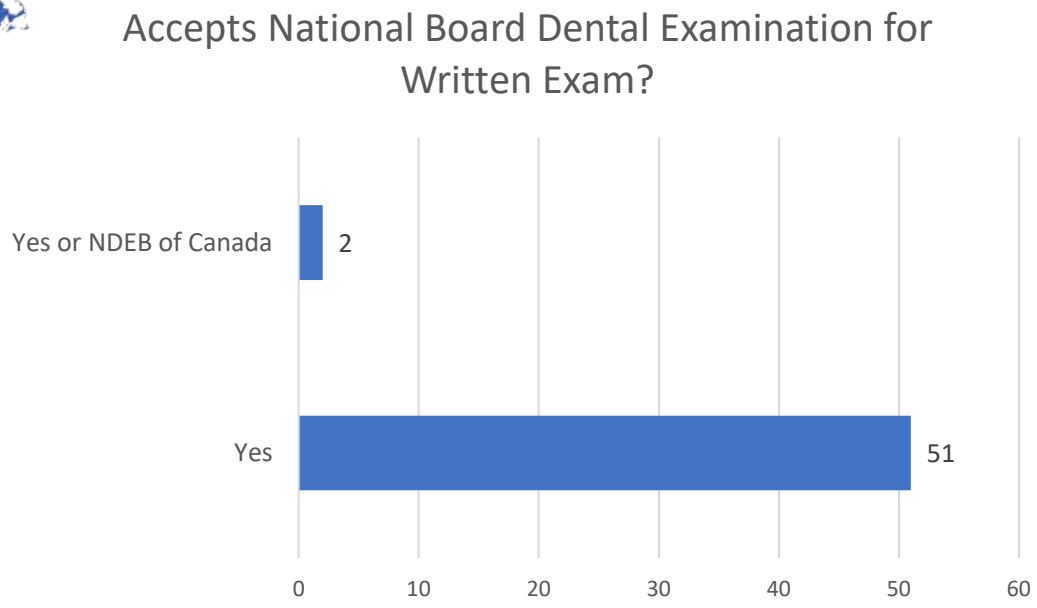




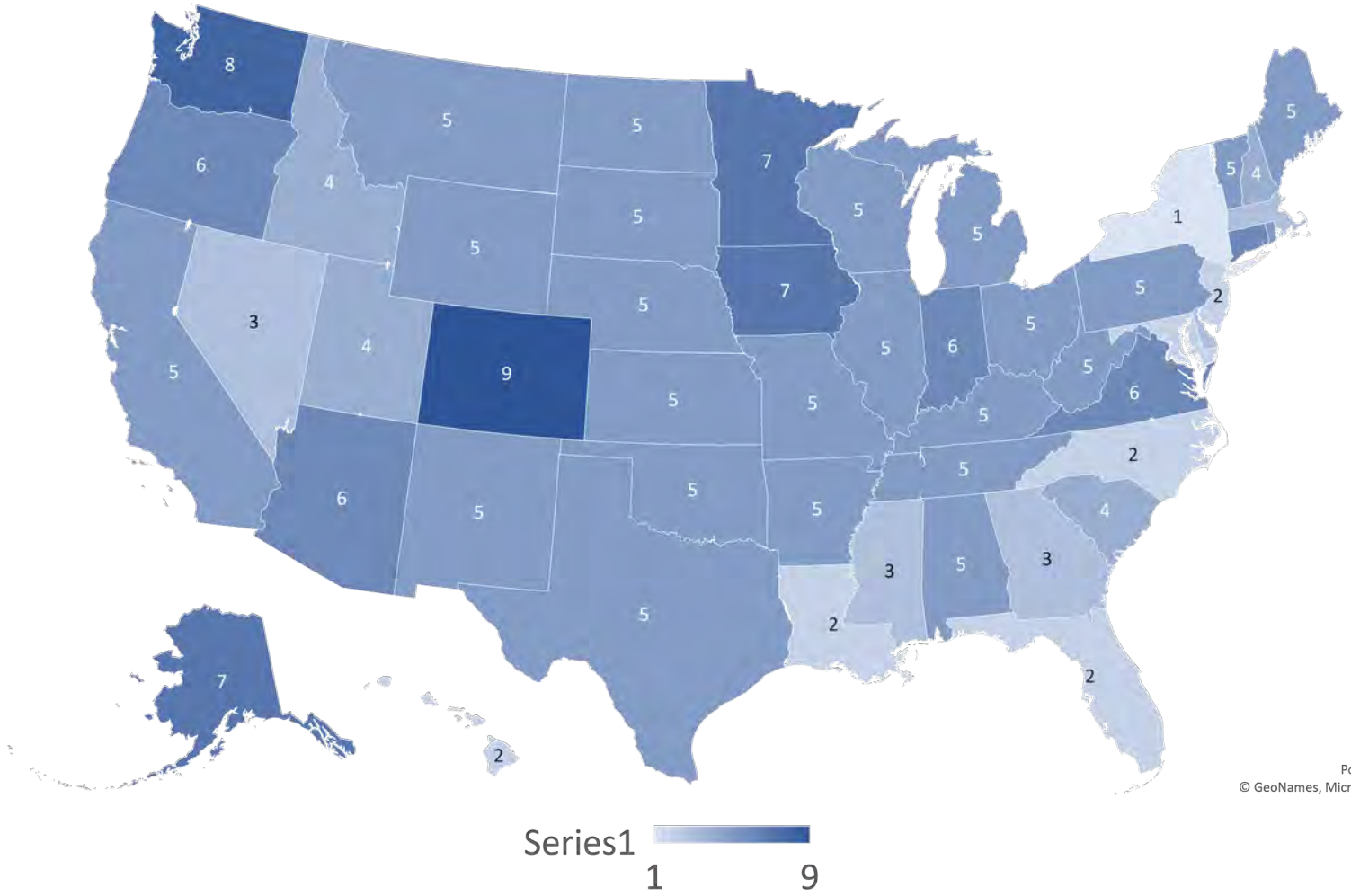
Graduation from CODA-Accredited Program See notes No (IED Review allowed)

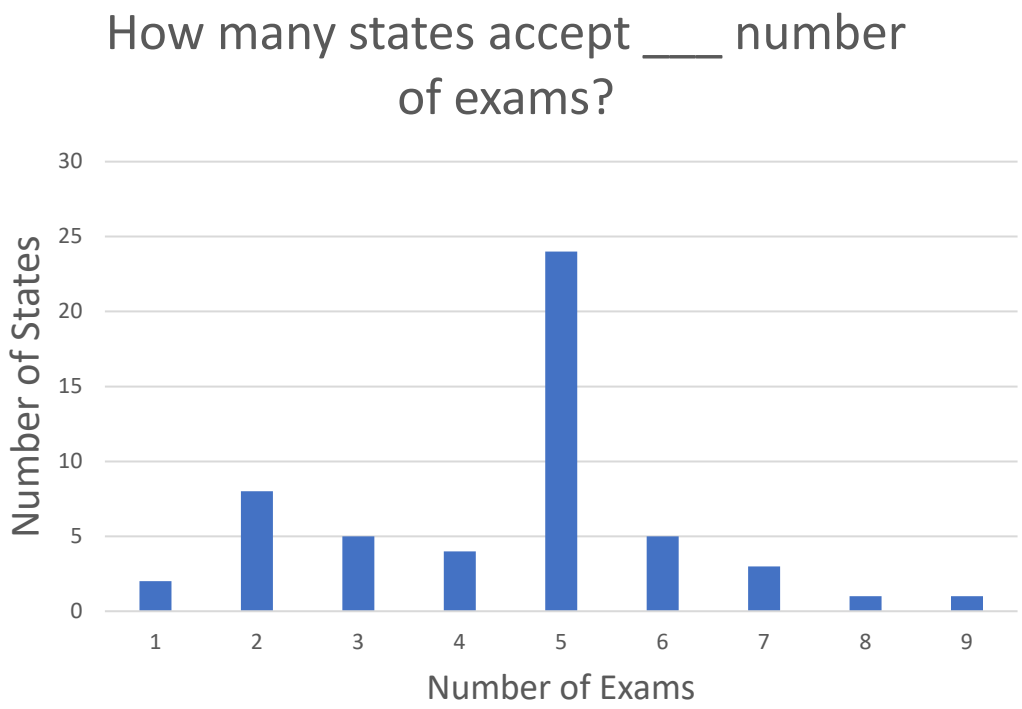
Written Exam (National Board Dental Examination)



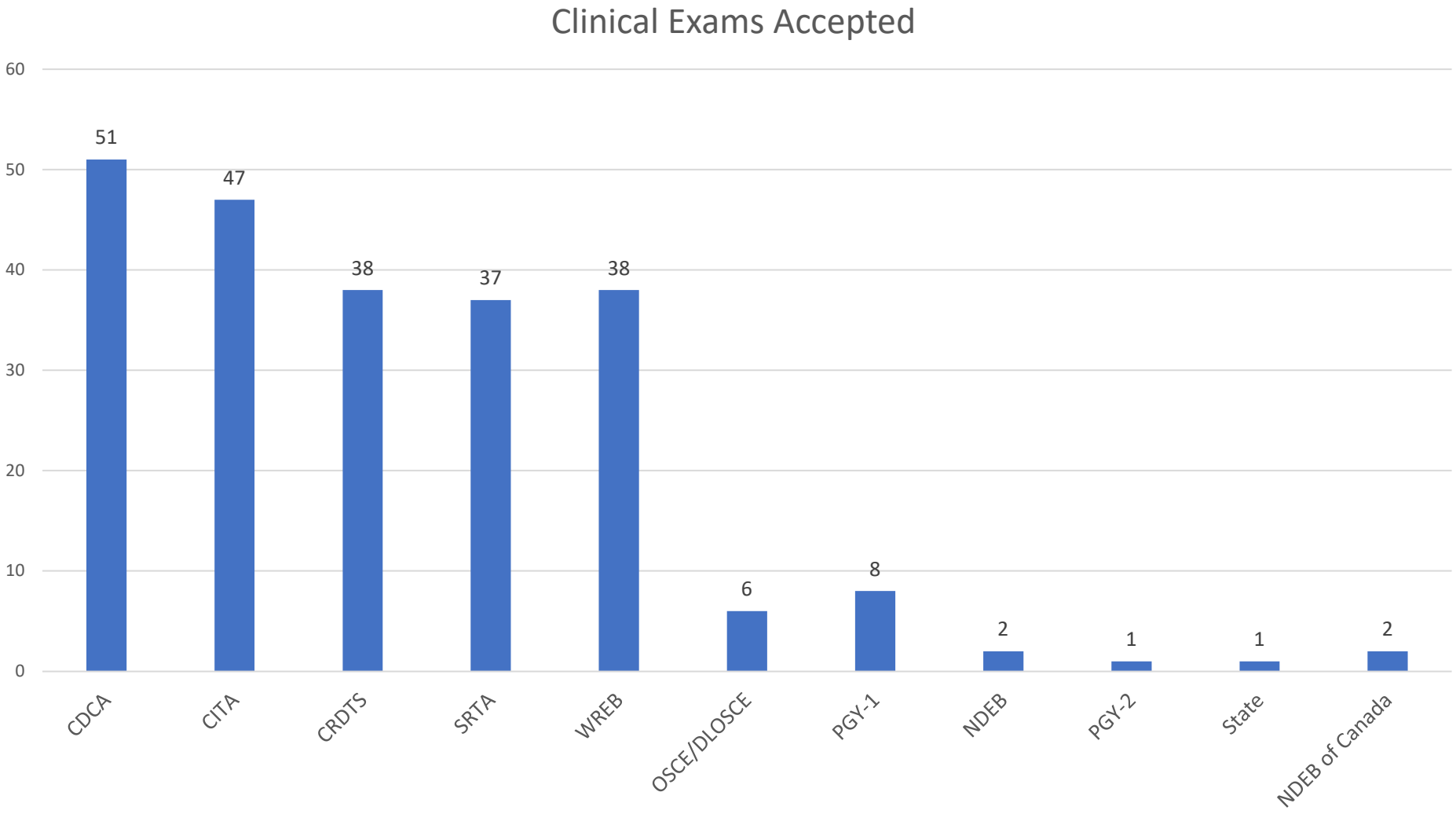


Clinical Exam

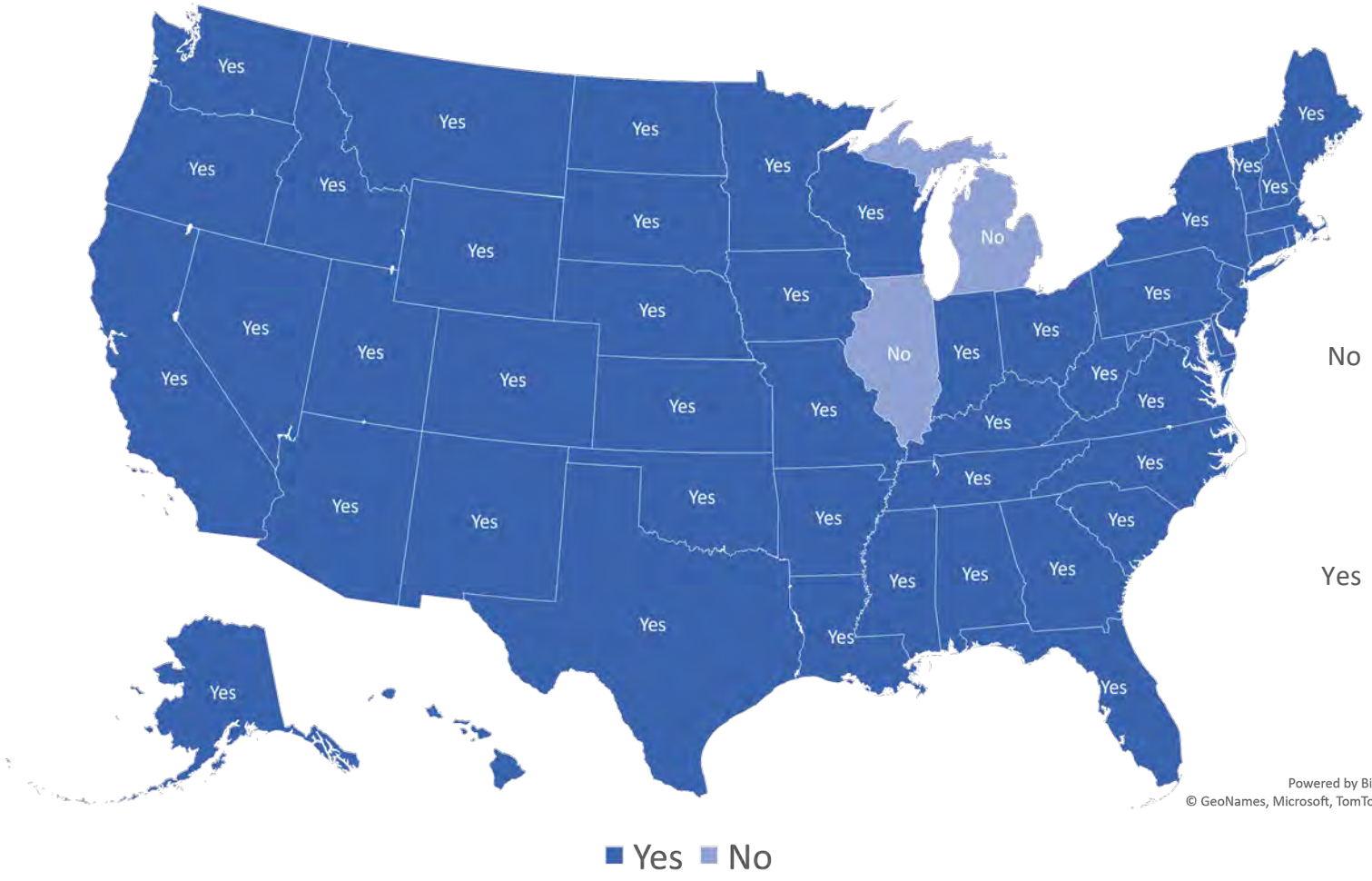


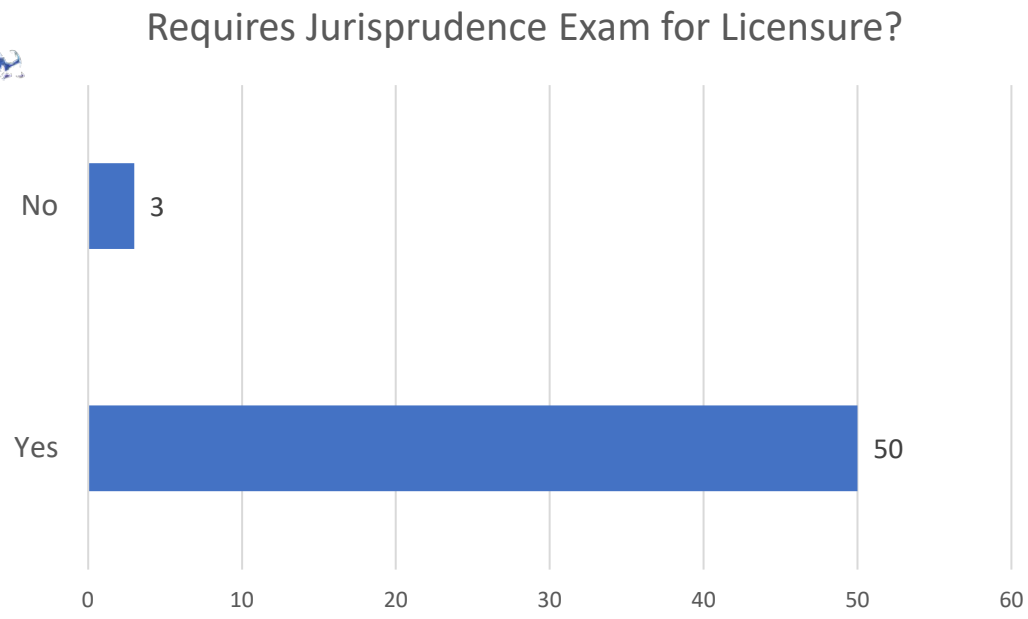


Clinical Exam

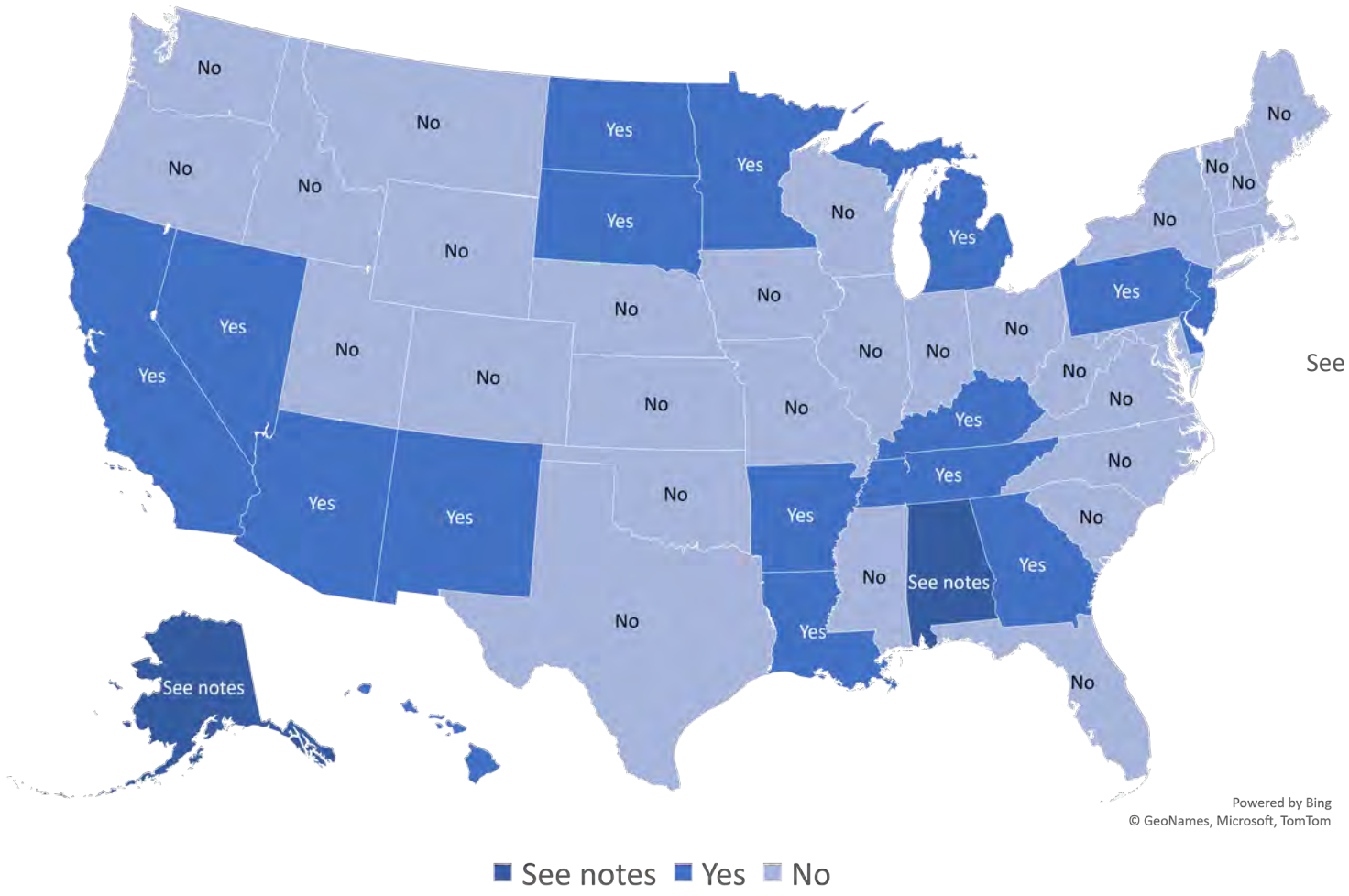


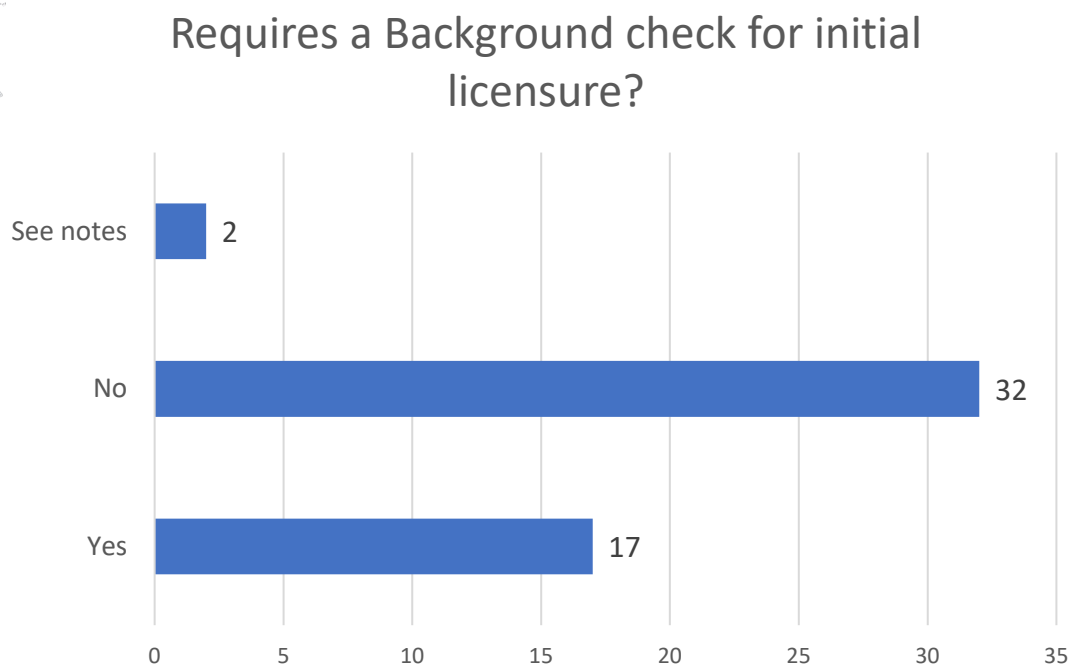
Jurisprudence Exam



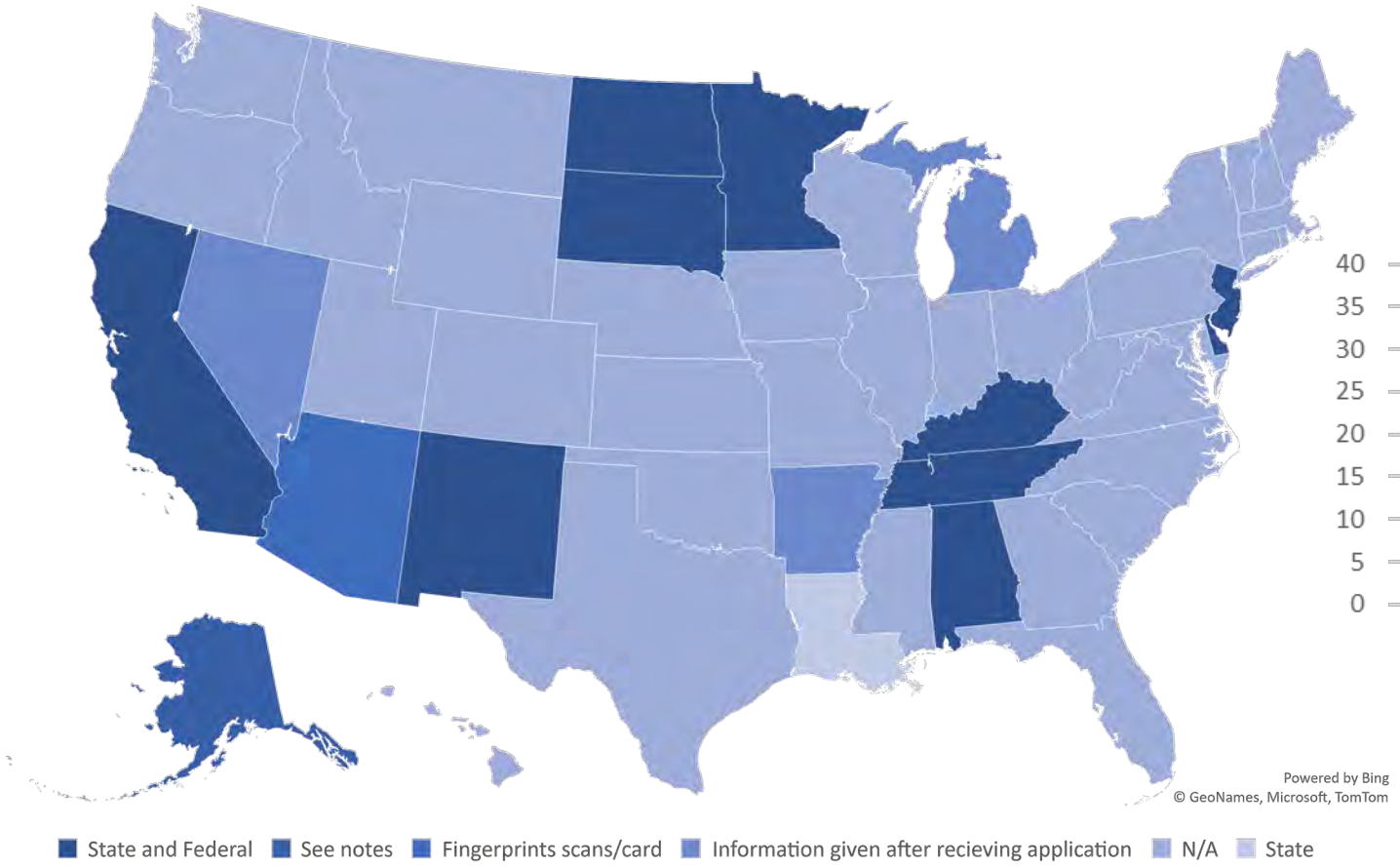


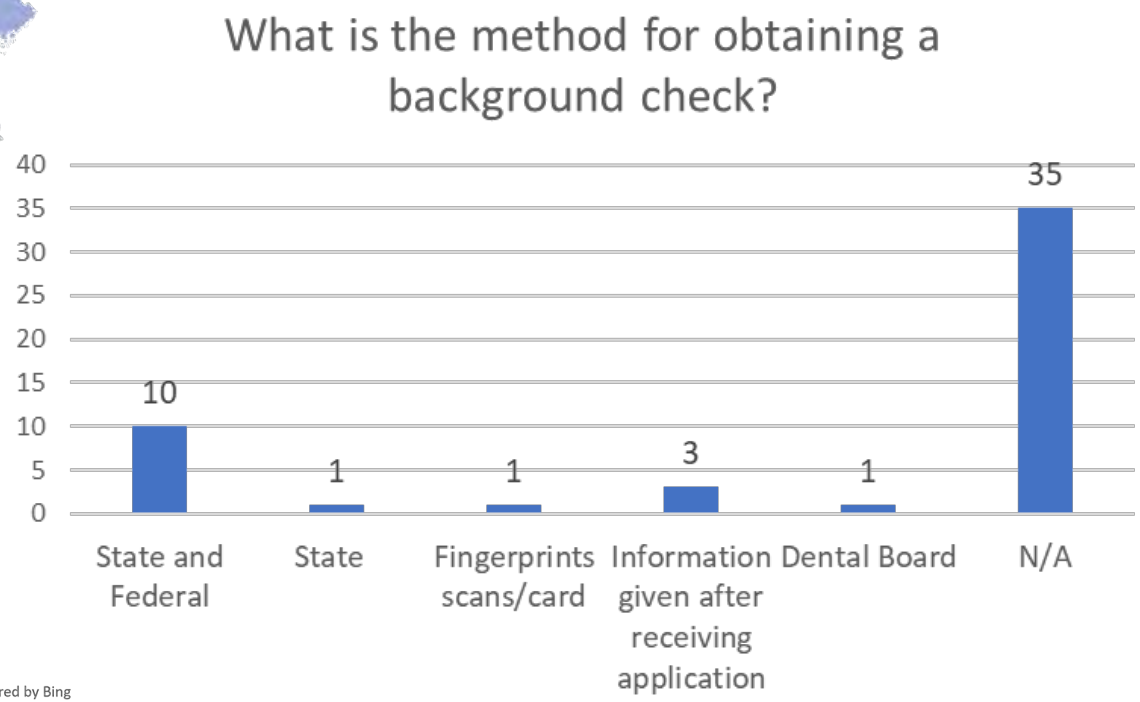
Background Check



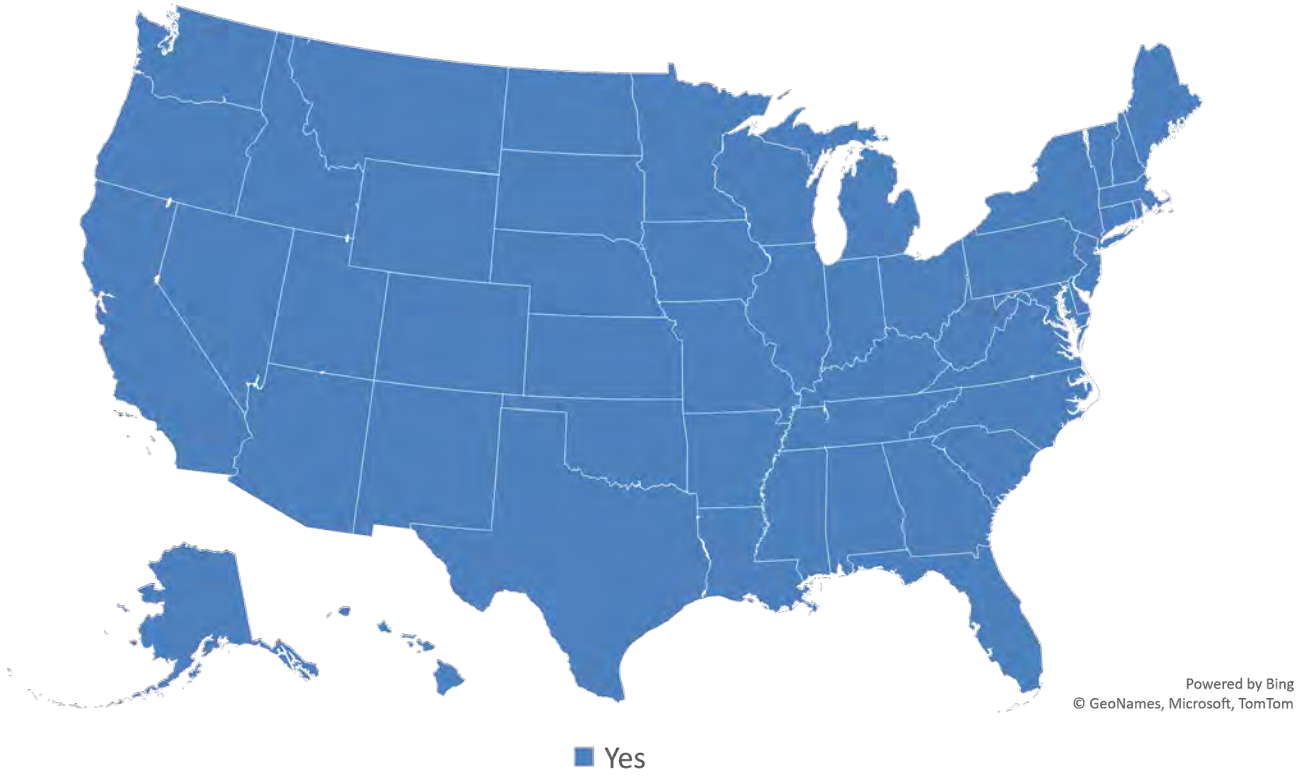


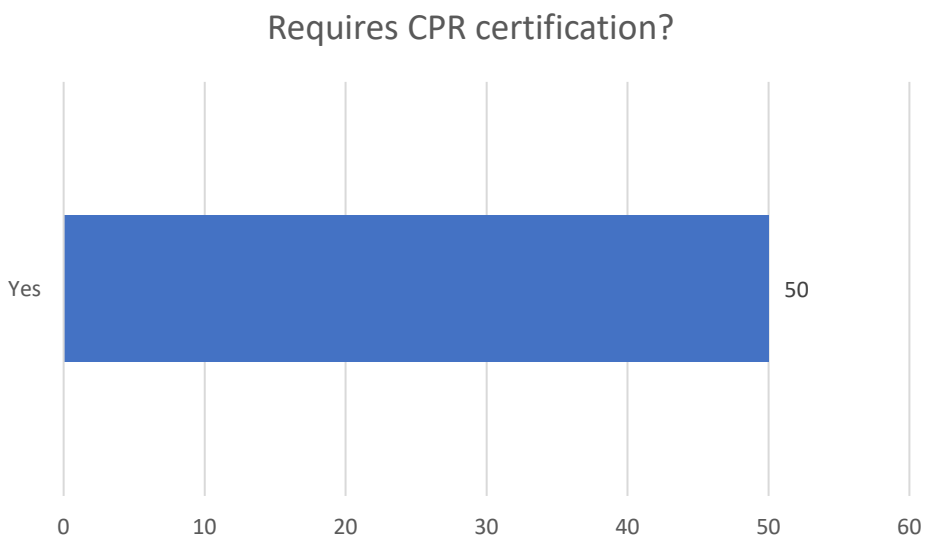
Background Check Method





CPR Certification

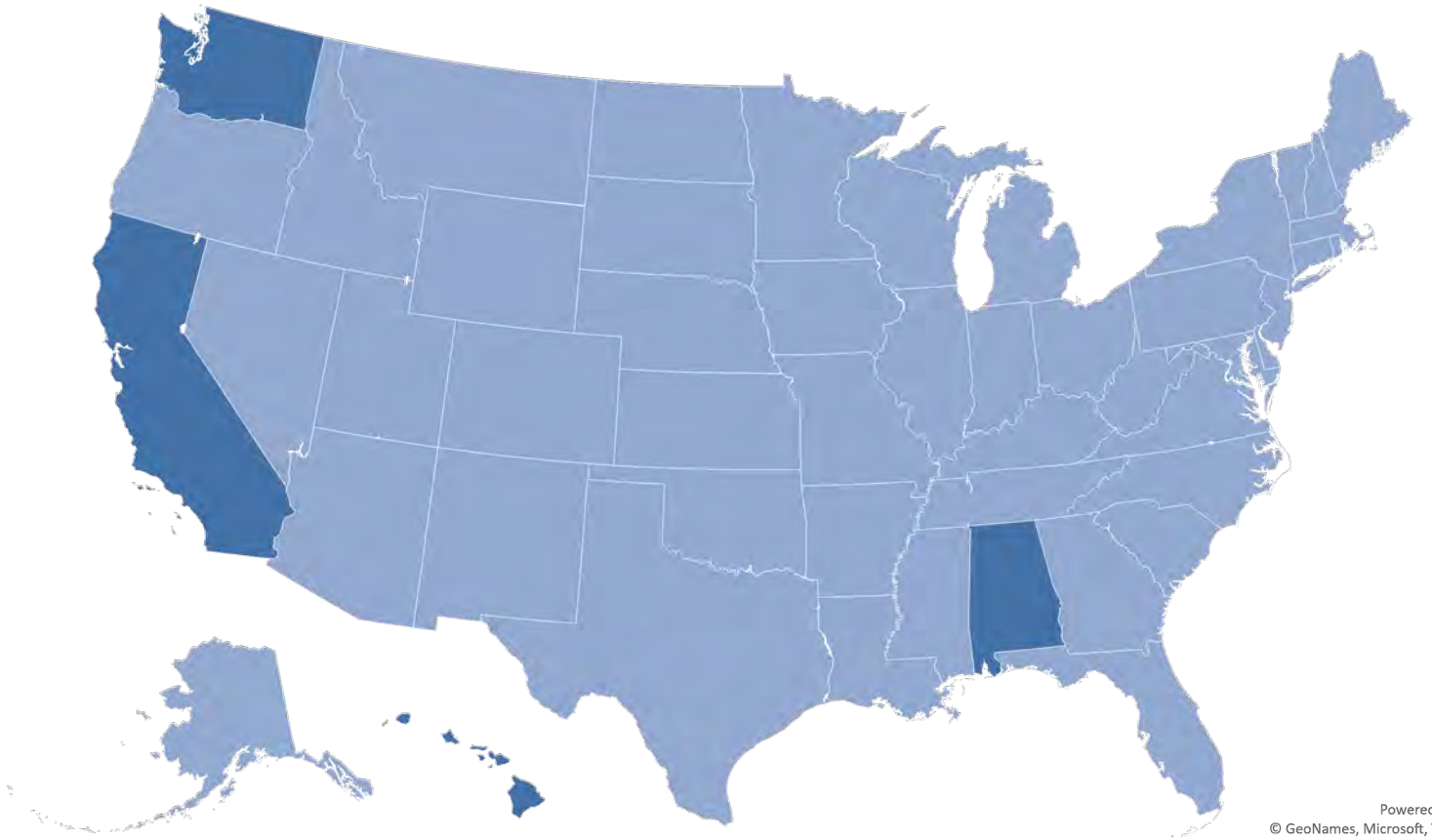


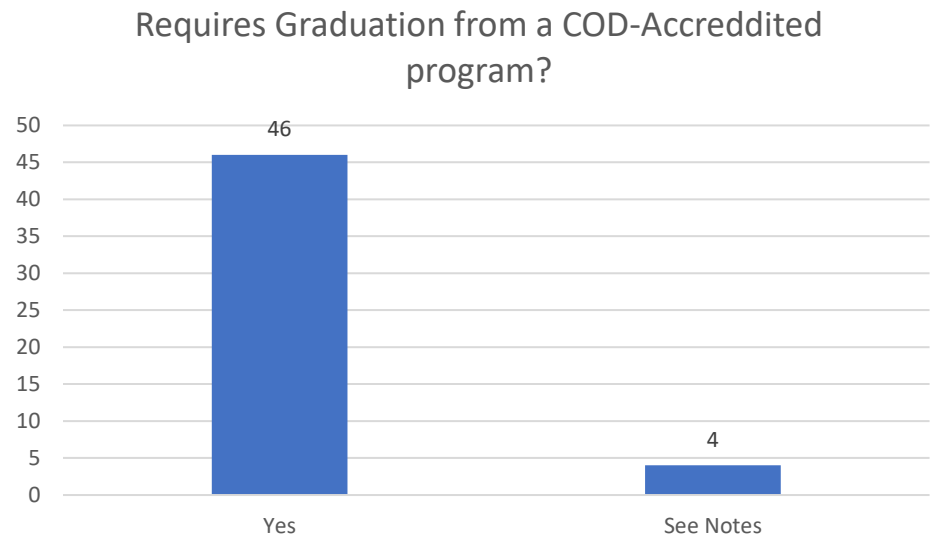


Uniformity in Dental Hygiene

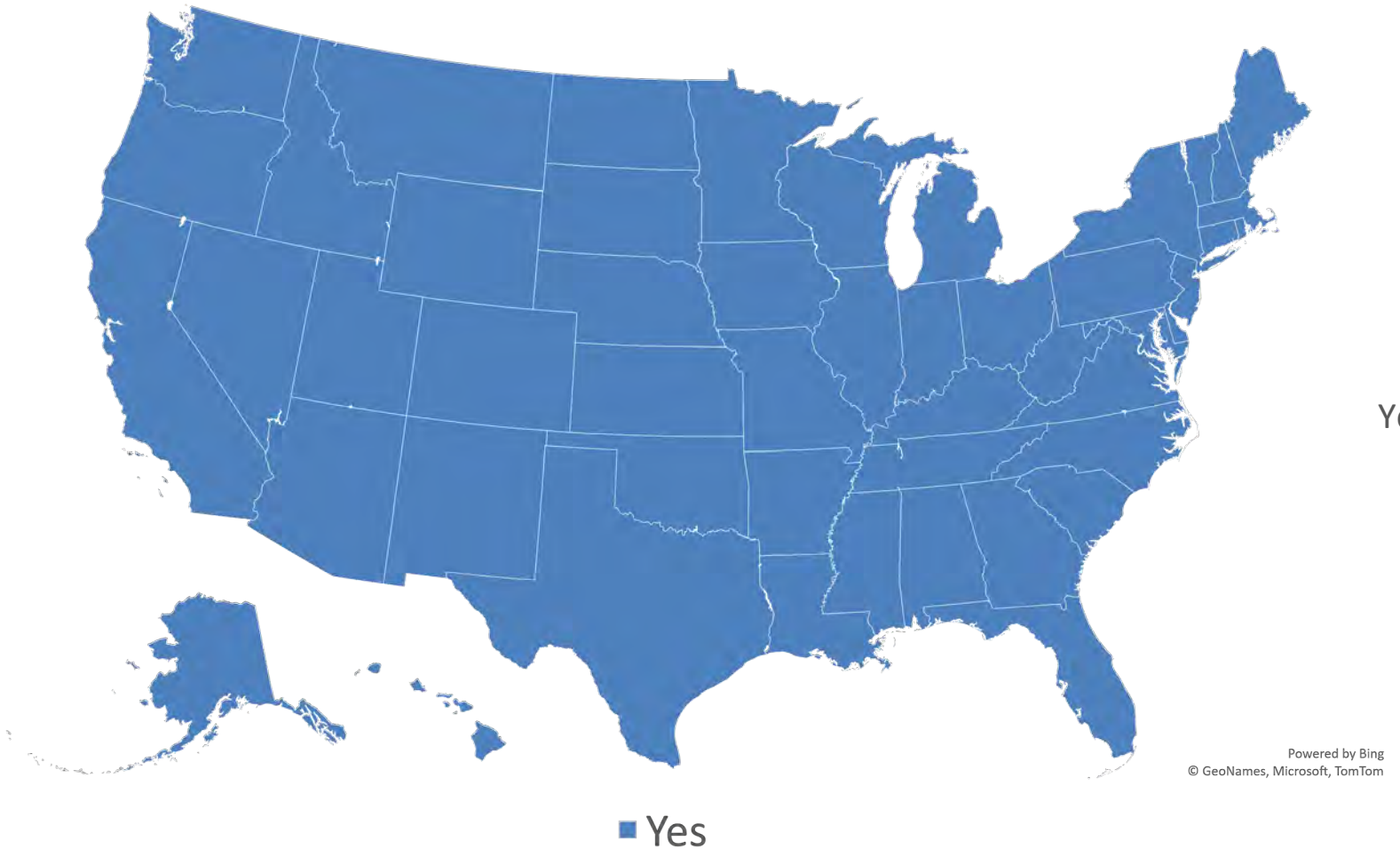
- **Overview:**
  - Dental Hygiene is licensed in all 50 states and Washington D.C.
  - Initial licensure requirements for Dental Hygiene include: *Education Requirements, Written Exam (NBDHE), Regional/ State Clinical Exam, Clinical Exam Method, Jurisprudence Exam, Background Check, and CPR Certification*
- **Challenges:**
  - Regional/ State Clinical Exam and Method vary greatly by state
    - CITA CRDTS CDCA SRTA WREB State
  - Background checks
  - Jurisprudence exam

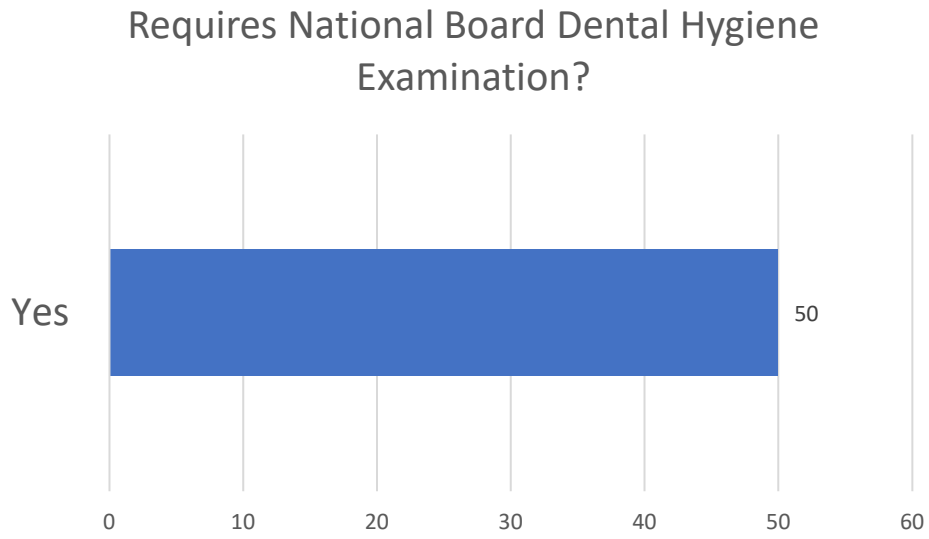
Education Requirement



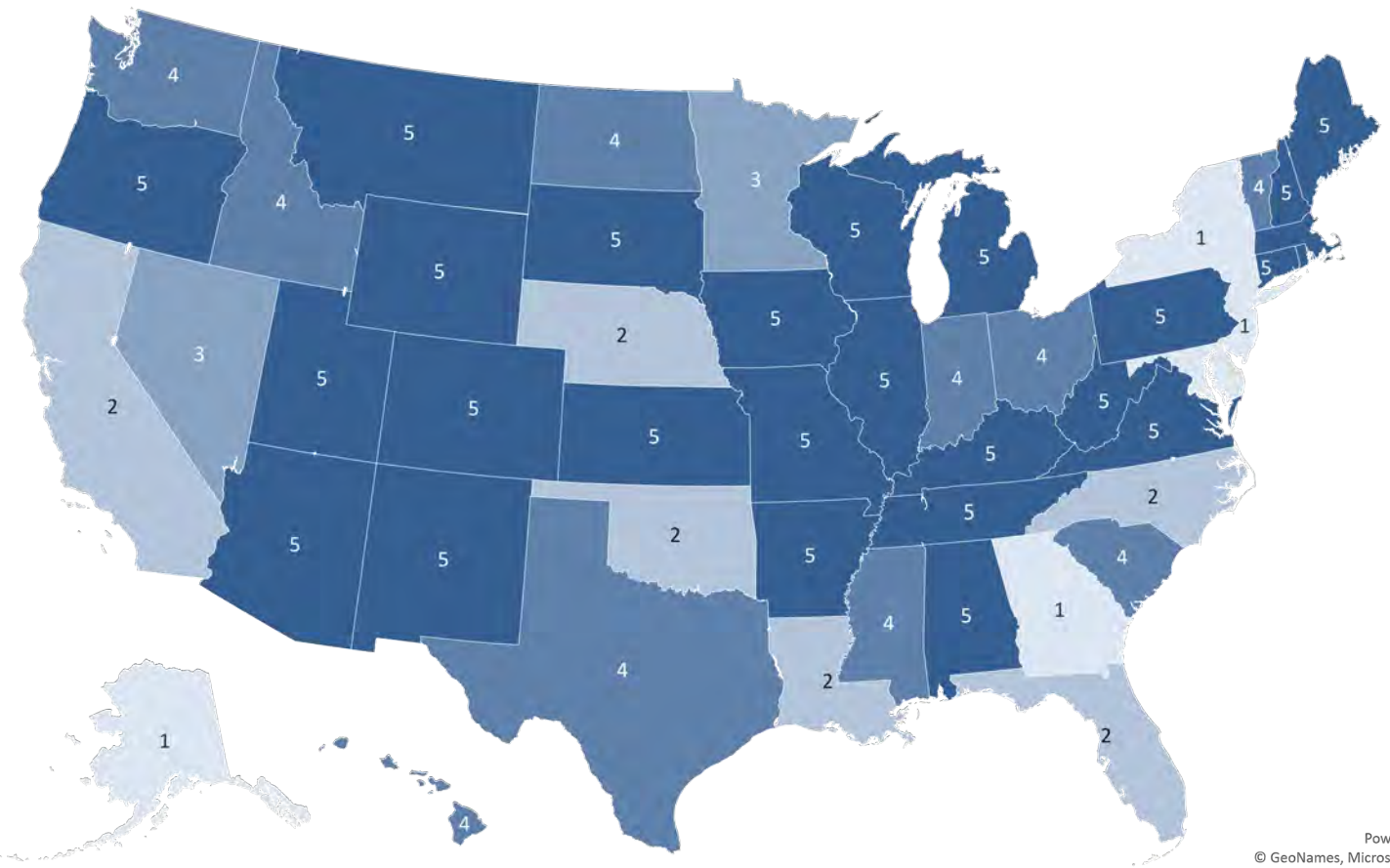


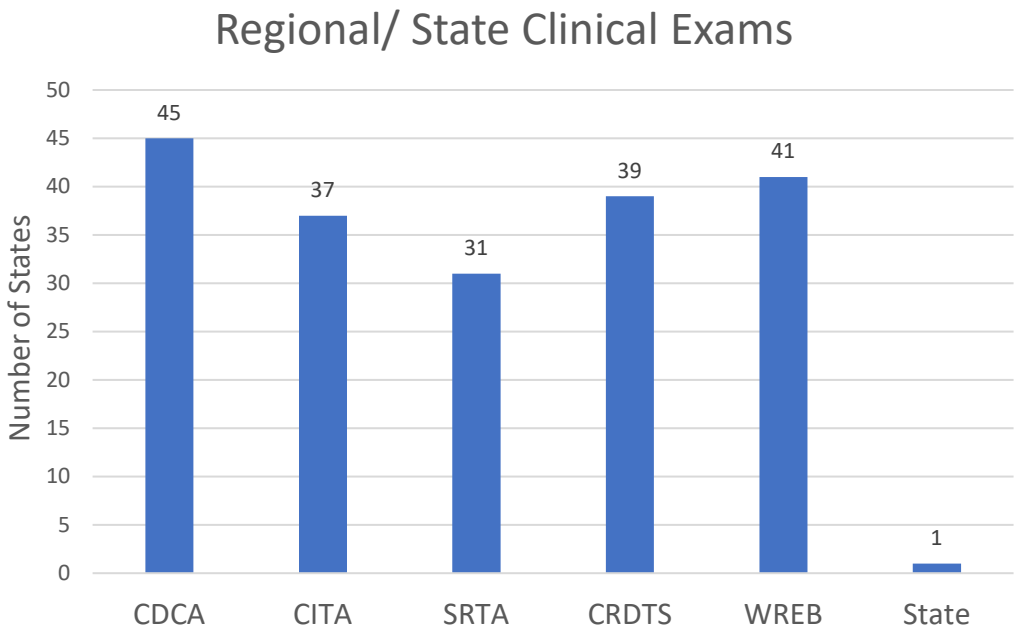
Written Exam (National Board Dental Hygiene Examination)



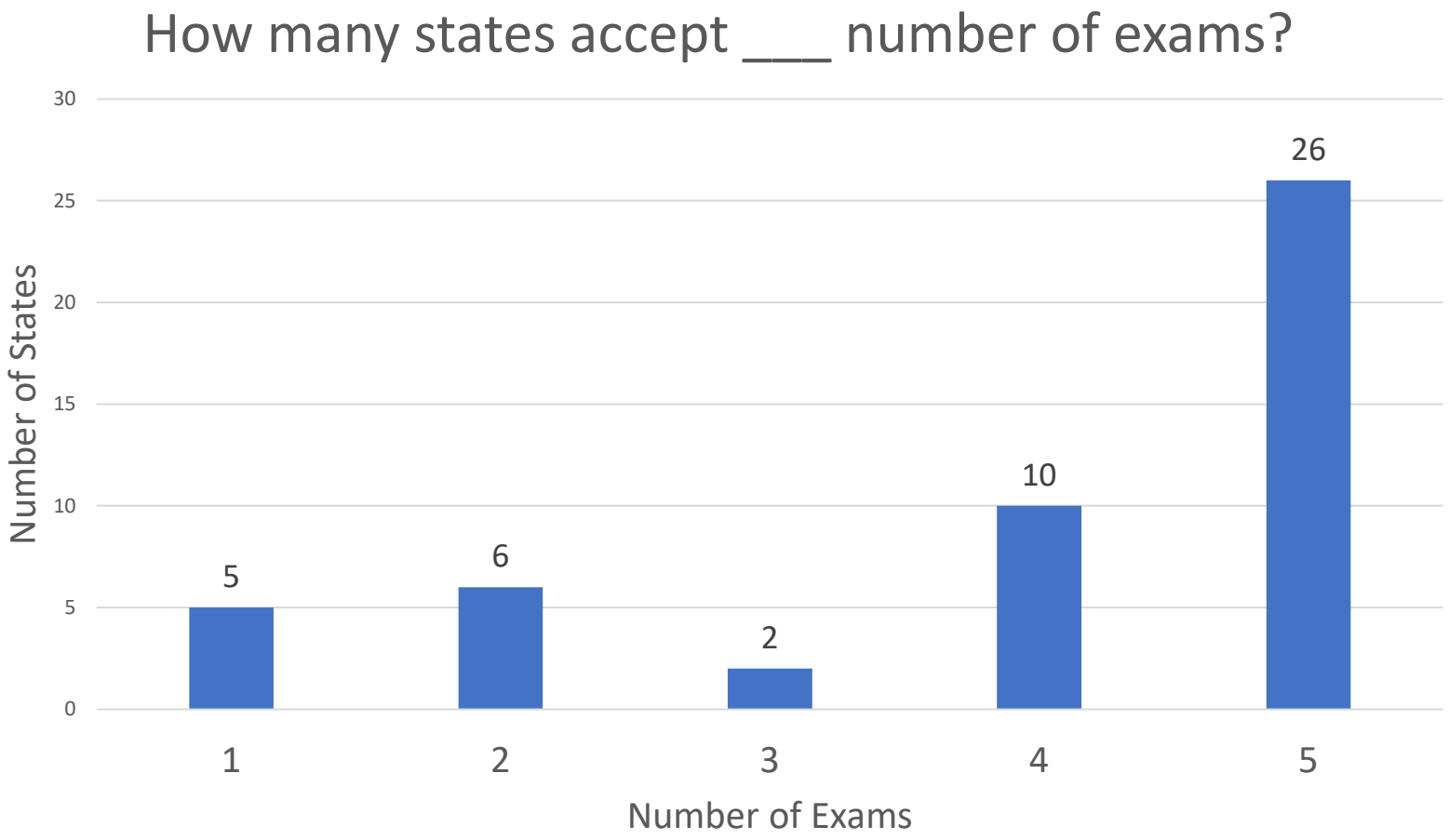


Regional/ State Clinical Exam





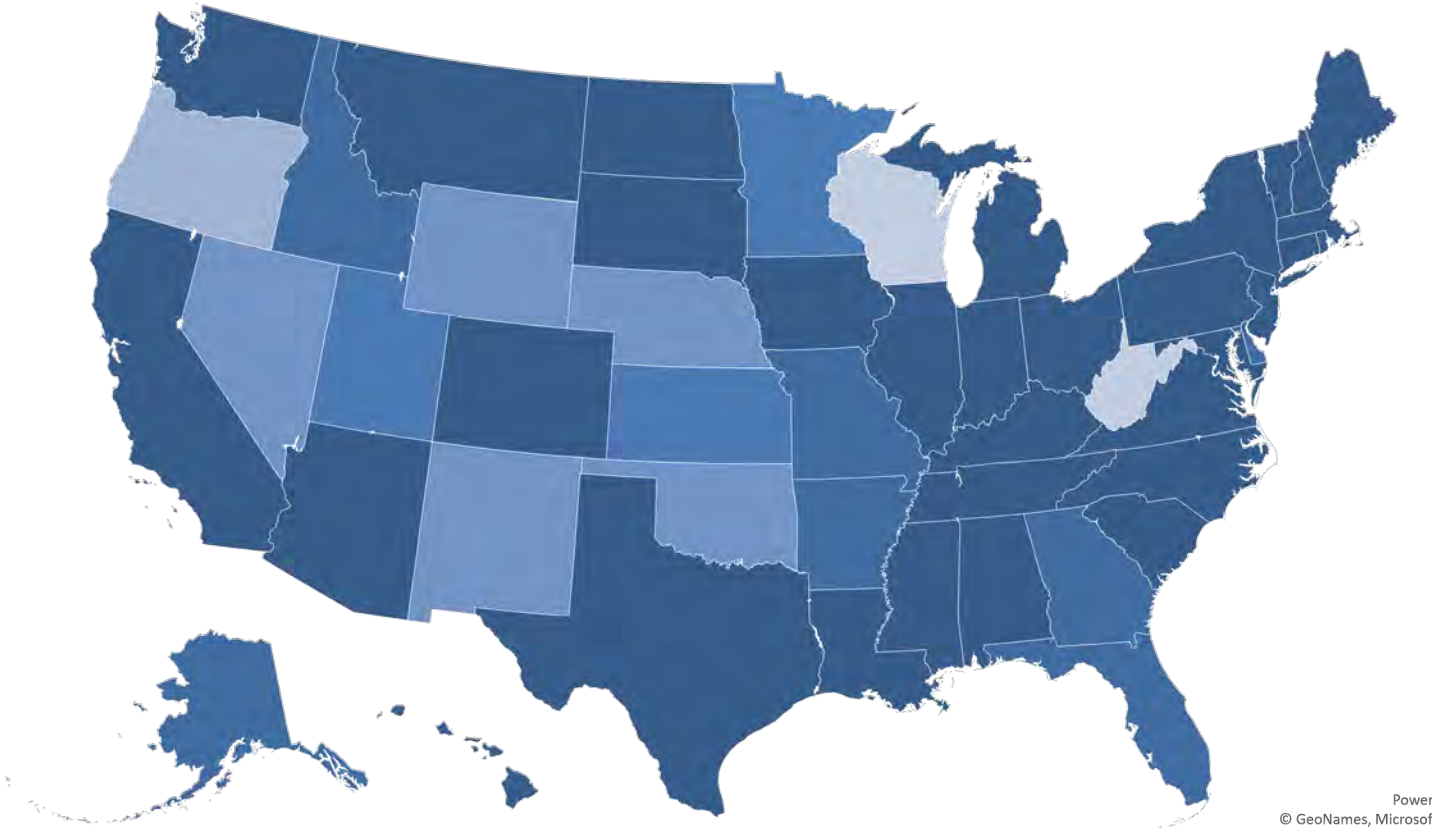
Clinical Exam

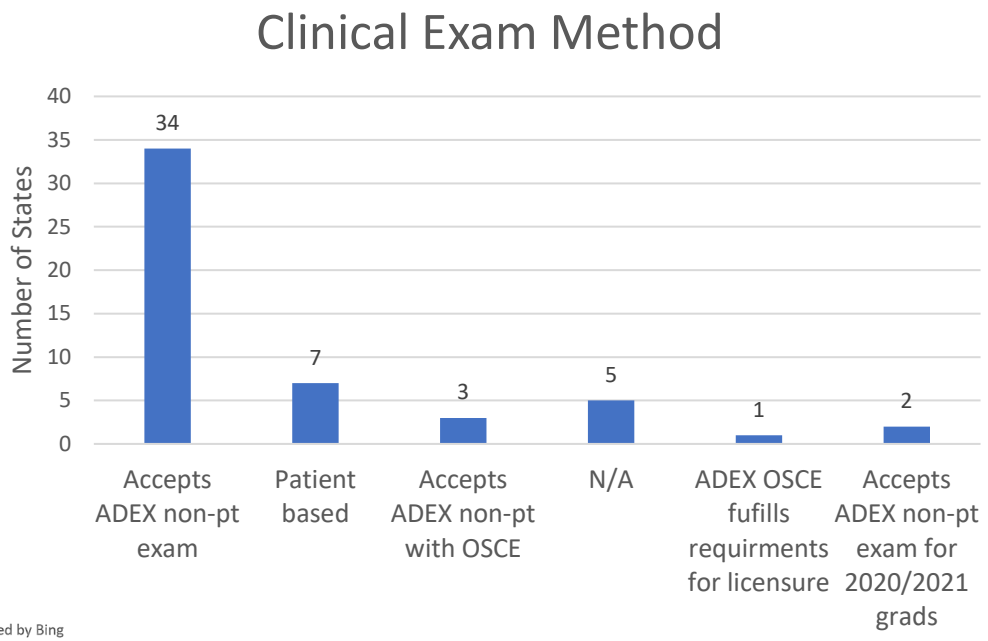


Regional/ State Clinical Exam: Notes

- The five clinical exams are: CITA, CRDTS, CDCA, SRTA, WREB
- Delaware is the only state with that only accepts a State Regional Exam

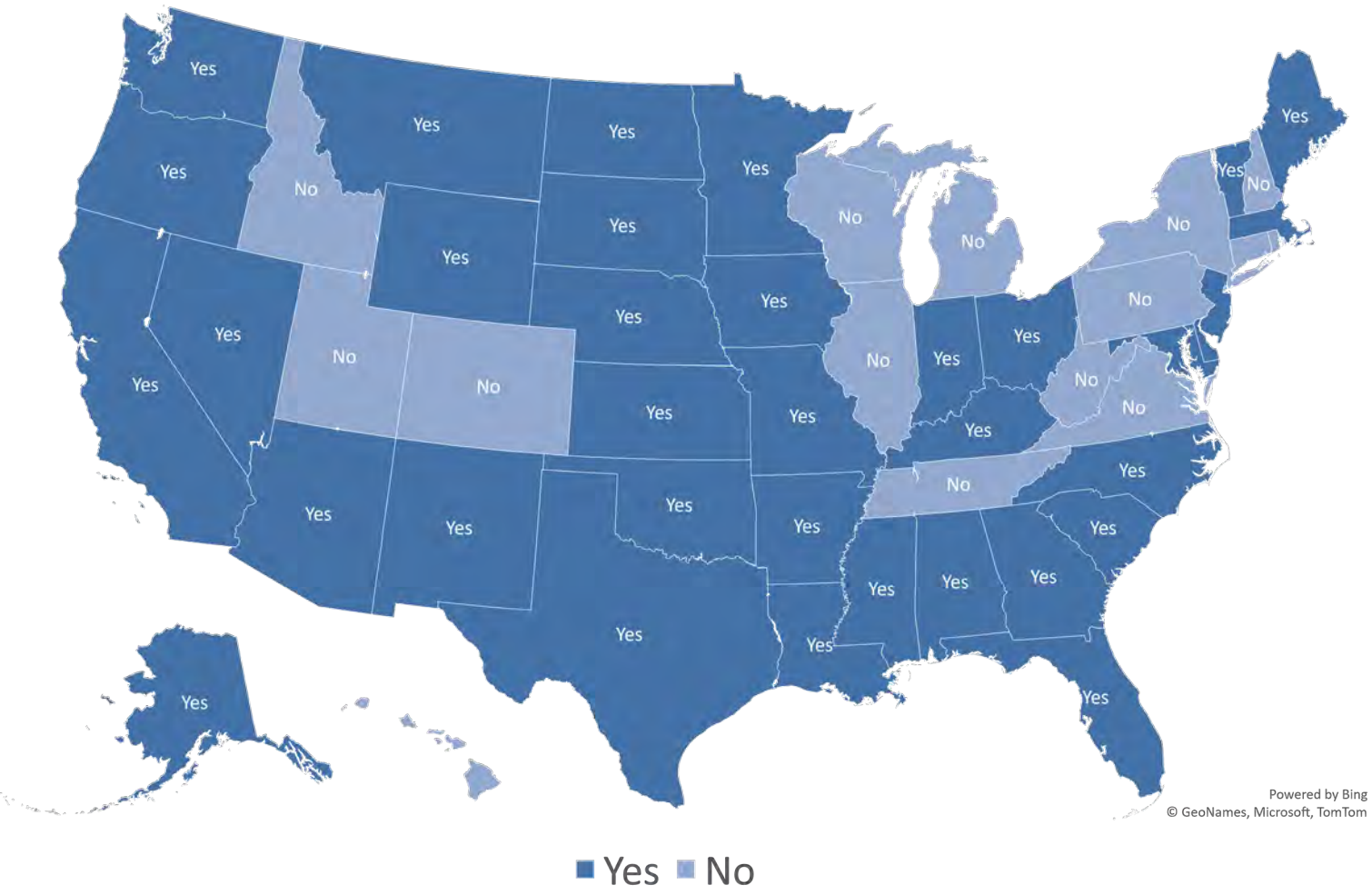
Clinical Exam Method

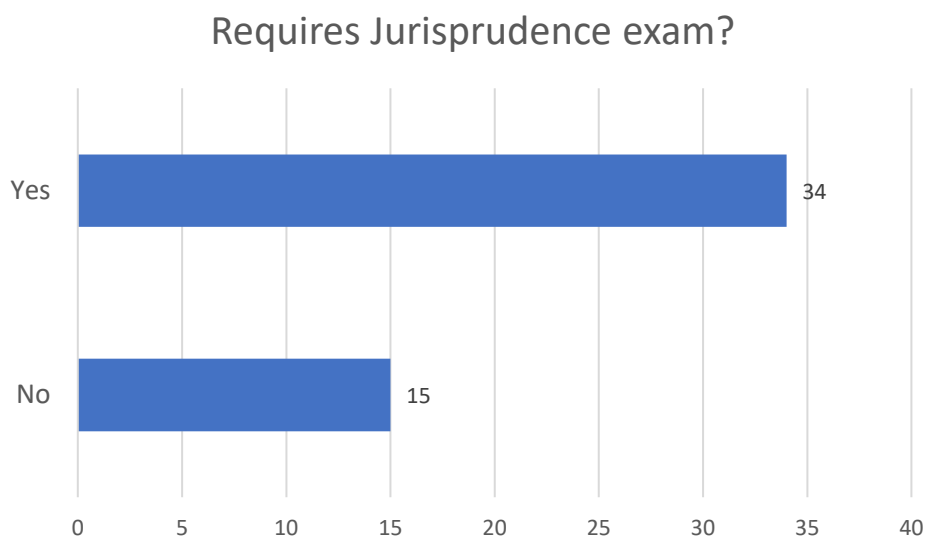




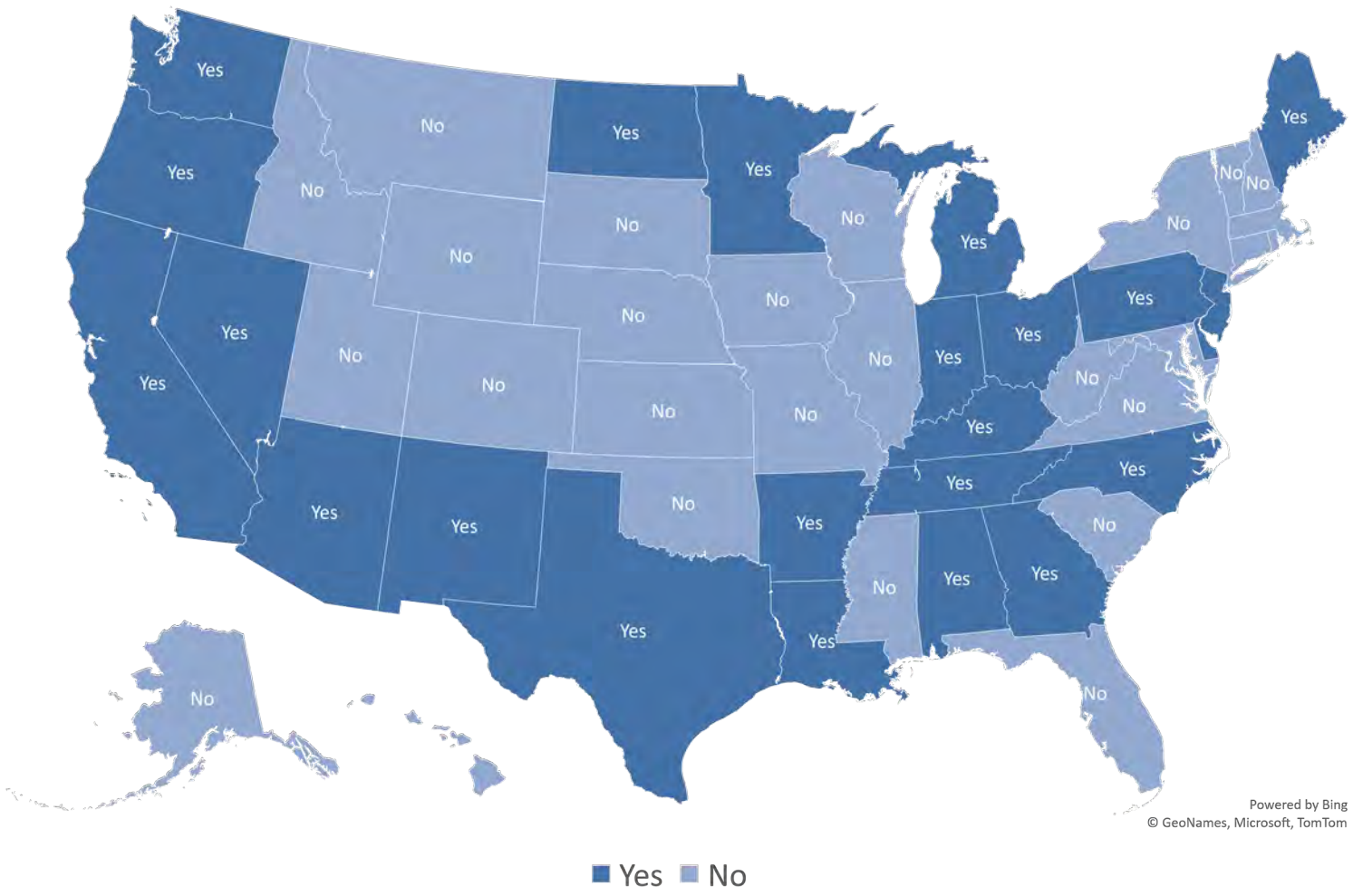
- Accepts ADEX non-pt exam
- Accepts ADEX non-pt with OSCE
- ADEX OSCE fulfills requirements for licensure
- Patient based
- N/A
- Accepts ADEX non-pt exam for 2020/2021 grads

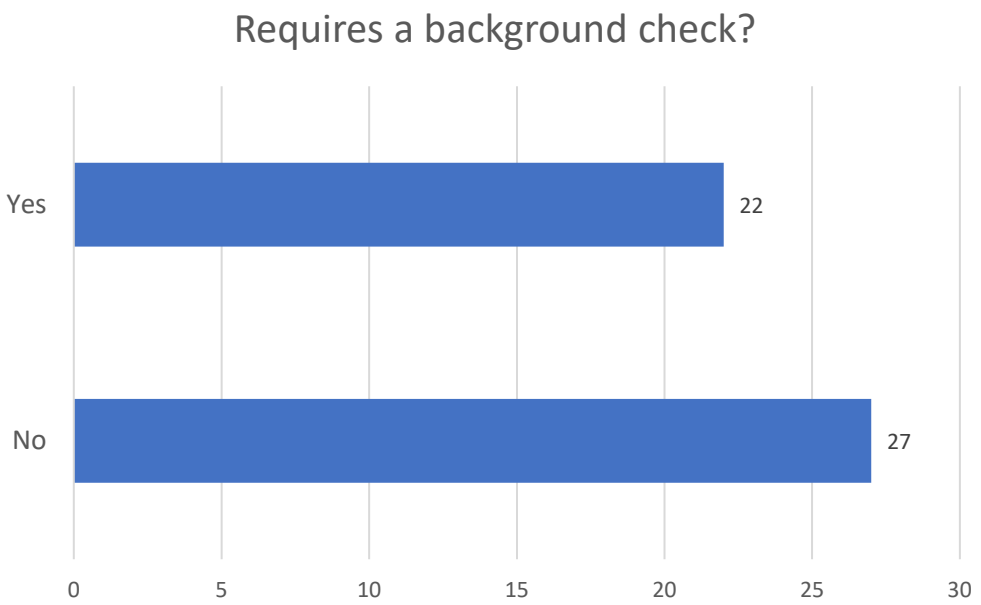
Jurisprudence Exam



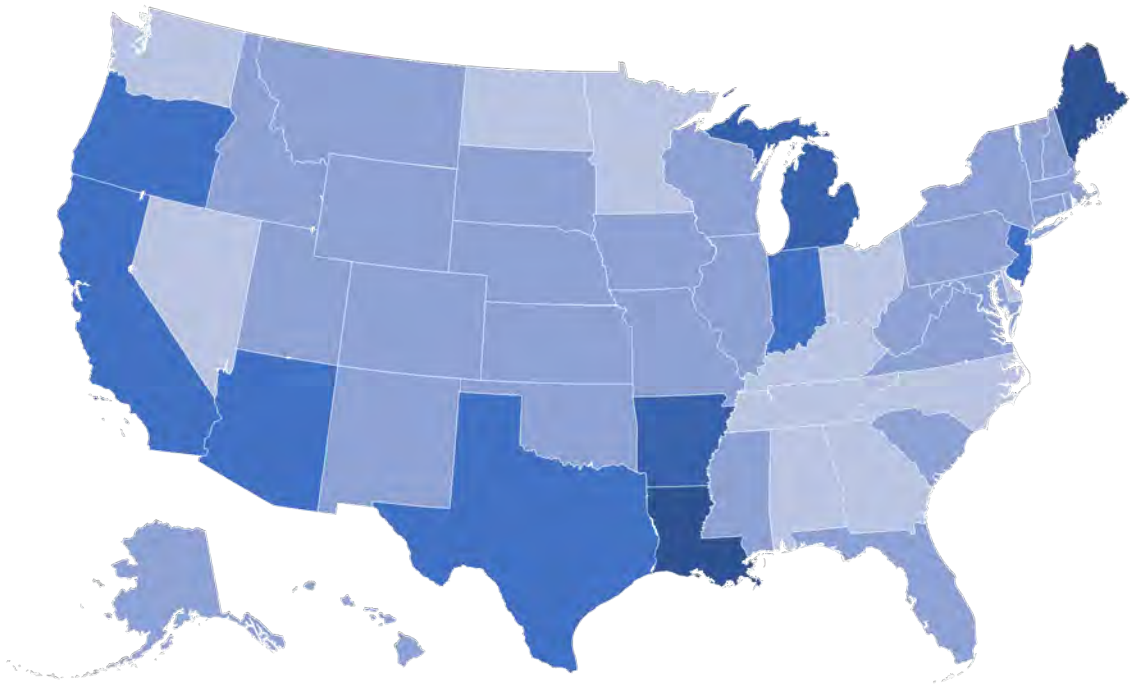


Background Check





Background Check Method



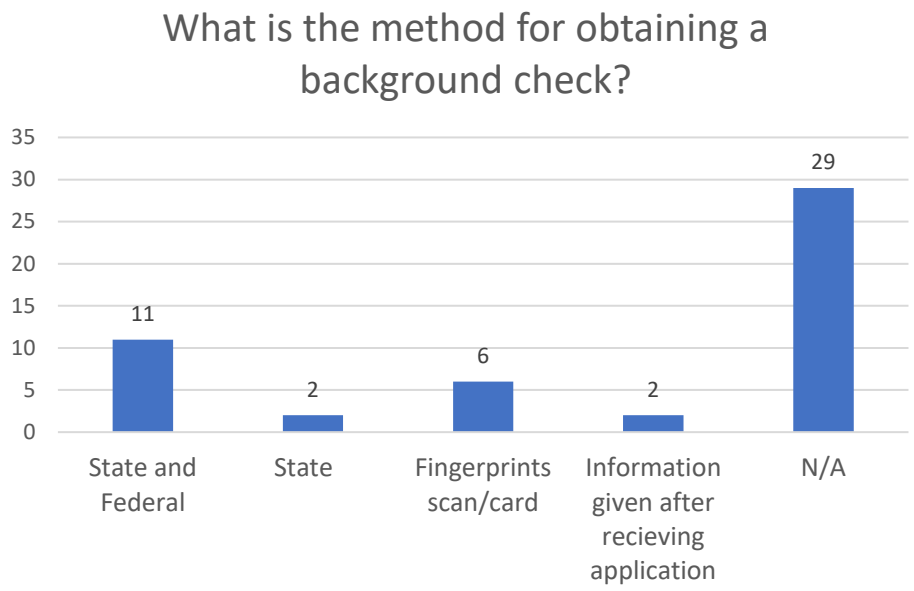
State and Federal

N/A

Fingerprints scan/card

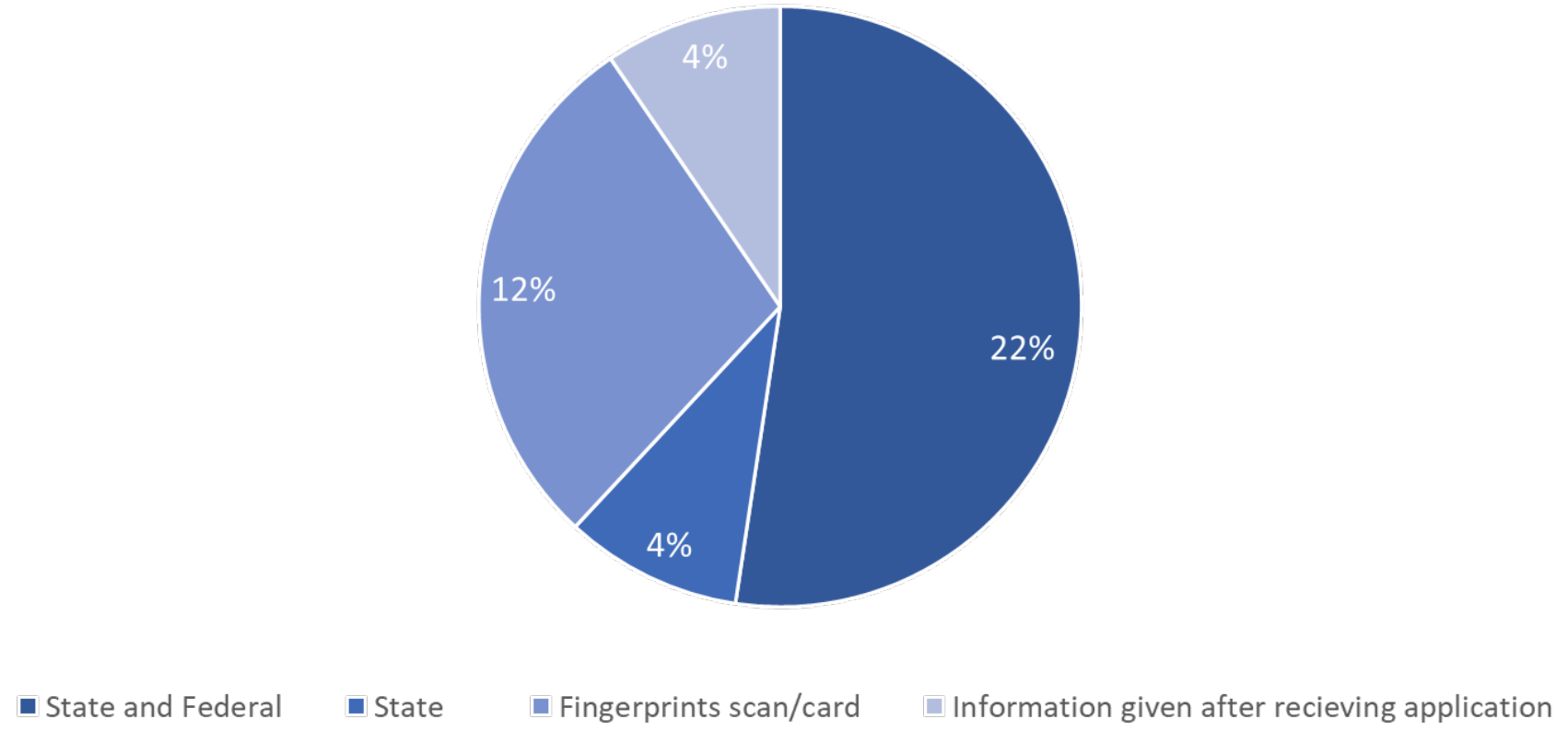
Information given after recieving application

State

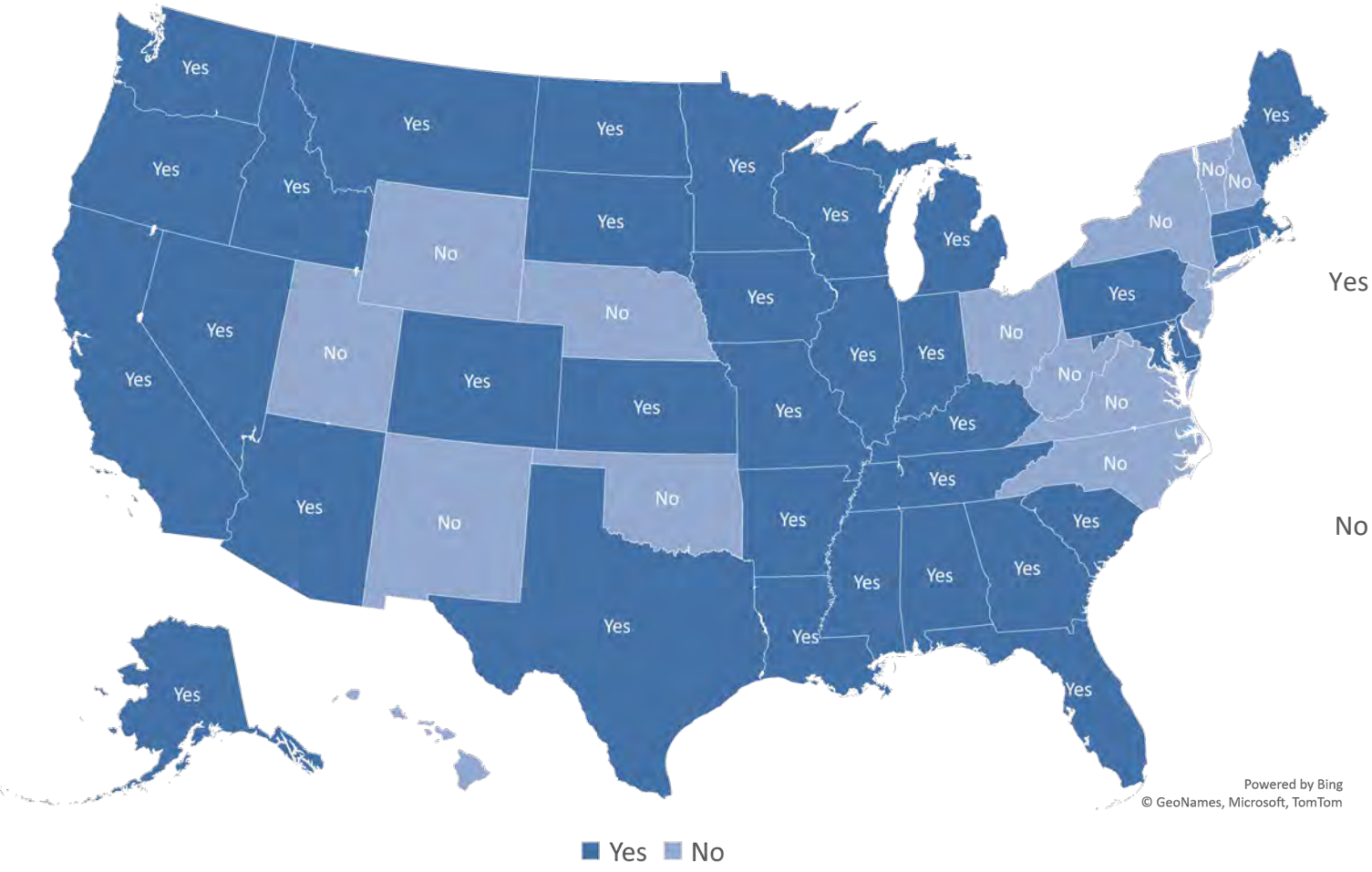


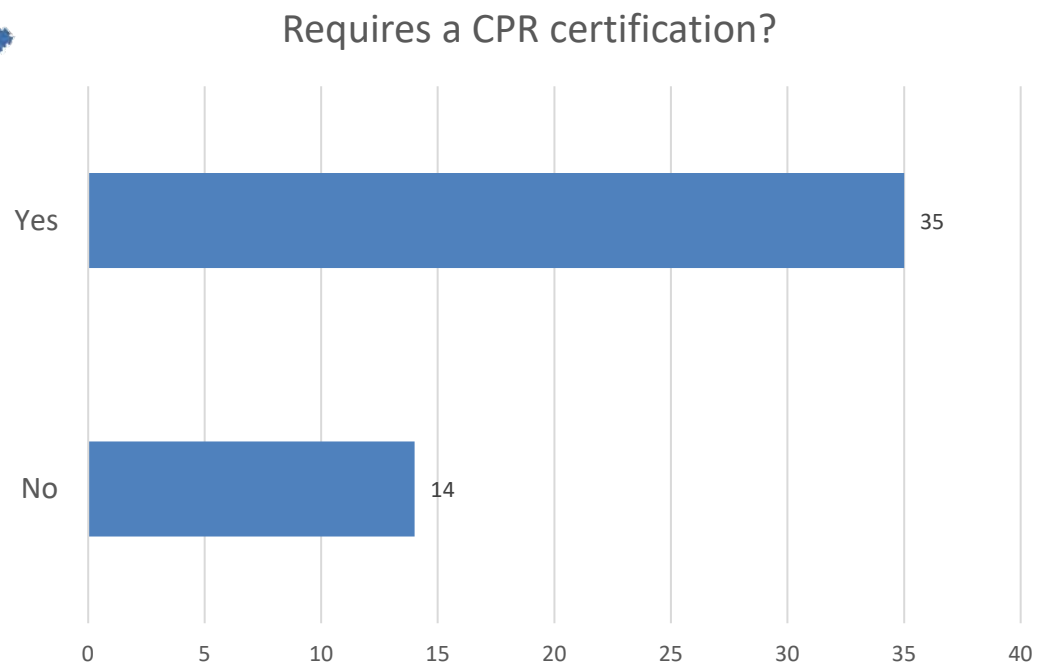
Background Check Method

What percent of background checks are done by each method?



CPR Certification





The Council of State Governments

Contact Info:

Kaitlyn Bison
kbison@csg.org

The Council of State Governments

Mobility in Dentistry and Dental Hygiene

Attachment #6

Consider These Scenarios

I am a dentist who is licensed and resides in Virginia, and I want to open offices for practice in DC and Maryland.

I am a dental hygienist licensed and resides in Arizona and I want to move to Illinois to be closer to my family.

I am a dentist who resides in Kentucky but is licensed in Ohio. I want to expand my practice and open new offices in Indiana.

Mobility in Dentistry/Dental Hygiene

From your perspective, which of these scenarios should the compact look to solve? Should the compact treat these scenarios differently?

Do dentists/hygienists frequently hold multiple licenses?

Do dentists/hygienists frequently change their state of residence?

Do dentists/hygienists practice in states where they do not live?

What are the biggest needs in the dentistry and dental hygiene related to licensing portability?

The Council of State Governments

Overview of Mutual Recognition Models

Dentistry and Dental Hygiene Compact
Technical Assistance Group
December 8, 2021

Attachment #6

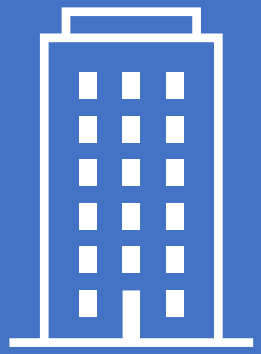
Licensed in Home State X

Chris wants to practice in Remote State Y and Remote State Z in addition to Home State X

Remote State Y

Remote State Z

Chris pays fee to the Compact Commission



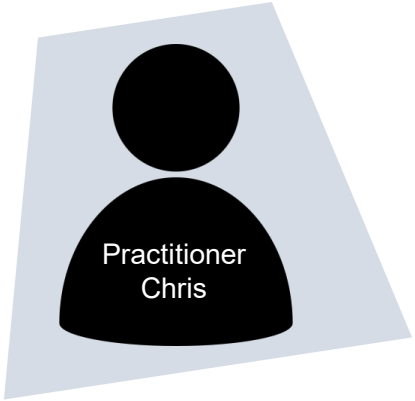
Compact Commission

- Confirms Chris's eligibility
  - ✓ Meets all practitioner participation eligibility requirements as stated in the compact
- Remits any fees to State Y and State Z
- Notifies State Y and State Z that Chris is coming

Remote State Y

Remote State Z

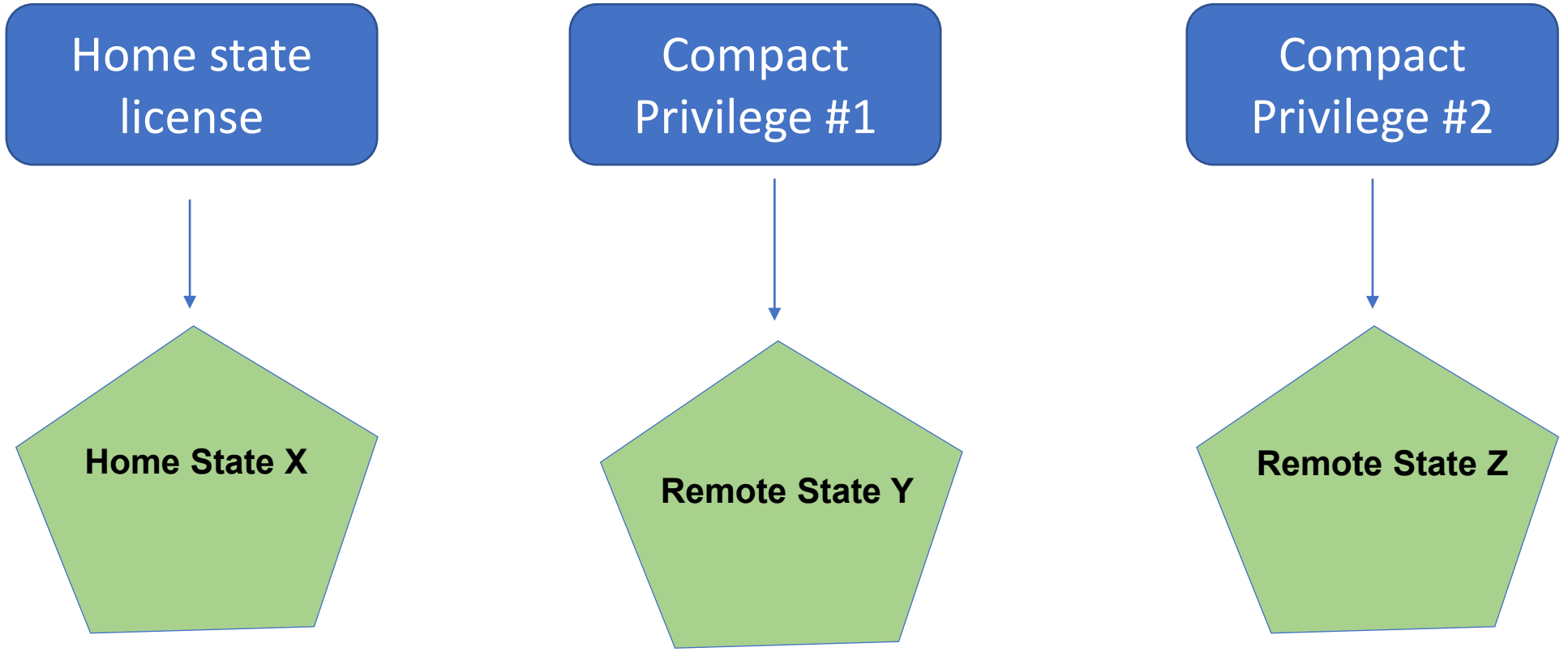
Remote States receive any required fees and are informed that Chris is coming



Chris receives two Compact Privileges & can now work in states X, Y and Z

The process repeats for any additional state that Chris would like to practice in

Privilege to Practice


Home state license
Compact Privilege #1
Compact Privilege #2
Home State X
Remote State Y
Remote State Z

Licensed in Home State X

Chris wants to practice in Remote State Y (compact member state) and Remote State Z (compact member state) in addition to Home State X

Remote State Y

Remote State Z

Chris contacts Home State X licensing board and applies for a multistate license.*

Pays Compact fee

note: some states issue a multistate license by default upon initial licensure if compact criteria are met

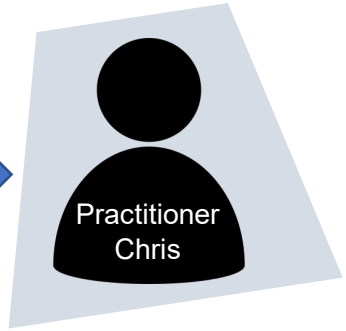
Home State X Licensing Board

- Confirms Chris's eligibility

✓Meets all practitioner participation eligibility requirements as stated in the compact

- Issues a multistate license that may be used in any compact state*

* note: States can still issue a single state license if compact criteria not met.*



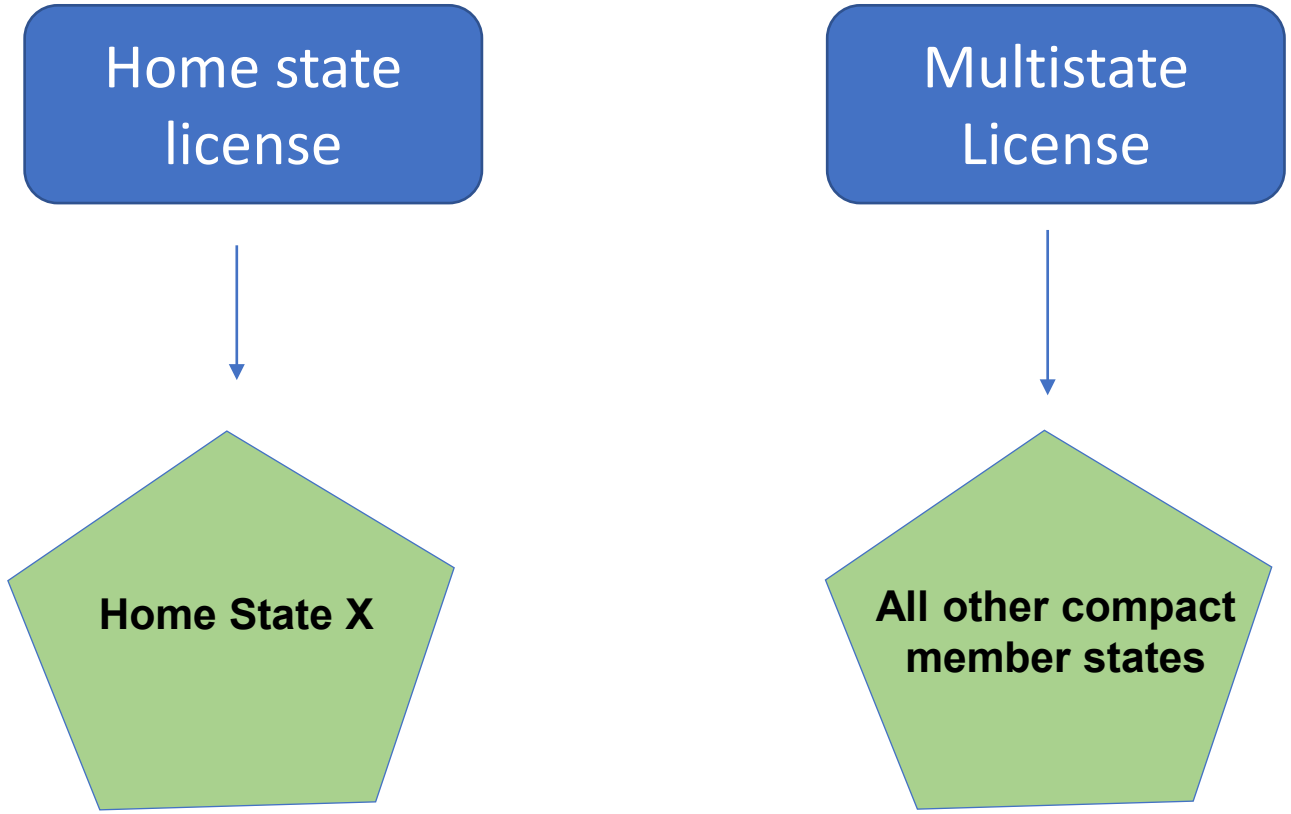
Chris receives multistate license & can practice in any other compact state with no additional action

Multistate License

Home State X

State Y, State Z, and all other compact member states

Multistate License


Home state license
Multistate License
Home State X
All other compact member states

Interstate Occupational Licensure Compacts – *Discipline and Governance*

The Council of State Governments

Dentistry and Dental Hygiene Compact
Technical Assistance Group
December 8, 2021

Attachment #6

Overview

- Compact Governance
- Licensee Discipline and Reporting
- Admission of Member States
- Member State Compliance

Compact Governance

Compact Commission

- Has ultimate legal responsibility
- Comprised of one delegate (or "commissioner") from each state
  - Appointee is typically chosen by the state licensing board
  - This creates dual duties, i.e., to the delegate's employer, and as a fiduciary to the Commission

Executive Board

- Usually comprised of the elected officers of the Commission
- May also include “at large” member(s)
- May also include *ex officio* members (non-voting)
  - Executive Director/Compact Administrator
  - National organization representative

Executive Board

- Delegation of Commission authority to Executive Board
  - EB usually meets more frequently than full Commission
  - May be more efficient for handling routine business

Open Meetings

- Both full Commission and Executive Board meetings are ordinarily conducted as public meetings
  - The model compact legislation identifies specific reasons why a meeting, or portion of a meeting, may be closed

Commission Duties

- Meet at least once annually
- Adopt bylaws
- Adopt rules
- Manage its finances
- Hire staff
- Establish an office
- Accept grants/ donations
- Perform other appropriate functions

Legal Aspects of Governance

- “Layers” of guidance
- Jurisdiction/Venue
- Liability and Qualified Immunity
- Indemnification

"Layers" of Guidance

- Main sources of guidance for a Commission:
  - The model compact legislation
  - Duly promulgated commission rules
  - Commission bylaws
    - *Robert's Rules of Order* often designated as the "gap filler"
  - Commission policies

Jurisdiction/Venue

- Compacts generally provide for jurisdiction and venue in the state where the compact maintains its principal office
  - This may be a source of lobbying by interest groups during the legislative process

Jurisdiction/Venue

- But, it is vital to note that these provisions do not affect where individual practitioners can be sued
  - For example, will *not* limit where a plaintiff's attorney can file a malpractice action against a licensed healthcare provider

Jurisdiction/Venue

- These provisions are vital to ensure consistency and uniformity in case law involving the interstate commission

Liability and Immunity

- Compact legislation typically includes a form of qualified or limited immunity for:
  - Commission members
  - Officers
  - Staff
  - Representatives

Liability and Immunity

- Limitations of official immunity:
  - Must be within scope of Commission duties
  - No protection for intentional, willful or wanton misconduct

Liability and Immunity

- Important note:
  - Just as with the venue provisions, the Compact does *not* provide any level immunity for licensed practitioners in the provision of healthcare
  - This is often misunderstood by trial lawyers' groups in the legislative process

Indemnification

- Compact legislation typically covers any settlement or judgment against Commission officials
  - Again, limited to official acts in the course of Commission business
  - Does *not* include indemnification for intentional, willful or wanton misconduct

Licensee Discipline and Reporting

Disciplinary Authority

- It is important to distinguish types of practice:
  - Practice under a ***state license***
  - Practice pursuant to an ***interstate privilege***

License vs. Privilege

- **License**
  - Discipline by the issuing state
  - A remote state may not impose discipline against a home state license
- **Privilege**
  - Discipline by the state where the individual is practicing
  - Discipline limited to the privilege to practice

Effect of Discipline

- **License**
  - Discipline by an issuing state against a *license* typically results in ***both:***
    - Loss or restrictions within the issuing state, and
    - Loss of the interstate privilege to practice, ***but…***
- **Privilege**
  - Discipline by a remote state against a *practice privilege* typically results in:
    - Loss of the privilege to practice in that remote state
    - In some compacts, this may also trigger an automatic loss of privileges in *all* other compact states, ***and…***

Effect of Discipline

- **License**
  - …a remote practice privilege *might* still be permitted if *written authorization* is given by *both* the home state and the remote state
- **Privilege**
  - …may *also* be a basis for a *home state* to take action against the ***license*** it issued

Disciplinary Jurisdiction

- Compact architecture can vary on which state has jurisdiction in investigating potential disciplinary matters

Disciplinary Jurisdiction

- In some compacts
  - The remote state where the alleged violation occurred under a practice privilege may be the primary investigating state
  - The remote state would then report its finding to the home state which issued the license

Disciplinary Jurisdiction

- In other compacts
  - The remote state where an alleged violation occurred under a practice privilege would refer the matter to the home state where the license was issued
  - That home state would then have primary disciplinary authority

Disciplinary Scenario 1

Nursing

Scenario 1 (Nursing)

- Mary is a resident of Texas (a compact state) and holds a Texas multistate license
- Mary accepts a temporary travel nurse assignment in Louisiana (a compact state)
- While practicing in LA, she violates the LA nurse practice act
- The hospital reports Mary to the LA Board
- LA Board receives the complaint and after a preliminary inquiry, decides that an investigation is warranted.
- LA Board conducts the investigation because that is where the violation occurred
- LA Board turns on the Nurse Alert in the licensee's Nursys file, as appropriate
- LA Board staff notifies TX that one of their multistate license holders is under investigation
- LA Board treats the licensee as if the licensee were a resident of LA, applying its state laws to the case when disciplining the compact privilege
- At the conclusion of the investigation, LA Board sends the licensee investigative file to TX Board
- TX Board takes action on the multistate license as if the violation occurred in TX, applying its own state laws (no repeat investigation.)
- TX Board converts the multistate license to single state, as appropriate

Disciplinary Scenario 2

Physical Therapy

Scenario 2 (PT)

- Mary is a resident of TX (a compact state) and holds a Louisiana compact privilege.
- While practicing in LA, she violates the LA PT practice act
- Someone reports Mary to the LA PT Board
- LA PT Board receives the complaint and decides that an investigation is warranted
- LA PT Board conducts the investigation because that is where the violation occurred
- LA PT Board flags Mary's record in the Federation of State Boards of Physical Therapy Exam Licensure and Disciplinary Database (ELDD) as under investigation once probable cause is met
- The investigation flag is displayed in the party state investigations queue for all other member state PT boards that are a party to that individual
- LA PT Board treats the compact privilege holder as if they held a regular licensee in LA, applying its state laws to the case when disciplining the compact privilege
- At the conclusion of the investigation, LA Board either enters the disciplinary action into the ELDD
  - Or removes the flag if no action is taken
- If disciplinary action is taken, *all* compact privileges for that individual are terminated immediately
  - Ineligible for compact privileges for at least 2 years
  - Doesn't affect any regular licenses held by the individual.
- Any state where the individual is licensed may choose to take its own actions

Disciplinary Scenario 3

EMS

Scenario 3 (EMS)

- In 2015, at the age of 18, Paul was arrested, charged and pled guilty to one count of burglary in the State of Colorado
- Paul was sentenced to 2 years of probation, which he completed successfully
- Paul has had no criminal record since then
- Paul completes paramedic school in 2021 and applies for a license from the Colorado Department of Public Health (compact state)
- Paul's 2015 conviction constitutes grounds for denial of a paramedic license
- However, CO DPH believes Paul does not pose a threat to public health or safety and issues a probationary license to Paul
- As part of the decision to issue the license, DPH and Paul enter into a stipulation agreement
- The agreement indicates that Paul may practice in a remote state under the EMS Compact interstate practice privilege, but only if any remote state in which he intends to practice provides such authorization in writing

Reporting

- Healthcare-related interstate commissions typically maintain centralized/coordinated database
- This is *essential* to permit member states to keep their promises to all other member states
  - Remember, a Compact is both a state law *and* an agreement between the member states!

Reporting

- Members states typically have the obligation to report to the Commission:
  - Any adverse actions by a home (licensing) state
    - Typically includes any findings of a violation of statute or regulation that results in discipline against a license
  - Any privilege to practice restrictions by a remote/distant state

Reporting

- Investigatory information
  - Some compacts require the reporting of active open, investigations prior to adjudication
  - Typically requires a finding of probable cause of a violation that could result in disciplinary action
    - Reportable even if the allegations have not yet been conclusively proven

Nonpublic Information

- Compact may permit the withholding of information specifically designated under state law as confidential or non-public

Alternative Programs

- Under a compact, a state typically reserves sole authority to determine if a licensee is eligible to participate in an alternative program
  - Substance abuse, addiction, etc.
  - Impaired professional programs

Alternative Programs

- The compact may establish rules regarding admission into such a program
  - May result in temporary loss of practice privileges during the duration of the program
  - May require specific approval to continue to practice under the privilege

Alternative Programs

- Again, key to this is the reporting of the alternative program participation by the licensee
- Reporting such participation to the commission does *not* mean:
  - The report must become public
  - The underlying details are disclosed to the commission

Admission of Member States

New States

- One issue that comes up is a state enacting legislation with some deviations from the model compact legislation
  - This creates potential legal problems
  - Can also impair proper administration of the compact
  - Should be discouraged whenever possible

Model Compact Deviations

- However, some deviations are purely cosmetic
  - Some states may have numbering conventions or codifying rules that require specific language be added to the statute
  - Other states may have drafting requirements
    - Example: no “whereas” or purpose clauses in legislation

Model Compact Deviations

- Some states may enact the compact law with substantive changes to the legislation
  - This may be due to:
    - Political pressure
    - State constitutional limitations

The Challenge

- The challenge for an interstate commission is to have a process in place to determine which changes are cosmetic or ***non-substantive***, and which are ***material***

The Challenge

- Since an interstate compact is an agreement between states, the terms must be consistent or a court could find no such agreement exists

Example: PSYPACT

Process for Review of New State Laws or Amendments to Compacts

10.5 Process for Review of New State Laws or Amendments to Compacts:

A. Upon enactment by a state of a law intended as that state's adoption of the Compact, the Executive Board shall review the enacted law to determine whether it contains any provisions which materially conflict with the Compact model legislation.

1. To the extent possible and practicable, this determination shall be made by the Executive Board after the date of enactment but before the effective date of such law. If the timeframe between enactment and effective date is insufficient to allow for this determination to be made by the Executive Board prior to the law's effective date, the Executive Board shall make the determination required by this paragraph as soon as practicable after the law's effective date. The fact that such a review may occur subsequent to the law's effective date shall not impair or prevent the application of the process set forth in this Section 10.5.

2. If the Executive Board determines that the enacted law contains no provision which materially conflicts with the Compact model legislation, the state shall be admitted as a party to the Compact and to membership in the Commission pursuant to Article X of the Compact upon the effective date of the state's law and thereafter be subject to all rights, privileges, benefits and obligations of the Compact, these Rules and the bylaws.

3. In the event the enacted law contains one or more provisions which the Executive Board determines materially conflicts with the Compact model legislation, the state shall be ineligible for membership in the Commission or to become a party to the Compact, and the state shall be so notified within fifteen (15) days of the Executive Board's decision.

4. A state deemed ineligible for Compact membership and Commission participation pursuant to this Section 10.5 shall not be entitled to any of the rights, privileges or benefits of a Compact State as set forth in the Compact, these Rules and/or the bylaws. Without limiting the foregoing, a state deemed ineligible for membership and participation shall not be entitled to appoint a Commissioner, to submit to and/or receive data from the Coordinated Licensure Information System and/or to avail itself of the default and technical assistance provisions of the Compact. Psychologists licensed in a state deemed ineligible for membership and participation hereunder shall be ineligible for the Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice set forth in the Compact and

Examples of Deviations That Might Disqualify a State

- Materially altering the rights or obligations of member states
- Eliminating qualified immunity for the Commission or its officials
- Enlarging choice of venue
- Imposing undue restrictions on privileges to practice compared to the model legislation
- Allowing state to negate Commission rules
- Eliminating fees applicable to the state

Member State Compliance

Member State Compliance

- After a state is admitted to the commission, its legislature could enact subsequent laws
  - Some might directly amend the previously-enacted compact
  - Some might be other, non-compact laws that nevertheless conflict with or limit the operation of the compact in that state

Example: Telehealth Laws

- As a result of the pandemic, some states have enacted or updated their telehealth/telemedicine laws
- In some cases, those laws have posed conflicts with interstate practice privileges

Other Compliance Issues

- Member states may also come into non-compliance with their compact obligations in other ways
  - Non-payment of fees or assessments
  - Failure to report required data to the commission
  - Failure to enforce disciplinary or adverse action obligations

Member State Compliance

- Model compact typically includes provisions to deal with non-compliance by a member state
- This is different than a state attempting to gain initial entry into the compact
- As a member state, there are additional due process considerations

Member State Compliance

- For existing member states found to be out of compliance, the model compact legislation will typically include a process for:
  - Notice and opportunity to be heard
  - Time for implementation of remedial measures
  - Technical advice or assistance to the state

Questions?

Revisiting Benefits and Challenges of a Dental Compact

I hope the compact achieves…

I have concerns/ am confused about…

UNFINISHED BUSINESS & RULES

At the December 8, 2021 Dental Therapy Rules Oversight (DTRO) Committee Meeting this rule was discussed and that Committee recommended the Board move it to the Anesthesia Committee for further review and discussion.

Specifically, the DTRO Committee wanted the Anesthesia Committee to take into consideration allowing more than one patient to be sedated with Nitrous Oxide at any time, due to the safe nature of it and its application.

818-026-0080
Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.
(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist~~, a dental hygienist or an Expanded Function Dental Assistant (EFDA)~~ who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document the patient's condition at discharge as required by the rules applicable to the level of anesthesia being induced. A copy of the anesthesia record shall be maintained in the patient's

dental record and is the responsibility of the dentist who is performing the dental procedures.
(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.
(8) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of ~~her or his~~ **their** intent. Such notification need only be submitted once every licensing period.

CORRESPONDENCE

Request for Approval of Specialty Examination for Limited Specialty License – American Board of Oral Medicine.

The American Board of Oral Medicine (ABOM) is requesting that the Board approve the ABOM specialty examination to fulfill the limited specialty license examination requirements for applicants seeking a limited specialty license to practice as an oral medicine specialist.

Relevant Rules:

OAR 818-021-0017 - Application to Practice as a Specialist

(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:
  (a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;
  (b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and
  (c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.
  (d) Passing the Board's jurisprudence examination.

(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;
  (d) Passing the Board's jurisprudence 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 postdoctoral dental specialty in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching the applicant's dental specialty by dentists employed by a dental education program in a CODA-accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical

dentistry in the specialty applicant is applying for, and any adverse actions or restrictions; and;

(B) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(4) Any applicant who does not pass the first examination for a specialty license may apply for a second and third regularly scheduled specialty examination. If the applicant fails to pass the third examination for the practice of a recognized specialty, the applicant will not be permitted to retake the particular specialty examination until he/she has attended and successfully passed a remedial program prescribed by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(5) Licenses issued under this rule shall be limited to the practice of the specialty only.

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140, 679.060, 679.065, 679.070 & 679.080 679.090
History:
OBD 2-2021, amend filed 11/08/2021, effective 07/01/2022
OBD 2-2019, amend filed 10/29/2019, effective 01/01/2020
OBD 4-2011, f. & cert. ef. 11-15-11
OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11
OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10
OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08
OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05
OBD 11-2001, f. & cert. ef. 1-8-01
OBD 5-1999, f. 6-25-99, cert. ef. 7-1-99
OBD 2-1999(Temp), f. 3-10-99, cert. ef. 3-15-99 thru 9-10-99
DE 4-1997, f. & cert. ef. 12-31-97

NYE Ingrid * OBD

From: ABOM Office <info@abomed.org>
Sent: Monday, January 31, 2022 8:38 AM
To: NYE Ingrid * OBD
Subject: Ticket# 717289/ ABOM RE: RE: ABOM Specialty Exam review - Oregon Board of Dentistry
Attachments: OBD_Request_2022_Final.doc; Appendix 5 ABOM Candidates guide.pdf

Ingrid,
I apologize for the delay in sending the request letter. Please accept our intentions for consideration.

Felicia D. Kenan, MPA, CAE, CMP
ABOM Exective Director

The American Board of Oral Medicine
2150 N 107th St, Suite 205
Seattle WA 98133
206-2095279 office
info@abomed.org
www.abomed.org

Mon 1/31/2022/11:51 AM UTC-05/ Felicia Kenan (time)-

Ingrid,
I apologize for the delay in sending the request letter. Please accept our intentions for consideration.

Felicia D. Kenan, MPA, CAE, CMP
ABOM Exective Director

Mon 1/24/2022/11:21 AM UTC-05/ ingrid.nye@obd.oregon.gov

Good morning!

Thank you so much for getting back to me - I am glad to hear this news! We are very excited to begin welcoming specialists in Oral Medicine to the state. I will keep an eye out for the letter. Please let me know if you have any questions!

Cordially,

Ingrid Nye

Investigator
Pronouns: she, her, hers

Oregon Board of Dentistry
1500 S.W. 1st Avenue, Suite #770

Portland, OR 97201
Phone: 971-673-3200
Fax: 971-673-3202
www.Oregon.gov/Dentistry

IMPORTANT NOTICE ABOUT COVID-19/NOVEL CORONAVIRUS: Throughout the pandemic, OBD Staff has continued to report to work without interruption. However, it remains a possibility that individual staff members may abruptly be absent from work and unable to respond to email, possibly for long periods of time, due to a quarantine after exposure to COVID-19, an illness, or a need to care for a family member. **Please allow 1-2 business days for a response to your email**. If you have not received a response, please emailinformation@obd.oregon.govor call 971-673-3200 and any available OBD Staff Member will respond. Thank you for your patience. **The OBD office is currently closed to the public.**

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Mon 1/24/2022/10:31 AM UTC-05/ Felicia Kenan (time)-
Ms Nye,
Yes we do. We are reviewing our submission letter tonight and will meet your indicated deadline.

Felicia D. Kenan, MPA, CAE, CMP
ABOM Executive Director

Wed 1/19/2022/1:07 PM UTC-05/ ingrid.nye@obd.oregon.gov
Good morning,

I am inquiring once again about whether the ABOM has any interest in requesting Oregon Board of Dentistry (OBD) approval of the ABOM specialty exam, which would allow ABOM diplomates who meet the requirements for limited specialty licensure to obtain a limited specialty license to practice Oral Medicine in Oregon.

We have received inquiries from ABOM diplomates about obtaining the limited specialty license. Unfortunately, unless the ABOM specialty examination is reviewed and approved by the OBD, we will not be able to issue licenses to these individuals, as passage of a OBD-approved specialty examination is one of the requirements for the limited specialty license.

We will need the request and any accompanying materials, as described below, to arrive no later than January 28, 2022, in order for the matter to appear on the agenda for the next Board Meeting, which will take place in February. After the February Board Meeting, the next Board Meeting will be in April.

Please let me know if you have any questions!
Sincerely,

Ingrid Nye

Investigator
Pronouns: she, her, hers

Oregon Board of Dentistry
1500 S.W. 1st Avenue, Suite #770

Portland, OR 97201
Phone: 971-673-3200
Fax: 971-673-3202
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******CONFIDENTIALITY NOTICE******

From: OBD Licensing * OBD
Sent: Tuesday, December 21, 2021 11:24 AM
To: 'info@abomed.org' <info@abomed.org>
Cc: VANDEBERG Samantha * OBD <samantha.vandeberg@obd.oregon.gov>
Subject: ABOM Specialty Exam review - Oregon Board of Dentistry
Importance: High

Good morning,

I am an Investigator for the Oregon Board of Dentistry (OBD). As you may be aware, the OBD offers a limited specialty license which is intended for individuals who may not meet the requirements for a general dental license in the State of Oregon. Qualified dental specialists can apply for a limited specialty license in any OBD-approved specialty. A rule change that goes into effect on January 1, 2022 will add Oral Medicine to the list of OBD-approved specialties. We are excited to begin welcoming Oral Medicine dental specialists to our State!

By the current rules, which appear inOAR 818-021-0017, individuals who have completed (among other requirements) a post-graduate specialty program of not less than two years at a CODA-accredited dental school, passage of a general clinical examination, and passage of the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination, must alsocomplete an OBD-approved specialty examination. We assume that, like other dental specialty boards, the American Board of Oral Medicine conducts a specialty examination. In order for that examination to be reviewed (and hopefully approved) by the OBD, we like to respectfully invite your organization to submit a letter formally requesting that the OBD approve the American Board of Oral Medicine's specialty examination. To assist the OBD in making an informed decision on this matter, it would be helpful to include detailed information about the content, format, structure, grading, and administration of the examination. A copy of the exam handbook or manual would be of great help; I was not able to find such a document on your website. The letter should be directed from the appropriate representative of the ABOM to the Members of the Oregon Board of Dentistry, and can be emailed tolicensing@obd.oregon.gov or mailed to the mailing address below my signature line. If it is possible to receive this request January 28, 2022, we could get it onto the agenda for the next Board Meeting in February 2022, which would allow Oral Medicine dental specialists to start obtaining specialty licenses in Oregon as soon as possible.

Thank you very much for your assistance with this matter. Please feel free to contact me or our Examination & Licensing Manager Samantha VandeBerg, who is copied on this email, if you have any questions! I hope you have a very happy holiday season!

Cordially,

Ingrid Nye

Investigator
Pronouns: she, her, hers

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Board Examination Candidate Guide

The American Board of Oral Medicine (ABOM) promotes and maintains the highest standards of teaching, research, and patient care in the specialty of oral medicine for the benefit of the public. In 2020, Oral Medicine was recognized by the ADA as the 11th Dental Specialty.

ABOM administers a specialty certification process and examination for dentists who are accomplished in the field. Individuals who pass all requirements of this Board become Diplomates of the American Board of Oral Medicine.
In order to be eligible for the ABOM certification examination, certain initial eligibility requirements must be met:

Section 1. Application Process

1. Application forms may be obtained from the ABOM website.
2. Deadline for applications are posted on the ABOM website (the deadline is typically 8 weeks before the Board examinations). No application will be accepted after the announced deadline.
3. Application documents for both Parts A and B examinations shall be submitted electronically to the Secretary of the American Board of Oral Medicine and include:
    1. Completed application form
    2. One current photograph of the applicant
    3. Evidence of enrollment (minimum 2nd year status) for Part A or completion of a CODA accredited oral medicine program (i.e. official transcript, certificate, or official letter from program director) for Parts A or B
    4. Curriculum vitae
    5. Evidence of membership in good standing in an oral medicine organization (eg American Academy of Oral Medicine).
    6. Evidence of oral medicine specialty clinical practice for a minimum of eighteen (18) months after receiving a certificate or degree (Part B only). Such evidence might include a letter from a qualified colleague, usually the director of the program that trained the applicant (sample

document is available on the website)

4. An non-refundable initial application fee covering both Parts A and B (see fee guide below) made payable to American Board of Oral Medicine, Inc.
5. Fee Guide

Fee Guide* (effective 2021)	**Fee**
Application fee (payable in addition to Part A and/or Part B fees as listed below)	$200.00 USD
Part A examination	$800.00 USD
Part B examination	$800.00 USD
Total fees for initial application	**$1800.00 USD**
Re-take of Part A or Part B	$750.00 USD

*All fees are non-refundable

Notes: Applicants will be notified of acceptance for Part A and Part B of the examination by the Secretary and will be invited to take the examination part at the designated time of convocation of the Board. An applicant approved eligible will remain so for 5 years from the date of the first opportunity to test. During this period, the candidate must take and successfully complete the entire examination or forfeit the examination fee, application fee and eligibility status. Applicants must confirm their intention to appear for the examination by notifying the Secretary of the Board and remitting the examination fee for the Part they have been accepted to take (see fee guide below). All fees are payable to the American Board of Oral Medicine, Inc. A fee of $50.00 will be charged if the examination fee is not received within 30 days of the examination. If a candidate misses an examination, the fees paid will be applied toward the examination fee the following year. Fees are subject to increases. A candidate who is determined for any reason to be non-eligible may solicit a ruling by the board as to what additional training or experience would be necessary to become eligible.

Section 2. Examination Procedures

Examination Location:
Typically, the ABOM certification examination is conducted at the same site as the AAOM Annual Meeting. However, there may be occasional reasons to change this.

Examination Format:

There are two parts to the ABOM Examination/certification. Part A is a written multiple choice format examination over a one day period comprised of a series of five examinations (60 questions each) covering the main topics (Medically Complex Patients, Oral Mucosal Diseases/Salivary Gland Disorders, Orofacial Pain, Pharmacology, and Laboratory Medicine). Candidates who successfully pass part A and are eligible can take Part B. Part B is primarily an oral examination of the same 5 main topics along with a separate written clinicopathologic conference section covering both Oral and Maxillofacial Radiology and Oral and Maxillofacial Pathology. Part B is takes place over a single day. Details about the examination procedures are found below under "Examination Administration".

Examination Scope:
The ultimate goal of the board examination is to fairly and accurately test graduates of accredited oral medicine programs to a level of knowledge pertinent to patient care in oral medicine as it is practiced in the USA. The candidate will be expected to have expert knowledge at the level of completing a CODA-approved Oral Medicine program, in the following domains:

1. Medically complex patients: Signs and symptoms of general medical conditions; review of systems; physical diagnosis; physical evaluation; significance of systemic conditions on patient management
2. Oral mucosal disease: Clinical evaluation and management of systemic, skin and mucosal diseases
3. Salivary gland and chemosensory disorders: Clinical evaluation and management of patient with salivary gland disorders (ie xerostomia/salivary gland hypofunction and sialorrhea), and taste disorders (ie dygeusia).
4. Orofacial pain
   Diagnosis and management of orofacial pain disorders, including:
   - temporomandibular disorders
   - common dental pain conditions
   - burning mouth disorders
   - neuropathic orofacial pain and atypical facial pain
   - trigeminal autonomic cephalgias
   - complex chronic pain/fibromyalgia
   - headache disorders

The candidate will be also expected to have education and knowledge in the fundamentals of:

1. Laboratory medicine: Indications for and interpretation of laboratory tests.
2. Pharmacology/pharmacotherapeutics: It is necessary to have an understanding of the top 30 drugs prescribed in the United States; actions and interactions of commonly used medications; indications and contraindications of specific

medications of both prescribed and over-the-counter medications utilized within oral medicine practices. Furthermore, knowledge regarding applying current pharmacotherapeutic guidelines related to oral medicine issues will be covered.
3. Oral and Maxillofacial Radiology: Primarily interpretation: other subject areas may include radiation biology and physics, basic principles of imaging and techniques and interpretation of advanced imaging modalities.
4. Oral and Maxillofacial Pathology: Basic histopathology: clinical identification of cell types; pattern description; correlation of histopathology to patient history; etiology and pathogenesis of diseases, identification of specific disease processes (inflammation and repair, neoplasia).

Examination Preparation:
At the AAOM annual meeting, there is a Board review course organized by the group of oral medicine residency program directors. This is an opportunity to understand the depth and extent of the knowledge required to successfully challenge the ABOM certification examination. There is also a recommended reading list (See Below)

The ABOM review course provides a comprehensive review of oral medicine related topics. During the course, there will be interactive case-based studies and tips on test-taking strategies. Presentations will have question and answer sessions designed to simulate board examination. At the conclusion, participants will have learned the key information needed for the oral medicine certification examination.

2019 AAOM Board Review Course Presentations:
Presentation slides from the AAOM Board Review Course held during the 2019 AAOM Annual Conference in New Orleans, Louisiana are available to all AAOM members at no charge. Presentations will be available after June 1, 2019. AAOM Members can view the 2018 presentations here:
https://maaom.memberclicks.net/2018-board-review-course-presentations

Examination Procedures:
1. On-Site Parts A/B
    a. Arrival Day 1 (Part A) or Day 2 (Part B): Examiners and candidates arrive 30 minutes early to the main room for a continental breakfast. At 7:55AM, all of the board examiners are assembled in the front of the room, and candidates are welcomed followed by opening remarks by the President, and an introduction to the Board examiners. Candidates are to leave belongings, i.e. coats, electronic devices, purse, briefcase etc., in the

secured main room during the examination. All candidates will receive a paper copy of the final examination schedules (ie for Part A or Part B).

b. Registration and Verification of ID: Each candidate will register by showing their ID. The examiner will place a checkmark on the master spreadsheet and verify which sections the candidate is taking (ie full examination, or sections, if a partial re-take)
c. Honor Code: Candidates are obligated to conduct themselves in a manner that does not arouse suspicion or cause a question of integrity. An Honor Code will be distributed to candidates, briefly discussed by the designated examiner, and then signed and handed in. The key element of the code is that candidates work independently without aid from others or using any other information.
d. Late Arrival of a Candidate: Any candidate arriving late for an examination may not be permitted to take the examination unless he/she has received permission from a Board Director.
e. Breakfast & Lunch: Meals will be served, with breakfast beginning at 7.00AM, and Lunch from 1-2PM.

2. On-Site Specific to Part A
    a. Distribution of Part A Examinations: The candidates will be ushered into the examination room. The room will contain tables and each candidate will be adequately spaced apart. There are to be no personal belongings besides pencil and erasers at the candidate's seat during the examination. The packet of all written examinations scantron forms will be distributed. Information about how to complete the Scantron for each section is provided: name and section, and that ALL answers must be coded in by #2 pencil on the scantron form (#2 pencils will be provided).
    b. Proctoring: Board examiners will leave the room and convene into an adjacent room to have their annual board meeting. One examiner or a designated proctor will be at the front of the room to monitor the test-taking. That person will be able to contact the examiner for each section if a question arises and then the examiner can be called into the room to answer the question. If the candidate needs to leave to go to the washroom, he/she must ask permission. Only one candidate may leave the examination room at a time. The candidate must leave the examination papers in the room when they leave. Candidates are free to leave once they complete all the sections. As candidates leave, the proctor/examiner should collect each exam and each scantron sheet, making sure the scantron has the name of each candidate on each of the 7 separate examination sections. With 30 minutes remaining, the candidates still taking the exam should be given a verbal notification. With 10 minutes remaining, another warning,

and then with a 2 minutes remaining, the last notification. At 5 pm, all remaining exams are collected, counted, and collated into their respective sections.

3. On-site Specific to Part B
    a. Rooms for Part B: Four rooms will be identified for the Part B sections (Orofacial Pain, Medically Complex Patients, Oral Mucosal Diseases/Salivary Gland Disorders, and Pharmacology). The candidates will rotate through each of these sections, with up to 45 minutes allotted for each section, and an additional 15 minutes between sections. They will wait in the main room until the examiner for each section collects them and ushers them into examination room. All Part B candidates will later convene in a room identified for the Clinicopathologic Conference Section.
    b. Oral Examination: Two examiners will sit across from a candidate. One examiner is the primary examiner (ie s/he has developed the cases and structured questions), and the other examiner is the observer. Case(s) will have been selected for each of the 4 sections. Each section has been standardized so to ensure each candidate is examined on the same material. They will be provided the details of the clinical case, accompanied by images as appropriate), with adequate time allowed for them to digest the details. A series of open-ended structured questions, are asked in a systematic fashion for each candidate. The questions are initially simple ("ice-breaker") questions based on foundational knowledge and continue with greater complexity. The examiner may ask supplemental questions or reframe questions based on the candidate's understanding. Once the time has elapsed, the examiner will state that the questioning has concluded and the candidate will leave the room and be ushered back to the main room.
    c. Recusing Examiners: Examiners will be recused and replaced on a case by case basis when the candidate is a trainee in the same Oral Medicine training program that the examiner is affiliated with. The goal of this is to avoid conflicts.

Notification of Results:
Candidates will be notified of results by e mail within 3 months of the date of the examination. The Board does not provide individual feedback to any candidate other than reporting passing/failing the Board examination.

Certification:

Those who have successfully completed both Parts A and B, will receive a certificate bearing the seal of the American Board of Oral Medicine and the signatures of the Directors shall be awarded to each candidate who has successfully passed the examination, indicating certification as a Diplomate in the specialty of Oral Medicine. The action of the Directors regarding the certification of any candidate shall be final.

Policies on Fairness in Test Taking and Test Use:

1. All steps in the examination process, including examination design, validation, development, administration, and scoring procedures, are reviewed by the psychometrician in order to minimize construct-irrelevant variance and to promote valid score interpretations for all board candidates.
2. All candidates will receive comparable treatment during the administration of the examination and scoring process.
3. The ABOM is responsible for providing test accommodations, when appropriate and feasible, to remove barriers that otherwise would interfere with candidate's ability to demonstrate their ability on the examination.

Policies on the Rights and Responsibilities of Test Takers

1. Candidates have the right to adequate information (free of charge and in accessible formats) to help them properly prepare for the Board Examination. Information about content should be available to all candidates prior to testing.
2. Candidates will be provided in advance with as much information about the examinations, the examination process, the intended use of the examination, examination scoring criteria and interpretation, and availability of accommodations.
3. Candidates have the right to protection of their personally identifiable score results from unauthorized access, use, or disclosure.
4. Candidates have the responsibility to represent themselves accurately in the testing process and to respect copyright in test materials.
5. Candidates will be made aware that having someone else take the test for them, disclosing confidential test material, or engaging in any other form of cheating is unacceptable and that such behavior may result in sanctions.
6. When a candidate's examination result is expected to be significantly delayed beyond a brief investigative period because of possible irregularities such as suspected misconduct, the candidate will be notified and given the reason for the investigation.
7. When it is deemed necessary to cancel or withhold a candidate's result because of possible testing irregularities, including suspected misconduct, the type of evidence and the general procedures to be used to investigate the irregularity

should be explained to all candidates whose scores are directly affected by the decision. Candidates should be given a timely opportunity to provide evidence that the result should not be canceled or withheld. Evidence considered in deciding on the final action should be made available to the candidate upon request.

8. Candidates are entitled to fair treatment and a reasonable resolution process, appropriate to the particular circumstances, regarding charges associated with examination irregularities, or challenges issued by the test taker regarding accuracies of the scoring or scoring key. Candidates are entitled to be informed of any available means of recourse.

Policies on Testing Individuals of Diverse Linguistic Backgrounds
Candidates applying to challenge the ABOM are/were enrolled in CODA-accredited Oral Medicine Training programs with requirements for proficiency in English. As such there are no accommodations for candidates to take the examinations in any other language.

Policies on Testing Individuals with Disabilities
Reasonable accommodations will be provided to candidates with disabilities when appropriate and feasible, to remove barriers that otherwise would interfere with candidate's ability to demonstrate their ability on the examination.

ABOM Examination Failure :
In the event of failure to pass either Part of the examination, the following applies:

1. A candidate may be admitted for re-examination within a period of three (3) years following the original examination (ie. either Part A or Part B)
2. Any candidate failing greater than 50% of the sections of Part A or Part B must retake that entire examination.
3. Any candidate failing less than 50% of the sections of Part A or of Part B may retake only those sections.
4. A candidate can re-test either exam (Part A or Part B) twice. (ie. total of 3 attempts to complete either Part). Candidate must retake the entire exam in total that is Part A and Part B after the 3rd unsuccessful attempt of either Part A or Part B. The candidate must initiate a new application process including new fees, and show proof of additional training that satisfies the board to qualify for additional examinations.
5. There is a non-refundable re-examination fee for each Part A and Part B (see fee guide).

Appeal Process:

Grounds for Appeal include significant irregularities in procedures that could potentially affect the candidate's performance (eg delay in start time, disruption during examination, equipment used for examination faulty. A request for appeal must be submitted in writing within thirty days of the date of the letter notifying the candidate of the examination results. The request must include a detailed explanation of the facts, circumstances and rationale relating to the alleged process irregularity.

1. The Appeal will be forwarded to all Directors of the American Board of Oral Medicine for their input and discussion.
2. The candidate appealing may be asked to provide further clarification and explanation of the alleged irregularity.
3. A written response to the appeal will be forwarded to the candidate from the Secretary of the ABOM.
4. Decision options include:
    a. No process irregularity has occurred.
    b. A process irregularity occurred but was not of a magnitude that it would substantially affect the candidate's performance.
    c. A process irregularity occurred and was of sufficient magnitude to substantially affect the candidate' performance. In this case, either a repeat examination is granted for the next examination session or a pass is awarded without further examination of the candidate.
5. The decision made by the ABOM is final.

Recommended Reading List:

Radiology

White SC and Pharoah M. Oral Radiology: Principles and Interpretation. 8th Edition, 2019.

AAOMR and AAE. Use of cone beam computed tomography in endodontics . Oral Surg Oral Med Oral Pathol Endod 2011:111(2):234-7.

Tyndall DA, Price JB, Tetradis S, et al. Position statement of the American Academy of Oral and Maxillofacial Radiology on selection criteria for the use of radiology in dental implantology with emphasis on cone beam computed tomography. Oral Surg Oral Med Oral Pathol Endod 2012;113(6): 817-26.

Treister NS, Friedland B, Woo S-B. Use of cone-beam computerized tomography for evaluation of bisphosphonate-associated osteonecrosis of the jaws. Oral Surg Oral Med Oral Pathol Endod 2010;109(5): 753-64.

Bag AK, Gaddikeri S, Singhal A, Hardin S, Tran BD, Medina JA, Cure JK. Imaging of the temporomandibular joint: an update. World Journal of Radiology 2014;6(8):567- 582.

Mancuso AA, Ojiri H, Quisling RG. Head and Neck Radiology: A teaching file. Lippincott Williams & Wilkins Philadelphia, PA 19109, 2002.

Laboratory Medicine

Burket's Oral Medicine. 12th Edition, M. Glick editor, 2014.

AAOM Clinician's Guide to Treatment of HIV-infected Patients. Lauren L. Patton.

AAOM Clinician's Guide Salivary Gland and Chemosensory Disorders. Michael T. Brennan and Philip C. Fox.

AAOM Clinician's Guide Medically Complex Dental Patients, 5th edition, Musbah T and Miller.CS.

Clinician's Pocket Reference, 11th Edition. Leonard Gomella and Steven Haist.

Dental Management of the Medically Compromised Patient, 9th Edition. James W. Little, Craig S. Miller, Nelson L. Rhodus.

Clinical Approaches to Oral Mucosal Disorders: Part 1 Dent Clin North Am 2013; 57. Sollecito, TP and Stoopler, ET.

Clinical Approaches to Oral Mucosal Disorders: Part 2 Dent Clin North Am 2014; 58.Sollecito, TP and Stoopler, ET.

Oral Pathology

Oral and Maxillofacial Pathology, 4th - edition. BW Neville, DD Damm, CM Allen, AC Chi, Elsevier, 2016.

Oral Pathology: Clinical Pathologic Correlations. 7th edition. JA Regezi, JJ Sciubba & RCK Jordan, Elsevier, 2017.

Clinical Outline of Oral Pathology: Diagnosis and Treatment. 4th edition. LR Eversole, People's Medical Publishing House-USA, 2011.

Color Atlas of Common Oral Diseases, 5th edition. RP Langlais, CS Miller, JS Gehrig, 2016.

Pharmacology

AAOM Pharmacology Clinical Guide. Casiglia and Jacobsen.

AAOM Common Oral Lesions Guide. Siegel, Sollecito, and Silverman.

AAOM Chronic Orofacial Pain Guide. Brown, Arm, and Epstein.

Epinephrine and local anesthesia revisited. Brown & Rhodus. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2005;Oct;100(4):401-8.

Amalgam--resurrection and redemption. Part 2: The medical mythology of anti-amalgam. Wahl MJ. Quintessence Int. 2001 Oct;32(9):696-710.

The dental treatment of patients with joint replacements: a position paper from the American Academy of Oral Medicine. Little JW, Jacobson JJ, Lockhart PB JADA 2010;141(6):667-71.

Prevention of infective endocarditis: guidelines. Wilson et al. JADA 2007;138(6)739-45.

Medically Complex Dental Patients

AAOM Clinician's Guide for the Medically Complex Dental Patient. 5th edition, Musbah and Miller,

Dental Management of the Medically Compromised Patient, 9th Edition. James W. Little, Craig S. Miller, Nelson L. Rhodus.

Mucosal and Salivary Gland Disease

AAOM Clinician's Guide to Treatment of Common Oral Conditions (8th edition). Siegel MA, Silverman S Jr, Sollecito TP (eds). 2009.

Burket's Oral Medicine (12th edition). Glick M (ed). Shelton: People's Medical Publishing House- USA, 2015.

Oral and Maxillofacial Pathology, 4th - edition. BW Neville, DD Damm, CM Allen, AC Chi, Elsevier, 2016

Langlais RP & Miller CS. Color Atlas of Common Oral Diseases, 4th ed. Lippincott, 2013.

Dawes C, et al The Functions of Human Saliva: A Review Sponsored by the World Workshop on Oral Medicine VI . Archives of Oral Biology. 2015 Jun;60(6):863-74

AAOM Clinician's Guide to Salivary Gland and Chemosensory Disorders. (1st Edition). Michael T Brennan and , Philip C Fox (eds). 2009

The ADA Practical Guide to Patients with Medical Conditions (2nd edition). Patton LL and Glick M (eds). Hoboken: John Wiley & Sons, Inc., 2015.

Orofacial Pain

Orofacial Pain: From Basic Science to Clinical Management, Second Edition. Sessle, Lavigne, Lund, Dubner, 2008.

Classifying orofacial pains: a new proposal of taxonomy based on ontology. Nixdorf DR, Drangsholt MT, Ettlin DA, Gaul C, De Leeuw R, Svensson P, Zakrzewska JM, De Laat A, Ceusters W; International RDC-TMD Consortium. J Oral Rehabil. 2012; 39(3):161-9.

Orofacial Pain: Guidelines for Assessment, Diagnosis, and Management, Fifth Edition. Reny de Leeuw and Gary D Klasser, 2013.

Amended: July 10, 2020

OTHER ISSUES

Oregon Board of Dentistry

Strategic Plan 2022-2025

Draft 2.0

As of February 14, 2022

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Oregon Board of Dentistry

2022-2025 Strategic Plan

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

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Oregon Board of Dentistry
Strategic Plan Overview

The Oregon Board of Dentistry's (OBD) responsibilities and oversight authority is bestowed from the Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.010 to 680.205 (Dental Hygienists), Oregon Administrative Rules Chapter 818. In addition, direction for Dental Therapists is guided by HB 2528 (2021) and the addition of Interim Therapeutic Restorations, HB 2627 (2021) for Expanded Practice Dental Hygienists. These new statutes task the OBD with regulation and oversight of the practice of dentistry and dental hygiene by enforcing standards of practice established in the Oregon Legislature statutes and rule.

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

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

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

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

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

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

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

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

Oregon Board of Dentistry
Mission Statement & Core Values

Mission of the Oregon Board of Dentistry:

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

Oregon Board of Dentistry Core Values:

- Integrity
- Fairness
- Responsibility
- Community

Oregon Board of Dentistry

Organizational & External Influences Analysis

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

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

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

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

STRATEGIC PRIORITY A

Licensure Evolution

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

Goals

⇒ Develop and implement rules based on legislation changes

⇒ Successfully implement Dental Therapy license

Action Items

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

STRATEGIC PRIORITY B

Dental Practice Accountability

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

Goals

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

⇒ Increase OBD visibility into practice ownership models

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

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

Action Items

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

STRATEGIC PRIORITY C

Community Interaction and Equity

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

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

Goals

⇒ Communicate and market to reach the diverse communities within Oregon

⇒ Increase ease of access to OBD services

⇒ Ensure equity exists in Investigation outcomes

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

Action Items

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

STRATEGIC PRIORITY D

Workplace Environment

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

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

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

Goals

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

⟹ Increase workplace flexibility through a hybrid workplace guideline

⟹ Increase workplace satisfaction and career development conversations

Action Items

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

STRATEGIC PRIORITY E

Technology & Processes

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

Goals

⇒ Improve efficiency and resource utilization through online record keeping

⇒ Increase ability to complete analytics related to licensees and investigations

⇒ Improve investigation case management with archived files

Action Items

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

Oregon Board of Dentistry Strategic Plan 2022-2025

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

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

Oregon Board of Dentistry 2022-2025 Strategic Plan

Roadmap and Goals

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

Oregon
Kate Brown, Governor

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

TO: OBD Board Members

FROM: Stephen Prisby, OBD Executive Director

DATE: February 7, 2022

SUBJECT: Draft - OBD Tribal Relationship & Cooperation Policy

The Oregon Board of Dentistry (OBD) is mandated to comply and follow SB 770, ORS 182.164 and ORS 182.166. I have reached out to all 9 Federally Recognized Tribes regarding this Draft Policy. The Tribes have been invited to the February 25, 2022 Meeting to help foster open and positive communication on this proposed policy, dental therapy and any other important issue.

Enrolled
Senate Bill 770

Sponsored by Senators BROWN, CLARNO; Senators CASTILLO, CORCORAN, DECKERT, FERRIOLI, GORDLY, MESSERLE, METSGER, NELSON, SHIELDS, STARR, TROW, Representatives GARDNER, KNOPP, KRIEGER, MONNES ANDERSON, NOLAN, ROSENBAUM, G SMITH, VERGER, V WALKER, WESTLUND (at the request of Commission on Indian Services)

CHAPTER .....

AN ACT

Relating to government-to-government relations between the State of Oregon and American Indian tribes in Oregon.

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

SECTION 1. As used in sections 1 to 4 of this 2001 Act:

(1) "State agency" has the meaning given that term in ORS 358.635.

(2) "Tribe" means a federally recognized Indian tribe in Oregon.

SECTION 2. (1) A state agency shall develop and implement a policy that:

(a) Identifies individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(b) Establishes a process to identify the programs of the state agency that affect tribes.

(c) Promotes communication between the state agency and tribes.

(d) Promotes positive government-to-government relations between the state and tribes.

(e) Establishes a method for notifying employees of the state agency of the provisions of sections 1 to 4 of this 2001 Act and the policy the state agency adopts under this section.

(2) In the process of identifying and developing the programs of the state agency that affect tribes, a state agency shall include representatives designated by the tribes.

(3) A state agency shall make a reasonable effort to cooperate with tribes in the development and implementation of programs of the state agency that affect tribes, including the use of agreements authorized by ORS 190.110.

SECTION 3. (1) At least once a year, the Oregon Department of Administrative Services, in consultation with the Commission on Indian Services, shall provide training to state agency managers and employees who have regular communication with tribes on the legal status of tribes, the legal rights of members of tribes and issues of concern to tribes.

(2) Once a year, the Governor shall convene a meeting at which representatives of state agencies and tribes may work together to achieve mutual goals.

(3) No later than December 15 of every year, a state agency shall submit a report to the Governor and to the Commission on Indian Services on the activities of the state agency under sections 1 to 4 of this 2001 Act. The report shall include:

(a) The policy the state agency adopted under section 2 of this 2001 Act.

(b) The names of the individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(c) The process the state agency established to identify the programs of the state agency that affect tribes.

(d) The efforts of the state agency to promote communication between the state agency and tribes and government-to-government relations between the state and tribes.

(e) A description of the training required by subsection (1) of this section.

(f) The method the state agency established for notifying employees of the state agency of the provisions of sections 1 to 4 of this 2001 Act and the policy the state agency adopts under section 2 of this 2001 Act.

SECTION 4. Nothing in sections 1 to 4 of this 2001 Act creates a right of action against a state agency or a right of review of an action of a state agency.

Passed by Senate April 2, 2001

.....
Secretary of Senate

.....
President of Senate

Passed by House May 11, 2001

.....
Speaker of House

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2001

.....
Secretary of State

182.164 State agencies to develop and implement policy on relationship with tribes; cooperation with tribes. (1) A state agency shall develop and implement a policy that:

(a) Identifies individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(b) Establishes a process to identify the programs of the state agency that affect tribes.

(c) Promotes communication between the state agency and tribes.

(d) Promotes positive government-to-government relations between the state and tribes.

(e) Establishes a method for notifying employees of the state agency of the provisions of ORS 182.162 to 182.168 and the policy the state agency adopts under this section.

(2) In the process of identifying and developing the programs of the state agency that affect tribes, a state agency shall include representatives designated by the tribes.

(3) A state agency shall make a reasonable effort to cooperate with tribes in the development and implementation of programs of the state agency that affect tribes, including the use of agreements authorized by ORS 190.110. [2001 c.177 §2]

182.166 Training of state agency managers and employees who communicate with tribes; annual meetings of representatives of agencies and tribes; annual reports by state agencies. (1) At least once a year, the Oregon Department of Administrative Services, in consultation with the Commission on Indian Services, shall provide training to state agency managers and employees who have regular communication with tribes on the legal status of tribes, the legal rights of members of tribes and issues of concern to tribes.

(2) Once a year, the Governor shall convene a meeting at which representatives of state agencies and tribes may work together to achieve mutual goals.

(3) No later than December 15 of every year, a state agency shall submit a report to the Governor and to the Commission on Indian Services on the activities of the state agency under ORS 182.162 to 182.168. The report shall include:

(a) The policy the state agency adopted under ORS 182.164.

(b) The names of the individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(c) The process the state agency established to identify the programs of the state agency that affect tribes.

(d) The efforts of the state agency to promote communication between the state agency and tribes and government-to-government relations between the state and tribes.

(e) A description of the training required by subsection (1) of this section.

(f) The method the state agency established for notifying employees of the state agency of the provisions of ORS 182.162 to 182.168 and the policy the state agency adopts under ORS

Title: OBD Tribal Relationship & Cooperation Policy

Effective Date: TBD (once ratified by the Oregon Board of Dentistry)

Purpose:

The State of Oregon and the Oregon Board of Dentistry (OBD) share the goal to establish clear policies establishing the tribal consultation and requirements to further the government-to-government relationship between the OBD and the nine federally recognized Tribes of Oregon (Oregon Tribes) with the passage of HB 2528 (2021) and on any other matters that are important to the Tribes. This policy shall fulfill the requirements of ORS 182.164 & ORS 182.166.

Nine Federally Recognized Tribes of Oregon ("Oregon Tribes"):

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Other Organizations
Urban Indian Health Programs (UIHP)
Northwest Portland Area Indian Health Board (NPAIHB)

This Policy:

- Identifies individuals within the OBD who are responsible for developing and implementing programs, rules, policies and draft legislation that affect Tribes.
- Establishes a process to identify the OBD programs, rules, policies and draft legislation that impact Tribes.
- Promotes communication between the OBD and the Tribes.
- Promotes positive government-to-government relations between the OBD and Tribes.
- Promotes positive relationships with any entity that serves tribal members including the Northwest Portland Area Indian Health Board and Urban Indian Health Programs
- Establishes a method for ensuring that OBD employees comply with ORS 182.162 to 182.168 and this policy.
- Streamlined for ease to understand and apply: the OBD is a small agency with 8 employees.
- This Policy is to meet compliance with ORS 182.164, but also should be utilized in working with any tribal group, entity or organization that supports tribal members and is impacted by the OBD's work.

Meaningful consultation between tribal leadership and agency leadership shall result in information exchange, transparency, mutual understanding, and informed decision-making on

behalf of the Oregon Tribes and the State. One key goal of this policy is to prevent avoidable surprises between the OBD and Oregon Tribes.

Other key goals of this policy include, but are not limited to: helping to eliminate health and human service disparities of Indians; ensuring that access to critical health and human services is maximized; advancing and enhancing the social, physical, behavioral and oral health of Indians; making accommodations in State programs when possible to account for the unique nature of Indian health programs; collaborating on the development and improvement of programs, rules, policies and draft legislation; and ensuring that the Oregon Tribes are consulted to ensure meaningful and timely tribal input as required under Federal and State law when health and human service policies have an impact on Indians and the Oregon Tribes. To achieve this goal, and to the extent practicable and permitted by law, it is essential that the Oregon Tribes and the OBD engage in open, continuous and meaningful consultation and collaboration.

This policy applies to the OBD (Board Members and staff) and shall serve as a guide for the Oregon Tribes to participate in OBD legislative, rule and policy development to the greatest extent allowable under law. The relationship between the OBD and the Oregon Tribes is important and should be on a foundation of trust and mutual respect. It is important for the OBD to work closely with Oregon Tribes on issues related to Dental Therapy and any other matter that is important to the Oregon Tribes.

Policy #834-413-019 OBD Tribal Relationship & Cooperation Policy
Effective Date: TBD

Applicability: All Board Members, full and part time employees, temporary employees and volunteers

References:
(1) Purpose
This tribal relations policy is adopted pursuant to ORS 182.162 – 182.168, which requires state agencies to develop and implement tribal relations policies.
(2) General Policies and Principles
It is OBD's policy to promote the principle stated in Executive Order No.96-30 that "[a]s sovereigns the tribes and the State of Oregon must work together to develop mutual respect for the sovereign interests of both parties." OBD interacts with tribes in differing roles: in its role as legal advisor to and representative of other state agencies; and in its role as independent administrator of certain OBD programs. In all of its roles, it is OBD's policy to promote positive government to government relations with the federally recognized tribes in Oregon ("tribes") by
(a) Facilitating communication and understanding and appropriate dispute resolution among OBD, other state agencies and those tribes;
(b) Striving to prevent unnecessary conflict with tribes;
(c) Interacting with tribes in a spirit of mutual respect;
(d) Involving tribal representatives in the development and implementation of programs, rules, policies and draft legislation that affect them; and
(e) Seeking to understand the varying tribal perspectives.
(3) The OBD's Native American Affairs Coordinator is the OBD's Executive Director
(a) The state is best served through a coordinated approach to tribal issues. The OBD's Executive Director has been designated as the OBD's Native American Affairs Coordinator, who serves as the OBD's key contact with tribal representatives.
(b) Individuals at the OBD who are working on a significant matter involving or affecting a tribe

shall notify the Native American Affairs Coordinator.
(4) Dissemination of Tribal Relations Policy
(a) Upon adoption, this policy shall be disseminated to members of the OBD, and shall be incorporated into the OBD Policy Manual. In addition, this policy and information regarding ORS 182.162 – 168 shall be included in new Board Member and employee orientation.
(b) The Executive Director will be responsible for submitting the OBD's annual report in December to the Governor and the Commission on Indian Service per ORS 182.166 detailing its work with the Tribes for the prior year and this Policy.
(5) Training
(a) Appropriate OBD representatives will attend annual training provided by the Department of Administrative Services pursuant to ORS 182.166(1).
(b) The OBD's assigned attorney who may come into contact with tribes will be encouraged to consider taking advantage of outside CLE opportunities on Indian law and culture.
(7) Identification of OBD Programs Affecting Tribes
The Executive Director will compile a list of OBD programs, rules, policies and draft legislation that affect tribes, as well as the OBD individuals responsible for implementing them with feedback from the affected Tribes or tribal members.
(8) Guidelines for OBD Programs
The OBD will invite tribal participation on Dental Therapy issues and other areas of interest that the Tribes bring forth to the OBD.

OBD Commitment to Tribal Consultation

The OBD was established by the Oregon State Legislature in 1887 and is accountable to the people of Oregon, acknowledges this unique relationship, the statutory and regulatory framework for states to consult with Tribes, and recognizes the right of Indian tribes to self-determination and self-governance. The special government-to-government relationship between the Tribes and federal and state governments will be respected in all dealings with the Tribes and OBD. Relationship of State Agencies with Indian Tribes, ORS 182.162 to 182.168.

In order to fully effectuate this policy, OBD will:

- Ensure inclusion of the Tribes prior to the development of policies and program activities that impact Tribes, utilizing the OBD's formal notice that provides descriptive content and a timeline of all public meetings;
- Create opportunities for Tribes to raise issues with the OBD and for the OBD to seek consultation with Tribes;
- Establish communication channels with Tribes to increase knowledge and understanding of OBD programs;
- Support tribal self-determination;
- Include on every regular Board Meeting Agenda an opportunity for the Tribes to directly communicate with the OBD.

Tribal Consultation Principles:

Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation includes collaboration and often results in an iterative process between parties. Meaningful consultation is integral to a

deliberative process that results in effective collaboration and informed decision-making, with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government-to-government relationship, meaningful communication and consultation must occur on a regular and as needed basis so that Tribes have an opportunity to provide meaningful, and timely input on issues that may have an impact on Tribes. This government-to-government relationship applies between the Tribes and the State.

Consultation with the Tribes is important in the context of health programs because the Tribes serve many roles in their communities:

- Tribes and tribal governments are sovereign nations with inherent authority over their internal affairs; have a government-to-government relationship with the federal government, state governments, and other sovereigns; and have the responsibility to ensure the health and well-being of their tribal citizens, among various other governmental responsibilities.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of clinics and other health programs, which includes public health

Policy Action

It is the intent of OBD to meaningfully consult with Tribes on any rule changes, policy, programs, rules and draft legislation that will impact the Tribes before any action is taken.

Such rule changes or policies include those that:

- Have Indian or Tribal implications; or
- Have implications on the Indian Health Service, tribal health programs or urban Indian health program, or
- Have a direct effect on one or more Tribes, or
- Have a direct effect on the relationship between the state and Tribes, or
- Have a direct effect on the distribution of power and responsibilities between the state and Tribes; or
- Are a federally or statutorily mandated proposal or change in which OBD has flexibility in implementation.

Tribal Consultation Process:

An effective consultation between the OBD and the Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship.
Any Issue includes, but is not limited to:

- Policy, programs, rules and draft legislation development impacting the Tribes;
- Program activities that impacting Tribes;
- Data collection and reporting activities impacting Tribes;
- Rulemaking impacting Tribes; or
- Any other OBD action impacting Tribes or that has implications on the NPAIHB, UIHP, tribal health programs or urban Indian health program.

Upon identification of any Issue meeting any of the above criteria the OBD will initiate consultation regarding the issue.

To initiate and conduct consultation, the following serves as a guideline to be utilized by the OBD and the Tribes:

- Identify the Issue: complexity, implications, time constraints, deadlines and issue(s).
- Identify how the Issue impacts the Tribes.
- Identify affected/potentially affected Tribes.

Determining Consultation Mechanism: The most useful and appropriate consultation mechanisms can be determined by OBD and Tribes after considering the Issue and Tribes affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:

- Email
- Teleconferences
- Virtual Meetings
- Face-to-Face Meetings at regular Board or Committee Meetings
- Other regular or special consultation sessions needed.

Communication Methods: The determination of the Issue and the level of consultation mechanism to be used by OBD shall be communicated to affected/potentially affected Tribes using all appropriate methods and with as much advance notice as practicable or as required under this policy.

These methods include but are not limited to the following:

- Official Notification: Upon the determination of the consultation mechanism, proper notice of the Issue and the consultation mechanism utilized shall be communicated to affected/potentially affected Tribes using all appropriate methods including mailing and broadcast e-mail. Such notice shall be provided to:
    - Tribal Chair or Chief and their designated representative(s)
    - Any other entity that the Tribes identify that should be included

- The OBD will regularly update its mailing/email list to ensure notice is being provided to designated leadership. Each Tribe is responsible for providing this information to OBD's Executive Director to regularly update the list.

Rulemaking: The OBD will include the Tribes in all legislative, rulemaking and policy making processes that have tribal implications. The Tribes will have a regular and open invitation to attend any OBD Committee meeting or public rulemaking hearing to provide additional input on rule concepts and language.

Creation of Committees/Work Group(s): Round tables and work groups may be used for discussions, problem resolution, and preparation for communication and consultation related to an Issue but do not replace formal tribal consultation. Round tables and work groups will provide the opportunity for technical assistance from the OBD to Indian health programs and the Tribes to address challenges or barriers and work collaboratively on development of solutions to bring to the meetings.

Implementation Process and Responsibilities: The process should be reviewed and evaluated for effectiveness as requested.

Tribal Consultation Evaluation: The OBD is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of the OBD to incorporate tribal recommendations, the OBD may assess its performance on an annual basis in the Executive Director's performance review or as needed.

Meeting Records and Additional Reporting: The OBD is responsible for making and keeping records of all public meetings and its tribal consultation activity. All such records shall be made readily available to the Tribes.

Definitions:

Indian or American Indian/Alaska Native (AI/AN1Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13),1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

Is a member of a Federally recognized Indian Tribe;
Resides in an urban center and meets one or more of the four criteria:
Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
Is an Eskimo or Aleut or other Alaska Native;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is determined to be an Indian under regulations issued by the Secretary;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
Tribe. Tribe means any Federally recognized Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Oregon's nine Federally Recognized Tribes include:

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Disclaimer:

OBD respects the sovereignty of each of Oregon's Tribes. In executing this policy, no party waives any rights, including treaty rights; immunities, including sovereign immunities; or jurisdictions. This policy does not diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this policy, the parties strengthen their collective ability to successfully resolve issues of mutual concern. While the relationship described by this policy provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, the Governor’s Office.

Dental Pilot Projects Program

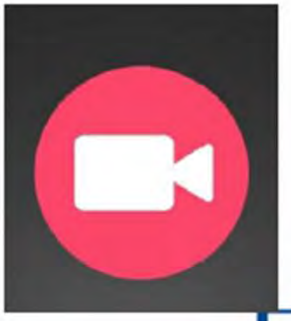
DPP #300 - Advisory Committee Meeting

January 31, 2022

Oregon Health Authority

Oral Health Program
Public Health Division

- Agenda Review & Meeting Guidance
- Please turn on your video camera.
- Please use chat function to ask question.
- MUTE yourself.
- Only Committee Members and Invited Guests will actively participate in the meeting.
- Public Meeting: Public Comment Period at End of Meeting
- Meetings are recorded for notetaking only



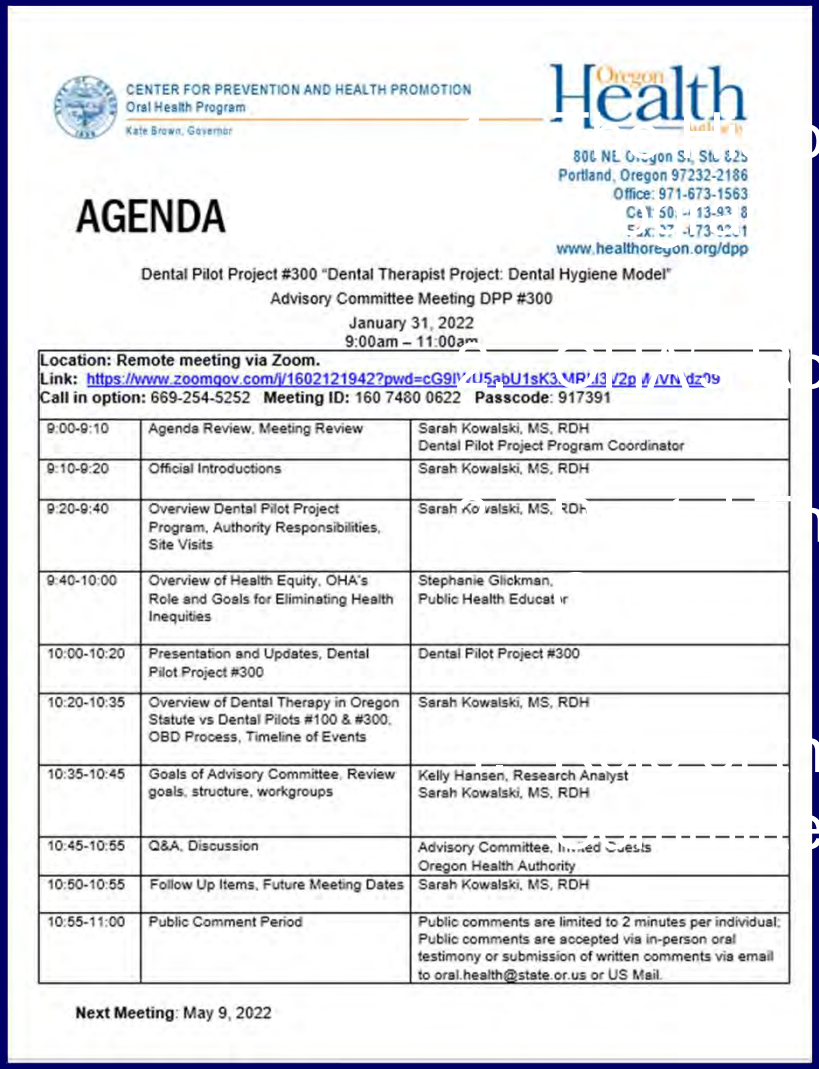
Oregon Health Authority

Dental Pilot Projects Program

Dental Pilot Projects Program

- Name & Organization
- What is your interest in participation on the Advisory Committee?

Dental Pilot Projects Program



CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St., Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 503-[illegible]
Fax: 971-673-[illegible]
www.healthoregon.org/dpp

AGENDA

Dental Pilot Project #300 "Dental Therapist Project: Dental Hygiene Model"
Advisory Committee Meeting DPP #300
January 31, 2022
9:00am – 11:00am

Location: Remote meeting via Zoom.
Link: https://www.zoomgov.com/j/1602121942?pwd=cG9l[illegible]
Call in option: 669-254-5252 **Meeting ID:** 160 7480 0622 **Passcode:** 917391

9:00-9:10	Agenda Review, Meeting Review	Sarah Kowalski, MS, RDH Dental Pilot Project Program Coordinator
9:10-9:20	Official Introductions	Sarah Kowalski, MS, RDH
9:20-9:40	Overview Dental Pilot Project Program, Authority Responsibilities, Site Visits	Sarah Kowalski, MS, RDH
9:40-10:00	Overview of Health Equity, OHA's Role and Goals for Eliminating Health Inequities	Stephanie Glickman, Public Health Educator
10:00-10:20	Presentation and Updates, Dental Pilot Project #300	Dental Pilot Project #300
10:20-10:35	Overview of Dental Therapy in Oregon Statute vs Dental Pilots #100 & #300, OBD Process, Timeline of Events	Sarah Kowalski, MS, RDH
10:35-10:45	Goals of Advisory Committee, Review goals, structure, workgroups	Kelly Hansen, Research Analyst Sarah Kowalski, MS, RDH
10:45-10:55	Q&A, Discussion	Advisory Committee, Invited Guests Oregon Health Authority
10:50-10:55	Follow Up Items, Future Meeting Dates	Sarah Kowalski, MS, RDH
10:55-11:00	Public Comment Period	Public comments are limited to 2 minutes per individual; Public comments are accepted via in-person oral testimony or submission of written comments via email to oral.health@state.or.us or US Mail.

Next Meeting: May 9, 2022

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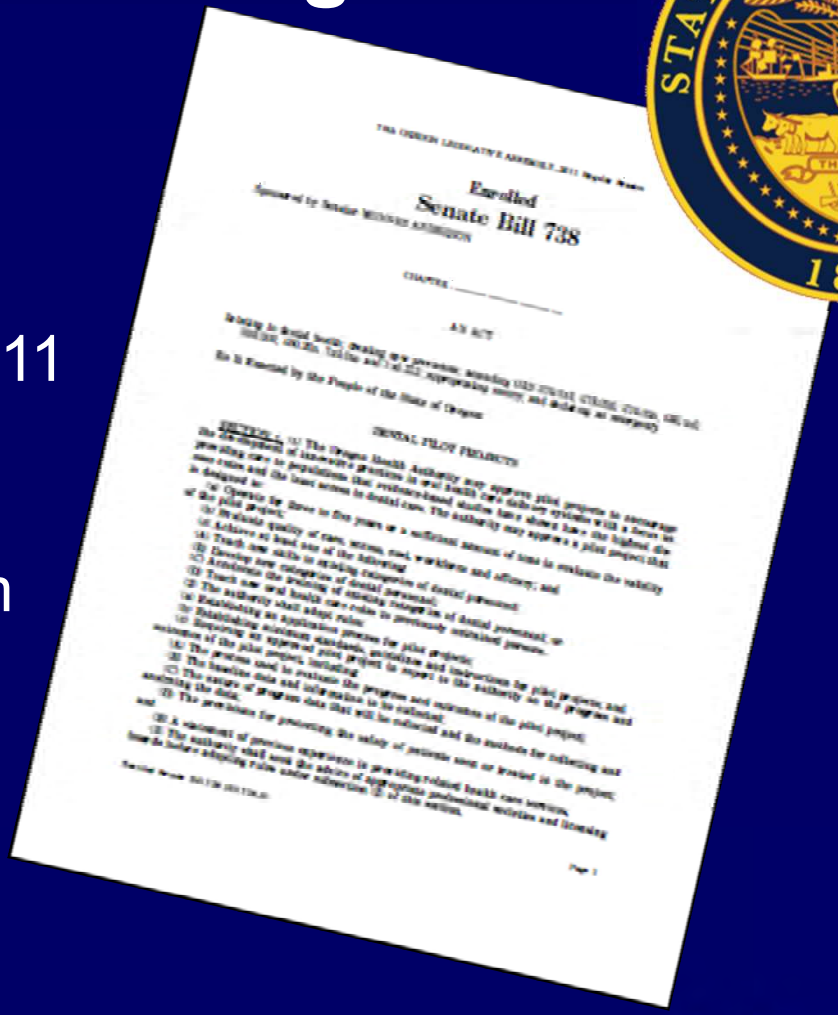
Dental Pilot Projects Program

Oregon Health Authority

Dental Pilot Projects Program

History of the Program

- SB 738 passed in 2011
- Established Dental Pilot Project Program
- Funded in 2014
- Started accepting applications 2015



Enrolled
Senate Bill 738

AN ACT

DENTAL PILOT PROJECTS

Oregon Health Authority

Dental Pilot Projects Program

Purpose of SB 738

- Encourage the development of innovative practices in oral health care delivery systems
- Focus on providing care to populations that have the highest disease rates and the least access to dental care

Dental Pilot Projects Program

- Offers opportunity to safely demonstrate and evaluate new approaches to care delivery before changing laws and regulations

- SB 738 Allows an unlicensed person to practice dentistry or dental hygiene in approved pilot project

Dental Pilot Projects Program

- Pilot Projects are designed to run 3-5 Years
- Pilot Projects can apply for a modification to extend the project timeline or other aspects of their projects, addition of sites, trainees, etc.

Oregon Health Authority

Dental Pilot Projects Program

- OHA Program Modeled after California Program
- California Health Workforce Pilot Project Program (HWPP)
- California HWPP began 1972

Oregon Health Authority

Dental Pilot Projects Program

- California Program Spans all Health Professions
- Oregon Program is Limited to Dental

Dental Pilot Projects Program

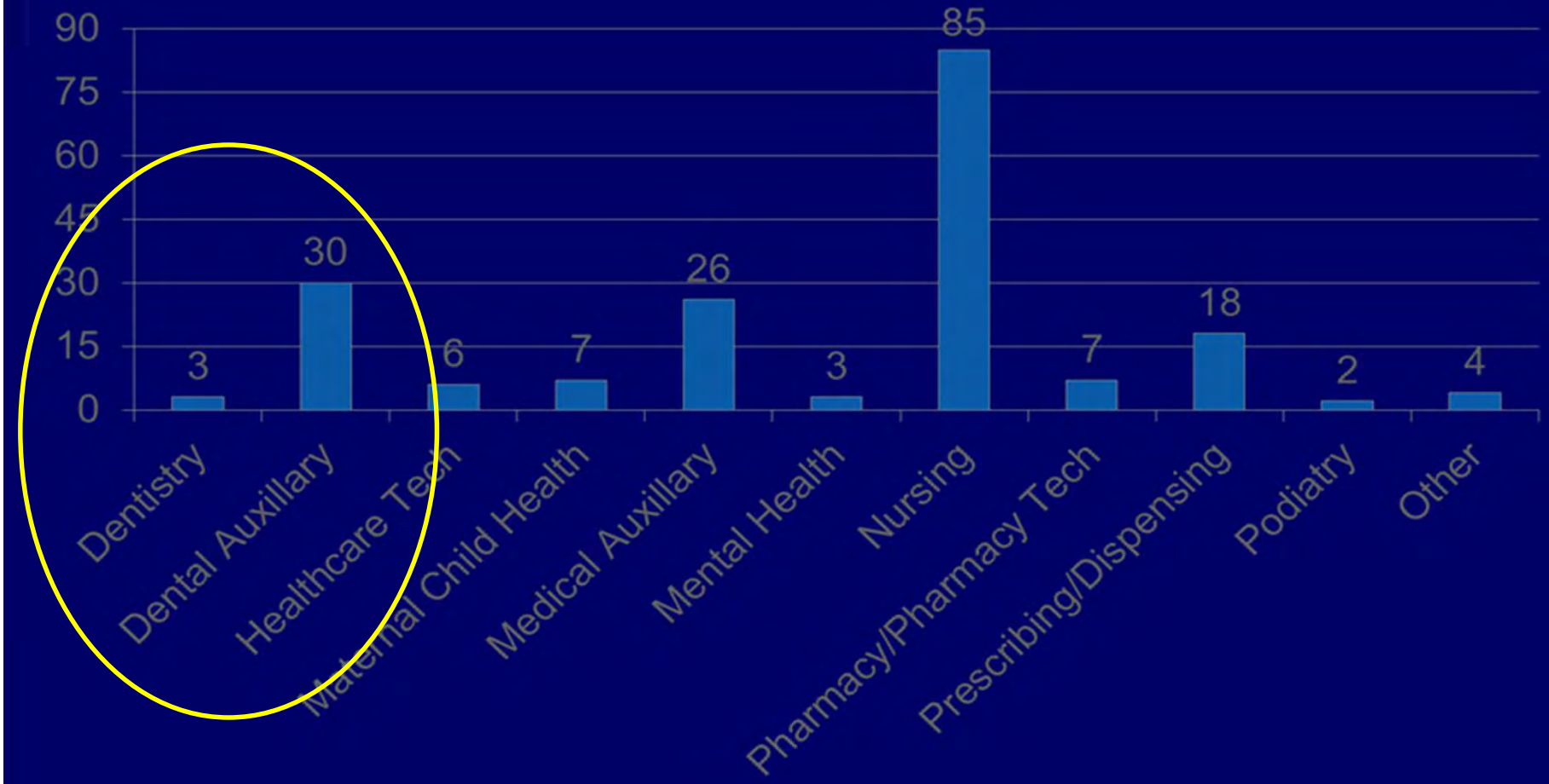
Oregon Health Authority

CALIFORNIA PROGRAM STATISTICS

- 173 sponsors have submitted applications since 1972
- 123 HWPP applications have been approved
- 117 HWPP applications have been administered
- 77 Pilot Projects have resulted in legislative and/or regulatory change

Oregon Health Authority

California Health Workforce Pilot Projects (HWPP)

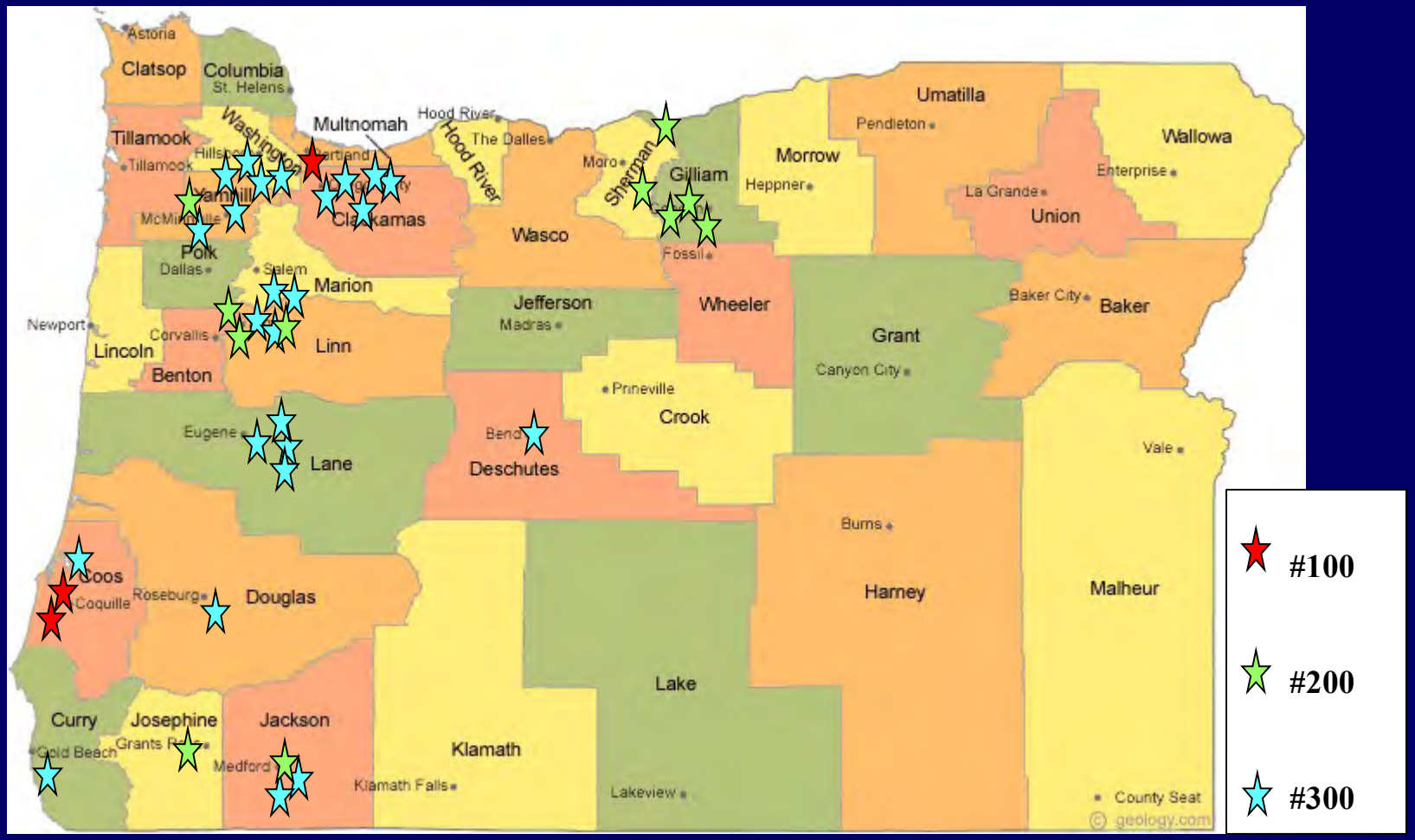


18% California HWPP have Dental Focus

Dental Pilot Projects Program

- DPP #100: Oregon Tribes Dental Health Aide Therapist Pilot Project (DHAT)
- DPP #200: Training Dental Hygienists to Place Interim Therapeutic Restorations (ITR)
- DPP #300: Dental Therapist Project: Dental Hygiene Model

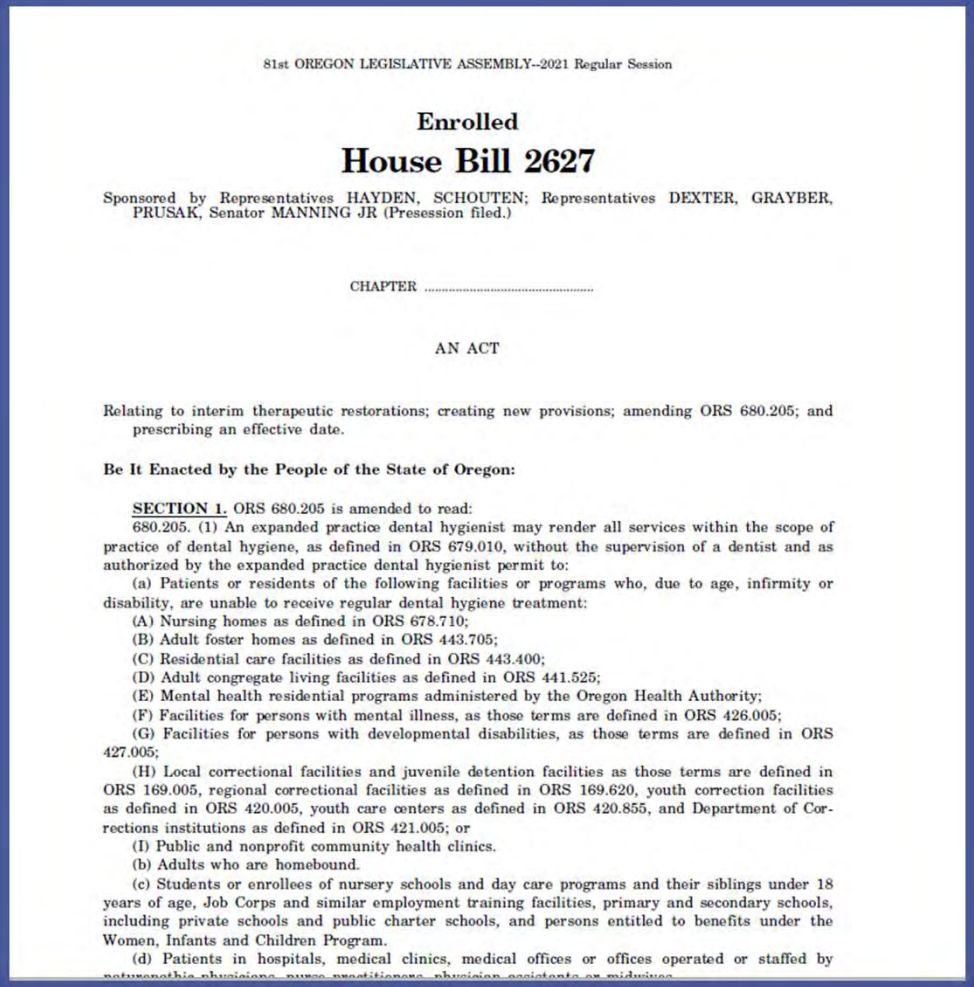
Dental Pilot Projects Program



Dental Pilot Projects Program

DPP #200: Training Dental Hygienists to Place Interim Therapeutic Restorations (ITR)

- Expand Scope of Practice Dental Hygienist
- EPDHs can place “Interim Therapeutic Restorations” (ITRs)
- Sponsored by OHSU School of Dentistry
- Capitol Dental, Virginia Garcia, Advantage Dental Care
- 8 trainees
- Approved 2016
- Concludes July 31, 2022



81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled

House Bill 2627

Sponsored by Representatives HAYDEN, SCHOUTEN; Representatives DEXTER, GRAYBER, PRUSAK, Senator MANNING JR (Presession filed.)

CHAPTER .....

AN ACT

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

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

SECTION 1. ORS 680.205 is amended to read:

680.205. (1) An expanded practice dental hygienist may render all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the expanded practice dental hygienist permit to:

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

(A) Nursing homes as defined in ORS 678.710;

(B) Adult foster homes as defined in ORS 443.705;

(C) Residential care facilities as defined in ORS 443.400;

(D) Adult congregate living facilities as defined in ORS 441.525;

(E) Mental health residential programs administered by the Oregon Health Authority;

(F) Facilities for persons with mental illness, as those terms are defined in ORS 426.005;

(G) Facilities for persons with developmental disabilities, as those terms are defined in ORS 427.005;

(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.

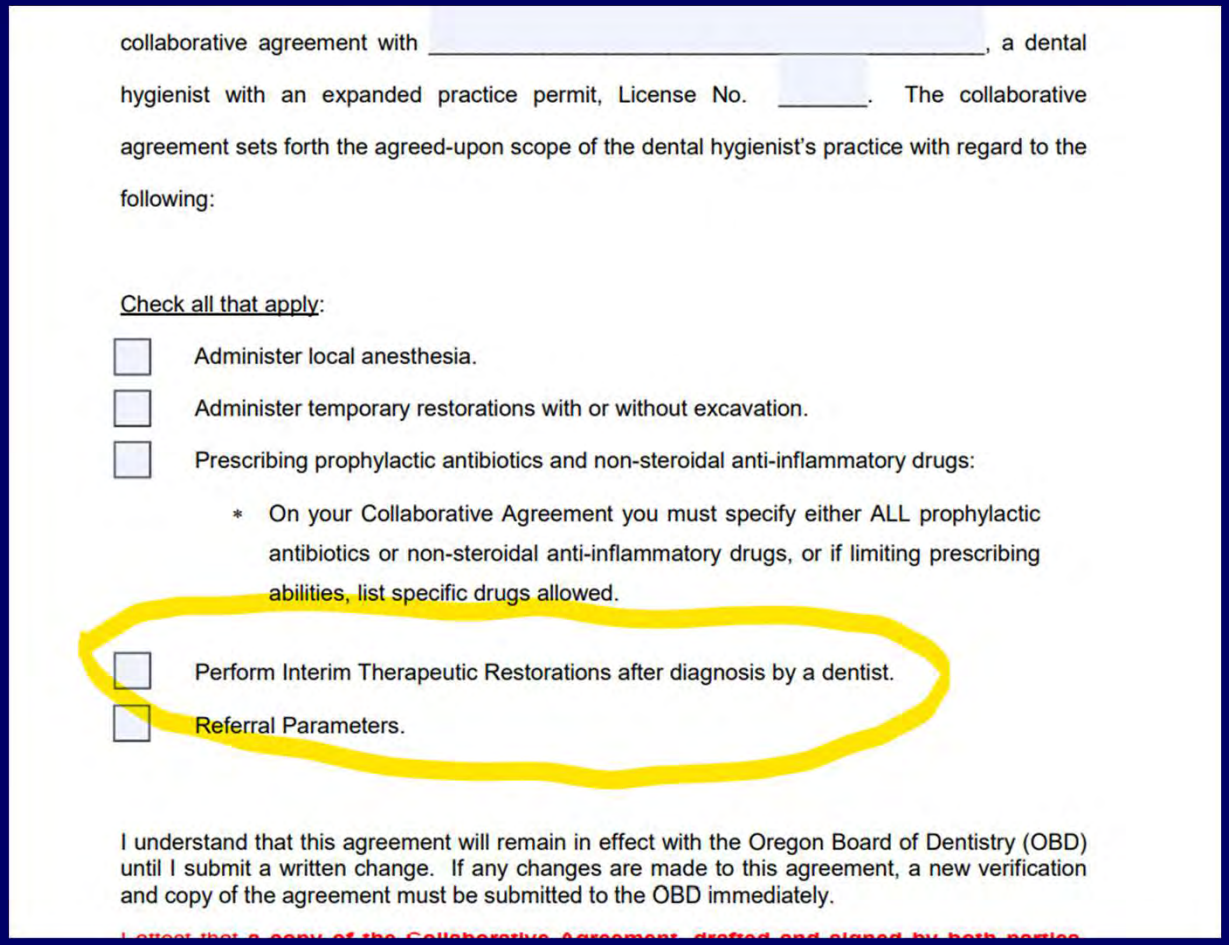
(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by

Dental Hygienists authorized to place Interim Therapeutic Restorations (ITR)

- Administrative Rules effective on January 1, 2022

Oregon Health Authority

Dental Pilot Projects Program



collaborative agreement with _____, a dental hygienist with an expanded practice permit, License No. _____. The collaborative agreement sets forth the agreed-upon scope of the dental hygienist's practice with regard to the following:

Check all that apply:

- ☐ Administer local anesthesia.
- ☐ Administer temporary restorations with or without excavation.
- ☐ Prescribing prophylactic antibiotics and non-steroidal anti-inflammatory drugs:
  - * On your Collaborative Agreement you must specify either ALL prophylactic antibiotics or non-steroidal anti-inflammatory drugs, or if limiting prescribing abilities, list specific drugs allowed.
- ☐ Perform Interim Therapeutic Restorations after diagnosis by a dentist.
- ☐ Referral Parameters.

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD immediately.

I attest that a copy of the Collaborative Agreement, drafted and signed by both parties

https://www.oregon.gov/dentistry/Documents/Form_Dental_Hygiene_Verification_Collaborative_Agreement.pdf#:~:text=The%20collaborative%20agreement%20sets%20forth%20the%20agreed-upon%20scope,excavation.%20Prescribing%20prophylactic%20antibiotics%20and%20non-steroidal%20anti-inflammatory%20drugs%3A

Oregon Health Authority

Dental Pilot Projects Program

DPP #100: Oregon Tribes Dental Health Aide Therapist Pilot Project (DHAT)

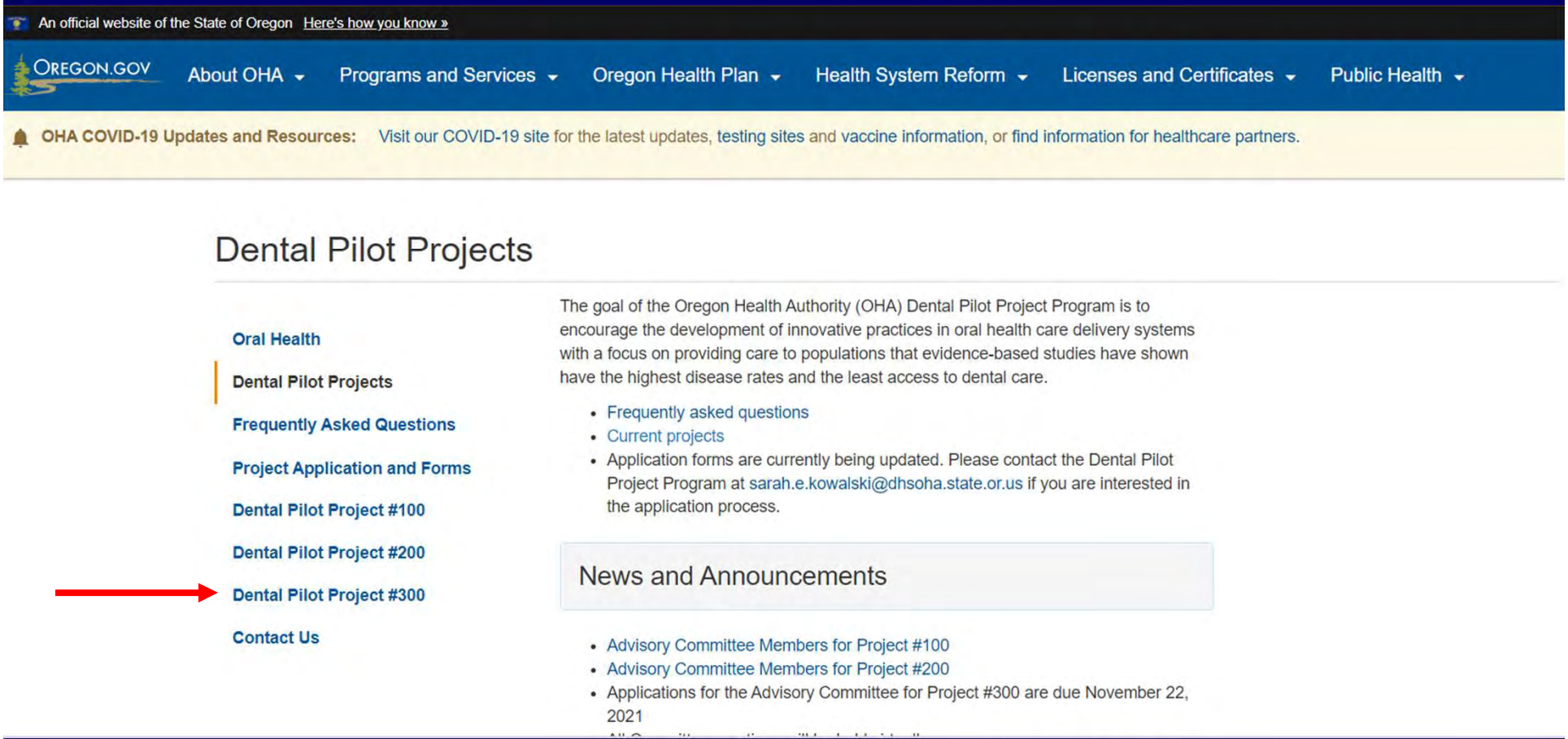
- Dental Therapist workforce model
- Sponsored by the Northwest Portland Area Indian Health Board
- 3 Sites in Oregon
- 5 trainees
- Approved 2016
- Concludes May 31, 2022

Dental Pilot Projects Program

DPP #300: Dental Therapist Project: Dental Hygiene Model
Concludes January 1, 2025

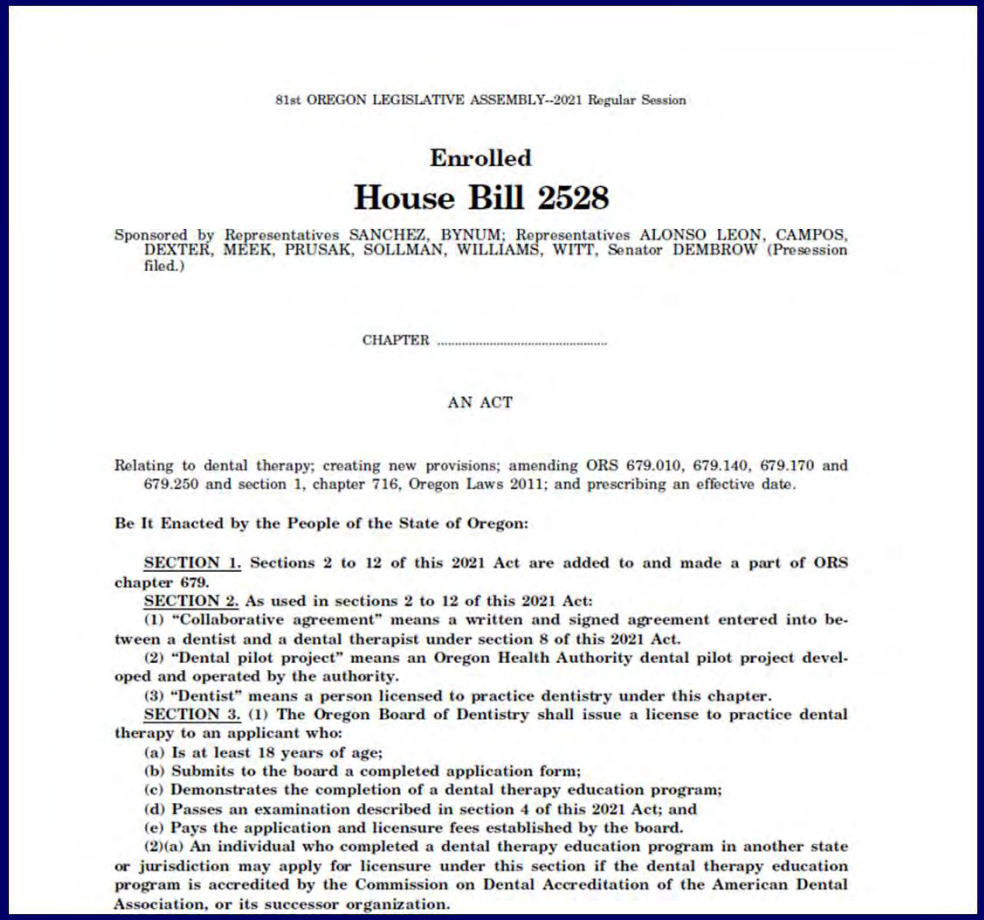
Oregon Health Authority

Dental Pilot Projects Program



Healthoregon.org/dpp

Dental Therapists authorized in Oregon



81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled

House Bill 2528

Sponsored by Representatives SANCHEZ, BYNUM; Representatives ALONSO LEON, CAMPOS, DEXTER, MEEK, PRUSAK, SOLLMAN, WILLIAMS, WITT, Senator DEMBROW (Presession filed.)

CHAPTER .....

AN ACT

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

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

SECTION 1. Sections 2 to 12 of this 2021 Act are added to and made a part of ORS chapter 679.

SECTION 2. As used in sections 2 to 12 of this 2021 Act:

(1) "Collaborative agreement" means a written and signed agreement entered into between a dentist and a dental therapist under section 8 of this 2021 Act.

(2) "Dental pilot project" means an Oregon Health Authority dental pilot project developed and operated by the authority.

(3) "Dentist" means a person licensed to practice dentistry under this chapter.

SECTION 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

- Administrative Rules currently being written by Oregon Board of Dentistry
- Oregon Board of Dentistry developing application for licensure, anticipated early mid-2022

Oregon Health Authority

Dental Pilot Projects Progra

Why do we still have a Dental Therapy Pilot Project if we have Dental Therapy legislation now in Oregon?

Oregon Health Authority

Dental Pilot Projects Program

Dental Pilot Projects Program

Oregon Health Authority Role

1. Program responsibilities
2. Support the state in reaching the goals outlined in the State Health Improvement Plan (SHIP)
3. Role of public health in implementation of legislation

Dental Pilot Projects Program

Program Responsibilities

Oregon Health Authority

Oregon Health Authority Role

- Approve Pilot Project applications through a process
- Monitor Pilot Projects through quarterly progress reports and site visits

Oregon Health Authority

Dental Pilot Projects Program

Oregon Health Authority Role

- OHA does not Develop Projects
- OHA does not Promote One Type of Model
- OHA does not Fund Projects

Dental Pilot Projects Program

- Monitors for patient safety
- Responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations

Dental Pilot Projects Program

"Adverse event" means unnecessary harm due to dental treatment

Dental Pilot Projects Program

https://www.youtube.com/watch?v=6ANPrKowGc8

Dental Pilot Projects Program


SITE
VISITS

Dental Pilot Projects Program

Site Visits

- Required by Oregon Administrative Rules
- 333-010-0790 Authority Responsibilities

  (b) Periodic, but at least annual, site visits to project offices, locations, or both, where trainees are being prepared or utilized

Dental Pilot Projects Program

- 333-010-0790 Authority Responsibilities

(3) Site visits.

(a) Site visits shall include, but are not limited to:

(A) Determination that adequate patient safeguards are being utilized;

(B) Validation that the project is complying with the approved or amended application;

(C) Interviews with project participants and recipients of care; and

(D) Reviews of patient records to monitor for patient safety and the applicable standard of care.

(b) If the Authority has convened an advisory committee, representatives of the committee may be invited by the Authority to participate in the site visit though the Authority may, at its discretion, limit the number of members who can participate;

Dental Pilot Projects Program

- 333-010-0750 Authority Responsibilities

  (b) The purpose of the advisory committee is to gather its members' collective knowledge, experience, expertise, and insight to assist the Authority in meeting its responsibilities.

Dental Pilot Projects Program

Program Goals

- Goal is to ultimately make recommendations for best practice approaches

- Report back to legislature at their request

Oregon Health Authority

Dental Pilot Projects Program

Oregon Health Authority Role

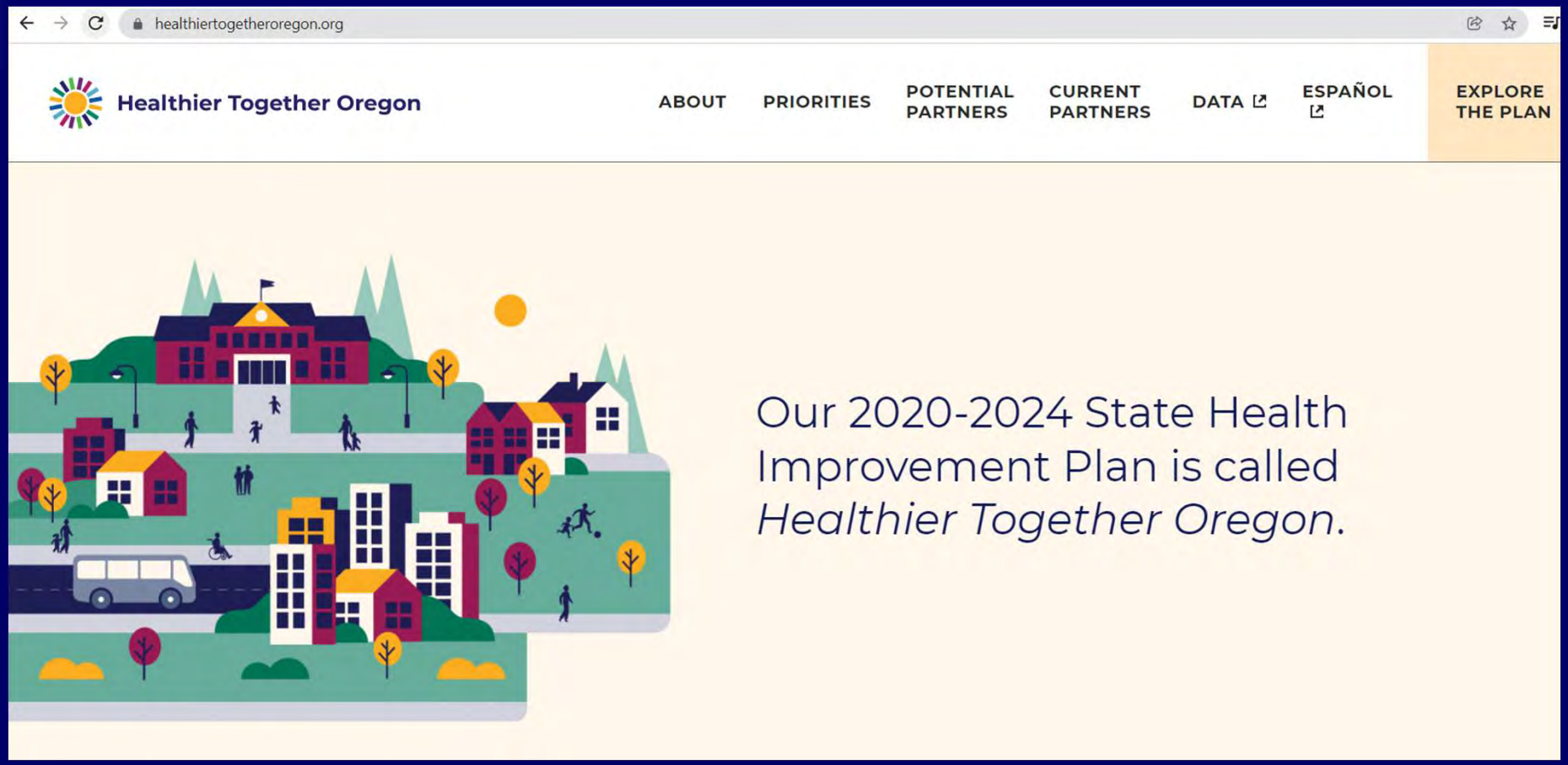
1. Program responsibilities
2. Support the state in reaching the goals outlined in the State Health Improvement Plan (SHIP)
3. Role of public health in implementation of legislation

Dental Pilot Projects Program

State Health Improvement Plan (SHIP) Goals

The Oregon Health Authority (OHA) has set a strategic goal of **eliminating health inequities by 2030**. Achieving this goal will require an immediate and significant shift in the programs and services supporting those experiencing health inequities

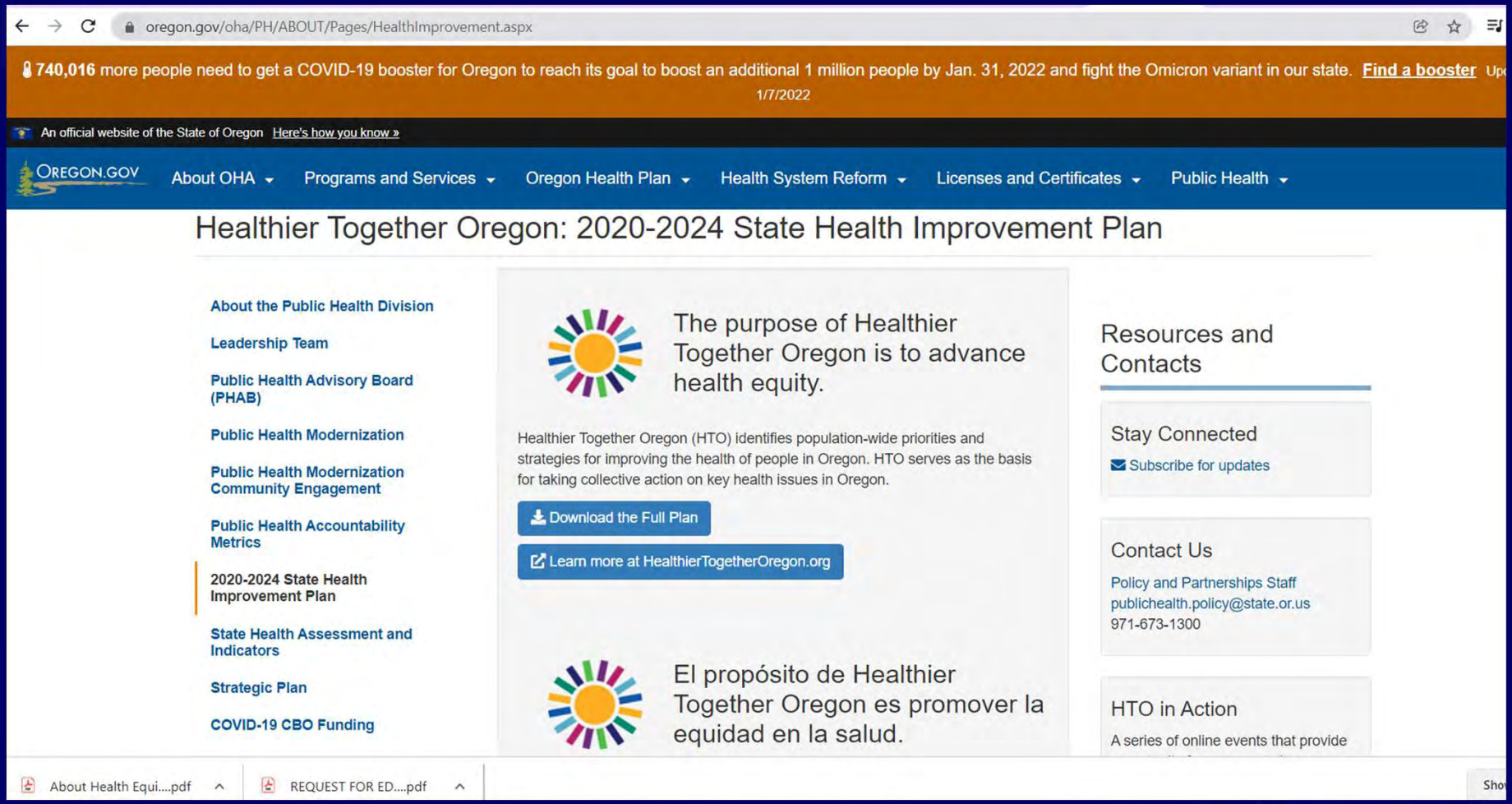
Dental Pilot Projects Program



https://healthiertogetheroregon.org/

Oregon Health Authority

Dental Pilot Projects Program



https://www.oregon.gov/oha/PH/ABOUT/Pages/HealthImprovement.aspx

Oregon Health Authority

Dental Pilot Projects Program

Access to equitable preventive health care

A higher number of people now have health insurance. Still, it is hard for many to get to a health care provider or see a dentist. One reason is because they do not feel comfortable with their provider due to language barriers or cultural difference.

Other reasons include:

- Provider shortages
- Health care costs
- Transportation barriers

Dental Pilot Projects Program

Goals

- Increase equitable access to and uptake of community-based preventive services.
- Increase equitable access to and uptake of clinical preventive services.
- Implement systemic and cross-collaborative changes to clinical and community-based health related service delivery to improve quality, equity, efficiency and effectiveness of services and intervention.

Oregon Health Authority

Dental Pilot Projects Program

OHA Health Equity Definition:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstance

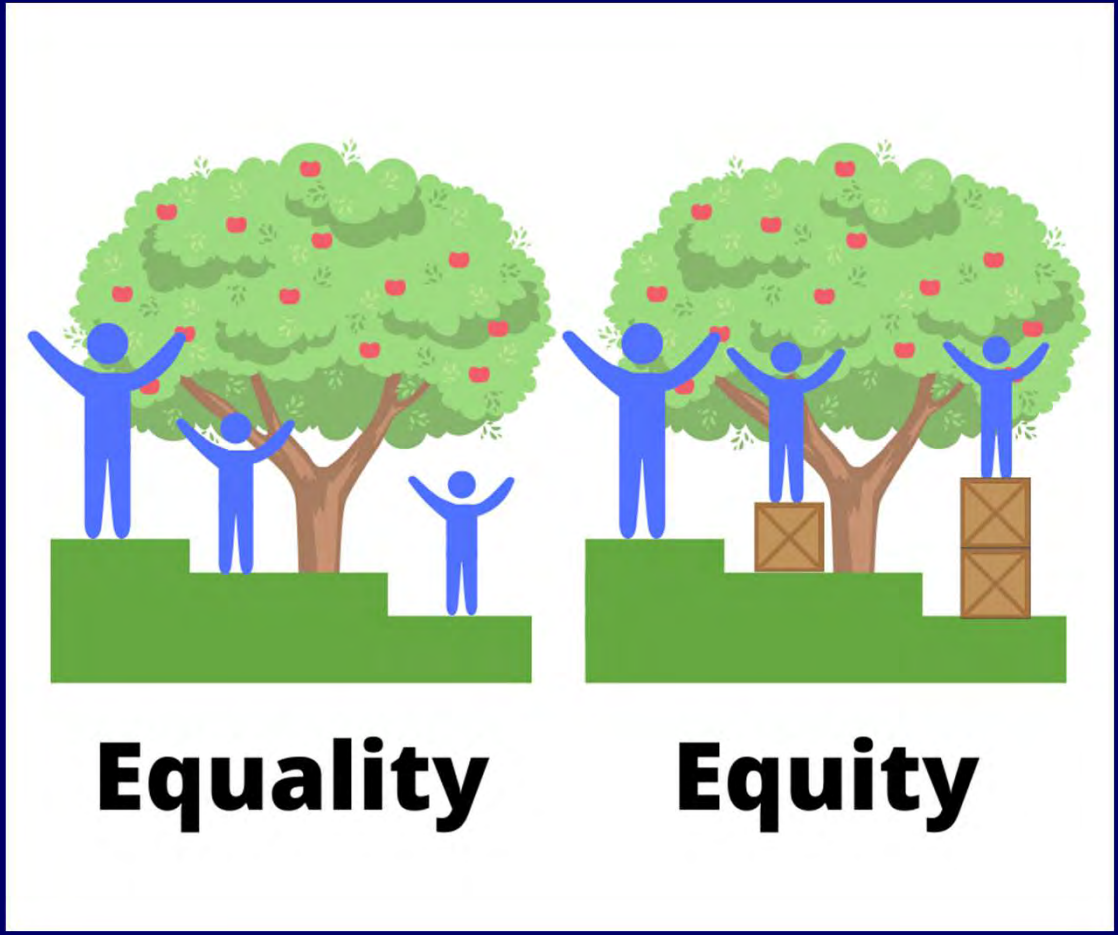
Dental Pilot Projects Program

OHA Health Equity Definition (continued):

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices

Dental Pilot Projects Program



Dental Pilot Projects are part of the bigger health equity story in Oregon

Dental Pilot Projects Program

We all win when our systems and foundation are stronger

Dental Pilot Projects Program

Everyone at the Oregon Oral Health Program is committed to health equity and we can offer support to help local programs as they work to implement health equity activities

Dental Pilot Projects Program

Racism is a Core Social Determinant of Health

- Racism has been linked to birth disparities and mental health problems in children
- Racism contributes to chronic/toxic stress, which leads to inflammation and chronic disease
- Racism plays a significant role in health care delivery and educational opportunities

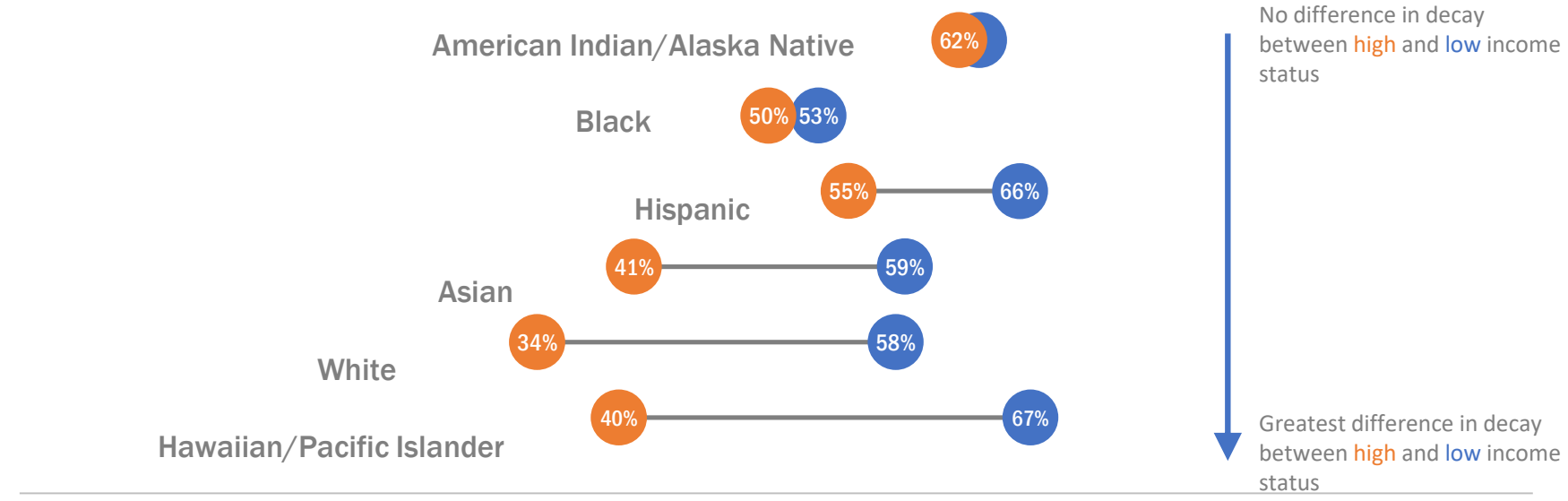
Source: https://pediatrics.aappublications.org/content/144/2/e20191765

Dental Pilot Projects Program

2017 Oregon Smile Survey Data

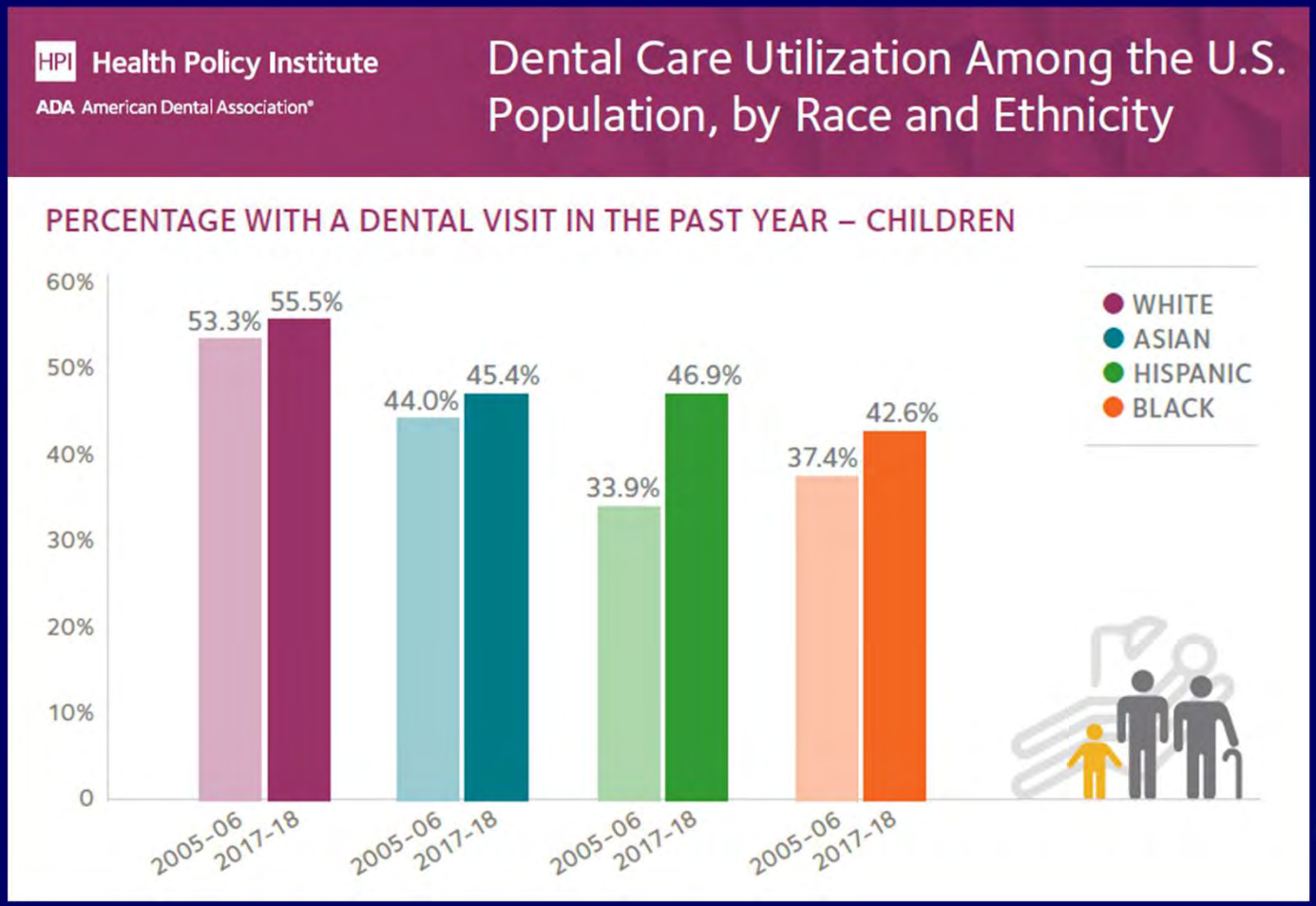
Percent of children with cavities remains high regardless of high or low income status.

Children may be represented by one or more racial/ethnic identity



Dental Pilot Projects Program

National trends in Oral Health Access



Dental Pilot Projects Program

Addressing Oral Health Equity in Oregon

- Dental Pilot Projects (access to care)
- School Dental Sealant Programs (access to care)
- Oregon Oral Health Surveillance System - e.g. Smile Survey, Student Health Survey, Behavioral Risk Factor Surveillance System (BRFSS), etc. (understanding health disparities)
- OHA staff receiving health equity training (support systems, policies, programs in having a health equity framework)
- Community Engagement (key stakeholders who represent the community involved in decision making)
- Many, many other initiatives in place to increase access to care!

Oregon Health Authority

Dental Pilot Projects Program

Oregon Health Authority Role

1. Program responsibilities
2. Support the state in reaching the goals outlined in the State Health Improvement Plan (SHIP)
3. Role of public health in implementation of legislation

Dental Pilot Projects Program

Public Health

Pilot Project 300 Overview & Update

January 31, 2022

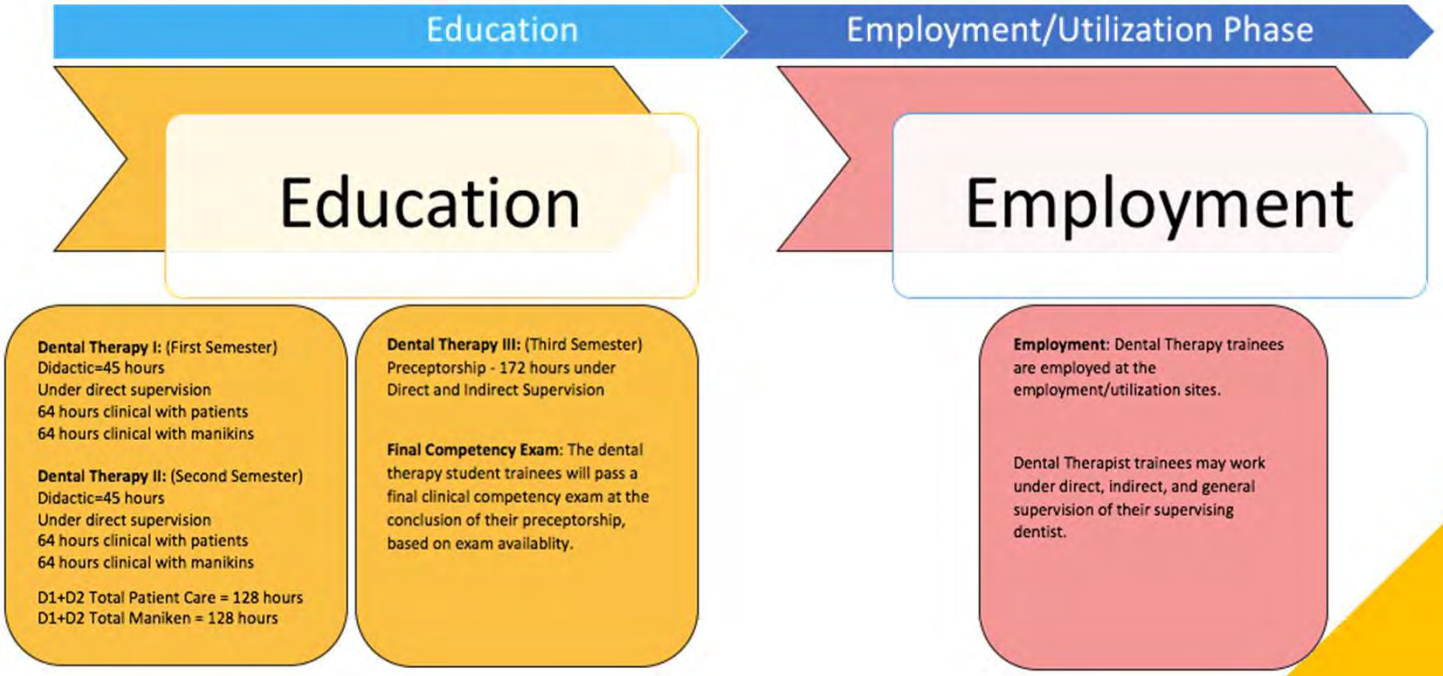
Pilot Project Team

- Project Director – Kristen Simmons
- Dental Director – Shannon English
- Didactic and Lab Instructor – Molly Saunders
- Data Specialist – Aaron Truong
- Administrative Support
  - Elisa Turpen
  - Natalie Horn
- Pacific Partner
  - Gail Aamodt
  - Amy Coplen

Dental Therapy Pilot Model

- Oregon hygienists w/ Restorative credential
- Working FT (minimum of 30 hours a week)
- CE Credit-Online learning through Power Points, Assigned Reading, Videos, Activities (20 weeks per semester)
- Hands on learning for 8 Saturdays at Pacific University for 8 hours for both semesters (DT1 and DT2)
- Additional on-site hands-on learning for 64 hours + 64 hours with supervising dentist during DT1 and DT2 (Direct Supervision)
- 3rd semester of practicum for 172 hours (Indirect and General Supervision)

Curriculum Review



13 New Skills

1. **Understanding the scope of practice of a dental therapist:** Identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers and manage referrals.

2. **Pharmacology**: Dispersing and administering via oral and/or topical route non-narcotic analgesics, anti- inflammatory and antibiotic medications as prescribed by a licensed healthcare provider.

3. **Extractions:** Simple extraction of erupted primary teeth and teeth with severe periodontal disease (Class III mobility).

4. **Emergency Care:** Emergency palliative treatment of dental pain limited to the procedures within the scope of practice of a dental therapist.

5. **Restorative:** Preparation and direct restorations in primary and permanent teeth. Covered under hygienists Restorative Credential.

6. **Temporary Crowns:** Fabrication and placement of single tooth temporary crowns.

13 New Skills Continued

7. **Stainless Steel Crowns:** Fabrication and placement of preformed crowns on primary teeth.

8. **Pulp Capping – primary and permanent teeth:** Indirect and direct pulp capping on permanent teeth & indirect pulp capping on primary teeth.

9. **Pulpotomy/Pulpal Debridement – primary teeth:** For the relief of acute pain

10. **Prosthetics:** Minor adjustments and repairs on removable prostheses.

11. **Space Retainer Removal:** Removal of space maintainers.

12. **Diagnosis of Decay Including Pulp Vitality Testing**

13. **Placement of sutures:** Removal of sutures is already a covered procedure in dental hygiene programs.

* There are some procedures that trainees can perform under the pilot project that are not included in the legislation that was passed in 2021.

Supervision Levels

Phase of Pilot Project	Level of Supervision	Supervision by
DT I course	Direct	Course Instructor Dentist Supervising Dentist
DT II course	Direct	Course Instructor Dentist Supervising Dentist
DT III - Preceptorship	Direct and Indirect	Supervising Dentist
Utilization	Indirect and general	Supervising Dentist – collaborative agreement

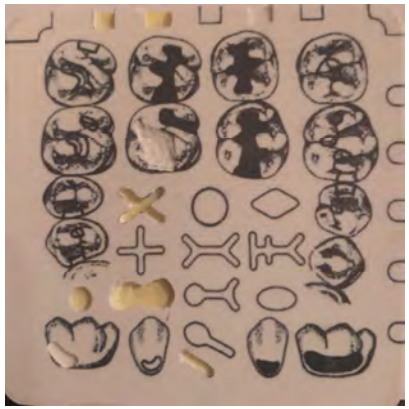
Saturday Lab

- Quiz – (10 pts) based on instruments, burs and preparations
- Learn new preparations, starting with learn a prep on the tabletop, then typodonts on a tabletop and finally working on a manikin
- Review a preparation learned in a previous lab
- Self-Critique and Peer-Critique
- Roundtable – Treatment planning cases, paper presentations

Sample Lab Schedule

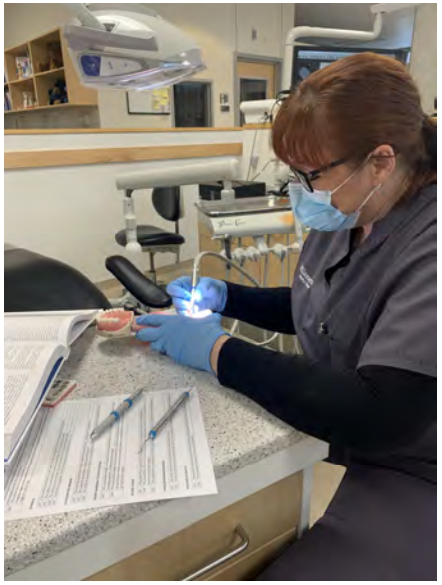
LAB B	LAB TOPICS	LAB WORK: AM	LAB WORK: PM	LAB HOMEWORK
Feb 15	REVIEW: • Class I Amalgam Preparations • Class I Amalgam Preparation Variations NEW: • Class II Amalgam Preparations • Competency Testing (Class I amalgam) • Roundtable Class I	• QUIZ 2 (10 pts/15mins to take/ 15 mins to review). Topics: Class II Amalgam Preparation, Anesthesia for Class I/II restorations, Instrument and bur identification • Class I Amalgam Preparations on Rod OL/OB • Class I Amalgam (12, 21, 29 occl) on Rod • Peer evaluation of restored Class I amalgam restorations and homework preparations • Self/Peer Evaluation of class I preps done today • Learn-A-Prep Class II Amalgam Preparations-use edge to prep boxes	• Class II Amalgam Preparations- Table top #3 MO; #19 DO • Class II Amalgam Preparations-Rod • Roundtable Class I • Self/Peer Critique of Class II Amalgam Preparations	• Restore all Class I preps in amalgam with typodont in rod • Restore all amalgam Class II preps from Lab B. Bring to Lab C • PREP: • Self-critique Preps and Restorations

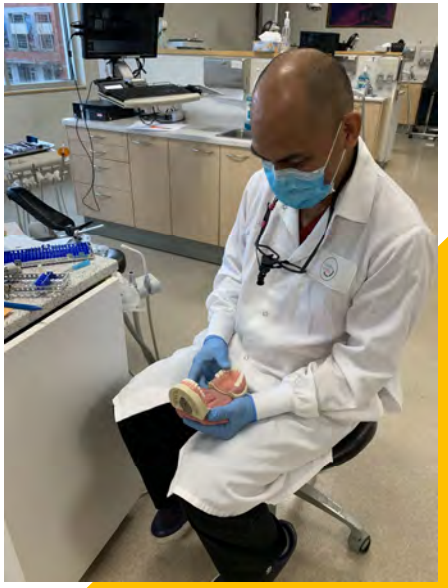
Learn-A-Prep



Tabletop Preps

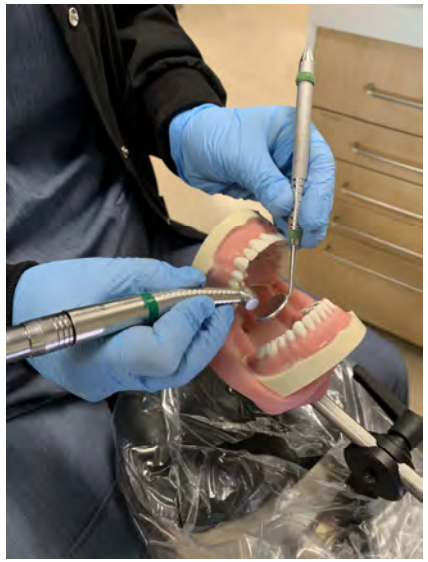
8 Hours of Fun





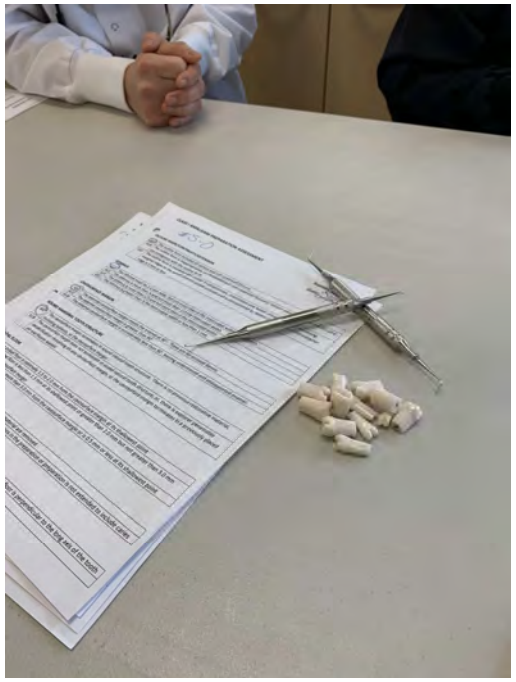
On the Manikin

Perfecting Skills

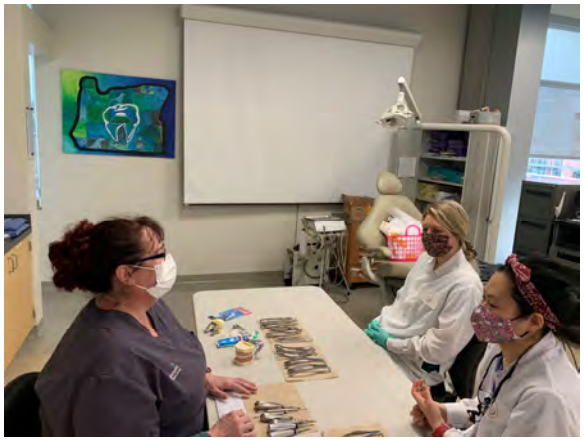


Professional Feedback

(pre-COVID photos)



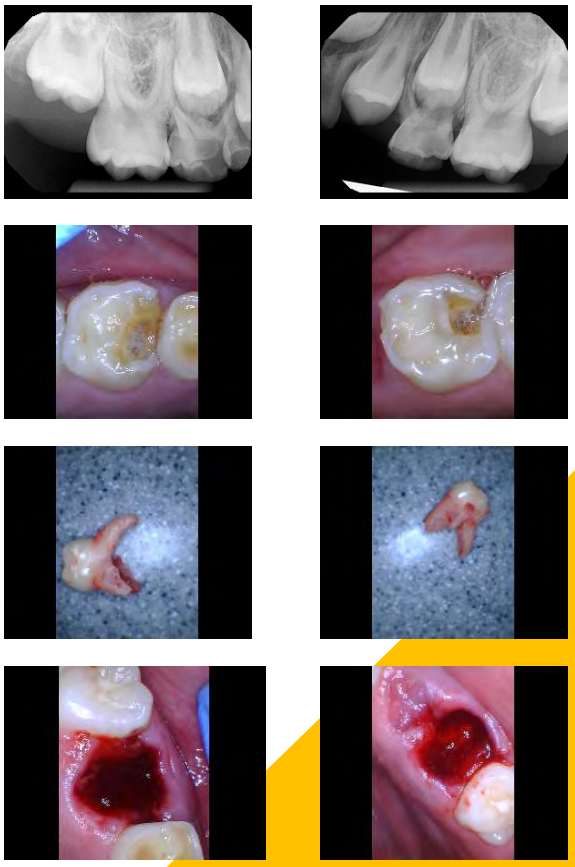
Sutures & Extractions

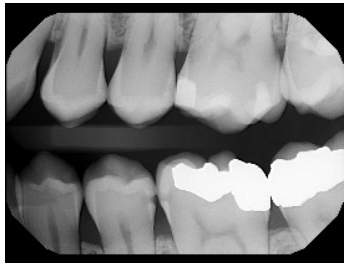
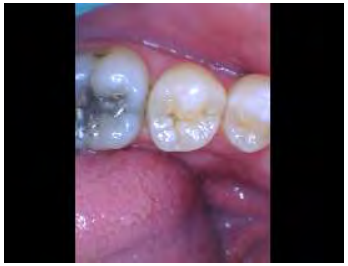
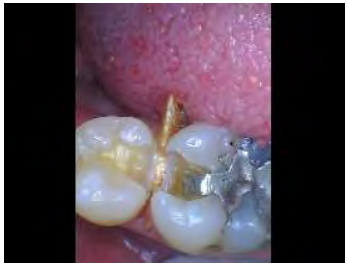
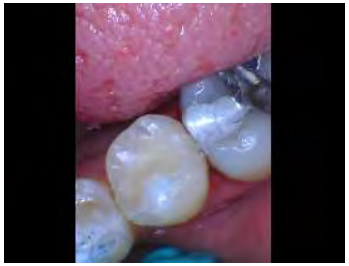


Some of our work so far

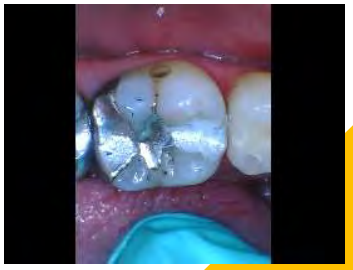
9-year-old patient seen 3 days prior for overdue Continuing Care experiencing nocturnal pain

Appt Type: Extraction, Medical History has been updated today , Patient's temperature today was below 100.4 F (COVID-19). Patient rinsed with 1 part hydrogen peroxide to 2 parts water for 30 seconds, pre-operatively. Patient wore a mask while in the building and not being directly treated (COVID-19). Patient's mom said that he took 1 dose of Clindamycin and vomited it and has not taken anymore. Told patient's mom that he does not need to take the antibiotics after today. Patient's mom signed DT consent, extraction consent and nitrous oxide consent. Patient's mom was in the operatory during procedure.
. Reviewed PARQ: Yes
Signed consent form: Yes
Current pre-op x-rays: Yes . Pre-op photo(s): Yes
Topical: 5% Lidocaine , Anesthetic: 1.75 Carpules , 2% Lidocaine + 1:100K epi , Infiltration ; * , * , * , Infiltration/PDL #A and #J administered. No adverse reaction to local anesthetic. Patient needed positive reinforcement and voice control for injections.
Tooth/Teeth Completely Removed: Yes , #A and #J
Curette Socket: Yes , *
Irrigation: Chlorhexidine
Packing Material: No , *
Sutures: N/A , *
Gauze/Pressure for Hemostasis: Yes
Post-Op Instructions Reviewed: Yes Went over post-op instructions with patient's mom. Patient does not need to take any more antibiotics. Patient is biting on guaze when he is leaving today. Take out gauze when you get home and put new gauze in if it is still bleeding, then wait for 20 minutes and take out gauze. Monitor patient and tell patient not to play with tongue, cheek or lip while it is numb. Careful eating and drinking while numb, avoid hard crunchy foods while numb. Soft food diet for a few days. Avoid drinking through a straw, avoid vigorous rinsing and vigorous activity for the next few days. Children's ibuprofen or tylenol as needed for the next day or two, not exceeding recommended dosage per age/weight. Patient weighs 100 lbs and patient's mom says that he takes adult dosage of tylenol and ibuprofen.
2 intraoral mounts of images taken to prevent loss of images from technical glitches. Patient wore safety glasses during procedure. Used tell-show-do, bite block, C-sponge, positive reinforcement, negative reinforcement and voice control. Patient needed a lot of encouragement but overall did well and was very brave. Patient earned 4 tokens. Patient dismissed alert and stable. Operative treatment complete.
Post-op photo(s): Yes
NV: 6 Month Caries Risk Assessment with Doctor of Record, Dr. Tolmach, due 4/22. Mia Bond, R.D.H. PARQ



Appt Type: Restorative, Medical History has been updated today , all covid qs neg, preop rinse completed. . Reviewed PARQ: Yes
Signed consent form: Yes
Current pre-op x-rays: Yes . Pre-op photo(s): Yes
Topical: 5% Lidocaine , Anesthetic: 1 Carpule , 3% Mepivicaine Plain , Block ; 1 Carpule , 2% Lidocaine + 1:100K epi , Block , *
Caries Removal: Complete , Sharon Reich DT trainee prepped #19 MO and 20 DO with bite block, prewedge and cotton isolation under indirect supervision of Beth Gorman DMD.
Operative photos: Yes
Base/Liner: * *
Protective Restoration Details: * * , * * , * *
Definitive Restoration Details: N/A , Alloy #19 MO tie in. ; Acid Etch / LC Adhesive , Composite Resin #20 DO venus pearl shade A2 ; * , * *
Diagnoses: D3 caries seen radiographically and visually #19 MO and 20 DO
Checked Occlusion/Contact: Yes
Post-Op Instructions to Patient: Yes , No hot foods/liquids and no chewing while numb. no chewing on left side until tomorrow.



Pt tolerated procedure well with no complications.
Post-Op photo(s): Yes
NV: CRA. THSMHG/ARZAR

Data Collection

- The clinical site is responsible for data collection and reposit to master data file as required by OHA.
- Reporting requirements include: collecting patient satisfaction surveys & consent forms, number and codes of procedures provided, patient demographic information
- The trainee cannot be responsible for the date reporting.

Where are we now?

Cohort 1

- 7 out of 10 student trainees completed the didactic and lab portions of DT I and DT II
- 4 trainees have entered utilization
- 2 trainees are completing preceptorship
- 1 trainee is close to entering preceptorship
- All trainees successfully passed the CRDTS board exam in May of 2021

Cohort 2

- 11 student trainees began in August 2021
- All trainees successfully completed DT I didactic and lab portion
- DT II began December 15th
- CRDTS Board exam for Cohort 2 is scheduled for May 2022

Dental Pilot Projects Program

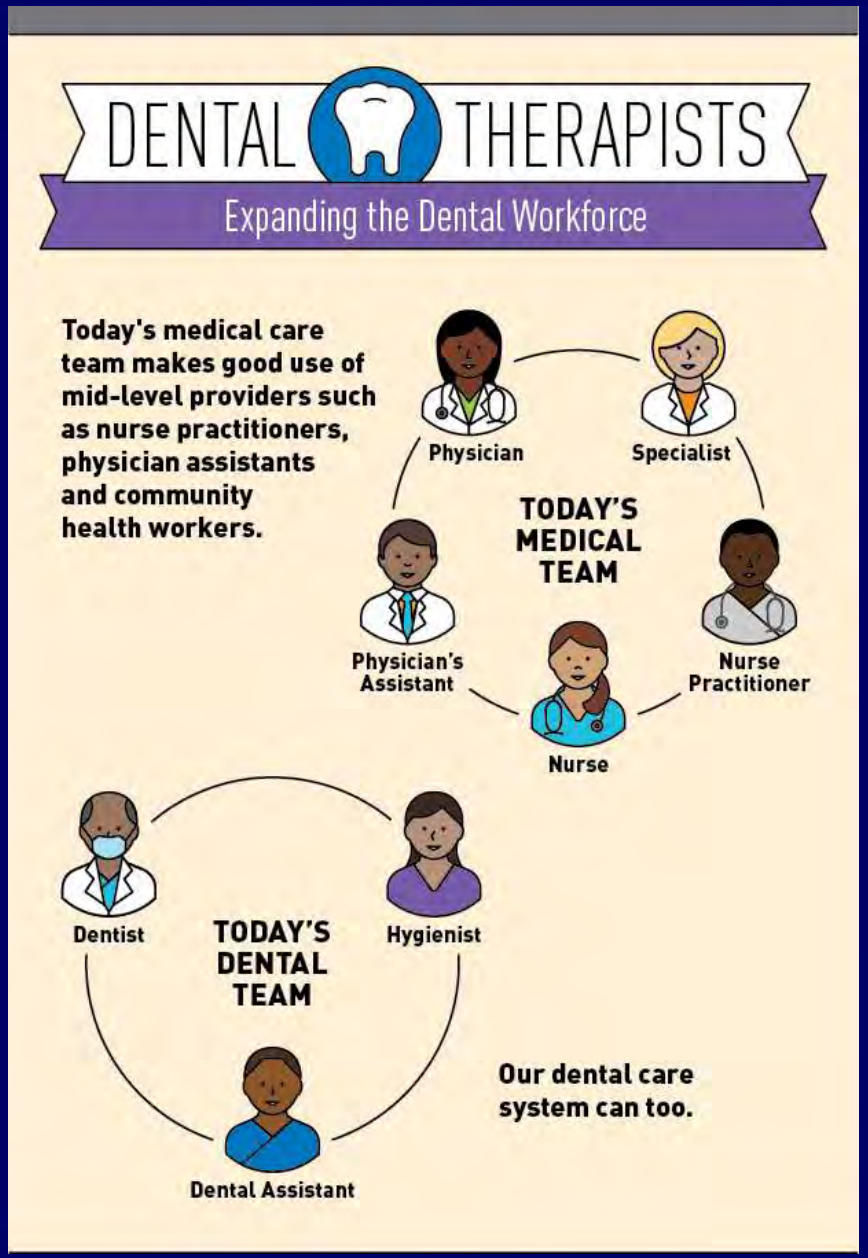
1. What is a Dental Therapist?

2. What is a Dental Therapist in Oregon?

3. Why do we still have a Dental Therapy Pilot Project if we have Dental Therapy legislation now in Oregon?

4. Role of the Advisory Committee

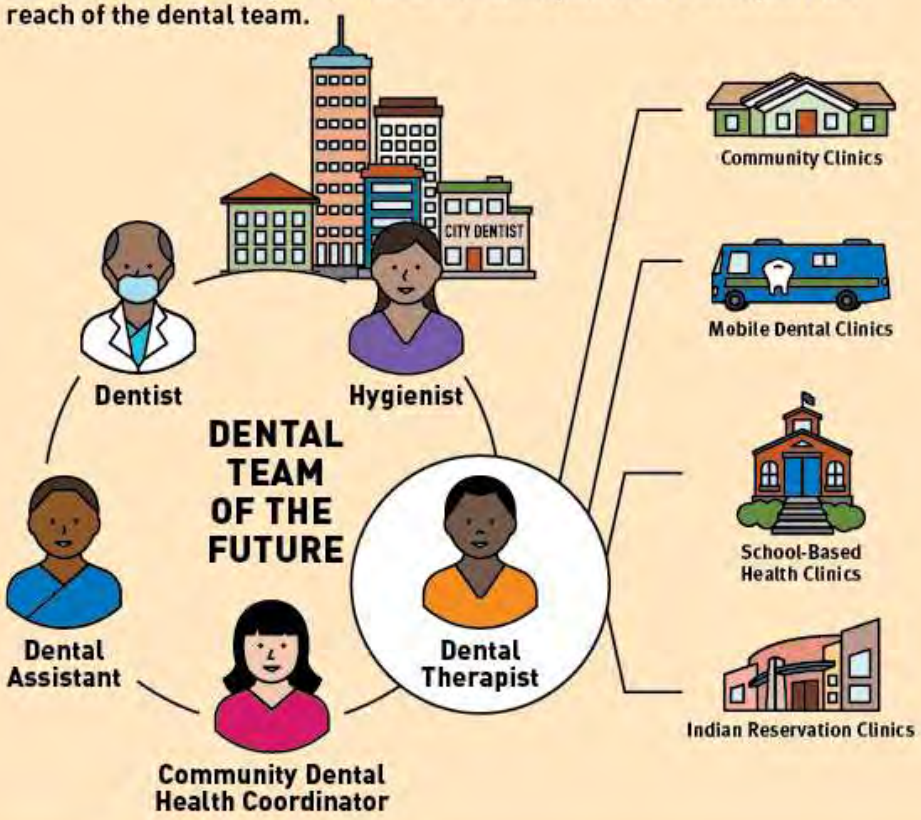
Oregon Health Authority



Oregon Health Authority

Dental therapists bring oral health education, prevention and treatment to communities, often where they live.

More than 158 million people in the U.S. don't have access to affordable dental care where they live; mid-level dental providers can expand the reach of the dental team.

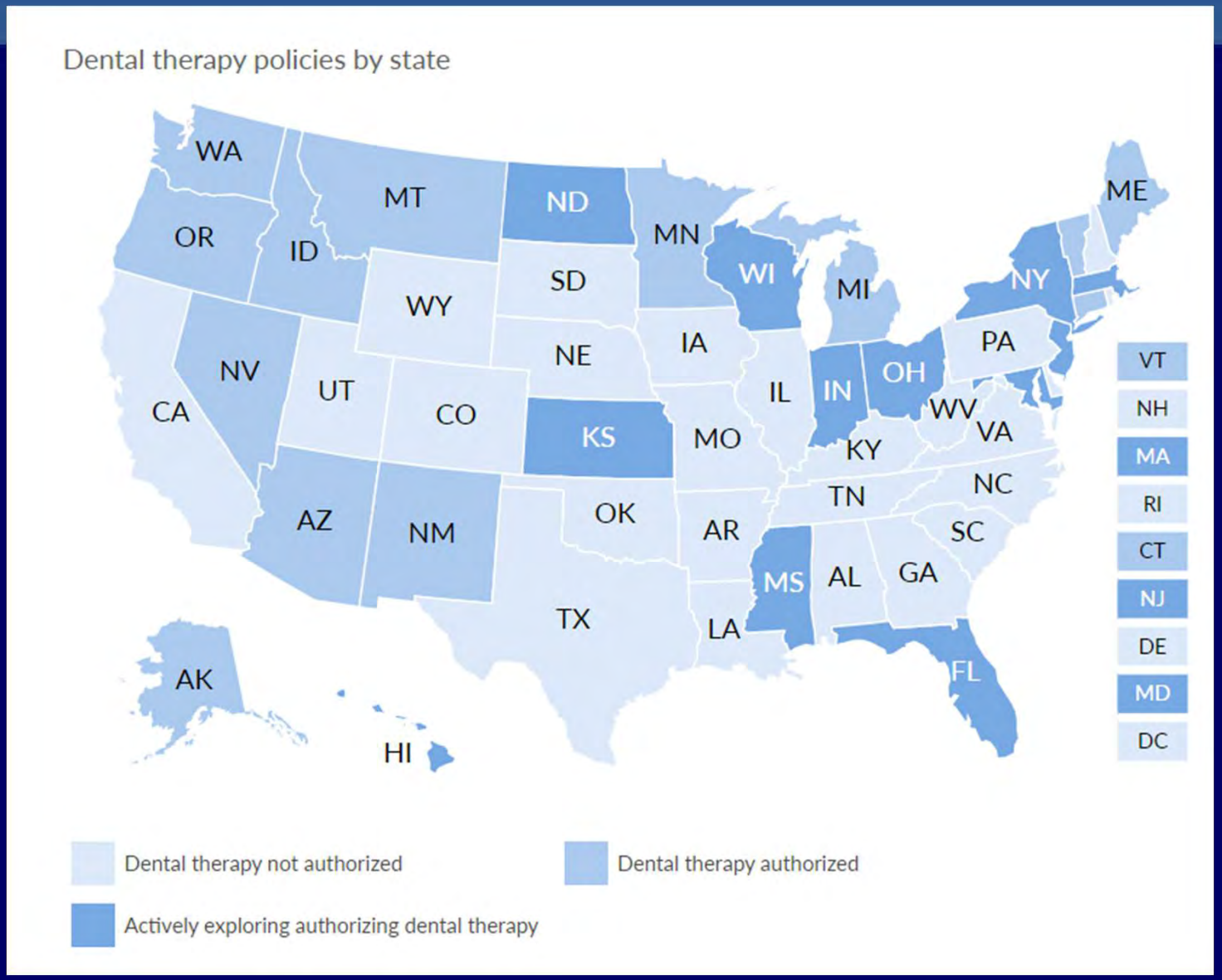


W.K. KELLOGG FOUNDATION™

www.wkkf.org

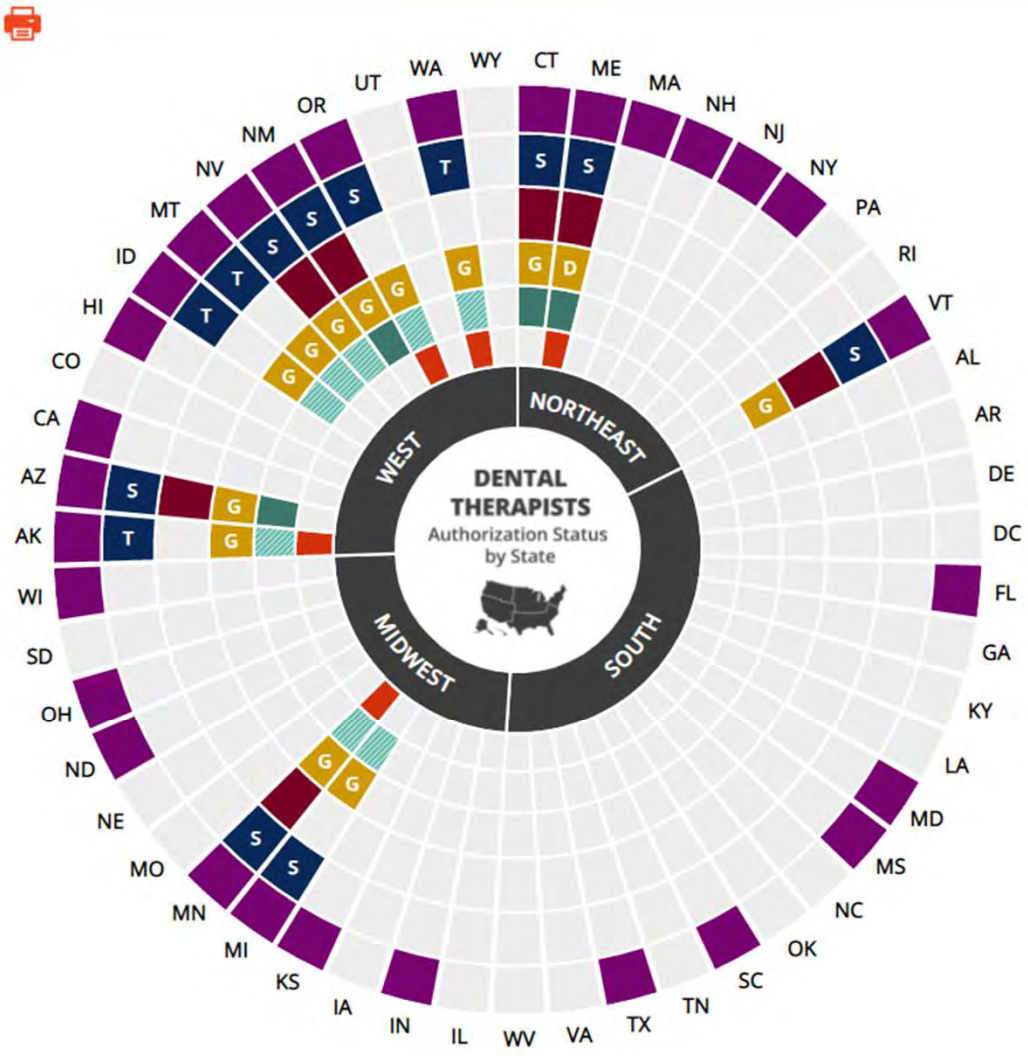
Oregon Health Authority

Dental Pilot Projects Program



https://www.pewtrusts.org/en/research-and-analysis/articles/2016/09/28/states-expand-the-use-of-dental-therapy

Oregon Health Authority



Campaign for Dental Therapy in the State (Active or Prior)

Authorization of Dental Therapy

T Tribal Dental Therapy S Statewide

Learn More >

Mandated Dual Dental Hygiene and/or Degree Requirement in State Statute

Dental Therapist Supervision Level by Dentist

D Direct I Indirect G General

Population/Setting Restrictions on DT Practice

Setting Only Population Only Both

Dental Therapists Practicing in the State

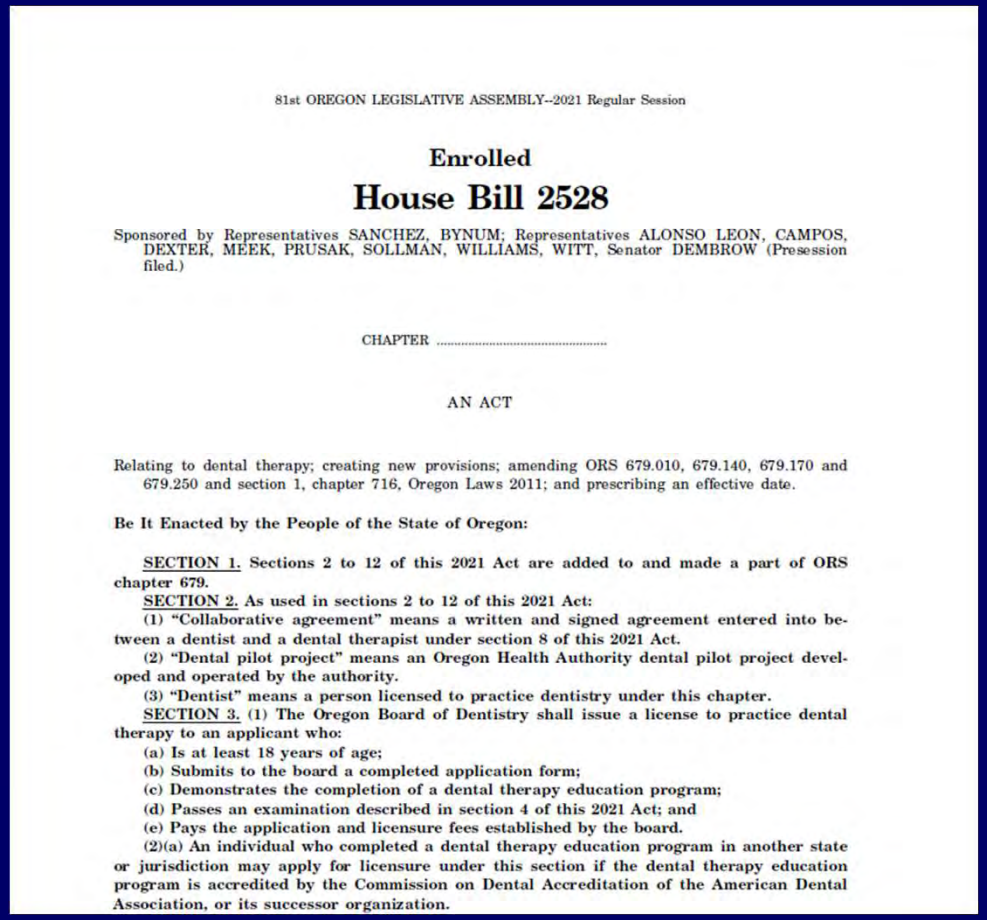
https://oralhealthworkforce.org/authorization-status-of-dental-therapists-by-state/

Oregon Health Authority

Dental Pilot Projects Progra

Why do we still have a Dental Therapy Pilot Project if we have Dental Therapy legislation now in Oregon?

Oregon Health Authority



81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled

House Bill 2528

Sponsored by Representatives SANCHEZ, BYNUM; Representatives ALONSO LEON, CAMPOS, DEXTER, MEEK, PRUSAK, SOLLMAN, WILLIAMS, WITT, Senator DEMBROW (Presession filed.)

CHAPTER .....

AN ACT

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

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

SECTION 1. Sections 2 to 12 of this 2021 Act are added to and made a part of ORS chapter 679.

SECTION 2. As used in sections 2 to 12 of this 2021 Act:

(1) "Collaborative agreement" means a written and signed agreement entered into between a dentist and a dental therapist under section 8 of this 2021 Act.

(2) "Dental pilot project" means an Oregon Health Authority dental pilot project developed and operated by the authority.

(3) "Dentist" means a person licensed to practice dentistry under this chapter.

SECTION 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

Dental Therapists authorized in Oregon

- Administrative Rules currently being written by Oregon Board of Dentistry
- Oregon Board of Dentistry developing application for licensure, anticipated early mid-2022

Oregon Health Authority

Dental Pilot Projects Program

Dental Therapy
Scope of Practice

Oregon Health Authority

Dental Pilot Projects Program

General Supervision

"General supervision" means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not requiring that a dentist be present when the authorized procedures are performed.

The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

ORS 679.010

Dental Pilot Projects Program

General Supervision

- Comprehensive, Limited & Periodic Exams & Diagnosis
- Simple extractions of erupted anterior primary teeth & coronal remnants
- Restoration of primary and permanent teeth
- Placement of temporary crowns
- Preparation and placement of preformed crowns
- Indirect pulp capping on primary and permanent teeth

Oregon Health Authority

Dental Pilot Projects Program

Indirect Supervision

"Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

ORS 679.010

Dental Pilot Projects Program

Indirect Supervision

- Simple extractions of erupted posterior primary teeth
- Extractions of permanent teeth with 2mm of vertical movement & at least 50% bone loss
- Direct pulp capping on permanent teeth
- Tooth reimplantation and stabilization
- Pulpotomies on primary teeth

Dental Pilot Projects Program

Nitrous Oxide Administration

Oregon Health Authority

Dental Pilot Projects Program

Collaborative Agreement

(1) "Collaborative agreement" means a written and signed agreement entered into between a dentist and a dental therapist under section 8 of this 2021 Act.

SECTION 8. (1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist's practice. The collaborative agreement must include at least the following information:

(a) The level of supervision required for each procedure performed by the dental therapist;

(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;

(c) The practice settings in which the dental therapist may provide care;

(d) Any limitation on the care the dental therapist may provide;

(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;

(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;

(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;

(i) Protocols for the dispensation and administration of drugs, as described in section 9 of this 2021 Act, by the dental therapist, including circumstances under which the dental therapist may dispense and administer drugs;

(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and

Oregon Health Authority

Dental Pilot Projects Program

SECTION 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

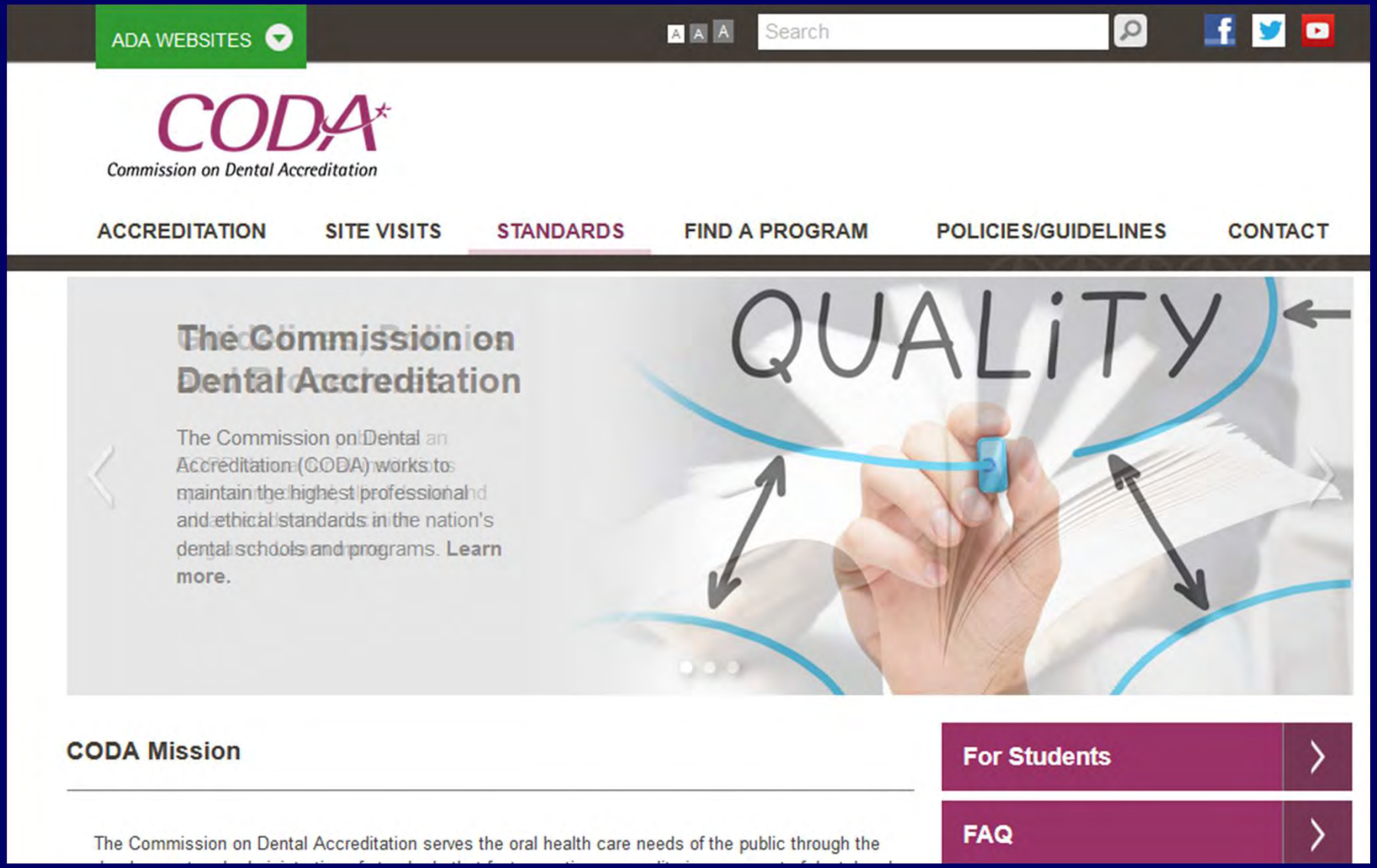
(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

Section 3 in effect until January 1, 2025

Oregon Health Authority



Oregon Health Authority

Dental Pilot Projects Program

Dental Therapy Education Program

- In-state only Pacific University under Dental Pilot Project

Commission on Dental Accreditation (CODA)

- CODA – Iḷisaġvik College in Utqiaġvik (Barrow) Alaska https://www.ilisagvik.edu/
- CODA Site Visit Scheduled for Skagit Valley College in Mount Vernon, Washington in February 2022 https://www.skagit.edu/

Dental Pilot Projects Program

- In process of applying to CODA
- No site visits scheduled yet by CODA

Dental Pilot Projects Program

SECTION 3a. Section 3 of this 2021 Act is amended to read:

Sec. 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates:

(A) The completion of a dental therapy education program **that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule; or**

(B) That the applicant is or was a participant in a dental pilot project;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

Section 3a in effect starting January 1, 2025

Oregon Health Authority

Dental Pilot Projects Program

SECTION 4. (1)(a) The Oregon Board of Dentistry may require an applicant for a license to practice dental therapy to pass written, laboratory or clinical examinations to test the professional knowledge and skills of the applicant.

(b) The examinations may not be affiliated with or administered by a dental pilot project or a dental therapy education program described in section 3 of this 2021 Act.

(c) The examinations must:

(A) Be elementary a iently thorough to test the fitness of the applicant to

(B) Be written in E

(C) Include questio erapy.

(2) If a test or exam the date of application and the applicant received a pa on, as established by the board by rule, the board:

(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.

(b) To satisfy the laboratory or clinical examination authorized under this section:

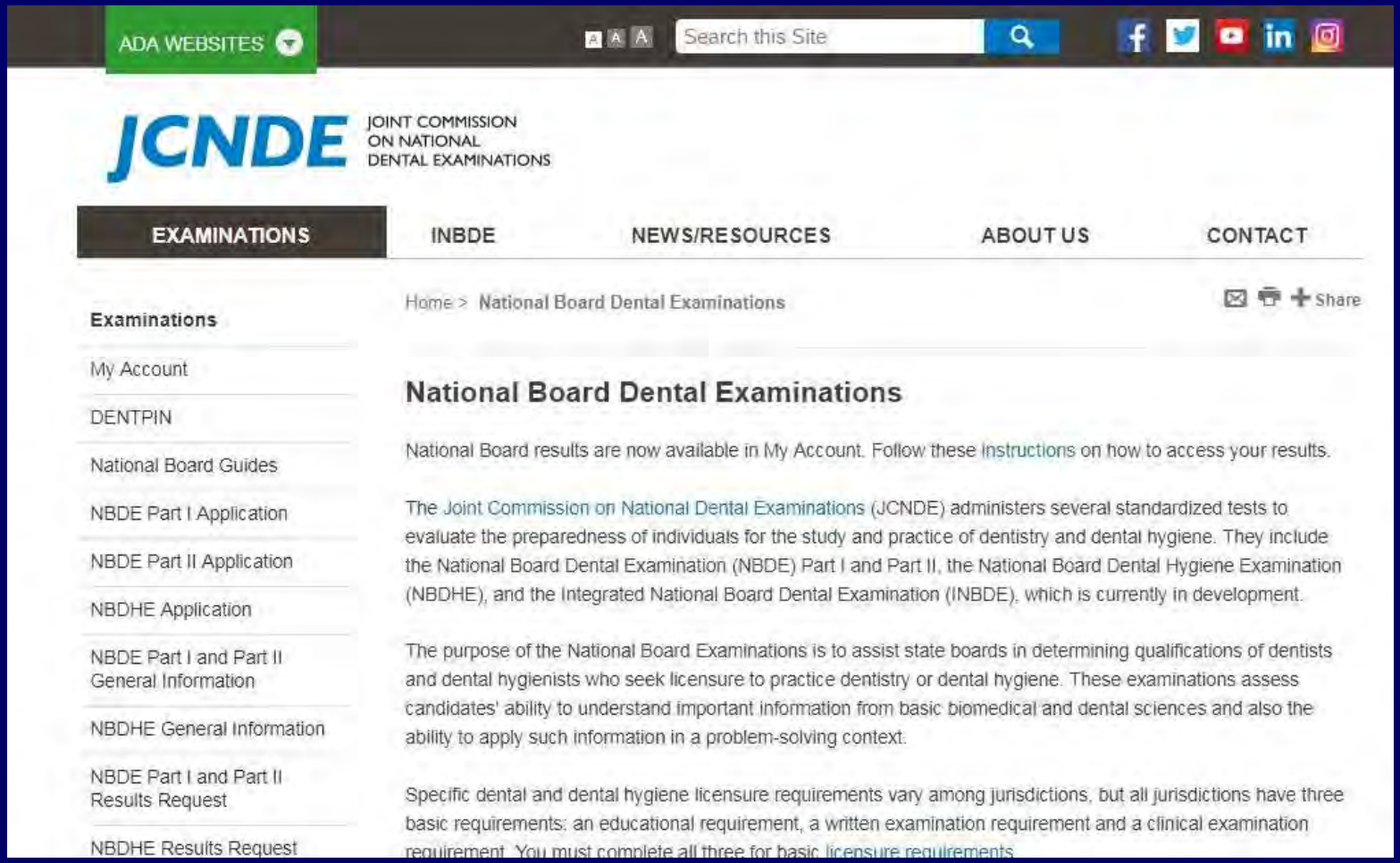
(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the

Exam

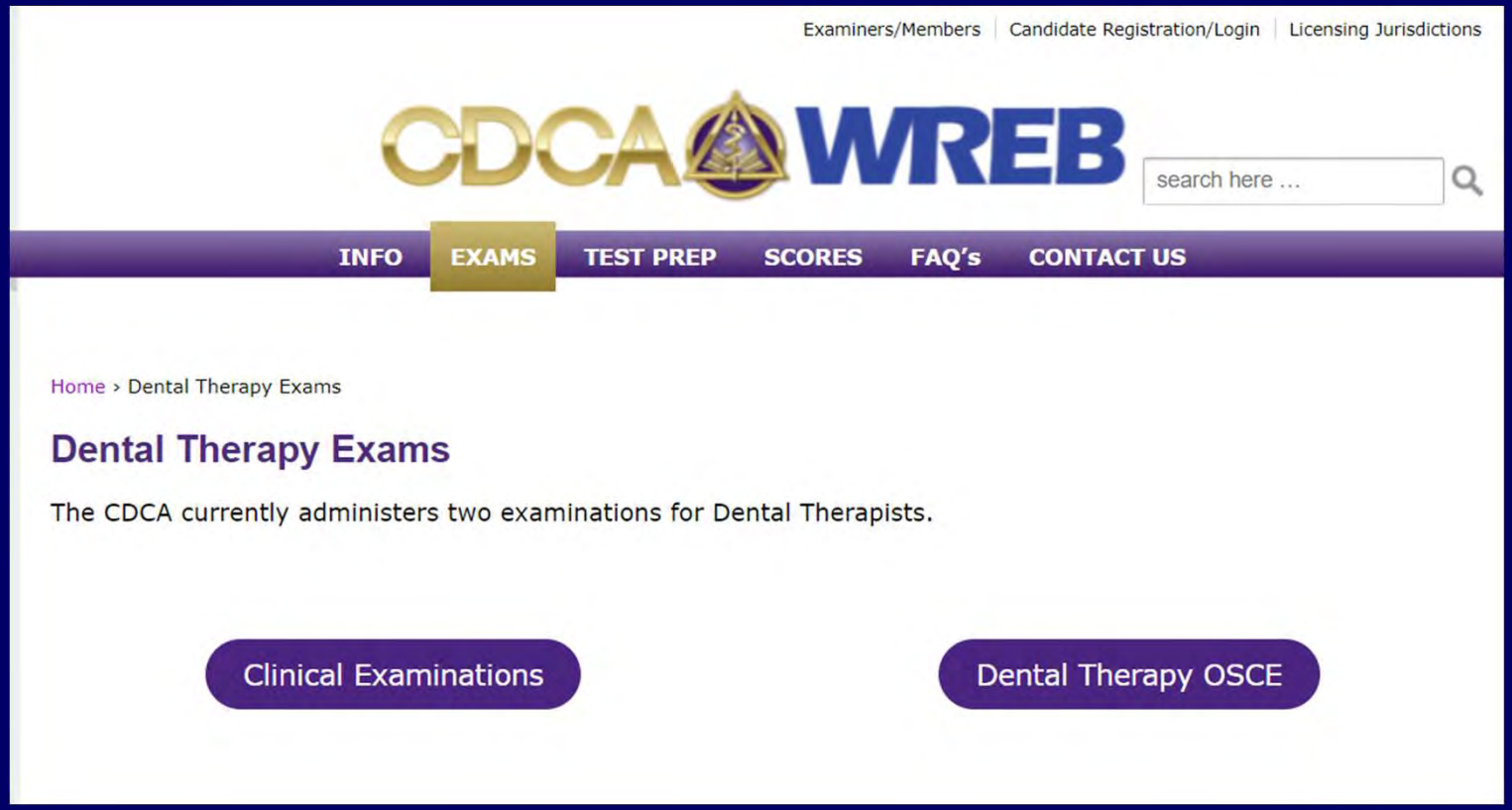
Dental Pilot Projects Program



Oregon Health Authority

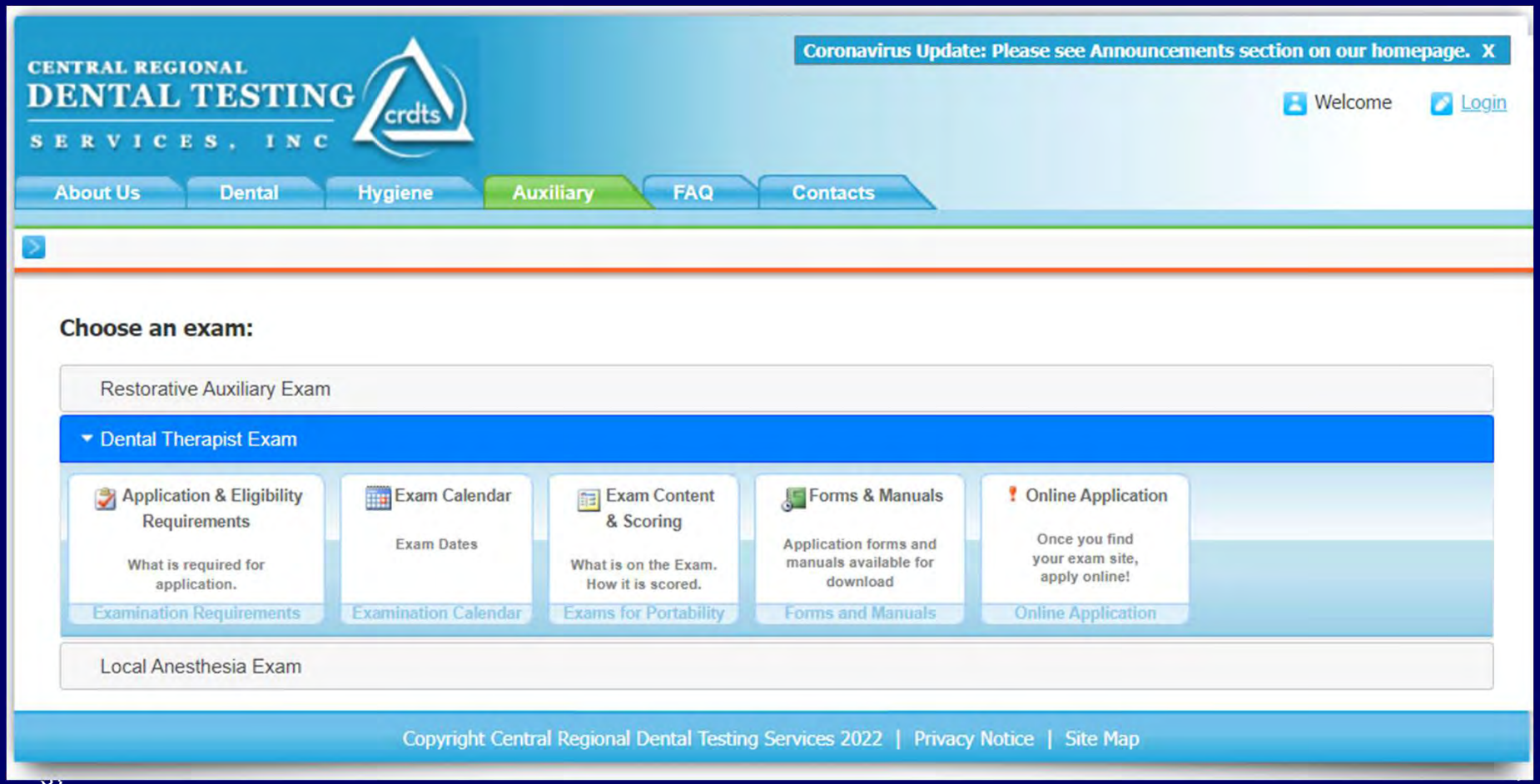
Dental Pilot Projects Program

CDCA-WREB (Western Regional Examining Board)



Dental Pilot Projects Program

CRDTS (Central Regional Dental Testing Service)



Dental Pilot Projects Program

CRDTS (Central Regional Dental Testing Service)

Oregon Health Authority

Dental Pilot Projects Program

(3) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

- Dedicate at least 51% to underserved populations
- "Underserved" being defined by OHA

OR

- Dental Health Professional Shortage Areas (DHPSA)

Oregon Health Authority

Dental Pilot Projects Program

DPP #300

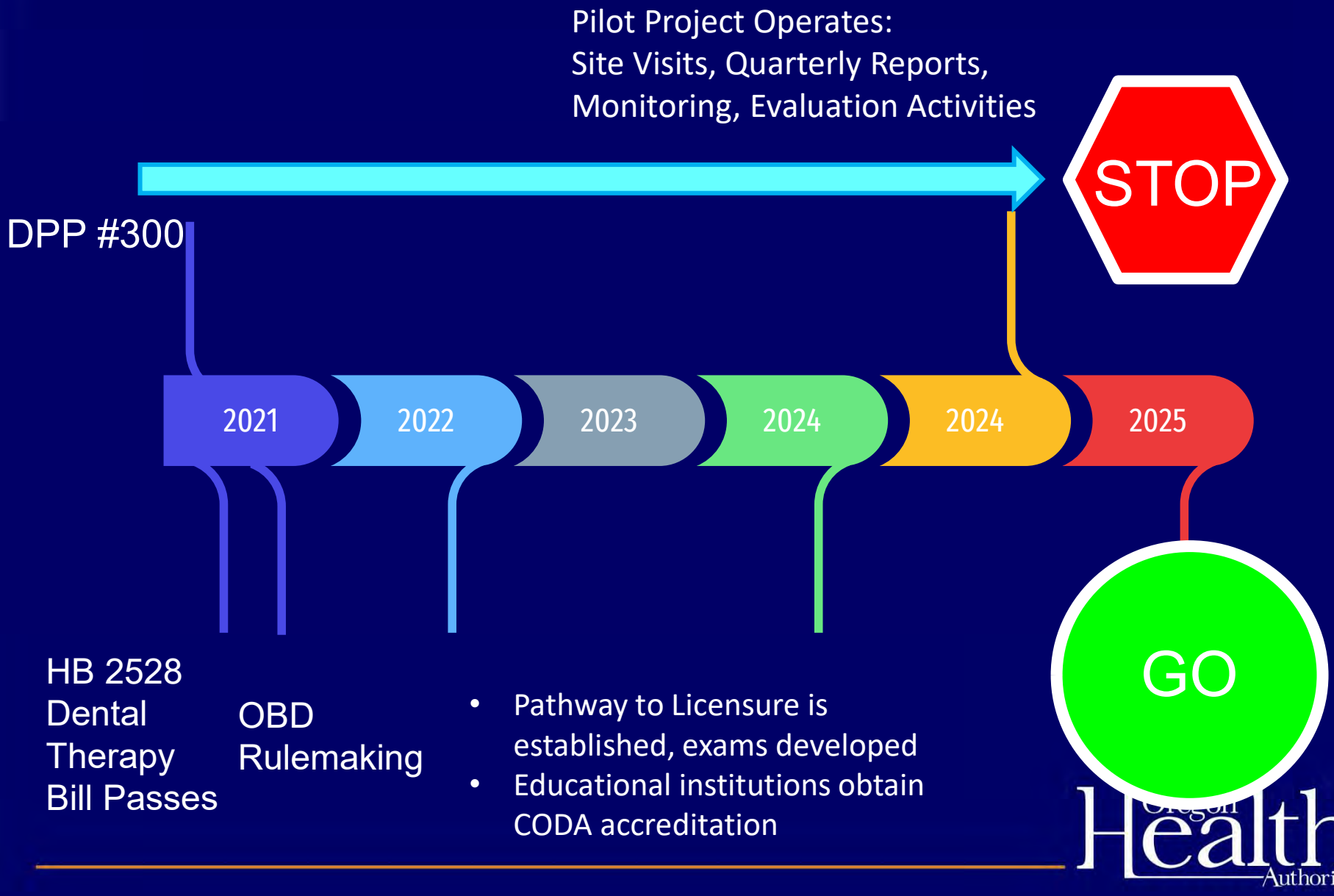
- Education Programs– do not have CODA for Dental Therapy
- General Supervision for entire Scope of Practice
- Must follow Dental Pilot Program administrative & evaluation requirements
- No licensure by Oregon Board of Dentistry

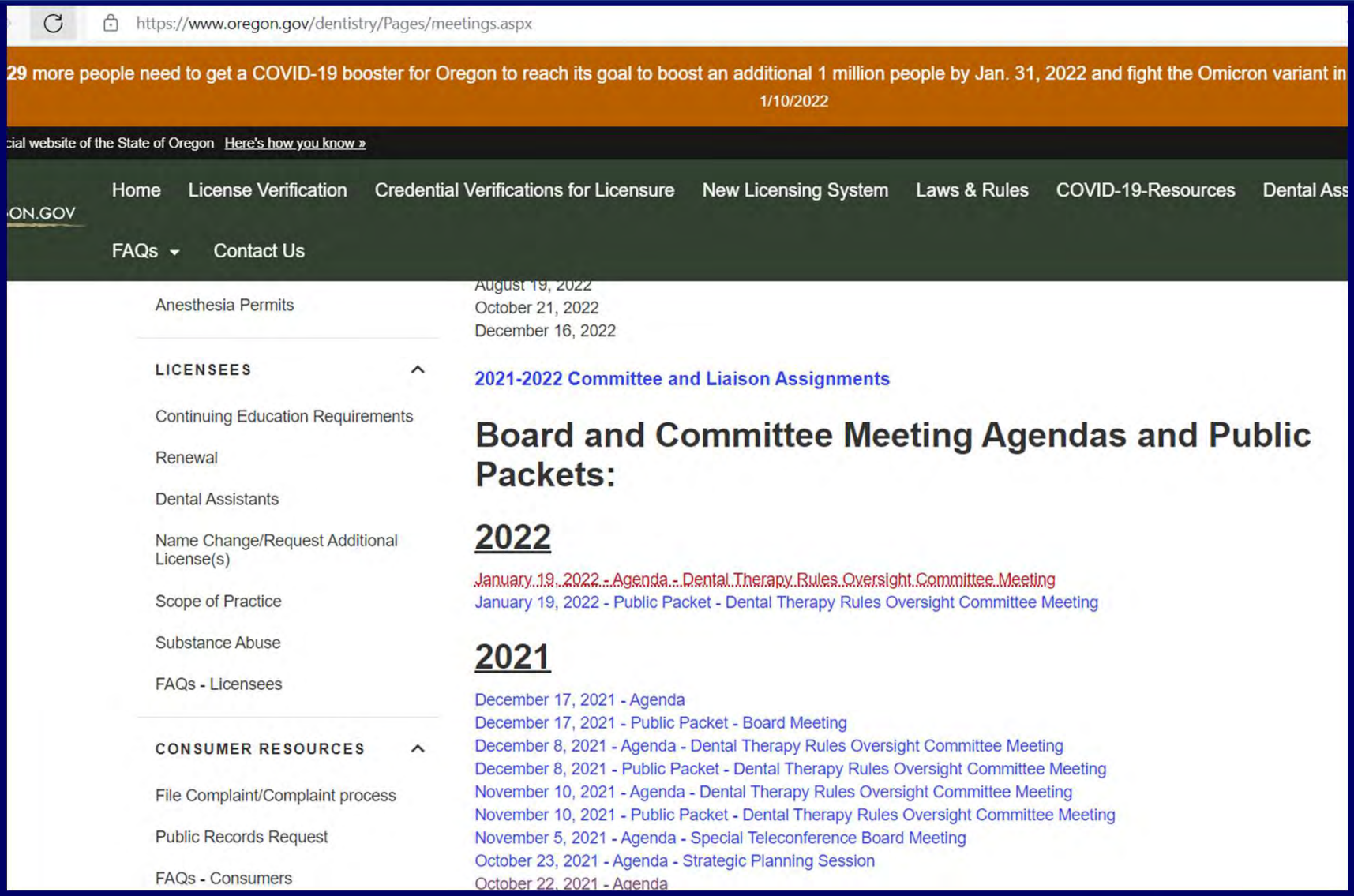
HB 2528

- Education Programs– must have CODA for Dental Therapy
- General Supervision for some procedures under Scope of Practice, Indirect for others
- Must be licensed by Oregon Board of Dentistry
    - Written & Clinical Exams

Oregon Health Authority

Timeline of Activities





https://www.oregon.gov/dentistry/Pages/meetings.aspx

Dental Pilot Projects Program

RAC Meets, Drafts Administrative Rules → Final Draft sent to main OBD Board → Public Comment Period → Filed with Secretary of State, becomes law

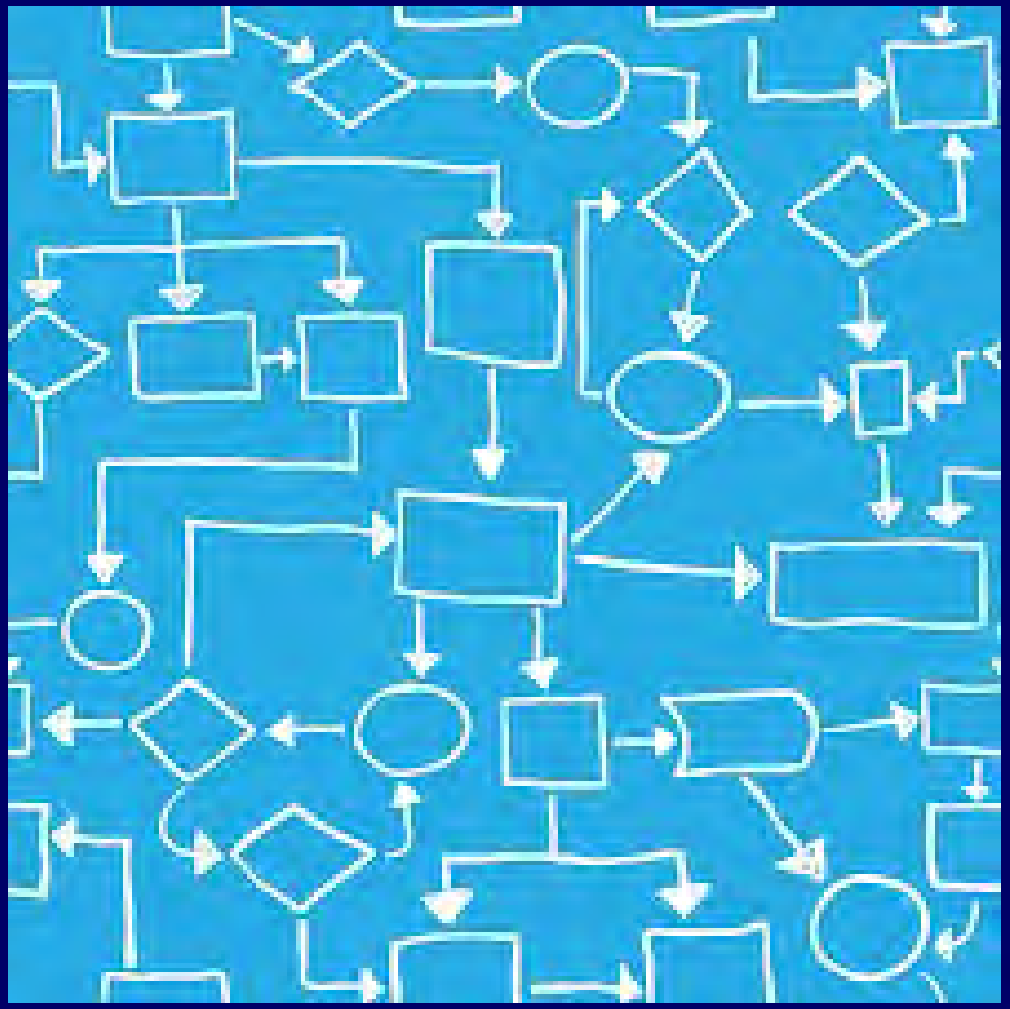
January 19, 2022
5:00 p.m. – 7:00 p.m.

Committee Members:

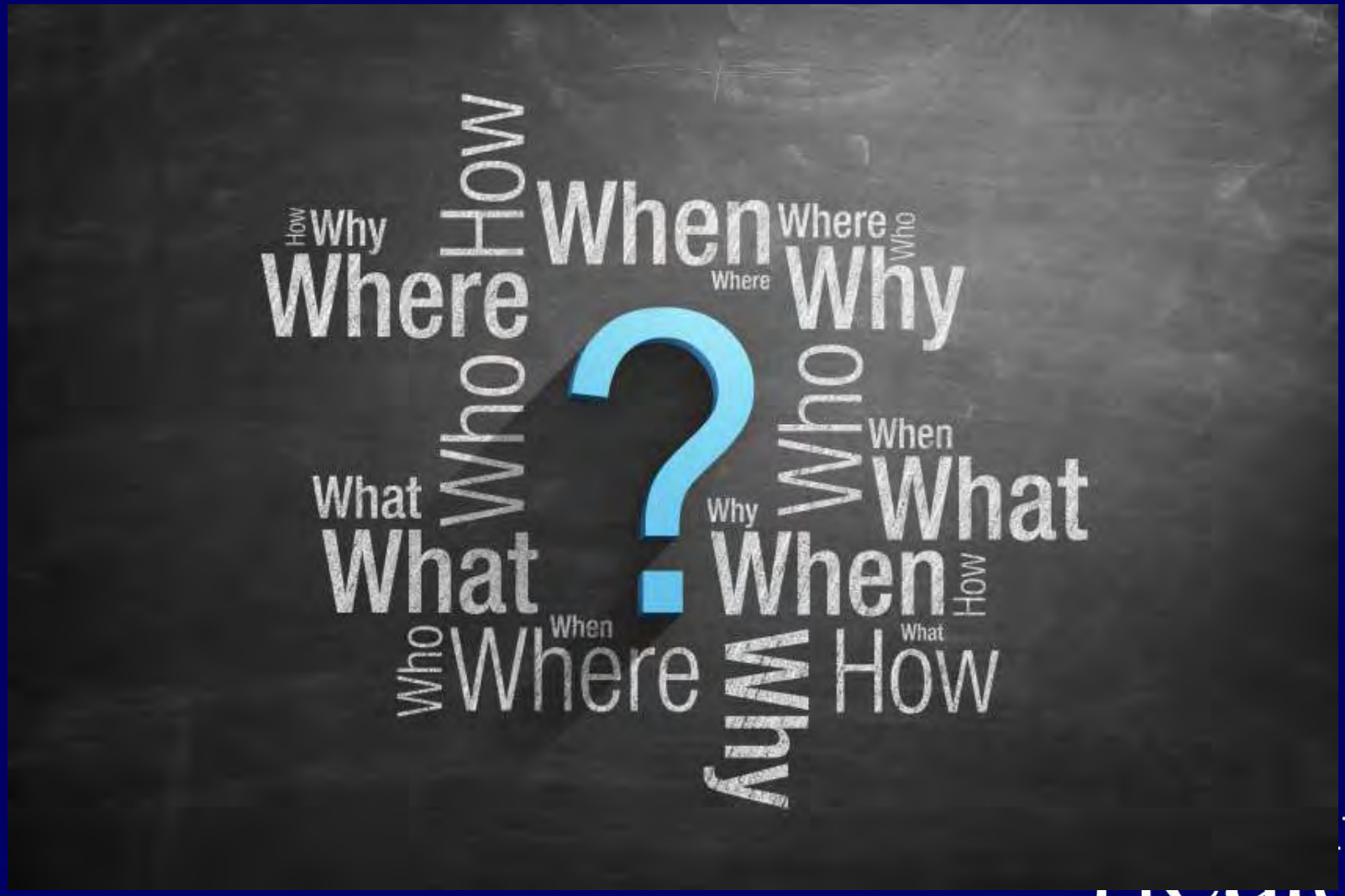
- Yadira Martinez, R.D.H., Chair – OBD Rep.
- Sheena Kansal, D.D.S. – OBD Rep.
- Jennifer Brixey– OBD Rep.
- Kaz Rafia, D.D.S. – OHA Rep.
- Brandon Schwindt, D.M.D. - ODA Rep.
- Amy Coplen, R.D.H. - ODHA Rep.
- Ginny Jorgensen, CDA- ODAA Rep.
- Miranda Davis, D.D.S. – Dental Therapy Rep.
- Kari Kuntzelman – Dental Therapy Rep.
- Jason Mecum – Dental Therapy Rep.

Oregon Health Authority

Dental Pilot Projects Program



Dental Pilot Projects Program



Dental Pilot Projects Program

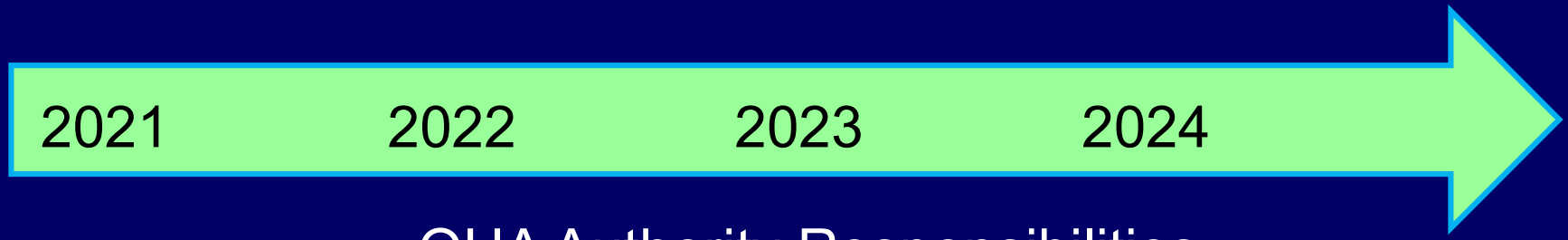
ROLE of the Advisory Committee

Oregon Health Authority

Dental Pilot Projects Program

Dental Pilot Projects Program

OHA Authority Responsibilities
Dental Pilot Project



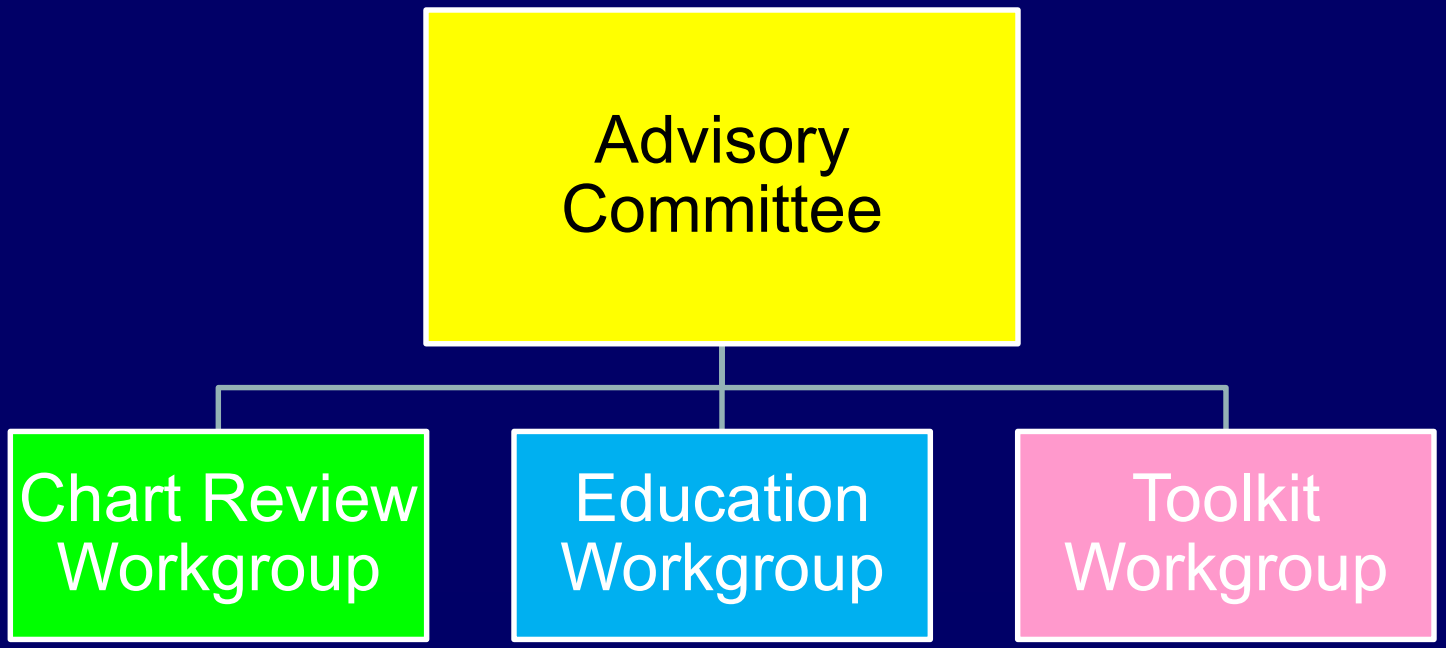
OHA Authority Responsibilities
Role in Implementation

Dental Pilot Projects Program

- Attendance in Dental Pilot Project Committee Meetings
- Advisement on the efficacies of training, competencies and the collection of data
- Review and advisement of project protocols related to the ongoing assurance of patient safety
- Participation and attendance in Site Visits. Members are requested to attend at least one Site Visit during each year of the pilot project.
- Advisement on the evaluation of project progress reports as needed
- Advisement on project issues, should they arise

Oregon Health Authority

Dental Pilot Projects Program



Dental Pilot Projects Program

Education Workgroup: Subject matter experts in dental education to review and make recommendations regarding future establishment of Dental Therapy education programs in Oregon.

- OHSU-School of Dentistry (1)
- Dental Hygiene Programs (6)
  - Lane Community College
  - Mount Hood Community College
  - Oregon Institute of Technology - Klamath Falls
  - Oregon Institute of Technology - Salem
  - Pacific University
  - Portland Community College
- DHAT (DPP #100) – Training Programs (0)

Dental Pilot Projects Program

Dental Therapy Toolkit Workgroup: Subject matter experts to explore development of a toolkit to be used by future employers and providers as a guide to help hire and implement a dental therapist into the dental clinic/team, etc.

- Advisory Committee members
- Invited subject-matter-experts

Dental Pilot Projects Program

Evaluation Efforts

- Approve and ensure that project Program Evaluation efforts comply with applicable OARs
  - DPP #300 has an approved Evaluation and Monitoring plan
- Monitor and evaluate for patient health and safety
  - Chart review workgroup

Dental Pilot Projects Program

Monitor and evaluate for patient health and safety

- Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application
- Purpose:
  - Opportunity to review trainee performance and quality in regard to patient safety
  - Lead to a greater understanding of the proposed workforce model
  - Use an *iterative* process to lead to quality improvement
  - Determine that a minimum standard of care is met
- Not the purpose:
  - To "root out bad quality"
  - Judge things you can't see
  - Prove or disprove the educational competency of the model

Dental Pilot Projects Program

Chart Review Workgroup

- Reviews conducted on an annual basis
- Stratified random sample of irreversible procedures
- Review tools include:
  - Chart Notes
  - Before and after intraoral photos
  - Radiographs as appropriate
  - Chart Review Form

Chart Review Example from DPP #100

OHA Clinical Chart Review Form & Guidelines : DPP #100

Sources: IHS Oral Health Program Guide, OHA DPP#100 Advisory Committee input, Western Regional Examining Board, Kalenderian E. Classifying Adverse Events in the Dental Office. Journal of Patient Safety. 2017

Chart Number:

Tooth Number:

Reminders:

- N/A (Not Applicable) and Unable to Determine are always additional answer options
- Please provide additional comments whenever possible. Comments are required when rating below the minimum standard of care.
- Please note in comment sections whenever images are not sufficient for dependable evaluation.

CRITERIA	Description			Assessment	Comments
Diagnosis					
1. Diagnosis Description Appropriate	**Yes:** Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
2. Planned treatment based upon the given diagnosis is appropriate.	**Yes:** Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
Images					
1. Radiographs available and sufficient for diagnosis	**1:** Radiographs are present and adequate for evaluation	**2:** Radiographs are present, but not adequate for evaluation. Please describe why.	**3:** Radiographs are not present for this procedure		
2. Intra-Oral Images are sufficient for evaluation.	**1:** Intra-oral images are present and adequate for evaluation	**2:** Intra-oral images are present, but not adequate for evaluation. Please describe why.	**3:** Intra-oral images are not present for this procedure		
Administration of Drugs					
1. Anesthetic used appropriate for procedure	**Yes:** Appropriate anesthetic, location, and dosage	**No:** Inappropriate anesthetic, location, or dosage			
2. Within recommended Limits	**Yes:** Drug dosages are within limits recommended by the Physician's Desk Reference or American Hospital Formulary Service. Dosage notation includes quantity, type, concentration and strength	**No:** Drug dosages are outside recommended limits.	**Unable to Determine**		

1

Version 9.202007

Dental Pilot Projects Program

- Email intensive committee
  - Dropbox
- Reduce the number of in person meetings
- Quarterly Meetings
- Meetings will be Virtual

Dental Pilot Projects Program

Proposed Meeting Dates 2022-2023

- **Meetings will be held on Mondays.**

January 31, 2022

May 9, 2022

August 1, 2022

November 1, 2022

January 30, 2023

May 8, 2023

August 7, 2023

November 6, 2023

- A poll will be sent to committee members following the first meeting to determine if these dates are agreeable to most individuals.

Oregon Health Authority

Dental Pilot Projects

PUBLIC COMMENT

- If you want to provide public comment, please:
  - Unmute yourself and let us know you would like to speak
  - Click on the “raise hand” icon under the reactions tab
  - Write in the chat box that you would like to provide public comment
- Each individual is limited to 1.5 - 2 minutes, depending on how many people sign-up

Oregon Health Authority

Dental Therapy Toolkit

A RESOURCE FOR POTENTIAL EMPLOYERS

February 2017

MDH Minnesota Department of Health
OFFICE OF RURAL HEALTH AND PRIMARY CARE

Minnesota Department of Human Services

health reform MINNESOTA
A Better State of Health

Acknowledgements

This report was developed for the Minnesota Department of Health by a partnership between the University of Minnesota School of Dentistry, Metropolitan State University/Normandale Community College, and MS Strategies.

Many dentists, clinic managers, dental therapists and other oral health professionals were consulted to develop this toolkit. The development team and the Minnesota Health Department would like to thank all of those individuals who contributed to making this a valuable tool for employers and potential employers to this emerging profession.

This project is part of a $45 million State Innovation Model (SIM) cooperative agreement project, awarded to the Minnesota Departments of Health and Human Services in 2013 by the Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Minnesota Department of Health
Office of Rural Health and Primary Care, Emerging Professions Program
PO Box 64882
St. Paul, MN 55164-0882
Phone: 651-201-3838
Web: http://www.health.state.mn.us/divs/orhpc/workforce/emerging/index.html

Table of Contents

Acronyms

ADT	Advanced Dental Therapist
BOD	Minnesota Board of Dentistry
CDS	Children's Dental Services
CDT	Current Dental Terminology
CMA	Collaborative Management Agreement
CODA	Commission on Dental Accreditation
CMMI	Center for Medicare and Medicaid Innovation
DA	Dental Assistant
DDS	Dentist
DH	Dental Hygienist
DHAT	Dental Health Aid Therapist
DHS	Minnesota Department of Human Services
DT	Dental Therapist
FQHC	Federally Qualified Health Center
MA	Medical Assistance
MCO	Managed Care Organization
MDH	Minnesota Department of Health
MDTA	Minnesota Dental Therapy Association
MS	Minnesota Statutes
NPI	National Provider Identifier
SIM	State Innovation Model

1. Introduction

In 2009 legislation was enacted by the Minnesota Legislature and signed into law authorizing the practice of dental therapy and establishing a licensing system for this new oral health professional. The law also stipulated that licensed Dental Therapists must serve primarily underserved patients. In 2011, the first Minnesota dental therapists graduated from state-approved education programs, obtained licenses from the Minnesota Board of Dentistry and entered practice providing care primarily to low-income, uninsured, and underserved individuals and communities. Six years later, more than 60 dental therapists are practicing in a wide variety of settings across Minnesota including private and nonprofit dental clinics in both urban and rural areas as well as providing services to underserved patients in community settings such as Head Start programs, schools and veteran's homes. Dental employers have found this new type of mid-level oral health provider to be a valuable member of the oral health team who is able to provide routine oral health care to their patients, improve access to oral health care in their communities and reduce their costs of providing dental services.

The primary purpose of this toolkit is to provide information to prospective dental employers to help them assess the potential benefit of hiring a dental therapist and, if they decide to hire one, to shorten the learning curve by providing information and resources that will be useful in recruiting and hiring a dental therapist and integrating them into their dental teams.

Toolkit Contents

This toolkit contains eleven sections:

1. Introduction
2. History and Overview of Dental Therapy
3. Regulation and Scope of Practice of Dental Therapy
4. Education and Training
5. Hiring, Onboarding and Integration
6. Supervision
7. Insurance and Billing
8. Successful Dental Therapy Models
9. Impact of Dental Therapists
10. Integration into New Care Models
11. Resources

Background Information about State Innovation Model

In 2013, the Minnesota Department of Health (MDH) and Minnesota Department of Human Services (DHS) were awarded a three-year, $45 million State Innovation Model (SIM) grant by the Center for Medicare and Medicaid Innovation (CMMI) with the goal of expanding and deepening accountable care models in the state. Minnesota's SIM grant expanded its Accountable Health Model framework with the ultimate goal of improving the Triple Aim of improving population health, improving the health care experience and lowering the per person cost of health care.

Accelerating the adoption of emerging health professionals was identified as an evidence-based strategy to achieve the Triple Aim. Minnesota's SIM Accountable Health Model focuses on supporting the adoption of three emerging professions, Community Health Workers, Community Paramedics, and Dental Therapists, through direct funding and technical assistance:

- An Emerging Professions Integration Grant Program awarded 14 organizations start-up funds to support the salary and fringe benefits of emerging professionals in innovative settings. Grant funds supported five Community Health Workers, five Community Paramedics, and four Dental Therapists.
- Three organizations were awarded contracts to develop Emerging Professions Toolkits, one for each emerging profession listed above. The intent was to aid prospective employers as they plan and hire these professionals. The DT toolkit was developed through a partnership between the University of Minnesota School of Dentistry, Metropolitan State University/Normandale Community College, and MS Strategies, LLC. Further information on each profession and respective toolkits can be found on the MDH Emerging Professions[1] website.

[1] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_EP

2. History and Overview

History of Dental Therapy

Lack of access to dental care is a serious problem in Minnesota, as it is across the country. Many Minnesotans lack access to dental care, but the problem is especially serious for low-income and uninsured Minnesotans and people with access barriers and special needs such as rural residents, the elderly, and people with disabilities. Although there are a number of factors contributing to the access problem, the shortage of dentists available to provide dental care to these populations and communities is a significant component. In 2007, a group of Minnesota oral health leaders, safety net health care providers, consumer advocacy organizations, dental educators and dental professionals decided to take action to address this workforce shortage as one component of a larger effort to improve access. After researching a wide range of possible workforce and access strategies used in the United States and in other countries, the group decided to seek a Minnesota state law to authorize a mid-level dental provider that would be specifically trained to provide routine oral health care to underserved individuals and communities in Minnesota.

In 2009, the Minnesota Legislature enacted a comprehensive dental therapy law, making Minnesota the first state to establish a state-licensed mid-level dental provider called a dental therapist (DT).

Dental therapists have practiced globally for decades, and the Minnesota law drew from research in other countries such as Canada, Great Britain, and Australia – as well as Alaska, where Dental Health Aid Therapists (DHATs) practice on tribal lands. The Alaskan example shows DTs can deliver safe, high quality dental care to both children and adults, improve access to dental services, reduce the costs of providing dental care, increase prevention and patient education, and provide services in community settings outside of dental clinics in order to reach patients who otherwise might not receive care.

With input from a wide range of stakeholders, dental professionals and organizations, Minnesota's dental therapy law addresses details such as educational programs, licensure requirements, the level of dentist supervision and the scope of services that dental therapists are authorized to provide in Minnesota.

Two education institutions, the University of Minnesota and Metropolitan State University in partnership with Normandale Community College, established dental therapy education programs and graduated their first classes in 2011. In 2010, the Minnesota Legislature

authorized coverage and payment for dental therapy services for people enrolled in Minnesota's state health care programs including Medicaid and MinnesotaCare.

For more information on the Alaska model and global implementation and research on mid-level dental providers, see the Literature Review[2] that was completed in conjunction with this toolkit or the history, training and scope of practice[3] table from MDH.

Overview of Dental Therapy

A Dental Therapist (DT) is a primary dental care provider licensed by the Minnesota Board of Dentistry (BOD) who provides routine preventive care and restorative services. An Advanced Dental Therapist (ADT) is a DT who obtains advanced practice certification by obtaining additional education, completing 2000 hours of supervised clinical practice and passing a certification examination.[4] A certified ADT is authorized to perform additional services and is also able to provide all services in clinical or community settings where there is no dentist on site. All DTs including ADTs must be supervised by a Minnesota-licensed dentist and are limited to practicing in settings that serve primarily low-income, uninsured or underserved patients or communities with a shortage of dental professionals such as many rural communities in Minnesota. Many ADTs are also licensed dental hygienists.

Below is a brief overview of dental therapy requirements:

- **Dentist Supervision and Collaborative Management Agreements**: All DTs must work under the supervision of a Minnesota-licensed dentist. The DT and the supervising dentist must enter into a written contract called a Collaborative Management Agreement (CMA). The CMA establishes the practice relationship and outlines how the DT and supervising dentist will work together. The collaborating dentist and DT may use the CMA as a tool to establish and limit the DT's scope of practice and the level of dentist supervision required. When DTs first began practicing in Minnesota, some CMAs included either scope of practice limitations or increased supervision requirements established by the supervising dentist. It has been typical that, after the dentist and DT work together under close supervision for a period of about six months, a level of

[2] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtlit2016.pdf

[3] http://www.health.state.mn.us/healthreform/oralhealth/dentaltherapist.pdf

[4] Dental Therapists and Advanced Dental Therapists are allowed under MS sections 150A.105 and 150A.106 accordingly.

confidence and trust develops to the point where a review of all CMAs filed with the BOD showed that in almost all of them the supervising dentist has allowed DTs and ADTs to practice their full scope of services.

The level of dentist supervision required varies depending on the type of services provided and whether the DT has advanced practice certification. Some procedures require the dentist to be onsite when services are provided. An ADT with advanced certification can practice in community settings, such as Head Start programs, elementary schools, nursing facilities, and veteran's homes to the extent authorized by the supervising dentist. A dentist may have a CMA with no more than five DTs at any given time. The format and content of the CMA are subject to minimum state law requirements and regulations established by the BOD. The BOD[5] is a good source of information for templates and additional requirements for the CMAs. The different levels of supervision, are defined by the Board of Dentistry and the Minnesota dental therapy statute specifies which DT and ADT services require which levels of dentist supervision. These requirements are described in more detail in the Regulation and Scope of Practice and Supervision sections of this toolkit.

- **Permitted Practice Settings**: By state law, all DTs are limited to practicing primarily in settings that serve low-income, uninsured and underserved patients or in dental practices located in a designated Dental Health Professional Shortage Area. These types of settings are defined in Minnesota's dental therapy statute, see MS 150A.05, subdivision 8. For more information, see the Impact of Dental Therapists sections of this toolkit.
- **Relationships with Other Oral Health Practitioners**: DTs may have CMAs with more than one collaborating dentist, and some DTs work for more than one dental practice. DTs can supervise dental assistants, but no more than four in any one practice setting. The DT scope of practice does not include dental hygiene services; however, some Minnesota DTs and many ADTs are dually licensed as both dental hygienists and DTs and therefore can provide both types of services.
  For more information, see the Regulation and Scope of Practice section of this toolkit.
- **Billing and Payment**: DT services are covered by Minnesota's Medicaid program (called Medical Assistance or "MA" in Minnesota) and MinnesotaCare program, the state's

[5] https://mn.gov/boards/dentistry/licensure/processingandapplications/dental-therapists.jsp

insurance program for low-income residents with incomes above MA eligibility. To be eligible for payments, a DT must be licensed, have a board-approved CMA with a supervising dentist and be employed by an oral health provider that is enrolled with the Minnesota Department of Human Services (DHS) to provide MA-covered services. DTs do not bill directly – their enrolled dental clinic or group practice serves as the "billing provider" and the DT's National Provider Identifier (NPI) is listed as the "rendering provider."

In Minnesota, coverage and payment under Minnesota's health care programs are provided either (1) directly by the state through the Fee-for-Service (FFS) system administered by the Minnesota Department of Human Services (DHS), or (2) through managed care organizations (MCOs) who administer their own provider payment systems. For patients in DHS' FFS system, DT services are reimbursed at the same reimbursement rate as dentists for the services as long as the billing and rendering providers are enrolled with DHS. For MA patients enrolled in an MCO, the MCO is required to cover DT services but may establish its own DT payment rates and may also establish additional enrollment, credentialing or payment requirements for providers. DT services provided at a Federally Qualified Health Center (FQHC) are paid for under a different reimbursement system than that used for other types of dental providers. For more information, see the Insurance and Billing section of this toolkit.

3. Regulation and Scope of Practice

DT and ADT Regulation Information

A Dental Therapist (DT) is a mid-level dental provider licensed by the Minnesota Board of Dentistry[6] under Minnesota Statutes (MS), section 150A.105[7]. An Advanced Dental Therapist (ADT) is a DT who obtains advanced practice certification under MS 150A.106[8] by obtaining additional education, completing 2000 hours of supervised clinical practice and passing a certification examination. An ADT is authorized to perform additional services described later in this section and is also able to provide all DT and ADT services in settings under "general supervision," which means there does not need to be a dentist on site and the ADT can perform the services within their scope of practice without an examination or diagnosis by the dentist. As noted above, all DTs and ADTs must be supervised by a Minnesota-licensed dentist and have a written agreement, called a Collaborative Management Agreement (CMA), with each dentist. The CMA outlines the working relationship between the dentist and dental therapist. The dentist may choose to further limit or restrict the DT's scope of practice to be narrower than what is allowed under state law, depending on the dentist's comfort level with the DT's experience and the collaborative relationship, although few dentists have chosen to do so. DTs are limited to practicing in settings that serve primarily low-income, uninsured or underserved patients or communities with a shortage of dental professionals.

DTs are subject to general licensure and regulatory requirements that apply more broadly to all oral health and dental professionals, including dentists, dental hygienists and dental assistants. Examples include continuing education requirements, and formal processes for complaint investigation and professional misconduct. For more information, see Minnesota State Laws

[6] https://mn.gov/boards/dentistry/

[7] https://www.revisor.mn.gov/statutes/?id=150A.105

[8] https://www.revisor.mn.gov/statutes/?id=150A.106

Relating to DTs and ADTs[9], which includes a list of all of the Board of Dentistry laws that include a reference to DTs or ADTs. Regulatory requirements are also contained in administrative rules adopted by the Board of Dentistry in Minnesota Rules, Chapter 3100. For more information on the statutory, regulatory and public program reimbursement requirements for DTs and ADTs, see Summary of Dental Therapy Regulatory and Payment Processes.[10]

DT and ADT Scope of Practice and Supervision

DTs and ADTs are authorized to perform over 80 oral health procedures, including drilling of cavities and placement of fillings (such as amalgams and resin-based composites), placement of sealants and stainless steel crowns, and extractions of baby teeth. DTs are authorized to perform roughly half of the procedures listed in their scope under general supervision without a dentist on-site and the other half under indirect supervision of an on-site dentist. ADTs are authorized to perform additional services beyond those provided by DTs, including oral health assessments, treatment planning and extractions of permanent teeth in some circumstances. ADTs also may perform all services within their scope of practice under general supervision without a dentist on-site.

The following are the Board of Dentistry's definitions of indirect and direct supervision (Minnesota Rule 3100.0100, subpart 21):

> ***Subp. 21.*** *Supervision.*
>
> *"Supervision" means one of the following levels of supervision, in descending order of restriction.*
>
> ***A.*** *"Personal supervision" means the dentist is personally operating on a patient and authorizes the allied dental personnel to aid in treatment by concurrently performing supportive procedures.*
>
> ***B.*** *"Direct supervision" means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient, evaluates the performance of the allied dental personnel.*

[9] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/2016laws.pdf

[10] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreg2016.pdf

C. *"Indirect supervision" means the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the allied dental personnel.*

D. *"General supervision" means the supervision of tasks or procedures that do not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed but require the tasks be performed with the prior knowledge and consent of the dentist.*

Table 1 shows the services in the DT and ADT scopes of practice and the level of dentist supervision required for each.

TABLE 1: DENTAL THERAPY AND ADVANCED DENTAL THERAPY SCOPE OF PRACTICE AND SUPERVISION REQUIREMENTS

Scope of Practice	Indirect Supervision DT	General Supervision DT	General Supervision ADT
Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis		X	X
Preliminary charting of the oral cavity		X	X
Making radiographs		X	X
Mechanical polishing		X	X
Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants		X	X
Pulp vitality testing		X	X
Application of desensitizing medication or resin		X	X
Fabrication of athletic mouth guards		X	X
Placement of temporary restorations		X	X
Fabrication of soft occlusal guards		X	X
Tissue conditioning and soft reline		X	X
Atraumatic restorative therapy		X	X
Dressing changes		X	X
Tooth reimplantation		X	X

Scope of Practice	Indirect Supervision DT	General Supervision DT	General Supervision ADT
Administration of local anesthetic		X	X
Administration of nitrous oxide		X	X
Emergency palliative treatment of dental pain	X		X
The placement and removal of space maintainers	X		X
Cavity preparation	X		X
Restoration of primary and permanent teeth	X		X
Placement of temporary crowns	X		X
Preparations and placement of preformed crowns	X		X
Pulpotomies on primary teeth	X		X
Indirect and direct pulp capping on primary and permanent teeth	X		X
Stabilization of reimplanted teeth	X		X
Extractions of primary teeth	X		X
Suture removal	X		X
Brush biopsies	X		X
Repair of defective prosthetic devices	X		X
Recementing of permanent crowns	X		X
An oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan authorized by the collaborating dentist			X
Nonsurgical extraction of periodontally diseased permanent teeth with tooth mobility of +3 to +4, if authorized in advance by the collaborating dentist			X

Data Source: MS 150A.106 and MS 150A.106

Most dental practices and organizations employing DTs find it is most efficient and cost-effective for all members of the dental team to practice at the top of their license, which often means having the DT provide all services that are within their scope of practice so that dentists are able to focus on more complex and advanced dental problems and procedures that a DT is not authorized to perform. The services most often performed by dental therapists varies from one setting to the next, depending on the type of setting, the needs of the patients they serve, and the practice style of the collaborating dentist or dental team.

Resources for more information on scope of practice and supervision requirements:

- Dental Therapy: Scope of Practice[11] and CMA[12]
- Advanced Dental Therapy: Scope of Practice[13] and CMA[14]
- For the most up-to-date information on DT and ADT scope of practice, visit the Minnesota Board of Dentistry page listing DT/ADT scopes of practice.[15] The BOD has also created a useful table of information to describe the specific codes DTs and ADTs can perform and the necessary supervision for each procedure, which can be found at Delegated Duties of Dental Therapist and Advanced Dental Therapist.[16]
- A Summary of Dental Therapy Regulatory and Payment Processes,[17] created as background for this toolkit, provides additional information on regulations and scope of practice.

[11] https://mn.gov/boards/assets/Dental%20Therapist_tcm21-46114.pdf

[12] https://mn.gov/boards/assets/Dental%20Therapist%202_tcm21-46117.pdf

[13] https://mn.gov/boards/assets/Adv%20Dental%20therapist_tcm21-46115.pdf

[14] https://mn.gov/boards/assets/ADV%20Dental%20Therapist%202_tcm21-46118.pdf

[15] https://mn.gov/boards/dentistry/licensure/processingandapplications/dental-therapists.jsp

[16] https://mn.gov/boards/assets/Delegated%20Duties_tcm21-46116.pdf

[17] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreg2016.pdf

Dual License with Dental Hygiene

A growing number of Minnesota clinics and dentists are finding the value and flexibility of employing a practitioner who is dually licensed as both a dental hygienist and a dental therapist to be beneficial. Employers have reported that dual licensed individuals spend a majority of their time on DT services, but they have the flexibility to be scheduled for hygiene care when needed. Additionally, a dually licensed ADT is able to provide both dental hygiene and dental therapy services to patients in remote, underserved or community-based settings such as schools or Head Start programs, when it is not practical or cost-effective to send multiple practitioners to these sites. Beginning with the incoming class in the fall of 2016, students graduating from both of Minnesota's DT education programs will be eligible to be dually licensed in dental hygiene and dental therapy. The Normandale Community College/Metropolitan State University program has had a prerequisite of a BS or BA in Dental Hygiene from its inception. The University of Minnesota, School of Dentistry transitioned its program in the fall of 2016 to train students in both dental hygiene and dental therapy.

4. Education and Training

Education Program Information

Two dental therapy education programs in Minnesota have been approved by the Minnesota Board of Dentistry: The University of Minnesota School of Dentistry and a Metropolitan State University program administered in partnership with Normandale Community College. Both programs prepare students for licensure as a dental therapist as well as certification as an advanced dental therapist. Below is a description of each educational program's requirements. Graduation statistics and future projections are provided in *Table 2*, below the descriptions.

- Before the incoming class in 2016, the **University of Minnesota, School of Dentistry's** Master in Dental Therapy program accepted applicants who had completed a BS or a BA degree along with specific prerequisite courses. Starting in the Fall 2016, the University of Minnesota moved to a 32 month, dual degree program accepting students with a minimum of one year of prerequisite courses. Graduates earn both a Bachelor of Science in Dental Hygiene and a Master in Dental Therapy. This allows graduates to be eligible to pursue licenses in both dental hygiene and dental therapy. Since the inception of the U of M program, dental therapy students have learned alongside dental and dental hygiene students, and in areas where the scope of practice of a dental therapist is the same, they complete the same clinical competencies. This model will continue with the program transitioning to dual training in DH and DT. For more information, visit the U of M Dental Therapy[18] webpage.

- At **Metropolitan State University and Normandale Community College's** Master of Science in Advanced Dental Therapy program**,** eligible applicants are Minnesota licensed dental hygienists who have earned a BS or a BA degree, completed a restorative functions course (credit or non-credit), and have a cumulative GPA of 3.0, along with other requirements. In this 16-month program, students are taught by dentists and – for procedures within their scope of practice – are educated to the level of a dentist. For more information, visit the Minnesota State Colleges and University Dental Therapy[19] webpage.

[18] https://www.dentistry.umn.edu/degrees-programs/dental-therapy

[19] http://www.mnscu.edu/college-search/public/institution/programProfile?rcId=0076&progId=8619

TABLE 2: EDUCATION PROGRAM DATA AND FUTURE PROJECTIONS, APRIL 2016

	Metropolitan State University and Normandale Community College	University of Minnesota School of Dentistry
Graduates	28	42
Graduates who have achieved ADT certification	18	10
Current students	11	15

Projected Future Graduate Numbers

Year	Metro & Normandale	U of MN
2016	12*	8
2017	6	7
2018	6	0*
2019	10	8

Data Source: Respective education institutions; December, 2016

**Due to changes in program structure and length, graduation trends show gaps in both programs. The program at Metropolitan State University and Normandale Community College shortened from 20 to 16 months starting in the fall of 2015. In 2016 there was one graduating class of 5 in May and there will be one graduating class of 6 in December. The University of Minnesota has redesigned its program from a 28-monnth to a 32-month program and due to these changes, there will be no graduates in 2018.*

After completion of either of the dental therapy education programs, each graduate will have the following competencies[20]:

- Ability to demonstrate the knowledge and clinical competence required to deliver comprehensive dental therapy services and treatment;
- Ability to exhibit the knowledge and skills required for client and dental therapy practice management;
- Ability to recognize how academic accomplishments will enable them to strategically advance within the dental therapy profession;
- Ability to demonstrate critical thinking, problem-solving, and reflective thinking skills for their professional and personal lives;
- Ability to recognize the importance of community service and leadership from a local and global perspective; and
- Ability to exhibit professional growth, self-knowledge, and lifelong learning strategies that can be implemented throughout their professional career.

Examination and License Information

Dental Therapist

To be eligible for licensure, a DT must have graduated from a dental therapy education program approved by the Board of Dentistry or accredited by the Commission on Dental Accreditation[21] (CODA) or another Board-approved accreditation body. The education program must be at least a baccalaureate level degree. To be licensed, a DT must pass a comprehensive, competency-based clinical examination that is approved by the Board and administered independently of an institution providing dental therapy education. A DT must also pass an examination that tests the applicant's knowledge of the Minnesota laws and rules relating to the practice of dentistry.

[20] Normandale Community College

[21] http://www.ada.org/en/coda

Advanced Dental Therapist

A licensed DT who meets all other DT licensure requirements is eligible for advanced dental therapy certification if the following additional requirements are met: (1) the DT graduated from an approved or CODA accredited Master's level education program; (2) the DT completed 2000 hours of clinical practice as a dental therapist under direct or indirect supervision of a dentist; and (3) the DT passed the Board of Dentistry's three-part examination which includes a patient records review, a written scenario exam, and an interview with the Board's Licensing and Credentials Committee. Upon successful completion of the three components of the Advanced Dental Therapy Certification Examination, the DT may be certified as an Advanced Dental Therapist.

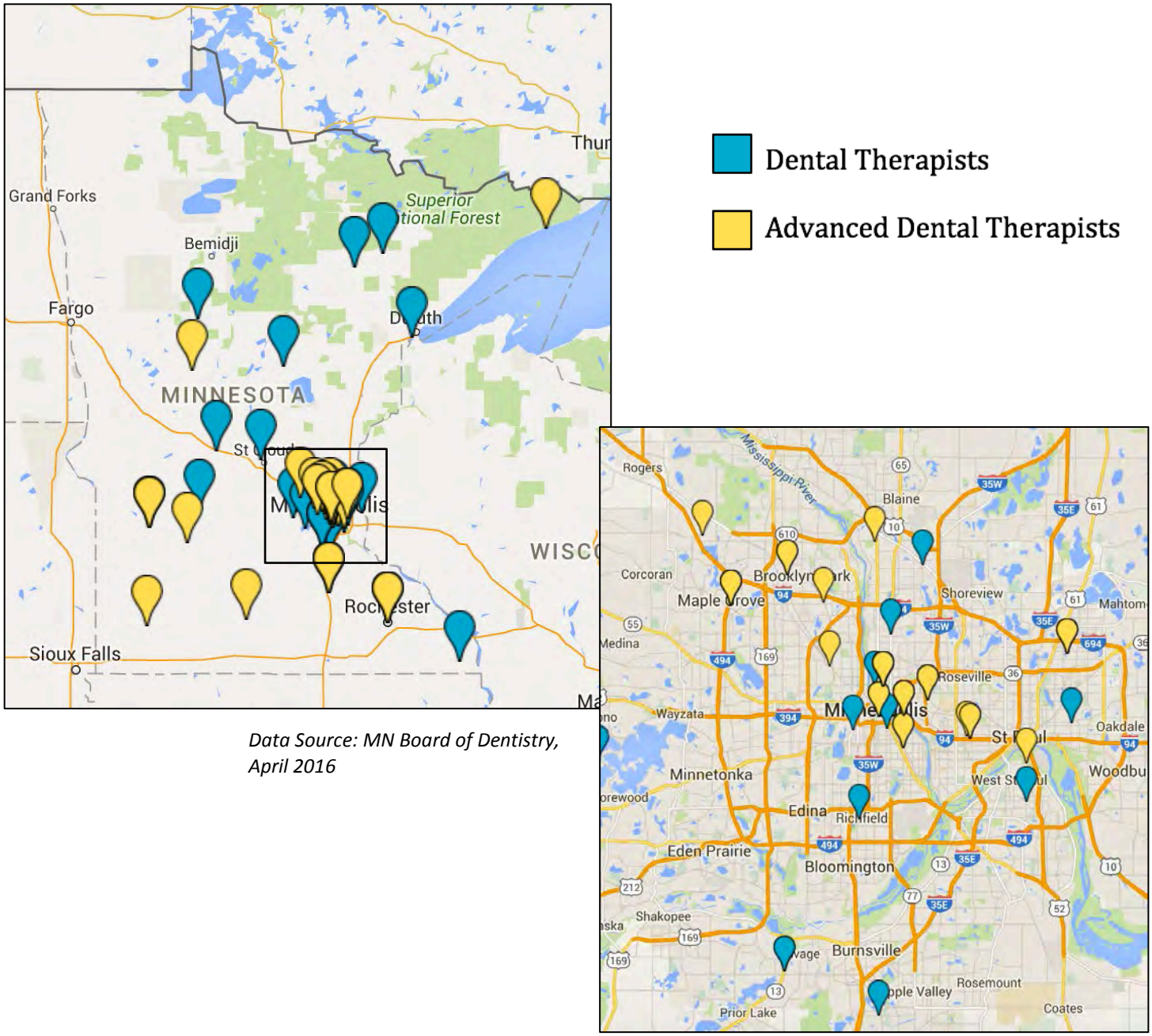
Licensed DTs and ADTs

As of January 2017, there were 64 DTs licensed in the state of Minnesota; 32 of the 64 had been certified as ADTs, and 26 of the 64 were dual licensed in dental hygiene and dental therapy.

Annual updates on the number of dental therapists, their demographics and practice settings is available from the Minnesota Department of Health at: http://www.health.state.mn.us/divs/orhpc/workforce/data.html.

Figure 1, below, shows the various clinical geographic locations at which DTs and ADTs are practicing. Sites where DTs or ADTs provide services in community settings outside of permanent dental clinic are not shown on the map.

FIGURE 1: MAP OF DENTAL THERAPISTS AND ADVANCED DENTAL THERAPISTS IN MINNESOTA



Data Source: MN Board of Dentistry, April 2016

Continuing Education and Volunteer Opportunities

Similar to dentists, DTs and ADTs must organize, complete, and document continuing education requirements, to ensure that they remain current on their oral health skills. DTs and ADTs are required to complete 50 credit hours for each biennial cycle, including a minimum of 30 fundamental credit hours and a maximum of 20 elective credit hours. Credits are granted on an hour-per-hour basis (one clock hour is equal to one credit hour). General attendance at a state or national convention is granted three elective credits.

Examples of Fundamental Courses:	Examples of Elective Types of Activities:
• Lecture/Symposiums/Seminars • Internet/Home study/Periodicals (with post-test) • Study Clubs • Advanced Education/College courses (1 college credit= 1 CE credit)	• Volunteerism/Community Service • Attendance at a state or national convention • Presenting a CE course • Self-Study ex: professional reading, published articles

TABLE 3: CONTINUING EDUCATION CORE SUBJECT AREAS AND EXAMPLES

Core Subject Areas	Examples
Infection Control	Courses about safety and sanitary conditions
Record Keeping	Record keeping courses, Risk management courses that include record keeping
Ethics	Vulnerability of patients, Boundary issues, Professional ethical code and guidelines
Patient Communications	Non-verbal communication, Courses on teamwork, Personal communication courses, Foreign languages/sign language
Management of Medical Emergencies	Medical emergencies in the dental office
Diagnosis and Treatment Planning	Periodontics, Prosthodontics, Endodontics, Restorative

Data Source: MN Board of Dentistry Core Subjects[22]

[22] https://mn.gov/boards/dentistry/professionaldevelopment/coresubjects.jsp

The Board of Dentistry monitors compliance with continuing education requirements, and approves courses and activities on a case-by-case basis. For more information on DT/ADT continuing education, visit the Minnesota BOD Professional Development[23] webpage. For more ideas on continuing education opportunities, contact the Minnesota Dental Therapy Association[24].

In order to maintain clinical skills, DTs or ADTs may choose to participate in volunteer opportunities like Give Kids a Smile[25] or Mission of Mercy.[26] If a DT or ADT volunteers, they are still required to have a collaborating dentist and CMA submitted to the Board of Dentistry.

[23] https://mn.gov/boards/dentistry/professionaldevelopment/

[24] http://www.mndta.org/

[25] https://www.mndental.org/events/give-kids-a-smile/

[26] https://www.mndental.org/events/mission-of-mercy/

5. Hiring, Onboarding and Integration

Resources for Employers

This section provides information that may be useful to dentists, dental clinics and other organizations who are considering hiring a DT. Every employer will have existing processes and procedures for recruiting and hiring new professionals. The focus of this section and this toolkit is to provide information that will address factors that are unique to the DT profession.

In addition to this toolkit and related MDH Emerging Professions – Dental Therapist Materials,[27] there are a number of additional hiring resources that may be useful to potential employers. The resources below cover a range of information related to hiring and employing dental therapists, from existing toolkits to information from the Board of Dentistry and other regulatory bodies, to social media outlets.

Hiring a DT/ADT Website (2014)

The Otto Bremer Foundation funded the development of an Internet-based Employer Toolkit[28] with resources for hiring a DT or ADT. The topics included in the website are:

- Scope of practice for DT and ADTs
- Practice settings
- Education and licensure
- Dental professionals' perspectives on the DT profession
- Collaborative Management Agreements
- Reimbursement for DTs and ADTs
- Professional liability

[27] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index2.html

[28] http://www.mchoralhealth.org/mn/dental-therapy/

- Checklist for considering adding a DT/ADT to your practice

In 2013, the Minnesota Dental Association created an issue brief with information related to the DT profession at that time; it can be found here.[29] While some of the information is out of date, it does provide a historical perspective and includes 2013 information on education programs, students and practitioners at that time.

For more recent information on practitioner and student information, see the Environmental Scan[30] created in conjunction with this toolkit.

Minnesota Board of Dentistry

Minnesota Board of Dentistry[31] provides useful information related to DTs on their website, including scope of practice, collaborative management agreements, advanced dental therapy certification, application forms, and license and certification verification.

Minnesota Dental Therapy Association

The Minnesota Dental Therapy Association is a network and association that is made up of Dental Therapists in the State of Minnesota that work together to respond to the needs of members, support the growth and development of dental therapy as a profession, and increase access to dental care for the public. For more information about the MDTA, visit their website[32] or contact the association: mndentaltherapyassociation@gmail.com.

Recruiting, Interviewing and Hiring

Before recruiting, interviewing or employing a DT, an employer should obtain a good understanding of the DT model, scope of practice and supervision requirements. Information is available in this toolkit and from other sources, but potential employers without experience working with DTs may also wish to contact an existing DT employer for information and advice. After obtaining a good understanding of the DT model, an employer can determine whether the

[29] http://www.ncsl.org/documents/health/OralHealth121113webinarhandout.pdf

[30] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtenv2016.pdf

[31] https://mn.gov/boards/dentistry/licensure/processingandapplications/dental-therapists.jsp

[32] http://www.mndta.org/

model fits with the practice's philosophy, goals, care model, business structure and the patients and communities served and move forward with hiring.

Because DTs will be working as one member of a dental team, employers may want to identify a varied hiring team to participate in determining how a DT may fit into the practice and then recruiting and hiring the DT. The team could include dentists, clinical managers, clinic staff or other members of the oral health team. Employers may want to contact organizations likely to be sources of patients for a dental therapist – schools, social service agencies, etc.

Once a decision is made to recruit a DT, the same best practices for recruiting and hiring any new oral health practitioner apply, whether it is a DT or a dentist, dental hygienist, dental assistant or other staff or team member. All new practitioners and employees should be carefully screened and vetted to be sure the candidate has a current state license, is well-trained and qualified to provide the services needed, and has strong references from previous employers and other sources. Employers should also seek information to assess whether a candidate will be a good fit and will be accepted by other dental team members, and is a good match with the patient population.

As with any business expansion employers should carefully assess the expected financial impact of hiring a DT on the employer's practice or organization. The financial analysis will assess, among other things, whether there is adequate patient need and demand to keep the DT and the team at full capacity and whether the additional payments and revenues generated by the team will be adequate to cover the added expenses and generate an acceptable margin or profit to support sustainable employment of the DT. Financial impact is best assessed by looking beyond the revenues generated by DT services in isolation, which should include how the DT will affect the productivity and profitability of the entire team. For example, many DT employers have found that a DT has enabled the overall team to increase its productivity and has freed up dentists to perform more complex procedures that are reimbursed at a higher level than the DT services.

Employers should factor in a start-up period before the new DT or ADT reaches full productivity. Experience to date has shown that the ramp up period for dental therapists is similar to that for new dentist graduates. Employers can assume DTs who have completed the required education programs and passed licensure requirements and examination possess the knowledge and clinical competencies required to deliver comprehensive dental therapy services and treatment. All new practitioners will need initial orientation and training and continued support and mentoring during the process of integrating them into the dental team and the practice. This is especially true of recent graduates who have not accrued substantial practice experience outside the academic and clinical training settings.

Given that there is a history of some political opposition to the DT role, employers should be prepared for the possibility that some members of their dental team or other dentists in the community may not be accepting of their DT, at least initially. Education within the practice, with external partners and with colleagues may be needed. Despite any initial resistance, most Minnesota dentists and employers who have hired DTs have found that with proper supervision and onboarding, DTs are accepted as a valued, productive member of the dental team. In fact, the prevailing experience in Minnesota is that dentists who initially resisted working with or supervising DTs eventually become supporters of the DT model as they see firsthand how it benefits them and their practice. In most cases, DTs have earned their place in dental practices by improving the practice's ability to reach and serve additional patients, to improve efficiency and productivity, and to increase the financial strength of the practice.

Seeking Candidates to Fill a DT position

Unless the clinic has identified an internal DT candidate and supported them through their training, the most common method used by dental employers to recruit a dental therapist is through the two DT education programs and their graduate placement programs. Potential employers who may have a DT position to fill and employers with general questions about dental therapists may contact the education program directors for more information, to provide a job posting, or to be given information on DT students or graduates who may be potential candidates for employment. The Minnesota Dental Therapy Association (MDTA),[33] the state's professional association of DTs and ADTs, is also a source of information and will send out career opportunities to its members. Another venue for dentists interested in learning about DTs or recruiting a DT is to contact the Minnesota Oral Health Coalition[34] or the Minnesota Department of Health.[35] These sources may also be able to put an employer in touch with an existing DT employer or an employed DT to talk more about the profession and how DTs can be integrated into a dental practice.

Most successful recruitment efforts begin with a posting or job description which then can be shared with the education institutions, the MDTA and other organizations. A job posting for a DT will be very similar to job postings for dental hygienists, dental assistants or dentists. Important elements to include are information about the type of dental practice and patients

[33] http://www.mndta.org/

[34] www.minnesotaoralhealthcoalition.org

[35] http://www.health.state.mn.us/oralhealth/

served, the locations where services are provided, whether the position is full time or part time, and contact information for those interested in the position. Employers should be sure that their practice is the type of practice or setting that qualifies for DT practice under state law, see MS 150A.05, subdivision 8. A sample DT job posting is provided in the Appendix section of this toolkit.

The Interview

The interview process is an important step in recruiting and hiring a DT. In addition to questions that would typically be asked in an interview with any oral health practitioner, a few additional questions that specifically relate to the dental therapy profession and could be included are:

- Why did you decide to become a dental therapist?
- What do you think are the most important skills and attributes of an individual going into this profession?
- What value and contributions do you think you will bring to our dental team?
- As a pioneer in this new Minnesota profession, what ideas do you have for how we can work together to build trust and help you develop a positive relationship with the dental team and your supervising dentist?

The idea of working with a dental therapist will be new to all or most team members, and the employer may want to include questions for the candidates about the DT model or the qualifications or training of DTs. For example, a DT trained and licensed in Minnesota will be able to describe their knowledge and training on their legal scope of practice, what to do if they encounter a dental problem that requires services that exceed their authorized scope of practice, or how they will work with their supervising dentist to develop a Collaborative Management Agreement that will contain the details for the working relationship and define the level of dentist supervision and authorization the dentist will require.

The DT Portfolio

Some DTs may have developed a professional portfolio and some employers may require applicants for employment to provide one. A portfolio showcases a DT's competence, knowledge, skills, and expertise gained while completing the dental therapy program and in other relevant areas of the DTs professional and personal experiences.

Examples of documentation that may be found in a professional portfolio:

- Practice philosophy
- Short and long-term goals
- Resume
- Presentations
- Writing samples
- Certificates
- Educational honors
- Cases of patients treated
- List of externship rotations
- Continuing education (especially if a practicing dental hygienist)
- Letters of recommendation

Employment Offer

After making a decision to offer employment to a DT, an employer will typically provide the DT with a written employment agreement with the same information that would be included in an employer offer to a dentist, dental hygienist or other member of the dental team. The employment offer typically describes the position, job title and start date; the salary, compensation and benefits offered; the reporting responsibilities and supervising dentist relationship; and performance expectations and goals.

Salary Ranges

Based on information collected from employers, educational institutions and other sources for this toolkit, *Table 4* summarizes general salary ranges for DTs and ADTs and compares their compensation to that of dentists. In general, DTs will be compensated at a higher hourly rate than dental hygienists. If they achieve ADT certification their compensation will increase. In some cases, compensation may be different for a dually licensed DT/Dental Hygienist. Both DTs and ADTs are compensated at lower wages than dentists. Some clinics pay practitioners in part or entirely based on their productivity rather than a fixed salary, in which case total compensation will vary even within a single clinic setting.

TABLE 4: HOURLY WAGES FOR DT, ADT, AND DENTISTS

	Metropolitan Twin Cities	Greater Minnesota
DT	$36-40	$35-44
ADT	$36-45	$40-45
Dentist	$60-100	$50-78

Data Source: Questionnaire responses collected for this toolkit, April and August 2016; Employer Presentations at Dental Therapy Site Visit, July 2016; salary.com; and: http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index.html#toolkit [1]

Onboarding

> ***"I'm very pleased at the patient reaction to this new provider in our practice."***
>
> *Dr. David Gesko, dental director for a nonprofit integrated health care system in Minnesota*

The integration of nurse practitioners (NPs) and physician assistants (PAs) into medicine offers some lessons for integrating dental therapists. Although NPs and PAs are generally accepted and understood by patients and other members of health care teams, the medical community still takes measures to ensure that these professionals are seamlessly introduced and integrated into their offices and are accepted by patients and fellow employees in the office. Full integration of a DT/ADT into the dental team is crucial for their success and for patient acceptance. The dentist, other oral health professionals and staff have an important role in educating and assuring patients that they will be receiving quality care from the oral health team. Introduction of a DT or ADT to the staff provides an opportunity to learn and ask questions about the dental therapy profession which will help ease the transition.

Tina Maluso-Bolton, an oncology nurse practitioner, identified seven common actions that allow practices to successfully integrate mid-level practitioners. These include:

(1) a clear, articulated job description;
(2) a committed mentor;
(3) leadership and administrative support;
(4) patient and coworker support;
(5) feelings of acceptance of the mid-level practitioner as a valued colleague by all concerned;
(6) an atmosphere that supports growth; and
(7) leadership willingness to delegate.

Dental practices should implement these steps with any new employee to create a productive and cohesive team.

For more information on preparing the oral health team, see the following articles: Maluso-Bolton, *Advanced Practice Clinicians: Integrating Advanced Practice Clinicians into your Oncology Practice,* 2006[36] and Yoder and DePaula, *Navigating Career Pathways- Dental Therapy in the Workforce: A Report of the Career Path Subcommittee,* 2011.[37]

During all stages of the hiring and onboarding process, it is important that office and clinical staff are aware and understand the role of the new professional. In addition to resources in this toolkit, like the Preparing the Oral Health Team and Office Communications sections, the DT or ADT can serve as a resource to the clinic and provide information and suggestions on integration and office communications. As with other professionals, the DT/ADT will need a clinical orientation to become more familiar with the clinic culture, operations, and clinic specific procedures and policies.

For smooth integration into the clinic, the DT/ADT may want to start with just one collaborating dentist. Once a trusting relationship has been developed and the DT/ADT and DDS are familiar with practice philosophy, treatment planning, and personal strengths, the DT/ADT will be established to add CMAs with additional collaborating dentists. Like recent dental graduates, new DT/ADTs may likely need some on the job training and time to ramp up skills to peak production. During this time, collaborating dentists may decide frequent procedure checks and case reviews are needed in order to build a trusting relationship. Once the dentist and therapist are familiar with each other's' practice styles, case reviews and procedure checks can taper off as they see fit.

[36] Maluso-Bolton T. Advanced practice clinicians: Integrating advanced practice clinicians into your oncology practice. *Journal of Oncology Practice/American Society of Clinical Oncology.* 2006: *2* (6): 289-93. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793646/

[37] Yoder, Karen, and Dominick DePaola. Navigating career pathways—dental therapists in the workforce: a report of the career path subcommittee. *Journal of public health dentistry* 2011*:* 71 (s2):S38-S41. https://www.ncbi.nlm.nih.gov/pubmed/21922706

Office Communications

To be effective, a DT will need the support of the dentists, other members of the dental team and administrative employees in the office. Scheduling staff should be very familiar with the allowed services in the DT/ADT scope of practice. Introducing the DT/ADT to patients is important and can be done through a number of methods, such as:

- Pamphlets in the office
- Information on the practice website
- Announcements on social media
- Verbally by oral health practitioners and administrative staff

Lessons Learned: Office Staff Acceptance

- Continuous and open communication is key for office and staff acceptance.
- While the dentist may clearly understand the DT/ADT's scope of practice, the rest of the office may not. It is important to make sure the entire office staff understands the scope of practice and the value the DT/ADTs bring to the overall practice and oral health team and to the community by improving access to oral health care.
- For practices hiring a DT or ADT for the first time, attention should be paid to planning how to integrate them into the oral health team and office staff.

"I was surprised and kind of worried about presenting them to the patients or having to defend it. It's been seamless. If the staff is on board then the patients are too."

Developing and disseminating written guidelines for communication from staff to patients regarding the addition of the dental therapist to the practice may be useful. Information for patients could include:

- DT/ADT education and training
- Explanation of the DT/ADT scope of practice
- Dental supervision and practice settings
- Comparisons of DT/ADTs to other mid-level providers

Endorsement by the dentists can help make patients comfortable and accepting of the DT/ADT. When feasible, a dentist could inform the patients that the office now has a DT/ADT to whom the dentist may delegate some of his or her preventive and restorative care. They could inform patients that the DT/ADT is a member of the dental team and has had the same education and training as a dentist within their scope of practice to perform quality, safe care. Educating staff and patients on the DT/ADT's scope of practice, education and training allows for smooth integration into the practice.

For more information on office communications, see Maluso-Bolton's

Lessons Learned: Patient Acceptance

- DTs/ADTs and employers have commented that their patients were very accepting of the new provider. While some patients (very few) asked for more information on DT/ADT training and background, comparing the profession to a physician's assistant typically helped patients feel at ease.
- DTs/ADTs have stated that their patients express gratitude for being able to finally access dental care.
- Many employers have found that having a DT or ADT has turned out to be a positive marketing tool because their patients appreciate that they are trying to improve access to care for the underserved.
- It has been reported that, once a DT/ADT has been fully accepted as a member of the oral health team and integrated into a practice, patient acceptance follows.

"My biggest concern… was that every day there's at least one patient who is going to come in and say, 'I don't want to be seen by a therapist, I need a dentist.' So, I was very, very much prepared for that. But it never happened – once. Which was great; I was almost overwhelmed by the response of patients. They were very, very appreciative… They're very comfortable with her."

Dr. Shiraz Asif, Family Dental Care, a community clinic in Minneapolis, MN

article: *Advanced Practice Clinicians: Integrating Advanced Practice Clinicians into your Oncology Practice,* 2006. [38]

Applications for the loan forgiveness program are open annually in November. Selection of awards is competitive, and not all applicants receive awards.

For more information on the program and for contact information for DT-related programs, visit this MDH Loan Forgiveness program webpage.[39]

Professional Liability Coverage for Dental Therapists

There is no statutory requirement for a dental therapist or advanced dental therapist to carry professional liability coverage, just as there is no requirement for a dentist to carry professional liability coverage. In general, the dental therapist is covered under the dentist's professional liability coverage much like a dental hygienist and dental assistant is covered. The dentist should contact their professional liability carrier to determine if their carrier requires any modifications to the dentist's policy.

There are currently two companies that offer professional liability coverage to dental therapists and advanced dental therapists in Minnesota: Dyste Williams[40] and Marsh Professional Liability.[41]

Policy and Procedure Manuals

Each practice setting will choose to integrate dental therapists in unique ways, depending on its current procedures and policies. A review of a practice's existing policies and procedures and compliance plan should be completed and changes made as needed. Changes may be needed to address the unique dentist supervision and CMA requirements that apply to dental therapists, but the DTs scope of services are not new. These are services dentists are already providing. The main changes are in who performs the services and the way in which the DT services are authorized and supervised by a dentist.

[38] Maluso-Bolton T. Advanced practice clinicians: Integrating advanced practice clinicians into your oncology practice. *Journal of Oncology Practice/American Society of Clinical Oncology.* 2006: *2* (6): 289-93

[39] http://www.health.state.mn.us/divs/orhpc/funding/loans/

[40] http://dystewilliams.com/programs/dentists-oral-surgeons/

[41] https://www.marsh.com/us/services/financial-professional-liability.html

Some examples of policies and procedures that may need to be updated:

- Dental programs policies and procedures
- Organization chart
- Dental program summary
- New employee orientation
- Staff assignments and duties
- Scheduling and appointment procedures
- Clinical services information
- Quality assurance
- Community health
- Human Resources and general personnel policies
- Other areas within policy manuals that include lists of providers, where applicable

Triage Protocols

Something else to consider when onboarding a new hire is the best use of their skills to maximize efficiency in the practice. Some employers, clinics and dentists use ADTs to triage new patients, walk in patients or urgent patient needs to do an initial assessment of what services are needed, how quickly and by which member of the dental team. A DT is authorized to deliver palliative emergency treatment of dental pain as well as other initial services. For more information on the services DTs and ADTs are authorized to deliver and the type of dentist supervision or authorization is required, see Delegated Duties of Dental Therapists and Advanced Dental Therapists.[42]

Pursuing Advanced Practice Certification

Upon hiring, it may be important to learn about the employee's professional goals. If a DT will be seeking advanced practice certification, the DT and other team members will want to begin identifying patient cases and records that can be submitted to the Board of Dentistry as Part I of the ADT certification. These records will be reviewed for comprehensiveness and compliance with current record-keeping regulations as well as evaluated for evidence and demonstration of critical thinking and decision making.

[42] https://mn.gov/boards/assets/DT%20Chart%20BA_tcm21-262696.pdf

Minnesota Department of Health Loan Forgiveness Program

Employers may also want to make new hires aware of programs that can assist them. The Minnesota Department of Health's Office of Rural Health and Primary Care offers a range of loan forgiveness and repayment programs to health care students or residents, and dental therapists are eligible for the program. Licensed graduates of a DT/ADT program are eligible for $10,000 per year for up to four years, if they serve in a rural area for a minimum of three years. Practicing DT/ADTs are eligible for loan forgiveness, but priority is given to recent graduates.

6. Supervision

Collaborative Management Agreements

Both Minnesota educational programs teach students the required components of Collaborative Management Agreements (CMAs) and provide training on how to work with supervising dentists to formulate the CMA and then work together as a team. The final CMA must be agreed to and signed by both the DT/ADT and the dentist.

Although the scope of practice for DTs and ADTs is specified in statute, the supervising dentist has the authority to further limit the functions, or increase supervision, of an individual DT or ADT through the CMA. CMAs are filed with the Minnesota Board of Dentistry and reviewed annually, but a CMA may be altered at any time. For example, a dentist may initially choose to limit the DT/ADT scope of practice and later decide limitations are no longer necessary due to the demonstrated competency of the DT/ADT and can amend the CMA at that time. A CMA or supervising dentist may not authorize a DT/ADT to practice beyond the scope of practice outlined in statute.

Refer to the BOD website[43] for current information on the DT/ADT scope of practice and formulating a CMA and to view CMA templates for DTs and ADTs.

Collaborating Dentist and Dental Therapist Relationship

Communication is critical to relationship building between the dentist and the dental therapist. Collaborating dentists and dental therapists may want to discuss:

- **Mission and Vision.** It is important to have a conversation about the mission and vision of the practice as well as the patient population that is served. It may be useful to have the dental therapist shadow the dentist to experience how patient care is delivered.
- **Scheduling.** It is beneficial to have the dentist and DT/ADT develop written scheduling guidelines, review and revise guidelines on a specified basis, and clearly communicate expectations to scheduling staff. A typical day for a DT/ADT will vary based on a number of factors including:

[43] https://mn.gov/boards/dentistry/licensure/processingandapplications/dental-therapists.jsp

  - The clinic's patient population;
  - Where the ADT is practicing (in the clinic or in a community setting);
  - Whether they are a DT or ADT or dually licensed in DH and DT;
  - The collaborating dentist and scope of practice identified in the CMA;
  - The needs of the clinic; and more.

Dental therapists generally see between four and eight patients in the morning and again in the afternoon. Typically, a DT/ADT is scheduled for restorative, pediatric, and preventive care appointments and can operate in one or two dental chairs with one or two dental assistants.

- **Regular check-ins.** Begin each day with a team meeting to review patients and treatments scheduled for the day. This provides an opportunity to discuss any questions or concerns related to each patient's treatment plan.
- **Work evaluations.** Until comfortable and familiar with the dental therapist's work, the dentist may want to evaluate preparations and restorations. For example, this may be done for all patients for the first two weeks and more complicated procedures for the first two months. The exact arrangement will depend on the relationship that develops between the dentist and the dental therapist. After the dentist is comfortable with no longer evaluating all procedures, the dentist and dental therapist should schedule time weekly to review difficult cases or answer questions the dental therapist may have. A best practice could be to develop and

Lessons Learned: Dentist-Dental Therapist Relationship

- Continuous and open communication with the dental therapist, hiring team, and other collaborating dentists is key.
- When building a relationship, it is important to go through treatment planning together and share philosophical information to build a shared philosophy with regards to clinical decision making. DT/ADTs and collaborating dentists should set goals together.
- It may work best in some practices to have a recent DT graduate paired with only one dentist during their initial training and onboarding time and then work with additional dentists once they are oriented.
- Dentists do not need to check every single procedure that a DT/ADT does, although it may be beneficial to start with more checks and taper off as the DT/ADT gets more comfortable in the work setting.

"I'm very comfortable with our dental therapists; otherwise I wouldn't allow them to practice. Because I have confidence in them because I have critiqued the work over a number of years and I can see that they do it well. The quality of our dental therapists' work is on par with that of a dentist and in some cases better than new dentists."

Dr. Mark Kelso, dental director at Norton Sound Health Corporation in Nome, AK

implement a Quality Assurance program where chart audits are done quarterly for the first year and then every six months after.

Recent graduates and newly hired DTs will need additional orientation, mentoring and supervision until they are fully integrated into the team and the dentist and other team members become familiar with the DTs experience, skill and practice style. This initial period establishes the foundation for an ongoing working relationship between the DT and supervising dentist and other team members. Based on information and advice received from Minnesota DT employers, an employer onboarding a new DT into the team may choose to establish a protocol of daily team meetings each morning. Suggested timing and topics for team meetings are shown below:

Recent Graduate, Newly Hired First 3-6 months)	Fully integrated DT/ADT (after 3-6 month onboarding period)
• Morning Team Meeting: approximately 30 minutes to review all necessary cases, treatment plans and procedure preparations and checks • Dentist closely monitors the DTs work, especially more complex procedures • Daily or weekly review 5-10 cases, discuss treatment plans and set aside adequate time to fully discuss why treatment plans were developed and executed accordingly	• Morning Team Meeting: 15-30 minutes to discuss daily schedule and the most complex cases • Procedure checks and preparation checks periodically, as needed • Weekly review 5-10 patient charts for more complex patients or patients that need additional attention in treatment planning and execution

7. Insurance and Billing

Under MS 256B.0625[44], subdivision 59, Minnesota's Medical Assistance (MA) program covers services provided by dental therapists and advanced dental therapists that fall within the scope of practice identified in state law in MS 150A.105 and 150A.106. This statute also has the effect of providing for coverage under the state's MinnesotaCare program. The current list of services in the DT and ADT scopes of practice is available in Section 3 of this Toolkit.

To be eligible for payment, the DT must be licensed, have a board-approved Collaborative Management Agreement(CMA) with a supervising dentist, and be employed by an oral health clinic or provider that is enrolled with the Minnesota Department of Human Services (DHS) to provide MA-covered services. DTs and ADTs do not bill directly for their services; services are billed through their enrolled dental clinic or group practice that serves as the "billing provider." However, the DT or ADT must still obtain their own National Provider Identifier (NPI) number and enroll with DHS as an individual practitioner by completing the individual practitioner enrollment forms and application. To obtain reimbursement for DT/ADT services, the billing provider must submit the claim and include the DT or ADT's NPI number as the "rendering provider."

At times, enrolling a provider with DHS can take months – as of early 2017 a six-month wait was not uncommon – and this wait is not unique to dental therapy. DHS is working to address the backlog, but supervising dentists and clinics should plan accordingly. For more information on the enrollment process and the enrollment forms, visit the DHS provider enrollment[45] website.

As with other oral health practitioners, in order to be paid for providing services to patients enrolled in a Managed Care Organization (MCO) and insurance companies, -- including MCOs

[44] https://www.revisor.mn.gov/statutes/?id=256B.0625

[45] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000090#enrollment

that contract with Medicaid – the billing provider and DT must complete any applicable enrollment and credentialing requirements established by each individual insurance company. Each insurance company has its own credentialing process. Some require brief forms, others require forms of 40+ pages. Turnaround times for credentialing of either dental therapists or dentists vary as well – average times may be from six weeks to six months, depending on the company.

Adding complexity, not all health plans contracting with Medicaid credential providers the same way. HealthPartners, for example,[46] currently credentials Advanced Dental Therapists, but not Dental Therapists. Blue Cross / Blue Shield of Minnesota[47] currently does not credential either DTs or ADTs, and requires dentists to bill DT or ADT services using the dentist's NPI. Contact each health plan for details on their credentialing processes.

Clinics consulted for this Toolkit recommended maintaining positive relationships with health plan representatives, and following up on faxed or emailed documentation to make sure it was received. A good working relationship can make credentialing a provider easier.

Once enrolled with DHS and/or the MCO that manages care for Medicaid or MinnesotaCare enrollees, the billing provider may bill for the DT services provided to an eligible MA, MinnesotaCare or – if the service is covered – privately insured patient. For services that are reimbursed directly by DHS (also known as Fee-For-Service Medicaid), DT and ADT services are currently reimbursed at 100% of the MA reimbursement rates established by DHS for dentists providing these services. For MA patients who are enrolled in a managed care plan (also known as the Prepaid Medical Assistance Program, or PMAP), the plan may establish its own DT/ADT payment rates and may also establish additional credentialing or payment requirements for DTs and ADTs, as long as they are providing their enrollees with access to DT and ADT services. All services within the DT/ADT scope of practice are reimbursable services in DHS programs.

[46] https://www.healthpartners.com/provider-public/credentialing-and-enrollment/

[47] https://www.bluecrossmn.com/healthy/public/portalcomponents/PublicContentServlet?contentId=P11GA_12867461

Minnesota Federally Qualified Health Centers (FQHCs) have special payment methodologies under the MA program that provide for payment of a per-visit "encounter payment" rate for dental services.

The DT and ADT DHS Provider Manuals, linked below, contain the most accurate and up-to-date payment policies and detailed requirements established by DHS for enrollment, billing and reimbursement of DT and ADT services.

DT provider manual[48]

ADT provider manual[49]

For private insurance, many plans reimburse for DT or ADT services billed by the supervising dentist – similar to how Dental Hygiene services are billed. Most private insurance plans do not credential DTs or ADTs as billing providers. Contact each health plan for details on billing procedures for DT and ADT services.

The Board of Dentistry initially created a guide to help everyone understand how the DT/ADT scope of practice translated into the Current Dental Terminology (CDT) code set. This Board of Dentistry DT/ADT Delegated Duties[50] document contains information on billing codes, supervision requirements, and covered services for both DTs and ADTs as of 2016.

For more information on reimbursable services, see the Scope of Practice section of this toolkit or the Summary of Dental Therapy Regulatory and Payment Processes.[51]

[48] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166842

[49] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166843

[50] https://mn.gov/boards/assets/DT%20Chart%20BA_tcm21-262696.pdf

[51] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreg2016.pdf

8. Examples of Successful Dental Therapy Models

With more than 60 dental therapists practicing in a wide range of settings across Minnesota, evidence is now clear that DTs can be employed successfully by many different types of employers and can practice in many different types of practice settings. Even so, any employer that is considering hiring a DT should consider a number of factors and variables to determine if the model will work for them. More information on these factors and variables and other considerations are outlined in the Financial Impact section of this toolkit.

Minnesota's five years of experience with dental therapists has demonstrated there is clearly a strong need and market demand for employing dental therapists in a wide range of dental practices and settings with differing practice models, patient populations, geographic locations, employment and compensation models, and funding and payment methods. This section gives several examples including a rural private practice, an urban hospital, a Federally Qualified Health Center, an urban nonprofit dental group, and mobile services in community settings.

Rural Private Practice

Private dental practices across the state have adopted dental therapy into their care models. Almost one-half of Minnesota's DTs are practicing in rural communities, which approximates the distribution of the state's population and is a much higher rural distribution than other health care professionals whose locations of practice are skewed in favor of metropolitan areas.

Dr. John Powers,

Main Street Dental Care,

Montevideo, MN

shares his experience with dental therapy:

Dr. Powers on Dental Therapists

Main Street Dental[52] in Montevideo, MN was the first private practice to hire a dental therapist in 2012 and has now expanded its care team to include two DTs and two ADTs. The dental therapists provide all restorative and pediatric care.

[52] http://www.mymainstreetdental.com/

The dentist's schedule then allows for more endodontic treatment, permanent crowns, implants and prosthetic appointments. The DT's schedule contains about 91% Medicaid and Medicare insurance patients. The DTs are able to provide services at a lower cost, which results in a positive financial return for the dental practice.

Dr. Shiraz Asif,

Family Dental Care,

Minneapolis, MN

shares his experience with dental therapy:

https://www.youtube.com/watch?v=nGQmHPonScM

Dr. John Powers, of Main Street Dental, reports that his employment of DTs has resulted in:

- Providing care to more patients. Patients who previously were not able to obtain dental care because of low government health care program reimbursement rates are now being seen in their practice and receiving dental care. The low payment rates made it cost prohibitive for a dentist to provide routine dental services but financially beneficial if provided by a lower cost DT.
- Allowing the dentist to focus on more complex cases that require greater training and skill and for which payment rates are higher. For example, the dentist has been able to provide more dental implant and cosmetic dental services and perform more sedation dentistry because the DT could provide the routine dental services needed by patients.
- Increased revenues and profitability. Employing DTs made it possible to both increase the volume of services and reduce the per-service cost of providing services, resulting in an improvement in total revenues and clinic profitability.

Urban Hospital

At Hennepin County Medical Center (HCMC)[53], an urban, safety net hospital located in Minneapolis, Minnesota, DTs are currently integrated into the hospital's care team in three different ways:

- As part of HCMC's own dental clinic and dental services programs.

[53] http://www.hcmc.org/clinics/dentalclinic/HCMC_CLINICS_288

- In HCMC's Obstetrics (OB) clinic, where two dually licensed DH/DTs work three days per week to improve services to low-income pregnant women who have substantial dental care needs during pregnancy. Dental residents provide the new patient exams and treatment planning and the DTs work with the dental residents and collaborating dentists to complete the treatment plan. Allowing DTs to provide services within their scope of practice lowers the hospitals costs and makes these procedures more financially feasible under low government program payment rates.
- In HCMC's Coordinated Care Center, which is described in a later section on DTs in coordinated care models.

Federally Qualified Health Centers (FQHCs)

Minnesota's Federally Qualified Health Centers (FQHC), or Community Health Centers, are a source of community-based primary care to low-income, uninsured and under-insured Minnesotans. There are 17 FQHCs in Minnesota with more than 70 locations ranging from isolated rural communities to small towns and inner-city neighborhoods. The FQHCs are an integral part of the safety net system in Minnesota. In addition to providing primary care to their patients, most FQHCs also provide behavioral health and oral health services at the same location where medical services are provided. For more information on the FQHCs in Minnesota and their approach to health integration, visit the Minnesota Association of Community Health Centers[54] website.

As of April 2016, seven Minnesota DTs were employed by five different FQHCs. Feedback from FQHC employers of DTs has been positive. The comments of the chief dental officer of one urban FQHC are typical of the FQHCs' experience when he reported that working in a team with a DT has allowed his clinic to see more patients at a lower cost and freed him up to provide

[54] http://www.mnachc.org/index.html

more complex dental procedures. He reported that his patients have been very receptive to having dental care provided by a DT.

Two Minnesota FQHCs employing dental therapists are also educational training sites for the University of Minnesota School of Dentistry: Community University Health Care Center[55] and Native American Community Clinic[56].

Urban Non-Profit Dental Group

The HealthPartners Dental Group[57] was an early adopter of dental therapy into their oral health care model and has hired two DTs. HealthPartners has the largest number of Medicaid patients in the state. At the Midway clinic in St. Paul, 93% of patients are Medicaid patients. The clinic uses a dovetail and flex scheduling to accommodate emergencies. The DTs have allowed for cost containment and free the dentists to manage more complex procedures while DTs are the primary provider for children.

According to HealthPartners, the use of DTs has resulted in a 10.5 -11.4% increase in dentist production and reduced wait times for new patients.

Mobile Services in Community Settings

Children's Dental Services (CDS)[58] provides dental services to children up to age 26 and pregnant women across the state of Minnesota. Children's Dental Services hired the first dental therapist in 2011, and now employs three ADTs who are fully credentialed and able to work remotely in community settings without a dentist present.

[55] http://www.cuhcc.umn.edu/

[56] http://nacc-healthcare.org/

[57] https://www.healthpartners.com/hp/doctors-clinics/specialties/dentistry/index.html

[58] http://childrensdentalservices.org/

ADTs at CDS provide dental care at their two dental clinic locations in Minneapolis and at over 600 satellite locations including Head Start programs, elementary, middle and high schools, WIC clinics, public health facilities, and community settings. Forty-seven percent of the patients seen by ADTs are at their portable, satellite locations and 32% have been in rural Minnesota. A full range of preventive and restorative care can be provided in a satellite location, however if necessary, a patient is referred to a local dental office or back to one of their Minneapolis locations.

The integration of dental therapists into the CDS care team has shown a positive effect on financial viability, patient access and patient wait times at Children's Dental Services. One ADT providing services for 40 hours per week at a public health clinic saves $62,400 per year. Since 2011, CDS's ADTs have provided care to over 18,000 patients. Overall appointment wait times have decreased by two weeks and overall patient time with provider has increased by 10 minutes.

Another nonprofit dental provider, Apple Tree Dental[59], also uses DTs extensively in a hub-and-spoke model that uses advanced mobile equipment to deliver on-site care to elderly nursing facility residents, disabled adults living in group homes, residents of veterans' homes, low-income children at Head Start centers, schools, and other locations. Apple Tree also uses DTs to provide services in its six clinic offices in Minnesota. Their dental team includes two DTs and three ADTs.

Additional Lessons Learned from Early Employers

A number of lessons have been learned about hiring and integrating dental therapists into practice. Overall, the early employers have overcome initial challenges in hiring and integrating dental therapists through strong and consistent communication between team members, consulting colleagues and the education programs for clarity around dental therapy practice issues. Most employers are very positive about the addition of dental therapists or advanced dental therapists to their oral health teams. They note having a DT/ADT adds flexibility, variability and often economic benefits to their oral health teams. The complete integration did not come without challenges, but the added value has been worth the effort to overcome these challenges. Many dentists and clinic leaders have publically spoken in support of dental therapy:

[59] http://www.appletreedental.org/

- "We've had a full year of experience now with our two dental therapists, and I've had an opportunity to meet with employers of other dental therapist, and it's gone extraordinarily well." -Dr. Michael Helgeson, CEO of a nonprofit dental organization in Minnesota (http://www.pewtrusts.org/en/research-and-analysis/analysis/2014/10/02/working-with-midlevel-providers-dentists-perspectives)
- "While there is a shift in the number of services [provided by the DT] from quarter to quarter, the data demonstrates that the Dental Therapist is providing many services that increase access to care, and allows the dentists to pursue more complicated procedures…. Patients are very accepting of a dental therapist." – Lois Berndt, Dental Clinics Manager of an FQHC in St Paul.
- "Our new ADT, like each of the ADT and DT graduates [we] have hired, has been exceptionally well prepared to practice public health dentistry. She has established productive working relationships with colleagues and is on track to increase the number of underserved children and pregnant women served by approximately 2000 in her first year of employment." – Sarah Wovcha, ED of a nonprofit dental organization in Minnesota
- "All four dentists in my practice consider our dental therapist to be an outstanding co-worker and colleague. She is invaluable to our practice for her patient care, skills and professionalism. Our DT allows us to serve Medicaid and uninsured patients more economically. We recently celebrated her Advanced Dental Therapist licensure." – Dr. Adele Della Torre, founder of a dental practice in Minneapolis
- "Prior to [hiring an ADT], we held meetings with our doctors to provide information on how to work as a team with an ADT. The ADT received coaching from several doctors as she was integrated into the team, and was accepted by the clinic staff. The doctors welcomed her into their office and she was given a desk alongside theirs. The [dual-licensed] ADT had a full schedule, and when some patients cancelled or did not show, she was ready to jump in and provide hygiene services to other patients." – Carolyn Bass, clinic manager of a nonprofit dental clinic in St Paul.

- "The dentist actually has a better work scenario because of the dental therapists. The patients that the dentist is then treating have been prescreened, they have a higher level of need, and the need is more uniquely suited to what the dentist can provide." -Dr. Michael Helgeson, CEO of a nonprofit dental organization in Minnesota

- "I have more time for implants, I have more time for cosmetic dentistry, I have more time for sedation patients… I can do a lot more of the procedures that we tend to put off because we don't have the block of time to be able to do it." – Dr. John Powers**,** owner of a private dental practice in Montevideo, MN

9. Impact of Dental Therapists

Measuring the specific impact of dental therapy is difficult, in part because DTs and ADTs are working in a wide range of dental practices, seeing different types of patients, and providing a variety of services that most meet the needs of their practice. However, the picture of dental therapy's overall impact is coming into focus, and it is largely positive, with only a handful of negative examples.

In an effort to document the impact for this toolkit, dental providers who employ DTs and ADTs were contacted between April 2016 and August 2016 to complete a questionnaire and provide information related to wages, productivity, financial impact on the clinic, patient response and patient access and wait times. Results show that after five years of dental therapy experience in Minnesota and more than 60 DTs working in a variety of practices, the employment of DTs and ADTs is having a positive impact on patient access, clinic productivity and clinic finances without a reduction in quality of care, safety or patient satisfaction.

Among the 60+ working DTs, there have been only three instances identified where a DT was not successfully integrated into a practice. These happened due to either a lack of compatibility of the individual DT with the clinic that hired them, or because the hiring clinic was not well suited for a DT or not adequately prepared to integrate this new type of professional into the existing team.

Lessons Learned: Reimbursement and Financial

- When fully integrated and used in a practice, DTs and ADTs generate production and revenues that can produce a financial benefit to the employer. One employer reported that their DT brings in three to four times their salary per hour. Another employer expressed saving around $60,000 per year per ADT on the team.
- Typically, a ramp-up period of three to six months is needed for a new DT/ADT's production to reach the point where it is profitable for the professional. This is similar to and expected for any newly hired oral health professional.
- For most practices seeking to improve access for underserved populations, hiring a DT/ADT will be more cost effective than hiring a dentist.

"You're just introducing a new element that should be able to be bringing in more money into the practice."

Dr. John Powers, owner of a private dental

The lessons learned from the handful of negative experiences show that employers should thoroughly assess whether the DT model is right for them and, if it is, the practice should devote ample time and thought in deciding whether a particular DT is a good match for their clinic and dental team.

Impact on Patient Access

A major reason the Minnesota Legislature enacted the dental therapy act was to improve access to dental care for low-income, underserved, rural and special needs populations experiencing serious access problems. The law has exceeded even optimistic expectations of its impact. DTs are employed in a wide range of practice settings serving primarily these underserved populations. DTs can provide services in locations and settings where dentists are not available and can provide common, routine dental services at a lower cost to the clinic than a dentist. Reducing operating costs, increasing accessibility of services, and increasing the efficiency and productivity of the dental team has proven valuable in nearly every type of practice and clinic. This is especially vital for clinics who serve large numbers of low-income patients who are enrolled in government programs that pay low reimbursement rates or who are uninsured and unable to pay the full cost of care. *Table 5,* details firsthand clinic reports of the number of patients and the percentage of low-income, uninsured or underserved patients served.

TABLE 5: IMPACT ON ACCESS TO CARE FOR LOW-INCOME, UNDERSERVED, UNINSURED PATIENTS

Clinic Type	DT/ADT impact on access	Clinic Percent of MA/MNCare patients
Private	"In 2012, we opened our door to Medicaid/Medicare insurance programs."	91% seen by DTs
Non-profit	"Since December of 2011, DTs/ADTs combined have provided care to over 14,000 patients. On average over five years, this would be 2,800 patients per year."	85% and 14% uninsured
Non-profit	"Able to see a significant amount of more patients because of hiring dental therapists, directly with the patients the therapist sees but also indirectly with the increased access that the therapist creates for the rest of the team. Our dental therapists have had a significant role in increasing the access for our patients."	95% seen by DTs; 81% before hiring of DT
Private	"Employment of DT increased the number of patients on MA or MNCare; Percentage of revenue received from MA or MNCare is 12%."	Not reported
FQHC	"An estimate would be approximately 3,072 more patients per year between the 2 of them (dental therapist)."	Nearly 100%
Private	"Percent of patients on MA or MNCare has decreased 2%."	Not reported
Non-profit	"Totally depends on provider. Generally speaking, we feel an additional DDS or DT will enable our clinic to serve more patients."	84%
Non-profit	"We have been able to improve access to care and provide key services to a greater number of patients."	93%

Data Sources: Questionnaire responses collected for this toolkit, April and August 2016; Presentations at the Pew Charitable Trust Dental Therapy Site Visit, July 2016; and the MDH webpage on DT: http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index2.html

Data Sources: Questionnaire responses collected for this toolkit, April and August 2016; Presentations at the Pew Charitable Trust Dental Therapy Site Visit, July 2016; and the MDH webpage on DT: http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index2.html

Impact on Patient Wait Times

Dental practices employing DTs have reported a range of impacts on patient wait times, from decreases of several months to an increase in wait times to see emergency patients. Some examples are listed in *Table 6*.

TABLE 6: IMPACT ON PATIENT WAIT TIMES

Clinic Type	DT/ADT impact on wait times	Comments
Private		"Schedule began to be overbooked and patients were scheduling 3-4 months out. Another DT was added and as of today, the DTs schedules are booked 1-2 months out."
Non-profit	Decreased by 2 weeks	"Overall patient time with provider has increased by 10 minutes."
Non-profit		"DTs have opened time with the dentists to see patients for limited exams. As we collect more data we will have the ability to quantify this impact."
FQHC	Decrease from 7 months to 4 months earlier this year for restorative appointments	"Dentists can now see more denture, endo and oral surgery patients much faster than they could before."
Private	Longer wait time for advanced care in some cases when DT employed instead of dentist	"Because DTs are not authorized to provide the full scope of practice as a dentist, if a DT is hired instead of a dentist, patients needing more advanced care may have longer wait times if another dentist is not available to provide these services until later."
Non-profit	Decreased	"Wait time for new patients has decreased."

Data Sources: Questionnaire responses collected for this toolkit, April and August 2016; Presentations at the Pew Charitable Trust Dental Therapy Site Visit, July 2016; and http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index2.html

Financial Benefits to Dental Practices

Surveys, interviews and other methods of obtaining information from Minnesota DT employers were used to gather information for this toolkit. Nearly all Minnesota's DT employers have found DTs to be a financially beneficial addition to their dental teams. The financial benefit results from a combination of factors, including the lower cost to the clinic of providing routine dental services through a DT rather than a dentist, the DT's contribution to greater efficiency and productivity of the entire dental team, and the ability of dentists working with a DT in the

practice to spend more of their time on more complex and highly reimbursed services and procedures.

Minnesota's experience with DTs so far, while still based on a relatively small sample of clinics, has clearly shown that DTs can improve access to oral health services and improve the financial bottom line in the following types of dental practices as well as other settings not listed here:

- Private dental clinics in any geographic region, both urban and metropolitan
- Federally Qualified Health Centers
- Large dental group practices
- Nonprofit and community-based dental providers
- Organizations providing oral health services in community locations outside of dental clinics such as schools, Head Start programs, nursing homes and veteran's homes.
- Hospitals and hospital-based dental clinics
- Educational Institutions and teaching clinics
- Dental providers serving the elderly and people with disabilities or special needs
- Clinics serving culturally and socio-economically diverse patients

The following are selected examples of DT employers' reports on the impact of hiring a DT on their productivity and financial bottom line. The experiences and results will vary for each clinic and employers should be cautious when applying the results of other similar clinics to their unique circumstances.

Table 7, below, shows a sampling of clinic reports on productivity and financial return of DT/ADTs which are representative of the experiences of most of Minnesota's DT employers.

TABLE 7: SAMPLE REPORTED IMPACTS ON PRODUCTIVITY AND FINANCIAL RETURN

Clinic Type	DT/ADT impact on productivity and financial return
Private	"In 2012, the first year of DT employment, production increased by $300,000 and collections by $115,000. In 2015, with three DTs employed, production increased by $730,000 and collections by $330,000 over the previous year."
Non-profit	"Average production of ADT is consistently higher than average team production. In 2013, average ADT production is $365 per hour compared to team average of $337."
Non-profit	"Since June 2015, production has increased 5%."
FQHC	"We have experienced increased productivity and revenue due to the DTs on staff. Increased revenue of $8448 per week after payment of salaries, not including overhead expenses."
Non-profit	"Initial calculations reflect the ADT/DT cost per unit of care is 32-35% lower compared to our Dentists."

Data Source: Questionnaire responses collected for this toolkit, April and August 2016; Presentations at the Pew Charitable Trust Dental Therapy Site Visit, July 2016; and
http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/index.html#toolkit

Factors and Variables Affecting Financial Impact

Each dental practice understands its own market, budget, and potential for growth. While it is not possible to provide universally applicable guidelines on DT productivity, types of services, revenues generated and financial impact, it is possible to define the factors a practice should weigh when deciding whether to hire a DT. For example, the productivity and services of an ADT who sets up mobile dental equipment in a rural community, and provides services to families in a Head Start program will differ greatly from those of a DT who works in a large, urban dental clinic with a high volume of complex patients. The experience will also differ based on whether the DT has advanced practice certification or holds a dual dental hygiene license and provides both dental hygiene and dental therapy services. Other factors that contribute to variation between practices are the needs and characteristics of the patients served, the level of supervision required, and the conditions and protocols in the CMA.

<u>Factors and variables affecting the impact of the employment of DT/ADTs on dental practices are:</u>

- Location and type of clinic
- Number of patients needing oral health care
- Types of patients needing care (adults, children, seniors, patients with disabilities, etc.)
- Types of oral health services provided
- Insurance payer mix (commercial, government programs, uninsured)
- Clinic-specific payment rate (and for FQHCs, the type of FQHC payment methodology and the clinic's dental encounter rate)
- Practitioner compensation levels (Wages and Benefits)
- Availability of DTs and supervising dentists
- Acceptance and ongoing support from dentists and other team members.
- Whether the DT is dually licensed as a dental hygienist or has advanced practice certification
- The authorizations and protocols in the DT's CMA
- Socio-economic and demographic characteristics of patients (language barriers, transportation, cultural barriers)
- Productivity levels of dental team members (DDS, DT, DH, DA)
- Clinic space, capacity and configuration

- For mobile dental services:
  - Type of team and team members used
  - Type of setting (nursing home, school, dental clinic, group home, etc.)
  - Configuration of space at remote location.
  - Mobile equipment costs
  - Transportation
- Ramp-up time when productivity of the DT and supervising dentist may be lower

While the DT role is flexible enough to provide opportunities for a broad range of dental practices, it is not possible to include specific case study examples in this toolkit for every combination of the major factors and variables that will determine the financial impact of employing a DT in a particular dental practice. That stated, there are specific details and resources available within this toolkit document, in related toolkit materials, and in other cited sources that will enable potential employers to assess the potential impact on their own practice, given their unique circumstances.

Writing a formal or informal business plan is a good way to develop and display these components in detail. There are numerous dental practice business plan guides and templates available online, including Guidelines for Developing Business Plans from the American Dental Association.[60]

Technical assistance may also be available to potential employers to help them complete this assessment. Interested employers may contact Minnesota's DT educational institutions or MDH to learn more about what assistance may be available from various sources.

[60] http://success.ada.org/en/practice-management/finances/guidelines-for-developing-business-plans

10. Integration into New Care Models

Accountable Care Models and DT/ADTs

Although dental services are not yet commonly included in new health care delivery models, DTs have the potential to provide substantial value in emerging new health care practice models and payment methods. Responding to government- and employer-driven health reform pressures and marketplace trends, many health care provider organizations are planning and implementing new care delivery models and operating under alternative care delivery and payment approaches, such as Health Care Homes and Accountable Care Organizations (ACO).[61] Health Care Homes are designed to promote team-based, coordinated, patient-centered care. ACOs are designed to create greater provider accountability and financial incentives to achieve the Triple Aim, improving health outcomes and the patient experience while reducing the total cost of care.

In Minnesota, a number of organizations participate in federal ACO models, such as the Medicare Shared Savings or Pioneer ACO programs. Many more participate in the Minnesota-specific Medicaid ACO, known as Integrated Health Partnerships (IHPs),[62] or have entered into value-based payment arrangements with commercial insurers. Fifteen communities around the state have also established Accountable Communities for Health (ACH),[63] which are broad partnerships between health care providers (including ACOs) and community partners designed to move towards accountability for community-level health outcomes.

[61] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACO

[62] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

[63] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACH

With stronger incentives to produce better outcomes at a lower cost, providers are developing new ways to deliver and coordinate care across multiple sectors of health care and community services and are making workforce changes, including using more mid-level, paraprofessional, and new types of workers who are able to serve in diverse and nontraditional settings, work within teams to increase access to care in a cost effective way and successfully engage patients in managing their overall health and health care needs. In Minnesota, this framework is known as the Minnesota Accountable Health Model.[64]

Care Coordination Models and DT/ADTs

A cornerstone of emerging new care delivery and payment models such as ACOs, IHPs, ACHs and other accountable health models is coordination of all health care services needed by an individual in order to achieve better health and treatment outcomes and reduce the total cost of health care across a population of patients. In response to incentives and requirements from government programs, health plans and employers, health care providers and health systems are moving toward using primary care-based delivery models that provide care through integrated, inter-professional teams who coordinate all services needed by a patient under a shared, patient-centered care plan. DTs and ADTs will play a valuable role in these models as part of larger team of dentists, doctors, nurses and other professionals who coordinate both the oral health and medical services needed by a patient. The strategy for integrating DTs and ADTs into a patient's team will depend upon the specific setting and may vary from patient to patient.

The State of Minnesota has not mandated that oral health services be integrated into its Integrated Health Partnerships, or into Health Care Homes, but integration is encouraged by the state. Additionally, a number of organizations already integrate oral health and general health care in their practices. Some are early adopters and leaders who have voluntarily included oral health in their coordinated care or value-based payment models.

For more information on Minnesota's health care reform models, see the Summary of Health Reform Models[65] prepared as background for this toolkit.

[64] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home

[65] http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreform2016.pdf

Examples of DT/ADTs in new models of care

FQHC Urban Health Network (FUHN)

Minnesota FQHCs strive to provide fully coordinated culturally tailored services to meet the medical, dental, behavioral health needs of their diverse patients, and they also provide additional enabling services to address socio-economic barriers such as poverty, homelessness and language barriers. Ten FQHCs in the Minneapolis-St. Paul metropolitan area have formed an Accountable Care Organization (called an Integrated Health Partnership[66] in Minnesota's Medicaid Program) to provide enhanced integrated and coordinated care under reform payment models. As the state continues its move toward integrated care and increasingly brings oral health into the new models, FUHN will have increased opportunities to expand coordination of oral health services and DT/ADTs are expected to play an important role.

Community University Health Care Center (CUHCC)

At the Community University Health Care Center (CUHCC), care coordination[67] is designed to help patients achieve their health goals. The clinic has staff such as a CUHCC care coordinator, interpreter, and various providers who all work together across medical disciplines. In one effort, an ADT works with a pediatric nurse practitioner (NP) to identify the dental status of patients on the NP's schedule. The ADT is available to see those patients with a dental need in CUHCC's dental department or facilitate appropriate follow up care.

Coordinated Care Center at Hennepin County Medical Center (HCMC)

The Coordinated Care Center[68] at HCMC is an award-winning health care delivery model aimed at providing coordinated team-based primary care for patients with complex health problems thereby improving outcomes while also reducing the overall cost of care by reducing emergency room (ER) visits and inpatient admission rates for these patients. The clinic currently uses other care delivery professionals that are particularly useful in care coordination for patients with complex socio-economic barriers, including Community Health Workers and Social Workers, in addition to traditional health care providers. Dental care is currently being

[66] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441;

[67] http://www.cuhcc.umn.edu/patient-care-services/care-coordination-services

[68] http://www.hcmc.org/clinics/HCMC_P_048828

integrated into the Coordinated Care Center, which will use dental therapists three days a week, dental hygienists two days a week and tele-dentistry between this clinic and the main dental clinic at HCMC.

11. Resources

The following list of links is a summary of important resources detailed in the relevant sections. There are also additional resources and documents that prospective employers may find useful.

Regulation and Scope of Practice

- Summary of Dental Therapy Regulatory and Payment Processes
    - http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreg2016.pdf
- Board of Dentistry: Scope of Practice Information
    - DT: https://mn.gov/boards/assets/Dental%20Therapist_tcm21-46114.pdf
    - ADT: https://mn.gov/boards/assets/Adv%20Dental%20therapist_tcm21-46115.pdf
    - Delegated Duties of DT and ADT: https://mn.gov/boards/assets/DT%20Chart%20BA_tcm21-262696.pdf
- DT and ADT Enabling Legislation:
    - https://mn.gov/boards/assets/enabling Legislation_tcm21-46113.pdf

Education and Training

- University of Minnesota Dental Therapy Program
    - https://www.dentistry.umn.edu/degrees-programs/dental-therapy
- Metropolitan State University and Normandale Community College Dental Therapy Program
    - http://www.mnscu.edu/college-search/public/institution/programProfile?rcId=0076&progId=8619
- Continuing Education Core Subject Areas, MN Board of Dentistry
    - https://mn.gov/boards/assets/2%20Core%20subjects%20rev%209-2016_tcm21-256192.pdf

Hiring, Onboarding, and Integration

- ADT Certification Application
    - Certification Process: https://mn.gov/boards/assets/Adv dental therapy certification process_tcm21-46119.pdf
    - Patient Record Summary: https://mn.gov/boards/assets/Adv dental therapy patient record summary_tcm21-46120.pdf
    - Application Form: https://mn.gov/boards/assets/Adv dental therapy certification app_tcm21-46122.pdf

Checklist for Considering Dental Therapy in a Practice

Follow these steps when hiring a dental therapist or advanced dental therapist for your oral health care team.

Determine your practice's eligibility to employ a dental therapist or advanced dental therapist.

Eligible practice Settings

- Settings that serve low-income, uninsured and underserved patients:
    - Critical Access Dental Provider, as defined in MS 256B.76 Subd 4
    - Military/Veterans administration hospital, clinic, etc.
    - Private Residences for home-bound patients
    - Oral Health Education Institutions
    - Clinics in which at least 50% of the DT patients consist of patients who:
        - Are enrolled in a MN Health Care Program
        - Have a medical disability/chronic condition that creates an access barrier
        - Have no health coverage and have gross family income <200% federal poverty level

- Dental Health Professional Shortage Are
    - The U.S. Department of Health and Human Services Health Resources and Service Administration (HRSA) maintains a data warehouse[69] for identifying health profession shortage areas by a clinics address.
    - The Minnesota Department of Health has information on the Dental Health Professional Shortage Areas in Minnesota.[70]

Recruit a dental therapist or advanced dental therapist

- Prepare a job description
- Send information to the dental therapy educational programs or to the Minnesota Dental Therapy Association for distribution to dental therapists
- Consider compensation, hours, liability insurance

Prepare office and clinic staff for DT/ADT

- DT/ADT scheduling
- Education and training on DT and ADT scope of practice
- Discuss communicating with patients about DT/ADT

Complete logistical steps in order to bill for DT/ADT services

- Credential the dental therapist or advanced dental therapist with the MN State Department of Human Services
- Create and submit a Collaborative Management Agreement (CMA) to the Board of Dentistry

Prepare an orientation for your dental therapist or advanced dental therapist

- Similar to hiring other oral health professionals, the therapist will need an orientation on clinic culture, practice policies, and practice protocols, etc.

[69] http://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx

[70] http://www.health.state.mn.us/divs/orhpc/images/shortage/hpsadtrural.pdf

Sample Job Posting

DENTAL THERAPIST

Minnesota

The Dental Clinic, an award winning dental clinic, is expanding and will be hiring an Advanced Dental Therapist. We are looking for a caring ADT to join our great support staff to expand the high quality dental care and education The Dental Clinic has been well known since 2006.

The Dental Clinic uses the latest technology which allows our professional staff to provide efficient delivery of high quality patient care in an environment that shows we care greatly about our patients, our staff and their families.

The Dental Clinic believes that a quality dental provider deserves a commensurate salary based on the quality, not volume, of their work, as well as benefits, including; paid vacation, matching IRA, health insurance, CE/License reimbursement, ADA/MDA memberships, liability insurance, scrubs and coats, and sick and personal days. We also provide a sign-on bonus to help you with moving costs.

The Minnesota area offers numerous gorgeous lakes for fishing and fun, excellent schools, quality health care, theatre, lots of golf, and much more. Go to; minnesota.org to learn more about this great area in which to live and work.

Come join our exceptional crew, dedicated to their profession and to helping people.

Please contact Dr. Tooth, CEO of The Dental Clinic, to plan a visit or to submit a resume; drtooth@molars.com

Visit our website to view the latest information and news at The Dental Clinic.

Sample Patient Quality and Satisfaction Survey

We appreciate and value your feedback so that we may provide a quality experience for all of our clients. Thank you! Please rate your level of satisfaction regarding the following items:

	Strongly Agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly Disagree (1)
Were you able to get an appointment in a timely manner?					
Were you referred by a hospital/urgent care clinic for emergency dental care?					
Were you greeted promptly and in a courteous manner?					
Were you seen for your appointment in a timely manner?					
Was your dental provider professional and courteous?					
Was your provider sensitive to your treatment needs?					
Was the dental treatment explained so you were able to understand?					
Were all of your questions answered completely to your satisfaction?					
Were you confident with the dental treatment that was completed?					
Were you comfortable during the procedure?					
Was the dental treatment completed in a timely manner?					

	Strongly Agree (5)	**Agree (4)**	**Neutral (3)**	**Disagree (2)**	**Strongly Disagree (1)**
Was your dental treatment completed to your satisfaction?					
Were you satisfied with your overall dental experience?	No data	No data	No data	No data	No data
	0-6 months	6-12 months	1-2 years	2-5 years	>5 years
How long has it been since your last dental visit?	No data	No data	No data	No data	No data
	1-4 days	5-7 days	1-2 weeks	2-3 weeks	>3 weeks
How long after you made appointment did it take to get in to see a provider?					

Additional Comments:

Patient Quality and Satisfaction Survey Example provided by the University of Minnesota, School of Dentistry

Supervision

- Collaborative Management Agreement information from MN Board of Dentistry
    - DT: https://mn.gov/boards/assets/Dental%20Therapist%202_tcm21-46117.pdf
    - ADT: https://mn.gov/boards/assets/ADV%20Dental%20Therapist%202_tcm21-46118.pdf
- Guide for Evaluation of Dental Therapy, funded by the Robert Wood Johnson Foundation: https://www.westat.com/sites/westat.com/files/Dental_Therapy_Evaluation_Plan.pdf

Insurance and Billing

- Summary of Dental Therapy Regulatory and Payment Processes
    - http://www.health.state.mn.us/divs/orhpc/workforce/emerging/toolkit/dtreg2016.pdf
- DHS Provider Manual
    - DT: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166842
    - ADT: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166843

Video Testimonials

- The PEW Charitable Trusts series of videos: *Working with Midlevel Providers*: Dentists' Perspectives & Testimonials. http://www.pewtrusts.org/en/research-and-analysis/analysis/2014/10/02/working-with-midlevel-providers-dentists-perspectives
- Dr. John T. Powers: https://youtu.be/fP7M2hRzCrU
- Dr. Asif: https://youtu.be/nGQmHPonScM
- Ms. Christy Jo Fogarty: https://youtu.be/ZRa1N0O8cMk
- Dr. David Gesko: https://youtu.be/CBhkukfWslM
- Dr. Leon Assael: https://youtu.be/98Qbe0BaanM
- Dr. Michael Helgeson: https://youtu.be/VsI6K-cisLI

Relevant Statutes

Minnesota State Laws Containing References to Licensing and Regulatory Requirements for Dental Therapists and Advanced Dental Therapists:

- MS 150A.01 Subdivision 5a, Dental therapist
- MS 150A.01 Subdivision 1a, Advanced dental therapist
- MS 150A.05 Subdivision 1b, Practice of dental therapy
- MS 150A.05 Subdivision 2, Exemptions and exceptions of certain practices and operations
- MS 150A.06 Subdivision 1, Licensure
- MS 150A.06 Subdivision 2d, Continuing education and professional development waiver
- MS 150A.06 Subdivision 5, Fraud in securing licenses or registrations
- MS 150A.06 Subdivision 6, Display of name and certificates
- MS 150A.08 Subdivision 1, Grounds
- MS 150A.08 Subdivision 3a, Costs; additional penalties
- MS 150A.08 Subdivision 5, Medical examinations
- MS 150A.09 Subdivision 1, Registration information and procedure
- MS 150A.09 Subdivision 3, Current address, change of address
- MS 150A.091 Subdivision 2, Application fees
- MS 150A.091 Subdivision 3, Initial license or registration fees
- MS 150A.091 Subdivision 5, Biennial license or registration fees
- MS 150A.091 Subdivision 8, Duplicate license or registration fee
- MS 150A.091 Subdivision 10, Reinstatement fee
- MS 150A.10 Subdivision 1, Dental hygienists
- MS 150A.10 Subdivision 2, Dental assistants
- MS 150A.10 Subdivision 3, Dental technicians
- MS 150A.10 Subdivision 4, Restorative procedures
- MS 150A.11 Subdivision 4, Dividing fees
- MS 150A.12 Subdivision, Violation and defenses
- MS 150A.21 Subdivision 1, Patient's name and Social Security number
- MS 150A.21 Subdivision 4, Failure to comply
- MS 151.01 Subdivision 23, Practitioner
- MS 144.1501 Subdivisions 1-4, Loan Forgiveness
- Minnesota Laws 2009, Chapter 95, Article 3, section 31, Impact of Dental Therapist

NEWSLETTERS & ARTICLES OF INTEREST

Experts Develop Model Dental Therapy Regulations

FOR IMMEDIATE RELEASE
Jan. 26, 2022
Contact: Jack Cardinal, 781.960.5208, jcardinal@communitycatalyst.org

(BOSTON, MA) – Today, the National Partnership for Dental Therapy (NPDT) announced the release of the Model Dental Therapist Rule and Best Practices Guide (the Model Rule), which will support the implementation, regulation and growth of the dental therapy profession. It was written by the National Model Dental Therapy Rule Panel, a group of 15 experts with extensive experience in the regulation of dental professions, administrative law, Tribal law and dental therapy.

"The release of the Model Rule is another positive step in getting dental therapists into the field to provide effective, equitable and community-informed treatment to historically-excluded populations," said Tera Bianchi, program director for the Dental Access Project at Community Catalyst, a co-chair of NPDT.

The Model Rule will provide guidance to policymakers, state licensing agencies, dental boards, Tribes, dental and nonprofit organizations, and other interested stakeholders in states that enacted dental therapy legislation and are planning regulatory implementation. This publication is another valuable tool for the development of state-level infrastructure for dental therapy education, practice and implementation. Other fundamental resources include model dental therapy legislation and the Commission on Dental Accreditation's (CODA) national dental therapy education standards.

Kristen Mizzi Angelone, senior manager at The Pew Charitable Trusts, said, "The Model Rule provides evidence-based guidance that states need to develop rules to regulate the licensure and practice of this growing dental profession in the U.S. Along with the model legislation and CODA standards, this publication offers state stakeholders a foundation of dental therapy resources and reference materials as they move to authorize the practice of dental therapy, educate dental therapists, and then integrate these providers into their dental delivery systems—improving oral health and increasing access to care."

Dental therapists, skilled dental professionals similar to physician assistants in medicine, have been working around the world for 100 years and in the U.S. since 2005, beginning in Alaska Native communities. They are currently authorized to practice in a dozen states around the country, but many states have yet to complete the complex rulemaking process.

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About The National Partnership for Dental Therapy:

Co-chaired by Community Catalyst, the National Indian Health Board and the National Coalition of Dentists for Health Equity, the goal of the National Partnership for Dental Therapy is to elevate the

visibility and broad, multi-sectorial support for dental therapy as an evidence-based way to improve access to oral health. We believe all communities could benefit from dental therapists, but the focus of the Partnership is improving access to much needed dental care to communities where the needs are the greatest.

MODEL DENTAL THERAPIST RULE

Composed by

The National Model Dental Therapy Rule Panel

2022

Table of Contents

DENTAL THERAPY ADMINISTRATIVE RULEMAKING

Introduction, guidance and best practices for stakeholders and state government leaders

Introduction and Overview

Dental therapists are skilled dental professionals, similar to nurse practitioners or physician assistants in medicine. They work as part of a dental team alongside dental hygienists and dental assistants under the supervision of a dentist. They provide preventive and routine restorative procedures, including exams and fillings, to children and adults. They work in a variety of settings, but are trained to extend care into underserved areas, such as rural communities, nursing homes, and schools. Dental therapists have been practicing around the world for 100 years, and in the U.S. since 2005, beginning in Alaska Native communities. There is an extensive body of literature and research on dental therapy's history and outcomes showing that dental therapists provide safe, high-quality, cost-effective care to patients in Tribal health systems, nonprofit community clinics, traditional private practices, and other healthcare and community settings. Dental therapists are authorized by law or Tribal authority to practice in all or part of 13 states, but there is variation from state to state regarding their scope of practice, practice setting limitations, and other occupational parameters.

Health occupations are generally regulated by states and, in some instances, Tribal governments. State statutes or Tribal regulations commonly detail dental therapists' scope of practice, education, licensing and supervision requirements, and any limitations on where dental therapists may practice. Common regulatory provisions applicable to regulated occupations, such as license renewal and fees, discipline, and documentation of continuing education requirements, may be applied to dental therapists by statute or delegated to the regulatory agency and applied in rule. State statute usually assigns administration of dental therapy regulations to the board of dentistry or occupational licensing agency.

A major milestone in building the infrastructure for dental therapy took place in 2015, when the Commission on Dental Accreditation (CODA) adopted national accreditation standards for dental therapy education programs.[1] CODA is the national organization in the U.S. that evaluates and accredits education programs for all dental professions. In 2020, CODA accredited the country's first dental therapy program at Iḷisaġvik College in Utqiaġvik, Alaska.

Another milestone occurred in 2019, when the National Dental Therapy Standards Consortium, a consortium of individuals and organizations with extensive experience with the dental therapy profession, published the National Model Act for Licensing or Certification of Dental Therapists (the Model Act).[2] The Model Act provides guidance to policymakers, legislative staff, state agencies, licensing boards, oral health professionals, and consumer organizations working on legislation to authorize dental therapists in the U.S.

National Model Rule and Best Practices Guide

This Model Rule and Best Practices Guide represents another building block in the development of a standard state-level infrastructure and a shared knowledge base for dental therapy practice in the U.S. As with the Model Act, this publication will provide guidance to policymakers, state agencies, licensing boards and agencies, dental and nonprofit organizations, state governments, and other interested parties in states that enacted dental therapy legislation and are planning licensing and regulatory efforts. The model rule language will be useful to those drafting the regulations and participants in the regulatory process as they move through the rulemaking steps.

Administrative regulation is usually required following legislative enactment before licensing can begin. Practical regulation is important to safe and orderly dental therapy professional practice and to achieving dental therapy's potential to improve both access to dental services and oral health.

As a young health profession in the U.S., there is a relatively small body of common, professionally vetted experience to draw from as states consider developing dental therapy laws and regulations. Although the Uniform Law Commission provides states with "non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law,"[3] there is not a comparable reservoir of reference/standard administrative rules.

To fill that gap, this Model Rule and Best Practices Guide was developed through a consensus process by an expert panel comprised of national leaders in dental therapy, administrative rulemaking, and dental workforce regulation. In developing the guide and model rule, the National Model Rule Expert Panel drew from:

1. Experience and expertise of dental board and state agency leaders and of interested parties who have participated in dental therapy rulemaking to date.
2. Reference materials and sources, including state rule drafting manuals and literature on regulatory principles and best practices.
3. State dental therapy laws and dental therapy administrative rules adopted to date.

In contrast to the goal of legislation, which is to set public policy direction, the goal of administrative rulemaking is to effectuate the implementation of state statute consistent with law as efficiently as possible. Thus, the Model Rule and Best Practices Guide are focused on the technical and administrative aspects of launching and managing state licensing and regulation of dental therapists, rather than the substantive aspects of dental therapy legislation and statute.

National Model Dental Therapy Rule Expert Panel

The Model Rule and Best Practices Guide were developed and endorsed by a multi-disciplinary panel of national experts. Individuals were identified to serve on the review panel based on the following criteria:

- All panel members have expertise with the dental therapy profession, other oral health occupations, state administrative rulemaking, or with dental therapist rules and licensing.
- Panel membership is multi-disciplinary, representing boards of dentistry and other state regulatory agencies, state oral health programs, professional associations, and public interest organizations.

The panel approved, by consensus, the Best Practices in Dental Therapy Administrative Rulemaking and the National Model Dental Therapist Rule in the next sections. Staff support was provided by Mark Schoenbaum, MSW, consultant to states on dental therapy implementation.

National Model Dental Therapy Rule Panel members:

- Bridgett Anderson, LDA, MBA, Executive Director, Minnesota Board of Dentistry
- Kristen Boilini, PhD, MS, MA, Managing Partner, Pivotal Policy Consulting
- Michael Broschinsky, MPA, Director of the Utah Office of Administrative Rules and member, Administrative Codes and Registers Section of the National Association of Secretaries of State
- Allison Corr, MPH, MSW, Officer, Dental Campaign, The Pew Charitable Trusts
- Miranda Davis, DDS, Project Director, Native Dental Therapy Initiative, Northwest Portland Area Indian Health Board
- Christine Farrell, RDH, MPA, President, Association of State & Territorial Dental Directors and Director, Oral Health Program, Michigan Department of Health and Human Services
- Pamela Johnson, Project Manager, Native Dental Therapy Initiative, Northwest Portland Area Indian Health Board
- Deborah Kappes, MPH, RDH, Arizona Dental Hygienists' Association Advocacy Chair
- Alida Montiel, Director, Health & Human Services, Inter Tribal Council of Arizona
- Christina Peters, MJ, Project Director, Tribal Community Health Provider Project, Northwest Portland Indian Area Health Board
- Stephen Prisby, Executive Director, Oregon Board of Dentistry and President, American Association of Dental Administrators
- Kim Russell, MHA, Executive Director, Arizona Advisory Council on Indian Health Care
- Brett Weber, MPA, Public Health Policy & Programs Manager, National Indian Health Board
- Mary Williard, DDS, Capt. US Public Health Service, Dental Director, Ko-Kwel Wellness Center, Coquille Indian Tribe
- Amy Zaagman, MPA, Executive Director, Michigan Council for Maternal and Child Health

The Panel acknowledges the early research support of Sarah Radick and Cindy Schriber of Thomson Reuters.

Administrative Rule Defined

An administrative rule is "an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy...Rules that fall within the scope of authority delegated to the agency have the force and effect of law."[4]

Rules are developed and adopted ("promulgated") following enactment of legislation by executive branch boards or agencies in accordance with each state's Administrative Procedures Act (APA).

Overview

Dental Therapy Background

As of 2021, dental therapists are authorized to practice in all or part of 13 states by law or Tribal authority. State statutes or Tribal regulations commonly detail dental therapists' scope of practice, education, licensing and supervision requirements and any limitations on practice settings. Common regulatory provisions applicable to regulated occupations, such as license renewal and fees, discipline, and documentation of continuing education requirements, may be applied to dental therapists by statute or delegated to the regulatory agency and applied in rule. Statute usually assigns administration of dental therapy regulations to the board of dentistry or occupational licensing agency.

Rulemaking Background

Following enactment of a statute, rulemaking is generally initiated by the relevant board or executive branch agency to provide the details needed to implement the statute. Health professions rules typically include licensing and application details, fees, continuing education details, disciplinary procedures, code of conduct, and use of title expectations. Sometimes they also include requirements for educational institutions proposing to conduct dental therapy education in the state, advertising requirements or restrictions, and other provisions.

State APAs prescribe rulemaking steps, standards and timelines. APAs commonly detail requirements for public notice and participation, including providing for contested case hearings before an administrative law judge in certain circumstances. Requirements for a written rationale or cost estimate by the proposing agency and for maintaining an official rulemaking record may also be included in an APA.

Rulemaking is subsidiary to state statute as a form of law. As such, its limited purpose is to allow effective implementation of public policy decided by the legislature and signed into law by the governor. In other words, rulemaking is concerned with the process of implementing laws (the "how"), not the content (the "what"), unless there is a gap in

the law critical for its administration. Rulemaking should never cross the line into new deliberation and lawmaking by regulators, and APAs are designed to assure agency regulation stays within its implementation boundaries. Rule language that is proposed in response to statements such as, "Wouldn't it be a good idea if..." may raise a red flag that a proposal is in danger of exceeding statutory intent or the plain language limits of the law.

Rules that go beyond simply implementing statute can be rejected at the final approval or review step, which, depending on the state, may be the Attorney General, Secretary of State or a legislative body. Rules adopted that include language that strays too far from law can lead to additional legislative action following adoption to bring rules in line with legislative intent.

Dental therapists' scope of practice – what they can and cannot do – is most often explicitly detailed in statute. The accreditation standards by the Commission on Dental Accreditation (CODA) list the minimum procedures and services in which dental therapists must be proficient, and statute may reference these standards. Statute may also include procedures that are not part of the CODA standards.

Reviewing laws and rules for comparable advanced practice providers, such as advance practice registered nurses, physician assistants or clinical pharmacists may be informative.

Principles Regarding Rule Contents

Brevity, Clarity & Germaneness

1. Rules should generally include only provisions essential to implement the law as it was enacted.

2. Terms that have been defined in statute should not be redefined in rule. Administrative law attorneys often prohibit repetition of statutory language, except by reference as needed. "Reinventing the wheel" in rule is generally discouraged or prohibited. Language that was discarded in lawmaking and substantive provisions that were not addressed legislatively should not be included.

3. Language already in statute should not be repeated in rule. If statute later changes, duplicate statutory language in rule can require rule revisions that could have been avoided. In some states the practice is to list terms or provisions from statute with a citation or reference to the item's source.

4. Similarly, rules should use flexible language when there's a need to discuss topics like license examinations or continuing education details and courses. For example, rather than specifying a competency testing agency, use broader language requiring the use of a "board-approved clinical examination" or "competency-based clinical examination developed and scored by a board-approved clinical testing agency" or something similar, rather than naming a specific testing agency or exam. Although dental testing agencies such as the Commission on Dental Competency Assessments (CDCA) and Central Regional Dental Testing Services (CRDTS) administer dental therapist clinical exams, and other testing agencies, such as the Western Regional Examining Board (WREB), may develop dental therapist exams, this is an evolving aspect of dental therapist licensing. Naming a specific agency or test in rule may prevent a board from adjusting as the field evolves.

5. The responsibility of the board or rulemaking agency is to clarify and explain the legislation only to the extent needed to license and regulate the occupation as provided by the law. The deliberative policy process has been conducted and completed by the legislature before a rulemaking begins, and rulemaking should not be used to make or revise substantive policy.

6. Unnecessary provisions risk creating new regulatory burdens on regulated parties or artificial barriers to entry and should be minimized or avoided.

7. Regulators should seek uniformity with comparable rule provisions in other states so that, where applicable, license portability or reciprocity is straightforward.

8. Rule writers should use plain and direct language, including following any required construction and vocabulary standards, and avoiding double negatives. Avoid outdated terms now considered biased. Rules should be as short and straightforward as possible.

Need and Reasonableness Standard

Some states require regulators to justify and explain proposed rules or analyze costs and other burdens a proposed rule may create on regulated entities and state and local government. Regulation approval authorities (e.g., attorneys general, secretaries of state, agency commissioners, rule review panels) in the executive or legislative branch review these rationales as they conduct their final steps. Whether required or not by the APA or elsewhere in law, the exercise of articulating and defending a proposed rule can be helpful.

Core questions to ask and answer can include:

1. Is this provision, or a provision on this topic, necessary for implementation of the statute?

2. If more detail is needed for implementation on this topic, is the proposed provision a reasonable method for meeting the need?

3. Is the proposed provision consistent with the law's plain language or with legislative intent?

    a) Attempting to interpret legislative intent can be a fraught exercise and is best avoided, if possible. In some states, there may be judicial standards for determining intent, or there may be an explicit prohibition against executive branch agencies inferring intent at all. The most developed approaches to attempting to understand legislative intent are found in the judicial branch. As summarized by the Congressional Research Service, "judges often begin by looking to the ordinary meaning of the statutory text. Second, courts interpret specific provisions by looking to the broader statutory context. Third, judges may turn to the canons of construction, which are presumptions about how courts ordinarily read statutes. Fourth, courts may look to the legislative history of a provision. Finally, a judge might consider how a statute has been—or will be—implemented."[5] Again, this exercise is best avoided, and sticking by the ordinary meaning of the statutory text is the simplest and most easily defensible approach.

Best Practices

1. Study the technical and legal aspects of rulemaking in your state.

2. Become familiar with your state's APA.

3. The "personality" of rulemaking varies from state to state, as do points for public involvement, input, decision making and review. Learn the processes and structure for rulemaking in your state.

    a) Whether you are an advocate or state staff new to rulemaking, seek out someone who understands how the process usually flows and the impact points where decisions are made, such as in early informal input sessions, at the comments stage and in contested case hearings. Some boards of dentistry have standing rules committees that develop proposed rules. Some boards have formed ad hoc committees for dental therapy rulemaking. These committees may include non-board members.

    b) If your state agencies usually add in rule only minimal and essential language clearly absent from statute and clearly required for agency implementation, communicate the expectation that dental therapy rules follow this approach. If rules in your state often duplicate language from statute, that's probably the approach to be expected in dental therapy rulemaking.

4. Learn how rulemaking authorities communicate about the steps in the process and opportunities/methods for involvement and input. Sign up for listservs, official notification lists, and State Register notices. Be prepared to share information with your networks and engage them in providing feedback through public comment, public hearings, and at coalition and other meetings.

5. Some states produce a formal or informal/official or unofficial guide to rulemaking. Familiarize yourself with it if one is available in your state.

6. Learn the range of rule types (emergency, temporary, permanent) and rulemaking options (negotiated, non-contested, and contested) in your state to understand the procedures that will apply to the rules you're interested in.

7. Engage with stakeholders, and with regulators as appropriate, as early as possible.

8. Where essential details not provided in the statue must be added, consult the Model Act for guidance and consensus language. The Model Act includes detailed consensus language for provisions such as:

    - Reciprocity/licensing by credential,
    - Grandfathering pre-CODA accreditation graduates, and
    - Licensing standards for unique state scope items outside of core CODA curriculum.

TRIBAL REGULATION OF DENTAL THERAPISTS

Dental therapy in the U.S. began in 2005 under Tribal authority in Alaska, independent of any action by the state of Alaska and despite the absence of a state dental therapist licensing law. As of 2021, dental therapists are authorized to work in 13 states, including multiple states that only permit dental therapists to work in Tribal communities and facilities.

Tribal health and Tribal authority often intersect with state law and rules. The overview below is intended to alert those involved in rulemaking to be aware of and become familiar with these interactions so that Tribal and state dental therapy implementation occurs smoothly and without state/Tribal regulatory contradictions. State regulatory agencies are strongly encouraged to consult with Tribes throughout the rulemaking process.

Tribal governments have interest in and authority similar to that of states to regulate health occupations. Tribes as sovereign nations have a government-to-government relationship with the United States, and states do not have jurisdiction over Tribes except as delegated by Congress or determined by federal courts. In the area of health care, the federal government has a legal obligation through the trust and treaty responsibility to provide health care services to Tribes. The federal government created the Indian Health Service (IHS) to be the primary provider of this responsibility, and in the 1990s, Tribes began operating their own health care programs if they chose to do so. Now there are 132 self-governance agreements. In addition, federal law preempts state law when "state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[6]

Such is the case in Congress' establishment of the Community Health Aide Program (CHAP) in the Indian Health Care Improvement Act (IHCIA) in 1968. The IHS establishes education and practice standards for midlevel medical, behavioral, and dental health practitioners, including dental health aide therapists or dental therapists, who are certified by a CHAP Certification Board. Community health aides have worked in Alaska since the 1960s to combat unmet health needs in rural villages. Dental Health Aide Therapists in Alaska were added to CHAP through federal action in 2003.

Recognizing the success of these providers, under the 2010 amendment to IHCIA, Congress authorized the creation of a national CHAP to allow the use of community health aides for Tribes throughout the country. However, Tribes in the Lower 48 states are prohibited from employing dental therapists under CHAP unless located in a state where dental therapy services are authorized under state law. In these cases, dental therapists must comply with federal CHAP training and certification requirements, so Tribal coordination and involvement in state rulemaking is essential.

Tribes planning to implement dental therapy have options to provide the regulatory and public protection functions that usually accompany health occupational licensing and practice, including but not limited to:

1. Establish an area certification board and process under the federal CHAP Program. Currently, the Northwest Portland Area and Alaska Area operate CHAP Area Certification Boards, and the Billings Area has a CHAP Area Certification Board in development.

2. Establish reciprocity options to accept the certification of dental therapists certified by other CHAP Area Certification Boards.

3. Assert Tribal sovereignty and implement Tribal regulations for the practice of dental therapy. These services would only be available on Tribal lands and in Tribal facilities unless state law includes a provision that allows statewide practice for Tribally licensed or CHAP - certified dental therapists. Operating outside of state regulations and the IHS CHAP program may create challenges securing Medicaid or other reimbursement for dental therapist services. It would also exclude the providers from liability coverage under the Federal Tort Claim Act (FTCA).

4 Take no action. Dental therapists working for Tribes and Tribal facilities would be required to meet state licensing requirements.

The advantages and disadvantages of each option will vary by state and by Tribe.

The IHCIA establishes a multi-level regulatory structure for providers certified by CHAP, including dental therapists. Below is a brief overview of the CHAP regulatory structure, summarized from Indian Health Service Circular No. 20-06.

Certification Boards. Certification boards are the regulatory bodies for CHAP. All providers who wish to provide services under the CHAP must be certified by one of the following boards:

1. CHAP National Certification Board (NCB). The NCB is a federal board chaired by the IHS Chief Medical Officer (CMO) or his or her delegate and may be comprised of Federal and Tribal representatives from each Area Certification Board. Functions of the NCB and board composition are addressed in Circular No. 20-06's Standards and Procedures.

2. CHAP Area Certification Boards (ACBs). The ACBs are federal certification boards located in the contiguous 48 states and may be comprised of Federal and Tribal representatives. Their membership must include at least one

federal representative appointed by the respective IHS Area Director. The ACB establishes board composition in its standards and develops the procedures of each respective board to certify individuals as providers.

Standards and Procedures. In CHAP, Standards and Procedures serve the same functions as a medical or dental practice act and administrative rule.

1. National CHAP Standards and Procedures. Adopted in part from the Alaska CHAPCB Standards and Procedures to outline the minimum program standards for all CHAP provider types operating outside of Alaska. The National CHAP Standards and Procedures include, but are not limited to, the minimum training, training equivalency, supervision, and scope of practice requirements.

2. Area Standards and Procedures. At a minimum, the Area Standards and Procedures must include the National CHAP Standards and Procedures and may have additional supplemental requirements above and beyond the national standards that are specific to the cultural considerations of the region and community specific needs, as well as the health care delivery system.

Under CHAP, individual Tribes cannot amend or change the Standards and Procedures. Each regional board will have the ability to modify the National CHAP Standards and Procedures in order to address the specific needs in their area of the country, but these modifications will be subject to evaluation by the National CHAP Certification Board in order to ensure the modifications are in keeping with the spirit and character of the original Standards and Procedures.

Tribes and Tribal health organizations wishing to add dental therapists to their dental team should start by contacting their regional IHS Area Office.

As seen by this brief introduction, Tribal regulation of dental therapy and the interplay between Tribal and state regulation are complex issues, and an in-depth discussion is beyond the scope of this document. For additional resources, please see the appendix and the Tribal Oral Health Initiative of the National Indian Health Board.

MODEL DENTAL THERAPIST RULE

Conventions used in this document:

- "State-name" is the generic placeholder term where a specific state name would generally be used.
- "Board of Dentistry" and "Board" are used as placeholder names in this document for state dental or professional licensing regulatory agencies.
- Where the document shows examples of existing language edited to apply to dental therapists, proposed new language is underlined, and language proposed for removal is printed with ~~strikethroughs~~. Unchanged language appears without underlines or strikethroughs.
- Example references to a state's existing rules or statutes use the format "State-name Statute, section 123," "State-name Statutes, sections 123.456-789.012," etc. Official drafters in each state will modify these model rules for each state's format and construction requirements.
- "[Guidance]" is used to preface and identity recommendations from the National Model Rule Panel on a topic.

Overview

[Guidance] This model rule is constructed for use when an existing Board of Dentistry or other regulatory agency rule is being amended to add dental therapist licensing and regulatory provisions will be added. As such, it includes common health professional licensing and regulatory categories, with examples to illustrate the addition of dental therapists. It also includes new provisions that may be unique to dental therapist licensing and regulation.

1) SUPERVISION. [If not in statute]

2) LICENSURE BY EXAMINATION.

a) An applicant for dental therapist licensure by examination shall submit a completed application, on a form provided by the board, together with the requisite fee and shall meet all of the following requirements:

(i) Graduate from a dental therapy educational program that meets the standards in section 123.456.

(ii) Pass a comprehensive, competency-based clinical examination developed and scored by a board-approved clinical testing agency.

[GUIDANCE] Definitions of supervision levels should only be included if undefined in relevant statute or rule. Incorporation by reference may be appropriate; e.g., "General supervision has the meaning as defined in [add citation]."

[GUIDANCE] If limitations on the number of allied dental personnel a dental therapist may supervise are prescribed in statute, they need not be repeated in rule. If not in statute, such restrictions may go beyond legislative intent and should not be included.

[GUIDANCE] Arrangements and details for dentist supervision of dental therapists or dental therapist supervision of allied dental personnel may fit best in a collaborative agreement rather than in rule.

3) EXAMINATION OF DENTAL THERAPISTS.

a) Subp. 1. The examination of applicants for a license to practice dental therapy shall be sufficiently thorough to test the fitness of the applicant to practice dental therapy.

b) Subp. 2. Clinical examination. An applicant must pass a board-approved clinical examination designed to determine the applicant's clinical competency.

c) Subp. 3. Additional examination content. All applicants shall be examined for general knowledge of the act and the rules of the board. Additional written theoretical examinations may be administered by the board.

4) SCOPE OF PRACTICE. [If not in statute]

[DEFINITION] Use "board-approved clinical examination" or "competency-based clinical examination developed and scored by a board-approved clinical testing agency." Avoid naming specific testing agencies or exams, because this is an evolving aspect of dental therapist licensure.

[CAUTION] Naming a specific agency or test in rule may prevent a board from adjusting as the field evolves.

[DEFINITION] Scope of practice for dental therapists is detailed in statute in most states. Do not duplicate in rule language already found in statute. If state practice or stakeholder interest requires inclusion, use: "The scope of practice of a licensed dental therapist is set out in (cite Statute)."

[GUIDANCE] If scope of practice is not part of the statute and must be defined in rule, the scope found in the Model Act and the required services and procedures in the CODA standards can serve as a minimum scope of practice on which scope can be based.

5) LICENSURE BY ENDORSEMENT. [If not in statute, or if additional administrative details are required to implement]

6) COLLABORATIVE PRACTICE AGREEMENT. [If not in statute]

[GUIDANCE] Licensure by endorsement (or credential) for dental therapists should parallel rule language for dentists and dental hygienists. Because of variability in dental therapy licensing requirements, education standards, scope of practice, and terminology across jurisdictions, additional documentation may be needed to ensure applicants have received substantially equivalent training and experience as required by your state law. Consider language from the Model Act: "Licensing by credential is authorized for an applicant who holds a license or certification as a dental therapist, dental health aide therapist, or comparable professional in another state or Tribal jurisdiction."

[GUIDANCE] Collaborative practice agreement requirements and content may be detailed in statute. If so, add only necessary administrative requirements, if any (e.g. structure, filing instructions, and notifications). Rules should not be used to limit agreements in ways not explicitly provided in statute.

If collaborative practice language is needed, consult the collaborative agreement language in the Model Act, page 21.

Model Rule Language for Provisions Commonly Found in Dental Licensing and Regulation Administrative Rules

Applying standard licensing and regulation provisions can be as simple as adding the term "dental therapists" to existing language. In some instances, a parallel provision or section may need to be added, such as to specify dental therapist application details, fees or continuing education requirements. Some examples for common provisions are listed below.

Example 1 – Adding dental therapists to existing rules (from Minnesota rules):

DEFINITIONS. In these rules:

a) "Allied dental personnel" means the dentist's supporting team who receives appropriate delegation from the dentist or dental therapist to participate in dental treatment.

b) "Approved course" means a course offered by either a dental, dental therapy, dental hygiene, or dental assisting assistant program accredited by the Commission on Dental Accreditation or approved by the Board.

c) "Dental therapist" means a person licensed under State-name Statutes, Chapter 123, section 123, to provide the care and services and perform any of the duties described in State-name Statutes, Chapter 123, section 12.

[GUIDANCE] Only include definitions not found elsewhere in statute or in Board rules, or terms that have a different meaning when applied to dental therapist regulation or in its meaning in the specific section.

Example 2 – Adding dental therapists to existing rules (from Minnesota rules):

CONDUCT UNBECOMING A LICENSEE.

"Conduct unbecoming a person licensed to practice as a dentist, dental therapist, dental hygienist, or dental assistant, or conduct contrary to the best interests of the public," as used in State-name Statutes, section 123.456.

(A) shall include the act of a dentist, dental therapist, dental hygienist, licensed dental assistant, or applicant in:

(i) engaging in personal conduct that brings discredit to the profession of dentistry;

(ii) gross ignorance or incompetence or repeated performance of dental treatment that falls below accepted standards;

(iii) making suggestive, lewd, lascivious, or improper advances to a patient;

(iv) charging a patient an unconscionable fee or charging for services not rendered;

(v) performing unnecessary services;

(vi) dental therapists, hygienists, or licensed dental assistants performing services not authorized by the dentist under this chapter or in State-name Statutes, section 123.456.

Example 3 – Adding a parallel provision (from Vermont rules):

Renewal requirements.

(A) **Dentists.** To be eligible for renewal, a dentist must show:

(i) 30 hours of continuing education, including the emergency office procedures course, CPR course, and opioid-prescribing education where applicable; and,

(ii) active practice of at least 800 hours or 100 continuing education credits with in the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.

(B) Dental Therapists. To be eligible for renewal, a dental therapist must show:

(i) (# of hours in statute, if in statute) hours of continuing education, including the emergency office procedures course and the CPR course; and,

[GUIDANCE] See the discussion on making conforming changes to existing provisions in the Model Act, page 23, for additional guidance.

[GUIDANCE] If continuing education, fees or other such requirements for dental therapists are not specified in statute, rule makers may want to consider requirements that fall between those required for a dental hygienist and a dentist.

(ii) active practice of a least (# of credits in statute, if in statute) hours or (# of credits in statute, if in statute) continuing education credits within the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.

(C) **Dental Hygienists.** To be eligible for renewal, a dental hygienist must show:

(i) 18 hours of continuing education, including the emergency office procedures course and the CPR course; and,

(ii) active practice of a least 100 hours or 50 continuing education credits within the previous five years. A combination of practice hours and continuing education credits may be used. An applicant for renewal who has not met minimum practice-hour requirements must complete one of the clinical examinations required for initial licensure.

(D) **Dental Assistants.** To be eligible for renewal, a dental assistant must show 9 hours of continuing education, including the emergency office procedures course and the CPR course. A radiography specialty may be renewed only if the bearer has completed training within the preceding ten years or practiced radiography under the supervision of a licensed dentist within the preceding five years.

Other Common Provisions: Amending the standard provisions below can be as simple as adding the term “dental therapists” to existing language

1) Approval of dental professions schools; standards; adoption by reference
2) Licensing
   a) Incomplete applications
   b) Additional information from all applicants
   c) Terms and renewal of license or permit; general
   d) Terms and renewal of licensure; limited faculty and resident dentists
   e) Reinstatement of license
   f) Fees
3) Complaints
4) Suspension or revocation of license or registration
5) Statutory grounds for discipline
6) Conduct unbecoming a licensee
7) Voluntary termination of license
8) Allied dental personnel
9) Dental treatment records; requirements
10) Use of title
11) Display of license
12) Limited licenses; issuance; requirements

APPENDICES

I. Model Rule Expert Panel Members

II. Resources and References

a. References

b. Definition and Purpose of Administrative Rules – Some Examples

c. State Dental Therapy Rules Status

d. Endnotes

National Model Dental Therapy Rule Expert Panel – Panel Member Bios

Bridgett Anderson, LDA, MBA, is the Executive Director of the Minnesota Board of Dentistry, with over 20 years of experience in the dental field. Previously she was the Director of Regulatory Affairs with the Minnesota Dental Association. Her expertise ranges from clinical dentistry, previously as a licensed dental assistant and dental office manager, to dental safety, prevention and regulation, and as a lecturer in dental therapy and to providing guidance on regulation of dental therapy to other state boards. She holds an MBA degree from Bethel University, St. Paul, MN.

Kristen R. Boilini, PhD, MS, MA, is the managing partner of Pivotal Policy Consulting, a full-service public policy and government relations firm. She brings over 25 years of professional experience in the development and implementation of health care policy and reform efforts, with an emphasis on increasing access to care in tribal and underserved communities. She led the efforts to build the coalition supporting dental therapy (DentalCare4Az) in her home state of Arizona and served as the government relations lead in passing Arizona's dental therapy legislation in 2018. Kristen remains active in implementing Arizona's dental therapy law, including the promulgation of rules for the licensure and regulation of dental therapists, as well as working with educational institutions to develop dental therapy training programs.

For over two decades, Kristen has represented clients within the public policy arena across a diverse range of industries. She first developed her depth, knowledge and unique perspective on public policy serving in two gubernatorial administrations, where she developed agency budgets, created and implemented a variety of public finance and tax policy initiatives, as well as assisted state agencies to streamline and enhance the productivity of government operations. In these roles, Kristen developed a keen, in-depth understanding of state budgeting and the appropriations process, public finance, tax policy and government operations.

Today, Kristen's practice is quite diverse. She is a trusted advisor and advocate, working with a variety of clients in areas ranging from education and higher education to healthcare, tribal and municipal governments, housing and economic development interests, as well as serving clients in the business and non-profit sectors. Clients know and trust her not only for her knowledge and experience, but for the deep passion she brings to their issues. Kristen holds an MS in Economics, an MA in Human Development, and a PhD in Organizational Development.

Michael Broschinsky, MPA, is the director of Utah's Office of Administrative Rules. His academic training is in political science (BA 1987, University of Utah) and public administration (MPA 1992, University of Utah). Mike is a member of the Administrative Codes and Registers Section of the National Association of Secretaries of State. He is also an adjunct instructor in political science at Salt Lake Community College. Mike lives with his wife, three daughters, one grandson, and two cats in Taylorsville, Utah.

Allison Corr, MPH, MSW, is an officer for the Dental Campaign at the Pew Charitable Trusts. She has more than a decade of experience in federal and state health policy and research. At Pew, she manages efforts to improve access to oral health care, including work to authorize and implement dental therapy in states around the country. Previously, Allison worked on a range of health care issues for the Energy and Commerce Committee of the U.S. House of Representatives. She holds master's degrees in public health and social work from Columbia University and a bachelor's degree in psychology from the University of Virginia.

Miranda Davis, DDS, MPH, is the project director for the Native Dental Therapy Initiative at the Northwest Portland Area Indian Health Board. The mission of the Native Dental Therapy Initiative is to connect Tribal communities with innovative approaches to address AI/AN oral health disparities, to remove barriers impeding the creation of efficient, high quality, modern dental teams and to provide opportunities for AI/AN people to become oral health providers. Dr. Davis has provided clinical care with Tribes in the northwest for 15 years, in addition to several years of private practice and international volunteer work. She is passionate about public health, disease prevention, and expanding access to high quality oral health care. Dr. Davis graduated from the University of the Pacific Arthur A. Dugoni School of Dentistry. She holds a master's degree in public health from the University of Washington and a bachelor's degree from the University of California, Los Angeles.

Christine M. Farrell, RDH, BSDH, MPA, is the Oral Health Program Director for the Michigan Department of Health and Human Services. She has over 30 years of public service with the MDHHS since 1988 and has been the Oral Health Director since June 2010. She has a wealth of knowledge at both the state and federal levels and a great deal of experience advising public health staff and partners on a vast array of program, financial and administrative issues related to oral health, dental public health, Medicaid, and prevention programs. In addition, her duties include ensuring the oral health program effectively educates the public about oral health issues as well as the implementation of preventive activities to improve the oral health of Michigan residents throughout their lifetime. She is currently the President of the Association of State and Territorial Dental Directors (ASTDD). Chris received both her bachelor's degree in dental hygiene and a master's degree in public administration from the University of Michigan.

Pamela Johnson is a project manager for the Native Dental Therapy Initiative at the Northwest Portland Area Indian Health Board, where she leads the advocacy work to establish laws and policies necessary for dental therapists to thrive in Tribal communities across Washington, Idaho, and Oregon. Pam has 30 years of experience advocating for progressive change in environmental and health policy. She is a graduate of Pacific Lutheran University.

Deborah Kappes, MPH, RDH, is a staunch advocate of dental therapy in Arizona. As chair of the Arizona Dental Hygienists' Association's Advocacy Committee, Deborah

worked closely with the Dental Care for Arizona Coalition, lobbyists, and legislators to craft and pass dental therapy enabling legislation. Currently, Deborah is serving on the Rules Advisory Group for the Arizona State Board of Dental Examiners developing dental therapy administrative rules for the Board's consideration.

During her professional career, Deborah has been engaged in private practice dental hygiene and retired as a professor at Phoenix College where her primary role was full-time dental hygiene educator and included eight years serving as the dental department chair overseeing the dental hygiene, dental assisting, and continuing dental education programs. As a volunteer, Deborah has collaborated with many organizations to advance oral health including the American Dental Hygienists' Association, the Arizona Public Health Association, the Arizona Dental Association, the Arizona State Board of Dental Examiners, the Arizona Department of Health Services, and the Arizona Oral Health Coalition. Deborah earned a dental hygiene degree from Phoenix College, a bachelor's degree in community health education from Arizona State University, and a master's degree in public health from the University of Arizona.

Alida Montiel

Inepo Alida Montiel, Anía Voa, tea
Ínto Hiaki, Maayo, Mexica hamut
Lios enchim nauwerim

Ms. Montiel is the Director of Health & Human Services at the Inter Tribal Council of Arizona (ITCA). Since 1990, her principal responsibility is to analyze and address health policy formation at the direction of Tribal Leaders in Arizona, Nevada and Utah served by the Phoenix Area IHS, ranging from federal, state or specific Tribal policies and budgetary issues that affect the AI/AN health care system. In January 2019, she stepped into the management of all health and human service related projects at ITCA. She currently serves as the chairperson of the Arizona Advisory Council on Indian Health Care and is a member of the Arizona Behavioral Health Planning Council. These councils monitor and advocate for services provided to clients through Medicaid, the Children's Health Insurance Program and block grants awarded to the state.

Ms. Montiel has an Associate's Degree in American Indian Studies from Deganawidah-Quetzalcoatl University in Davis, California, a Tribal Management Associates Degree from Scottsdale Community College and a Bachelor's degree in Sociology from Arizona State University. Ceremonial responsibilities encompass Yaqui/Mayo life ways and a teacher of traditional Aztec (Mexica) Dance, a designation received in 1986, from her Elders.

Christina Peters, MJ, is the director for the Tribal Community Health Provider Project at the Northwest Portland Area Indian Health Board, where she and her team assist Tribes in Oregon, Washington, and Idaho as they explore opportunities to tackle important social determinants of health such as educational attainment, financial security, and

access to health while improving the system of health care through the implementation of the Community Health Aide Program. The TCHP Project focuses on breaking down barriers to education and care and dismantling the institutionalized and structural racism that denies health equity and educational attainment to Tribal communities. She received a bachelor's degree in economics from the University of Washington and a Master of Jurisprudence from the University of Washington School of Law.

Stephen Prisby has served as the Executive Director for the Oregon Board of Dentistry since 2015 and has been with the Board since 2012. His previous work experience was in higher education where he served in roles as a Campus Director and Director of Enrollment. He is the President of the American Association of Dental Administrators. The state of Oregon recently enacted new legislation - HB 2528 (2021) - that will require the Oregon Board of Dentistry to issue dental therapy licenses and promulgate rules to regulate this new type of licensee. The Oregon Board of Dentistry was created in 1887 and is the oldest health licensing regulatory board in Oregon.

Kim Russell, MHA, is of the Bitter Water People, born for the Tangle People. Her maternal grandfathers are of the Coyote Pass Clan and her paternal grandfathers are of the Bitter Water People. Ms. Russell is from Chinle, Arizona, and a citizen of the Navajo Nation. Ms. Russell is the Executive Director of the Arizona Advisory Council on Indian Health Care, an independent state agency whose mission is to advocate for increasing access to high quality health care programs for all American Indians in Arizona. Kim has worked with Tribes, Tribal Organizations, the Indian Health Service, and Urban Indian Health Programs to advance their health agendas and priorities her entire career. Ms. Russell received her Bachelor of Science degree in Biology and a Master's of Health Administration. Kim enjoys spending time with family and traveling.

Brett Weber, MPA, serves as a Public Health Policy & Programs Manager in the Public Health Department at the National Indian Health Board. Prior to NIHB, Mr. Weber worked at the United States Senate Committee on Indian Affairs as a Policy Fellow where he worked on health, environmental, energy, and other issues for then Vice Chairman Jon Tester (D-MT). He has also worked as an intern at the White House Office of Public Engagement and Intergovernmental Affairs. Mr. Weber completed his master's degree in Public Administration from the University of Georgia (Go Dawgs!). He also holds a bachelor's degree in Political Science.

Mary Williard, DDS, is a commissioned officer with the US Public Health Service/Indian Health Service detailed to the Coquille Indian Tribe in southwestern Oregon, where she is the Dental Director of the new dental clinic in the Ko-Kwel Wellness Center. She graduated from The Ohio State University College of Dentistry in 1994 and completed a 2-year General Practice Residency at the Carolinas' Medical Center in Charlotte, North Carolina in 1996. Dr. Willard's previous work includes having been the director of the first ever CODA accredited dental therapy educational program in the U.S., the Alaska Dental Therapy Educational Program.

Amy Zaagman, MPA, is the Executive Director of the Michigan Council for Maternal and Child Health, an organization of diverse partners comprised of hospital systems, statewide organizations, local public health advocates and individuals with an interest in shaping and influencing state policy that promotes the health and well-being of women, children and families in Michigan since 1983. MCMCH was the lead organization of the MI Dental Access coalition that developed and successfully lobbied for the 2018 dental therapy licensing act in Michigan. Amy and MCMCH continued advocacy throughout the rule-making process and are also engaged in ongoing promotion and implementation efforts for dental therapy.

Amy has been with MCMCH since 2009 and is a passionate advocate for improving health outcomes and ensuring equitable access to care and prevention services across the life course. Previously, Amy was the associate director of the state's community mental health association and served for over 13 years in various roles in the state Legislature. She holds a BBA and MPA from Western Michigan University.

Mark Schoenbaum, MSW, is a consultant on health workforce issues, working with states, health care organizations, higher education and other stakeholders. He is also Adjunct Health Policy faculty, University of Minnesota.

Mark was in a unique leadership position throughout Minnesota's consideration and development of dental therapy before retiring from a 38-year career in government and public health. As Director of Minnesota's Office of Rural Health and Primary Care from 2005 - 2018 he played an influential role in the process through which dental therapy became law and grew into an integral profession alongside other dental disciplines. He was lead staff to the 2008 Oral Health Practitioner Work Group that developed dental therapy recommendations for the state legislature and represented the Minnesota Department of Health during the 2009 legislative session's enactment of Minnesota's dental therapy law. He built relationships between the health department, the Medicaid agency, higher education and dental stakeholders, sponsored the 2014 report Early Impacts of Dental Therapists in Minnesota, chartered Minnesota's multi-stakeholder Dental Therapy Research Group, and developed toolkits for prospective dental therapy employers.

Mark is recognized as an expert on health workforce, scope of practice, licensing and emerging health professions issues. He directed health care workforce research and development for the health department, staffed the Minnesota Legislative Health Care Workforce Commission and led Minnesota participation in National Governor's Association and National Conference of State Legislatures scope of practice and health workforce Policy Academies. Mark holds an MSW from the University of Minnesota and a BA from Antioch College.

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Definition and Purpose of Administrative Rules – Some Examples

DEFINITION

The APA describes rulemaking as the "agency process for formulating, amending, or repealing a rule." A "rule," for purposes of the statute, is defined expansively to include any "agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency." Rules that are issued in compliance with certain legal requirements, and that fall within the scope of authority delegated to the agency by Congress, have the force and effect of law.

Garvey, T. (2017). Brief Overview of Rulemaking and Judicial Review. Congressional Research Service (CRS R41546). https://sgp.fas.org/crs/misc/R41546.pdf

PURPOSE STATEMENTS

1. The purpose of administrative rules is to accomplish the ends sought by legislation enacted by the General Assembly. Thus, "[r]ules promulgated by administrative agencies are valid and enforceable unless unreasonable or in conflict with statutory enactments covering the same subject matter."

   State, Ex Rel. Curry, V. Indus. Comm., 58 Ohio St.2d 268, 389 N.E.2d 1126 (1979)

2. If an administrative rule either adds to or subtracts from a legislative enactment, it creates a clear conflict with the statute, and the rule is invalid. "A rule that is in conflict with the law is unconstitutional because it surpasses administrative powers and constitutes a legislative function."

   Crawford-Cole v. Lucas County Department of Job & Family Services, 6th Dist. No. L-11-1177, 2012-Ohio-3506

3. The purpose of administrative rules is to limit the abuse of public power by public administrators either for self-interested or other ends.

   Spicer, M. W. (1995). *The Founders, the Constitution, and Public Administration: A Conflict in World Views.* Washington, DC: Georgetown University Press.

4. Purpose of Administrative Rules: Administrative rules are often written to define and describe how legislation will be implemented and enforced.

   State of Iowa, Office of the CIO. (n.d.). Administrative Rules Overview - Iowa Administrative Rules. Retrieved January 8, 2021, from https://rules.iowa.gov/info/rules-overview

DENTAL THERAPY STATE RULES STATUS						August 2021
	ALASKA	**MINNESOTA**	**MAINE**	**VERMONT**	**WASHINGTON**	**ARIZONA**
Date DT Law Passed	Tribal authorization in 2003	2009	2014	2016	2017	2018
DTs in Practice	36: 1st in 2005	100: 1st in 2011	1: 1st in 2021		8	
Status of DT Licensing and Rulemaking	CHAP Certification Board (CHAPCB). Standards & Procedures — equivalent to combined statute and rules. Alaska Tribal Health Consortium administers the CHAPCB.	DT licensing integrated into existing Board rules in 2011.	Rules adopted in April 2020.	Interim rules in place that allow for licensure. Draft rules submitted to Office of Professional Regulation for formal rulemaking process.	The Swinomish Indian Tribal Community adopted the Tribal Dental Health Provider Licensing and Standards Code in 2015. Law only authorizes practice in Tribal and related settings with CHAP certification. No state rules.	Draft rules under discussion by Board workgroup. State license not required for practice in Tribal and related settings.
Education and Clinical Hour Requirements	No minimum degree requirement. Alaska DHAT Educational Program or program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	Bachelor's degree for DT. Master's degree for advanced DT (ADT). 2,000 hours under direct supervision to become ADT.	Master's degree. Program that is CODA accredited or approved by BOD rule. 2,000 supervised hours for licensure.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.	No minimum degree requirement. Alaska DHAT Educational Program or a program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.
Notes	Practice limited to Tribal and related settings. Iḷisaġvik College's DT Program received CODA accreditation in 2020.	Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	On-site ("direct") supervision.	Must be a licensed dental hygienist for initial DT license but not for renewal.	Practice limited to Tribal and related settings.	Must be a licensed dental hygienist for initial DT license but not required for renewal. Practice limited to safety-net, public health, or non-profit settings, or private practices that serve patients referred by community health centers.

DENTAL THERAPY STATE RULES STATUS							August 2021
	MICHIGAN	**NEW MEXICO**	**IDAHO**	**CONNECTICUT**	**MONTANA**	**NEVADA**	**OREGON**
DT Law Passed	2018	2019	2019	2019	2019	2019	2021 (DT pilot projects began in 2016)
DTs in Practice			1 (pending pathway for pre-CODA graduates)				5
Status of DT Licensing and Rulemaking	Rules adopted in April 2021.	Rules adopted in May 2021. State license not required for practice in Tribal and related settings.	Rules are in effect as of 2020, pending legislative ratification. DT practice with state license and is limited to Tribal and related settings.	Rulemaking yet to begin.	No state rules. Law only authorizes practice in Tribal and related settings with CHAP certification.	Rulemaking process is underway. Licensure application is published.	Draft rules under discussion by BOD workgroup. State license not required for practice in Tribal and related settings.
Education and Clinical Hour Requirements	No minimum degree requirement. CODA accredited program. 500 hours under direct supervision as part of DT education program.	No minimum degree requirement. CODA accredited program. 1,500 - 2,000 hours for general supervision.	No minimum degree requirement. CODA accredited program. 500 hours under direct supervision for licensure.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.	No minimum degree requirement. Alaska DHAT Educational Program or a program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program. 500-1,500 hours under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program.
Notes	Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	Must be a licensed dental hygienist. Practice limited to Tribal, safety-net, public health, or non-profit settings.	Practice limited to Tribal and related settings.	Must be a licensed dental hygienist. Practice limited to "public health facilities" as defined in state statute.	Scope limited to preventive services. Practice limited to Tribal and related settings. Law sunsets in 2023.	Must be a licensed dental hygienist. Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	DTs practicing under pilot authority will be eligible for state license; DTs practicing for Tribes will not be required to get licensed. DT pilot project authority sunsets in 2025.

Endnotes

1 Commission on Dental Accreditation. (2015). *Accreditation Standards for Dental Therapy Education Programs*. https://coda.ada.org/~/media/CODA/Files/dental_therapy_standards.pdf?la=en

2 National Dental Therapy Standards Consortium. (2019). *National Model Act for Licensing or Certification of Dental Therapists*. https://www.dentaltherapy.org/resources/file/Dental-Therapist-National-Standards-Report-and-Model-Act_FINAL.pdf

3 Uniform Law Commission. (2021). *Uniform Law Commission: About Us*. Retrieved January 8, 2021, from http://www.uniformlaws.org/aboutulc/overview

4 Administrative Procedure Act, 5 U.S.C. § 551. (2021). Retrieved August 1, 2021, from https://www.law.cornell.edu/uscode/text/5/551

5 Garvey, T. (2017). *Brief Overview of Rulemaking and Judicial Review*. Congressional Research Service (CRS R41546). https://sgp.fas.org/crs/misc/R41546.pdf

6 Cornell Law School, Legal Information Institute. (n.d.) Preemption and reciprocity. Retrieved August 1, 2021, from https://www.law.cornell.edu/cfr/text/24/3282.11

Oregon Health & Science University names new dental school dean

Dr. Ronald Sakaguchi assumes role after serving as interim dean since October 2020

The Oregon Health & Science University's School of Dentistry announced Dec. 2 that it named Ronald Sakaguchi, D.D.S., Ph.D., as its new dean, assuming the role after serving as interim dean since October 2020.

Dr. Sakaguchi, a widely published dental biomaterials and biomechanics researcher, joined the OHSU School of Dentistry in 1994. He served in several dental school leadership roles over the years, including as the school's associate dean for research and innovation.

"I am committed to fostering an inclusive environment for learning and health care where everyone can thrive, as well as building an infrastructure that engages our community and partners, and enhances our education, clinical and research excellence," Dr. Sakaguchi said in a news release.

Dr. Sakaguchi received his doctoral degree from Northwestern University, and earned a Ph.D. in biomaterials and biomechanics from the University of Greenwich. He received training as a prosthodontist at the University of Minnesota School of Dentistry, where he became a member of its Department of Oral Sciences faculty and joined its Minnesota Dental Research Center for Biomaterials and Biomechanics.

He is a fellow and has served in leadership roles with the International Association for Dental Research and Academy of Dental Materials. He was an associate editor of the scientific journal Dental Materials and served as senior editor of Craig's Restorative Dental Materials 14th edition textbook.

"I am confident Dr. Sakaguchi's leadership will enhance the learning and health care environment in the School of Dentistry by building on existing strengths and forging new and meaningful paths to success across clinical, research and education systems while advancing diversity, equity, inclusion and belonging," said OHSU President Danny Jacobs, M.D.

Article by **Kimber Solana**

Published December 03, 2021 via https://www.ada.org/

Annual Report 2021

The report of the Commission on Dental Accreditation

CODA

Commission on Dental Accreditation

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The Commission's mission, vision and values were adopted August 5, 2016 in accordance with the development of the 2017-2021 Strategic Plan.

Mission

The Commission on Dental Accreditation serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Vision

The Commission on Dental Accreditation is a globally recognized leader for accrediting educational programs in the dental professions.

Values

The Commission is committed to:

***Integrity*: The quality of being honest, accountable, and principled.**

***Collegiality:* Working respectfully and collaboratively toward a common purpose.**

***Transparancy:* Being open about the process by which accreditation standards and policies are developed and implemented.**

***Consistency:* Fairness, objectivity, and the reliability of outcomes.**

Introduction

Who We Are

From 1937 to 1974, prior to the formation of the Commission on Dental Accreditation (CODA), the American Dental Association's Council on Dental Education (now known as the Council on Dental Education and Licensure) served as the accrediting agency for dental and dental-related education programs. In 1973, the House of Delegates of the American Dental Association approved the establishment of a Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. The Commission began operating in 1975, and in 1979 this body's name was officially changed to the Commission on Dental Accreditation.

Since 1952, the Commission on Dental Accreditation, and its predecessor, has been recognized by the Secretary of the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. CODA's mission is to serve the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. The general public and communities of interest have direct access to many important resources through CODA's website. The Commission also makes available to the public its Meeting Agenda and Materials in an effort to demonstrate transparency to its communities of interest. Additionally, updated information about CODA's activities is available by reviewing information in Accreditation Updates.

The Commission on Dental Accreditation accredits dental education programs, advanced dental education programs and allied dental education programs in the United States. The Commission also accredits fully-operational international dental education programs. The Commission functions independently and autonomously in all matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process. It is structured to include an appropriate representation of the communities of interest.

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Commission Structure

Site Visit Teams

The foundation of the accreditation process is the site visit, and the primary role of the Site Visit Team is to gather and evaluate data and facts. Members on each team can include those with expertise in the discipline, biomedical sciences, clinical sciences, curriculum, finance, or national licensure. To maintain accreditation, programs self-assess their compliance with CODA's accreditation standards and provide CODA with documented evidence through the Self-Study process. CODA's site visitors review such materials, visit programs to evaluate process, interview faculty and students/residents, tour facilities, and more in order to assess a program's compliance with CODA standards. The site visit team then clearly and comprehensively reports on its findings to the Review Committees and Commission.

Review Committees

Review Committees meet twice per year, two to three weeks before each Commission Meeting, to review reports submitted by Site Visit teams as well as programmatic reports and requests, and to discuss policy and procedures related to the committee's discipline. As of this publication, there are fourteen (14) Review Committees, each focused on one or more disciplines within dental education. Begining January 1, 2022, there will be seventeen (17) Review Committees, with the establishment of Review Committees for dental anesthesiology, oral medicine, and orofacial pain. These committees review and discuss the reports submitted by site visit teams and educational programs, and make recommendations to the Commission. The Review Committees also consider policy, some new and some annual recurring policy, which is applicable to the discipline. Note that the Review Committees do **not** make final accreditation or policy decisions – they instead make recommendations to the Commission, which then considers these recommendations at its Winter and Summer Meetings. In this regard, Review Committees are advisory to the Commission.

Commission on Dental Accreditation

The Commission on Dental Accreditation makes the final decision to grant, continue or withdraw an accreditation status to a dental education program. The Commission bases its decision on the program's compliance with the Accreditation Standards and Commission Policies. In this regard, the Commission continuously evaluates and monitors educational programs for compliance with the Accreditation Standards. The Commission also ensures Standards reflect the

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Composition of CODA Board of Commissioners

Organization	Appointments
American Dental Association (dental practitioners)	4
American Association of Dental Boards (licensure community)	4
American Dental Education Association (dental educators)	4
American Dental Education Association, Special Care Dentistry Association, American Society of Dentist Anesthesiologists, American Academy of Oral Medicine, American Academy of Orofacial Pain (joint appointment)	1
American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists (1 each)	9
American Dental Assistants Association (dental assistants)	1
American Dental Hygienists' Association (dental hygienists)	1
National Association of Dental Laboratories (dental laboratory technicians)	1
Public (consumers/public)	4
Student (American Dental Education Association, American Student Dental Association, joint appointment)	1
TOTAL	30

Note: Beginning January 1, 2022, the Commission will include Commissioners in the disciplines of dental anesthesiology (American Society of Dentist Anesthesiologists), Oral Medicine (American Academy of Oral Medicine), and Orofacial Pain (American Academy of Orofacial Pain)

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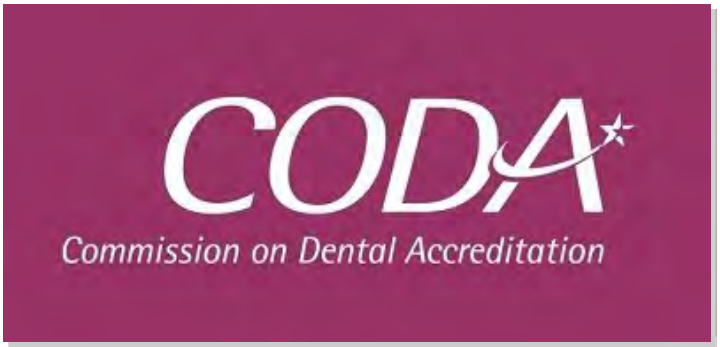
Continued from page 5

broad communities of interest related to the development and periodic revision of Accreditation Standards, thus ensuring the Standards remain current and define the quality of dental education. CODA maintains continuous contact with those important communities through various mechanisms. The Commission also establishes policies and procedures to guide the evaluation and decision making process to ensure fairness, consistency, and appropriate levels of due process.

Appeal Board

The principal function of the Appeal Board is to hear and make judgments on withdrawal of accreditation or denial of accreditation, at the request of an educational program or institution. The Appeal Board will determine whether the Commission on Dental Accreditation, in arriving at a decision regarding the withdrawal or denial of accreditation for a given program, has properly applied the facts presented to it. In addition, the Commission's Rules stipulate that the Appeal Board shall provide the educational program filing the appeal the opportunity to be represented by legal counsel and shall give the program the opportunity to offer evidence and argument in writing and/or orally to try to refute or overcome the findings and decision of the Commission. The Appeal Board is an autonomous body, separate from the Commission. Appeal Board members are selected in accordance with the Rules of the Commission on Dental Accreditation.



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The Year in Numbers

2021 February: Number of CODA-Accredited Programs

Discipline	Number of Programs	Approval without Reporting	Approval with Reporting*	Initial Accreditation	Approval without Reporting (teach out)	Approval with Reporting (teach out)	Initial Accreditation (teach out)
Predoctoral	67	63	2	2	0	0	0
Predoctoral International	1	1	0	0	0	0	0
Dental Assisting	238	233	2	1	2	0	0
Dental Hygiene	325	309	8	5	3	0	0
Dental Laboratory Technology	13	12	1	0	0	0	0
Dental Therapy	1	0	1	0	0	0	0
Advanced Education in General Dentistry	92	87	0	4	1	0	0
General Practice Residency	178	173	3	2	0	0	0
Orofacial Pain	12	10	0	1	1	0	0
Dental Anesthesiology	8	7	0	1	0	0	0
Oral Medicine	6	6	0	0	0	0	0
Oral Surgery (and clinical fellowships)	112	108	1	3	0	0	0
Orthodontics (and clinical fellowships)	73	72	0	0	1	0	0
Endodontics	55	54	0	1	0	0	0
Periodontics	56	54	1	1	0	0	0
Pediatric Dentistry	80	77	1	2	0	0	0
Prosthodontics (all, including MxPros and combined programs)	55	54	0	1	0	0	0
Oral and Maxillofacial Radiology	9	9	0	0	0	0	0
Oral and Maxillofacial Pathology	15	14	0	1	0	0	0
Dental Public Health	14	14	0	0	0	0	0
Ortho/Periodontic	1	1	0	0	0	0	0
TOTAL	**1411**	**1358**	**20**	**25**	**8**	**0**	**0**

*Includes programs on "Approval with Reporting Requirements," with "intent to withdraw" and "required period of non-enrollment" statuses.

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The Year in Numbers

2021 August: Number of CODA-Accredited Programs

Discipline	Number of Programs	Approval without Reporting	Approval with Reporting*	Initial Accreditation	Approval without Reporting (teach-out)	Approval with Reporting (teach-out)	Initial Accreditation (teach-out)
Predoctoral	67	63	2	2	0	0	0
Predoctoral International	1	1	0	0	0	0	0
Dental Assisting	240	232	4	2	2	0	0
Dental Hygiene	327	308	13	5	1	0	0
Dental Laboratory Technology	13	12	1	0	0	0	0
Dental Therapy	1	0	1	0	0	0	0
Advanced Education in General Dentistry	93	91	0	2	0	0	0
General Practice Residency	175	168	5	2	0	0	0
Orofacial Pain	12	12	0	0	0	0	0
Dental Anesthesiology	8	7	0	1	0	0	0
Oral Medicine	6	6	0	0	0	0	0
Oral Surgery (and clinical fellowships)	111	109	0	2	0	0	0
Orthodontics (and clinical fellowships)	73	72	0	1	0	0	0
Endodontics	55	53	1	1	0	0	0
Periodontics	56	55	1	0	0	0	0
Pediatric Dentistry	81	79	1	1	0	0	0
Prosthodontics (all, including MxPros and combined programs)	55	55	0	0	0	0	0
Oral and Maxillofacial Radiology	9	9	0	0	0	0	0
Oral and Maxillofacial Pathology	15	14	0	1	0	0	0
Dental Public Health	14	14	0	0	0	0	0
Ortho/Periodontic	1	1	0	0	0	0	0
TOTAL	**1413**	**1361**	**29**	**20**	**3**	**0**	**0**

*Includes programs on "Approval with Reporting Requirements," with "intent to withdraw" and "required period of non-enrollment" statuses.

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Total Enrollment in Dental Education Programs

Dental Education Area	Enrollment (difference from prior year)	Year
Predoctoral	25,995 (+188)	2020-2021
Advanced Education	7,343 (-12)	2020-2021
Dental Hygiene	16,178 (+44)	2019-2020
Dental Assisting	5,912 (-310)	2019-2020
DLT	470 (+5)	2019-2020
All Programs	**55,898**	**Source: Surveys of Dental Education Programs**

*Includes 638 students at King Abdulaziz University in Saudi Arabia.

You will find current Enrollment and other data on the Program Surveys page of the CODA website. Updates will be made to this page as available.

Programs, Volunteers, and Staff

- 1,413 CODA-accredited education programs in approximately 750+ institutions
- More than 600 Volunteer Commissioners, Site Visitors and Review Committee Members
- Eight Professional Staff
- One Coordinator of Operations
- Two Site Visit Coordinators
- Four Support Staff

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The Coronavirus Pandemic

In **2020**, as COVID-19 case rates rose and fell in every state, dental education programs and the Commission on Dental Accreditation had to manage the impact of the pandemic, while trying to balance and maintain the quality of educational programs.

The Commission conducted all of its work virtually, processing thousands of reports from CODA-accredited programs related to their response to the pandemic and their work to maintain the quality and efficacy of their educational programs. The Commission itself conducted all meetings virtually, including:

- More than 50 virtual Review Committee meetings
- Five virtual Commission meetings
- Five virtual webinars (with a grand total of almost 1,500 attendees)
- Four virtual public Hearings on Standards (with a grand total of more than 1,200 attendees)
- Digital versions of all Coronavirus-related announcements and guidance document
- Two days of virtual site visitor training
- Countless presentations to various audiences to provide updates
- Virtual Commission, Appeal Board, and Review Committee Member Orientations

Through the work of the Commission, following its July 9, 2020 special meeting, CODA staff deliver more than 1,400 digital accreditation letters related to temporary flexibility for the Class of 2020.

In **2021**, as the pandemic continued, the Commission and CODA staff remained committed to the Commission's mission of developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

The Commission launched its Electronic Accreditation portal to accept applications and self-study documents beginning in early February 2021. With the launch of the electronic portal, the Commission initiated its application review process through the E-Portal.

The Commission conducted a special meeting April 26, 2021 to consider temporary flexibility for the Class of 2021, and again CODA staff deliver more than 1,400 digital accreditation letters related to temporary flexibility. Flexibility for the Class of 2021 had previously been adopted by CODA in October 2020.

Following consideration of the report of its Ad Hoc Committee on Alternative Site Visit Methods, the Commission adopted the Policy on Temporary Use of Alternative Site Visit Methods, along with Site Visitor and Program Manuals on Alternative Site Visits to assist programs and CODA site visitors in preparing for the conduct of virtual or hybrid site visits. Webinars were offered to inform site visitors and programs of CODA's expectations.

The Commission began conducting virtual site visits in March 2021 and transitioned to hybrid and on-site visits, as appropriate, beginning in August 2021.

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2021 Highlights

CODA Adopts 2022-2026 Strategic Plan

The Commission engaged in a Closed Mega Issue Discussion on August 4, 2021 for the purpose of developing its 2022-2026 Strategic Plan. Following the Mega Issue Discussion, the Commission reviewed the report of the Standing Committee on Quality Assurance and Strategic Planning and adopted the proposed 2022-2026 CODA Mission, Vision and Values statements and 2022-2026 Strategic Plan, with implementation January 1, 2022.

The 2022-2026 Strategic Plan can be found at Mission Vision and Values

Finances

For 2021, the Commission:

- Adopted a 0% increase in annual accreditation fees for all domestic disciplines
- Maintained International fees
- Assessed the CODA Administrative Fund Fee of $25 per program in 2022

Find more details on the CODA website's Fees page.

Communication and Technology

The Commission has directed a review of the Communication Plan in 2022-2023 to ensure that the next communication plan addresses the Commission's strategic needs, as well as ongoing communication and technology needs of the Commission, including an electronic accreditation tool.

The Commission also continues its work to identify, secure, and develop a long-term solution for its electronic accreditation platform needs.

Submission of Petition for Re-recognition to the United States Department of Education

The Commission was informed by the United States Department of Education (USDE) that the re-recognition process would begin in Fall 2020. All agencies undergoing review by the USDE for recognition are expected to respond to all applicable criteria in their petitions. In mid-September 2020, Commission staff submitted CODA's petition to the USDE. As it reviews the Commission's petition, the USDE will send a representative to attend various Commission meetings and training sessions as an observer. The Commission's re-recognition process continued in 2021 with a file review conducted by the USDE. The Commission expects to complete the re-recognition evaluation by fall 2022.

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2021 Highlights

Ad Hoc Committees and their Progress

Ad Hoc Committee on Review Committee and Commission Structure and Function: Following review of the Standing Committee's report in Winter 2021, the Commission took several actions, including: 1) establishing separate review Committees for Dental Anesthesiology, Oral Medicine and Orofacial Pain; 2) directing appointment of three Commissioners, one for each area; 3) directing appointment of three Appeal Board members, one for each area; 4) updating CODA's Evaluation and Operational Policies and Procedures Manual; and 4) operationalizing the changes. The Commission also directed further review of CODA policies and procedures on CODA structure by the appropriate ad hoc or standing committee, which may include development of policies to initiate a discipline's oversight within the appropriate existing Review Committee, and require a minimum number of accredited programs and assurance of sufficient volunteers in the discipline, to warrant establishment of a separate Review Committee and additional Commissioner. Discussion of this topic occurred at the Strategic Planning Mega Issue Discussion.

Ad Hoc Committee on Educational Activity Sites: Following review of the Standing Committee's report in Winter 2021, the Commission took several actions, including:

1) directing the CODA Annual Surveys for dental and advanced dental education program be clarified related to questions on educational activity site usage;

2) directing all Review Committees to consider the Standards under their purview for potential revision to address expectations related to use of U.S.-based educational activity sites including, but not limited to: a) consideration of time away from the program and b) program use of best practices and quality assurance review systems to ensure calibration of faculty, and student/resident/fellow training and evaluation (formative and summative) comparable to the program's on-site clinic facility, with a report to the Commission in Summer 2021;

3) directing the use of international educational activity sites not be permitted until the Commission reviews, revises, adopts, and implements changes to its Accreditation Standards to address quality assurance and other expectations for the disciplines under CODA's purview, as noted above, related to use of domestic educational activity sites; and

4) directing that after Accreditation Standards are developed and implemented for the use of U.S.-based educational activity sites, the Commission review and revise its Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs to permit use of internationally located educational activity sites, as permitted by the discipline-specific Standards, and reported, approved and monitored by the Commission through its policies and procedures.

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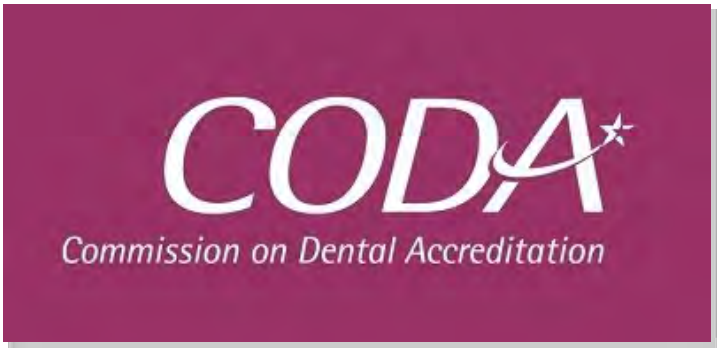
2021 Highlights

Ad Hoc Committee on Oral Medicine Reciprocity: Following consideration of a request from the Commission on Dental Accreditation of Canada (CDA), the Commission, at its February 2021 meeting, directed appointment of a Joint CODA-CDAC Ad Hoc Committee to examine the potential inclusion of Oral Medicine in the Reciprocity Agreement between the Commission on Dental Accreditation and Commission on Dental Accreditation of Canada.

Validity and Reliability Studies

Validity and Reliability Studies to occur in 2022 include the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry, Accreditation Standards for Advanced Dental Education Programs in General Practice Residency, Accreditation Standards for Advanced Dental Education Programs in Dental Public Health, and Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain.

The Commission's Policy on Assessing the Validity and Reliability of the Accreditation Standards states that the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of validity and reliability of these standards. When considering a comprehensive revision to standards, the validity and reliability of those standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. When the Commission revises policies or standards, it provides programs and the public with advance notice and a schedule for implementation.



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Annual Call for Nominations

The Commission on Dental Accreditation accepts nominations each year for volunteer Review Committee member and Site Visitor positions.

The mission of CODA is to serve the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. Accreditation is a peer-reviewed process, and CODA volunteers are an integral part of that process. The Commission provides comprehensive training to all its volunteers, so each will be ready to serve when their term begins. In addition, CODA staff is available for support throughout the process.

The Commission takes into account a balance in geographic distribution as well as representation of the various types of educational settings and diversity, including underrepresented groups. Board certification and experience requirements may apply.

The typical work of a Review Committee member includes the following:

- Review and become familiar with the CODA accreditation process, and participate in training at CODA headquarters.
- Review policy matters, site visit reports, progress reports and other reports on accredited or developing educational programs, which are submitted to the Commission for final action.
- Communicate by fax, electronic mail and the Commission's web-based communication tools.

  Time commitment can vary depending on committee assignment; however, CODA asks that you are willing to commit ten (10) to twenty (20) days per year to Review Committee activities.

The typical work of a Site Visitor includes the following:

- Attend training, conduct comprehensive review of print and electronically delivered materials and travel to Commission headquarters to learn and understand the requirements and guidelines for the accreditation of dental, advanced dental or allied dental educational programs.
- Objectively review materials which programs submit as evidence of the program's compliance with accreditation requirements.
- Visit educational programs to evaluate process, interview faculty and students/residents, view facilities, and more in order to assess the program's compliance with CODA standards.
- Develop reports on findings through review of the program's materials and on-site.
- Time commitment can vary; however, site visits are typically 1-4 days in length and require approximately 10+ hours of preparation. You may be asked so serve on at least 1 or more visits per year.

Nominating yourself or a peer is very straightforward. For a list of upcoming vacancies, the nomination criteria and nomination forms, as well as deadlines for nominations in each category, visit Call for Nominations, and then follow the instructions on that page.

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Accreditation Actions at the Winter and Summer 2021 Meetings

In 2021, the Commission reviewed accreditation reports and took **572 accreditation actions** on dental, advanced dental, and allied dental education programs and recorded **7 mail ballots** on dental, advanced dental, and allied dental education programs. A total of **11 new programs** were granted accreditation in August 2021:

Educational Program	Number
Predoctoral Dental Education	1
Dental Assisting Education	2
Dental Hygiene Education	4
Advanced Education in General Dentistry	2
Clinical Fellowship in Craniofacial and Special Care Orthodontics	1
Pediatric Dentistry	1

The Commission affirmed the reported voluntary discontinuance effective date or planned closure date of the following education programs, at the request of their respective sponsoring institutions:

Educational Program	Number
Dental Assisting	2
Dental Hygiene	2
Dental Laboratory Technology	1
Advanced Education in General Dentistry	1
General Practice Residency	2
Orthodontics and Dentofacial Orthopedics	1

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Standards Revisions at the Winter and Summer 2021 Meetings

The Commission adopted revisions to the following Accreditation Standards:

February 2021

- Accreditation Standards for Dental Assisting Education Programs, specifically intent statements of Standards 3-3 and 3-7, with immediate implementation.
- Accreditation Standards for Dental Hygiene Education Programs, with an implementation date of July 1, 2022.
- Accreditation Standards for Dental Laboratory Technology Education Programs, with an implementation date of January 1, 2022.
- Accreditation Standards for Advanced Dental Education Programs in Endodontics, with an implementation date of July 1, 2022.
- Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery, with immediate implementation.
- Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery, with immediate implementation.
- Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery, with an implementation date of January 1, 2022.
- Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics, with an implementation date of July 1, 2022.

August 2021

- Accreditation Standards for Dental Education Programs, revision to the term "Should" within the Definition of Terms, with immediate implementation.
- Accreditation Standards for Dental Therapy Education Programs, revision to the term "Should" within the Definition of Terms, with immediate implementation.
- Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology, as a result of the 2021 Validity and Reliability Study, with immediate implementation.

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Online Resources

The Commission's website, at Commission on Dental Accreditation (CODA), offers a wide variety of Commission reports, data, and valuable information:

- Accreditation Standards are available under the Standards tab
- Search for CODA-accredited programs on the Find a Program page
- Visit the Call for Nominations page to learn about and submit Review Committee Member and Site Visitor nominations
- To see schedules of Site Visits, go to the Site Visit Process and Schedule page
- Acquire a current copy of the Policy & Procedure Manual under the Policies/Guidelines tab

Additional Online Resources for Educational Programs:

- Program Change and Other Report Guidelines
  - Reporting Program Changes
  - Reporting Distance Education
  - Reporting a Teach-Out
  - Reporting a Transfer of Sponsorship
  - Reporting Use of Sites Where Educational Activity Occurs

  And More….

For futher information on topics in this Annual Report, please contact the Commission office.

CODA
Commission on Dental Accreditation

LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8353	JOSE ANTONIO ALCANTARA RUIZ, R.D.H.	11/30/2021
H8354	MANDY L LONG, R.D.H.	11/30/2021
H8355	BARBARA JO JONES, R.D.H.	12/1/2021
H8356	NANCY G RAMIREZ, R.D.H.	12/10/2021
H8357	NATALIE KRISTINE BAZ, R.D.H.	12/15/2021
H8358	JESSICA M WOOTEN, R.D.H.	12/17/2021
H8359	CATHERINE ANNE FATINO, R.D.H.	12/22/2021
H8360	LISA JOHANNA FERGUSON, R.D.H.	1/5/2022
H8361	LINDSAY T VALENCIA, R.D.H.	1/6/2022
H8362	MORGAN D CHAN, R.D.H.	1/7/2022
H8363	RENEE WHISENANT, R.D.H.	1/7/2022
H8364	TAMANH PHAM, R.D.H.	1/7/2022
H8365	ALLISON ROSE KRESSE, R.D.H.	1/7/2022
H8366	HYON GEORGIA KNORR SHAFFER, R.D.H.	1/7/2022
H8367	JANA ELIZABETH BURGBACHER, R.D.H.	1/7/2022
H8368	JENNIFER OSAWA, R.D.H.	1/7/2022
H8369	CYNTHIA YVETTE CASTILLO, R.D.H.	1/7/2022
H8370	CELESTE JOY HEINRICH LYANS, R.D.H.	1/10/2022
H8371	LAURA ELENA LOAICIGA ULLOA, R.D.H.	1/10/2022
H8372	CHRISTINA D OTTERSON, R.D.H.	1/21/2022
H8373	CHEYENNE C DECOURCEY, R.D.H.	1/21/2022
H8374	IRIS RANKIN, R.D.H.	1/21/2022
H8375	BAILEY EDMISTON, R.D.H.	1/25/2022
H8376	LISA M WILKES, R.D.H.	1/25/2022
H8377	CHEYENNE NICOLE LANGJAHR, R.D.H.	1/25/2022
H8378	MADISON EMMA COOPER, R.D.H.	1/25/2022
H8379	JUSTINE ELIZABETH MILLER, R.D.H.	1/25/2022
H8380	DANIEL N SIEMONEIT, R.D.H.	1/25/2022
H8381	ELOUAN AMERY CADE, R.D.H.	1/25/2022
H8382	MCKENZIE R JANECK, R.D.H.	1/25/2022
H8383	CHI T NGUYEN, R.D.H.	1/26/2022
H8384	TAMI R MEAD, R.D.H.	1/26/2022
H8385	ALEXANDRIA F BORLAND, R.D.H.	1/28/2022
H8386	SHELBY DANIELLE LATHAM, R.D.H.	1/28/2022
H8387	KAITLYN SUE BROWN, R.D.H.	2/10/2022

DENTISTS

D11564	SIVARAMAN PRAKASAM,	12/9/2021
D11565	FRANSISKUS ANDRIANTO TJIPTOWIDJOJO, D.D.S.	12/17/2021
D11566	MELISSA D DE MATTOS, D.D.S.	12/17/2021
D11567	DREW T PEARSON, D.M.D.	1/5/2022
D11568	SHAYD THOMAS NOBUO SHINSATO, D.M.D.	1/5/2022
D11569	ALEX A RAUCHLE, D.D.S.	1/6/2022
D11570	ALEXANDER CRAIG RISTAU, D.M.D.	1/7/2022

D11571	ARIELLE E AVANT, D.M.D.	1/19/2022
D11572	BYRON CHOU, D.D.S.	1/21/2022
D11573	SARAH MAHAMMAD, D.D.S.	1/25/2022
D11574	SPENCER WILLIAM TIPPETS, D.D.S.	1/28/2022
D11575	DAVID GU, D.M.D.	1/28/2022
D11576	AANYA SANGHVI, D.M.D.	2/2/2022
D11577	IAN T CRAIG, D.M.D.	2/10/2022

LICENSE, PERMIT & CERTIFICATION

7. Request for Approval of Soft Reline Course – Lindsey Chronicle, EFDA.

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.

Relevant Rules:

OAR 818-042-0090 – Additional Functions of EFDAs

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

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.
(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(3) Place cord subgingivally."

NYE Ingrid * OBD

From: Lindsey Chronicle <chronil@linnbenton.edu>
Sent: Friday, January 7, 2022 1:46 PM
To: OBD Info * OBD
Subject: Soft Reline Instructor Certification Submission
Attachments: ED I Syllabus & Outline for Soft Relines- Lindsey.docx; Exam for Soft Reline Certification 21-22.docx; Exam for Soft Reline Certification ANSWER KEY 21-22.docx; ED I LAB- Soft reline check off.doc; ED I Soft Relines.ppt

Dear Oregon Board of Dentistry,

I am submitting my documentation to become certified to teach and instruct EFDAs on SOFT RELINES for dentures. I have attached my course syllabus, lecture outline, written exam w/answer key, lab proficiency check off, and the PowerPoint for the lecture portion. Thank you for your time and consideration to approve this course of instruction for me.
I look forward to your reply.
--
Lindsey Chronicle, CDA, EFDA, BS
Faculty, Dental Assisting Department
Linn-Benton Community College
Health Occupations Center
Lebanon, OR 541-917-4496

CURRICULUM VITAE

Lindsey M. Chronicle CDA, EFDA, BS
4096 Elk Run Dr. SW
Albany, OR 97321
chronil@linnbenton.edu
541-990-2569

January 7, 2022

RE: Soft Reline Instructor Certification

Dear Oregon Board of Dentistry,

My name is Lindsey Chronicle, and I am seeking board approval to become a certified Instructor of Soft Relines. I have been in Dentistry for 23 years as an EFDA and have worked in many different aspects of the field. I graduated from Chemeketa Community College's Dental Assisting program in 1999 where I obtained my CDA and EFDA certifications. While working and gaining experience, I completed my sealant and soft reline certificates to further my skills and be utilized more. When I worked in group practice, I used both of those skills' multiple times a week. I have worked in both private and group practices over my career. In 2015, I took a position with Linn-Benton Community College's Dental Assisting program as an Instructional Assistant. I love being on the educational side of dental assisting. Its very rewarding seeing where students are when they start the program, to graduation and working in offices.

I completed my Associates degree in 2018 while working as an Instructional Assistant for the college. Most recently, this past summer I finished my bachelor's degree that I had been pursing for two years. This was a big accomplishment for me, mainly due to the fact I still was working full time in the program, as well as being a mom to three kids with their own distance learning during the pandemic. With that completed, I am able to teach the lecture portion of classes for the Dental Assisting program, as well as the lab classes. I also am the clinic coordinator for our Dental Link clinic, where we partner with Community Outreach to see low-income patients for dental treatment. We provide volunteer Dentists, and the students get to work and gain chairside experience.

Once I have the certification to be able to teach soft relines, I can be utilized more, and our other instructor will not be the only one who can teach the course. It is nice give our students one more certification they can receive after they complete the program. We like to offer as many certification opportunities as possible to the students, to make them more desirable when they seek employment after graduation.

Thank you for your time and consideration!

Lindsey Chronicle

OREGON BOARD OF DENTISTRY

Dental Assistant

113870

CERTIFICATE NUMBER

Lindsey M Chronicle

Expanded Functions Dental Assistant
Radiological Proficiency

Issued: October 13, 1999

THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF PATIENTS

Dental Assisting National Board, Inc.

This confirms that

Lindsey M Chronicle

has fulfilled the certification requirements approved by the Board of Directors
of the Dental Assisting National Board, Inc. and is authorized to use the certification mark

Certified Dental Assistant

Michael Conte, D.M.D., M.P.H.
DANB Board Chair

Lois Bell, CDA, CPFDA, CRFDA, FADAA
DANB Board Secretary

CDA

Certification Number: 158789
Expiration Date: 07/05/2022

Certificate of Instructor Approval

Presented to

LINDSEY M. CHRONICLE

For meeting the requirements to place
Soft-Relines for Dentures. Instructor approval given by Shelley Huser,
an Oregon Board of Dentistry Certified Instructor

March 1st, 2008

Oregon Dental
Education Services

SHuser RDH

Shelley Huser, RDH, I1701

Course Syllabus for Soft Relines

Offered as:
Continuing education for Expanded Function Dental Assistants to obtain the certification to apply Soft Relines.

Oregon Board of Dentistry
Rule 818-042-0090

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

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

INSTRUCTOR: Lindsey Chronicle, CDA, EFDA, BS

chronil@linnbenton.edu

541-917-4496

TEXT and RESOURCES: Bird and Robinson, Modern Dental Assisting, 13th ED.

Outline for lecture course

COURSE DESCRIPTION: This course is a detailed study of the rationale, criteria, and patient management for the placement of soft reline and tissue conditioner materials. This course will include materials knowledge and placement techniques as well. The student/EFDA will be under indirect supervision.

COURSE OBJECTIVES: ***DIDACTIC Session = 2 Hours***

The student/EFDA applicant will receive a detailed study and understand the use of soft reline and tissue conditioner applications, who can perform procedure, chemistry, patient management, comfort, retention, and expectations. The didactic session must be successfully completed with an 85% or higher before laboratory and clinical sessions can begin.

LABORATORY Session = 4 Hours

The student/EFDA applicant will be given a demonstration by the instructor on proper dispensing, denture preparation, mixing, placement, and trimming. The student/EFDA applicant will successfully prepare and place tissue conditioner AND soft reline material on a Maxillary AND Mandibular denture case model. The laboratory session must be successfully completed with an 85% or higher.

COURSE OUTLINE: Soft Relines for Dentures

I. The Denture Patient

A. Emotions of the Denture Patient (Be sensitive)

1. Very conscious of appearance
2. Apologetic for tooth loss
3. Angry
4. Sad
5. Unconcerned
6. Discomfort

B. Embarrassed/Ashamed

1. Possible blame

C. Unforeseen Circumstances for loss

1. Cancer/Medical treatment/Radiation
2. Finances/ lack of education

D. Some patients excited for new dentures

II. Complications of mastication- Need for Relines

A. Cannot chew/hard to chew properly

B. Denture floats/Rocks

C. Tips when biting into food

D. Biting cheek or tongue

III. The Denture- Pros and Cons

A. Several appointments Necessary

B. Can be expensive to fabricate

C. Reduced chewing capability

1. Unable to bite into/chew certain foods like with natural teeth

D. Can't go back once teeth are removed - Implants as option

1. Implants with dentures

a. Cost $

b. Bone level vs. loss

E. Constant changes in Soft and Hard tissues

1. Tissue swells after EXT

2. Time with healing, tissue shrinks/bone remodeling

3. Tissue changes with weight loss/gain

IV. Maxillary vs. Mandibular Dentures

A. Maxillary Dentures

1. Surface area is larger than mandibular

2. Suction increased-Palatal coverage

3. Occlusal force spread over entire arch

4. Bone resorption less than MAND.

5. Adaption for Patient

B. Mandibular Dentures

1. Tongue and Frenum attachments Pull
2. Less surface area for chewing strength
3. No suction
4. Thinner/less bone
5. More resorption
6. Adaption for patient

V. Types of Patients

A. Limited Access patients (Not in the Dental Office/Seen outside dental office)

1. Prescription needed still
2. EFDA credentials + Soft Reline certification
    a. Homebound
    b. Confined
    c. Unable to be transported
    d. Hospitalized
    e. Nursing home
    f. Home health services

VI. Objectives/Purpose for Soft Reline

A. A temporary measure

1. Length of time

B. Relieves Soreness

1. Most common

C. Allows/Improves chewing

1. Doesn't slip and move

D. Speech improvement

1. More stable

VII. Types of Denture Liners

A. Temporary Liners (tissue conditioning)

1. Length of time

a. Manufactures directions (2-3 weeks is best)

b. Tissue conditioners less than a week (3-4 days while irritated tissue heals)

2. Can be placed many times

3. Rehabilitates tissues

a. Typically, after placement of Immediate dentures

4. Ingredients

a. Zinc undulate is a base and ethyl alcohol liquid

Products: Coe-Comfort

B. Soft Relines

1. Temporary measure

a. length of time (manufactures directions, recommended 3-6 months)

b. the longer in place, the more difficult to remove

2. Relieves Soreness/Loose fitting dentures

3. Improves Speech/Chewing/Comfort

4. What's the next step = Plan? 6 months from now?

    a. Hard relines?

5. Ingredients

    a. polymethyl methacrylate powder and ethyl alcohol liquid

        Products: Coe-Soft

C. Laboratory Processed Relines

1. Impression of denture
2. Liner worn overnight
3. Timing for the patient – typically a 2-day process

D. OTC Denture products

1. Can be difficult to use

2. Hard to read directions

3. Need professional Diagnosis

    a. Products OTC

    Adhesives/Liners
    Repair kits
    Cleaners

VIII. Procedure for Soft Reline

1. Review Health and Dental HX
    a. Patient's Chief concern/complaint
    b. Dr. Evaluate/Diagnosis
    c. Options given
    d. Explain procedure
2. Visual exam/Try-in Denture
    a. Determine centric occlusion
    b. Explain to the patient to bite in that once liner is placed
    c. Start with MAX if possible
        1. Have all necessary armamentarium out/PPE
        2. Measure material per manufactures instructions
        3. Coat Denture surfaces
        4. Mix thoroughly – consistency
        5. Place material in denture, careful not to overfill
        6. Seat in patients' mouth, instruct to bite into occlusion-gentle muscle trim
        7. After 3 mins, remove denture
        8. Rinse under cold water, trim away excess material
        9. Reseat denture and check for patient comfort and satisfaction
        10. REPEAT on Mand. Denture if necessary and DX.
        11. Dr. to examine prior to patient dismissal

d. Home care Instructions
    1. First 24 hours
        a. No harsh abrasives or brushing vigorously
        b. Rinse gently with water if needed
    2. After 24 hours
        a. Resume normal eating and drinking
        b. Do not pick at material
        c. Soak teeth in cleaner at night
        d. Excess alcohol decreases longevity
            1. Acrylic is soluble in alcohol, can compromise structural integrity of denture/cause cracks.
    3. Chart Entries
        a. Note procedure in chart
        b. Dr. prescribed and why?
        c. Materials used
        d. Homecare instructions given
        e. Future plans and next visit for denture
        f. Your name/initials

Expanded Duties I

Soft Relines for Dentures

LEARNING OBJECTIVES

- Difference between a soft, tissue conditioning, & hard reline
- The purpose of each
- How often can they be changed/redone?
- Which one is temporary or permanent?
- Who can do this procedure?
- What are the characteristics: color and consistencies of products?
- Procedure/Homecare instructions for patients

THE DENTURE PATIENT

EMOTIONS OF THE DENTURE PATIENT

- **Be Sensitive to the Patients Feelings**

- **Very Conscious** of Appearance (especially females)
- **Apologetic** for Tooth Loss
- **Angry** About Loss
- **Sad** About Loss
- **Unconcerned** About Loss, *some
- **Constant Discomfort**

THE DENTURE PATIENT

EMOTIONS OF THE DENTURE PATIENT

*Feel ashamed

- Blame

*Unforeseen circumstances for loss

- cancer
- radiation
- lack of education and $

* Some Patients Excited for new teeth

THE DENTURE PATIENT

COMPLICATIONS OF MASTICATION

- **Can Not Chew Properly**
  - **denture(s) floats**
  - **denture(s) rocks or tips**
  - **biting cheek or tongue**
  - **hard to bite into food**
  - **hard to chew food**

THE DENTURE

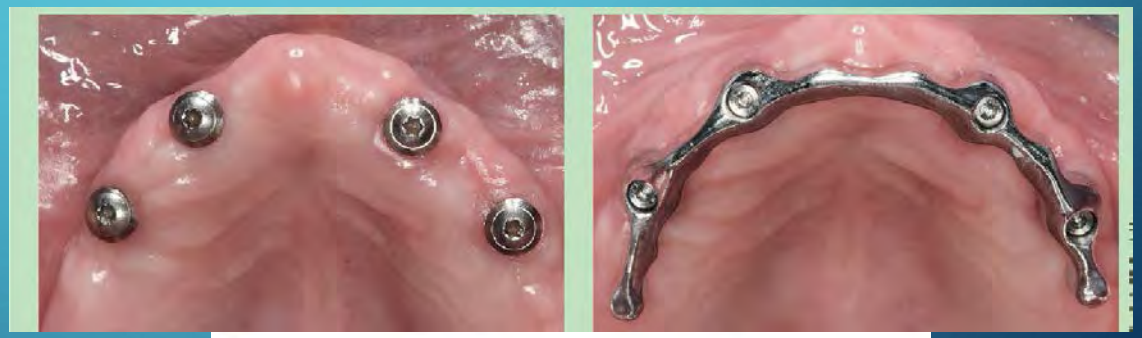
- **PROS vs. CONS**
- **Can Not Go Back**
  - Option: Implants
- **Constant Changes in Soft/Hard Tissues**
- **Natural Dentition vs. Porcelain/Plastic Teeth**

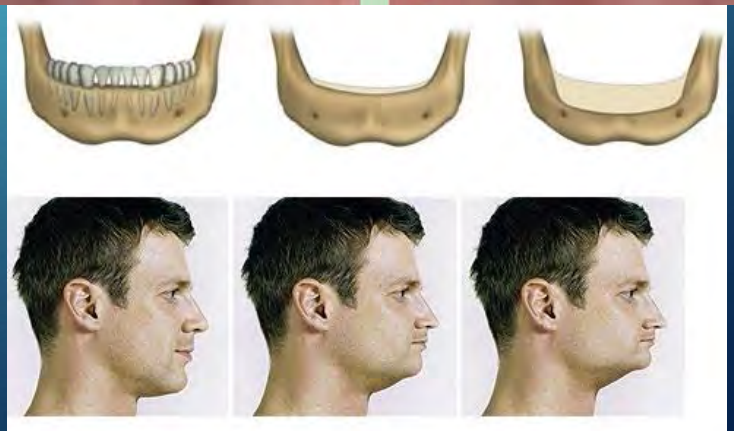
THE DENTURE

- Pros vs. Cons
  - Several appointments
  - Expensive to make (if pt. does not have insurance)
  - Reduced chewing capability
  - Never feels like real teeth

THE DENTURE

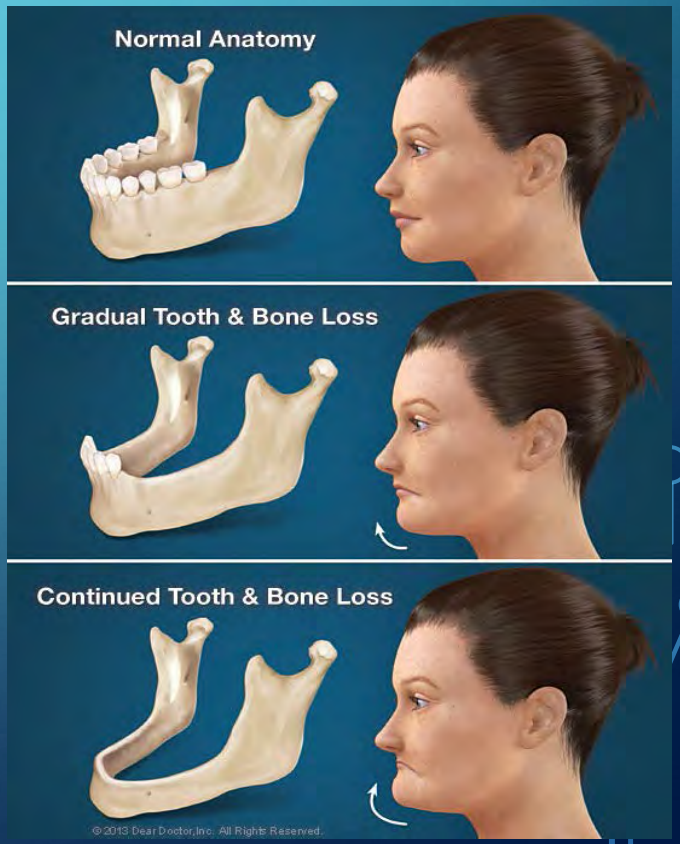
- Can't go back once teeth are removed
  - Implants as option (can be very expensive)
  - Bone loss





THE DENTURE

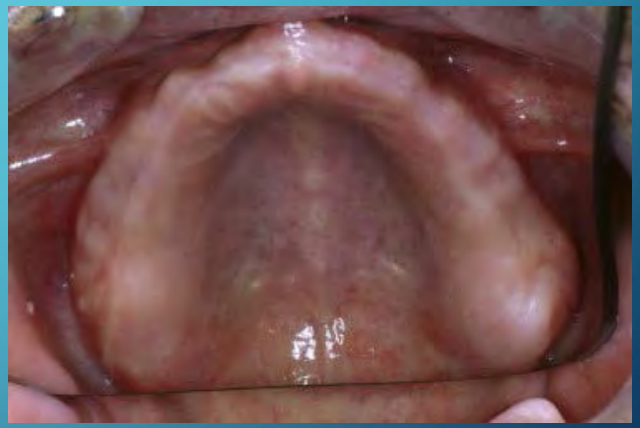
- Constant changes in soft tissue and hard tissue
  - Tissues swell after EXTS.
  - Over the healing time, they resorb and shrink
  - Tissue affected by weight loss/gain



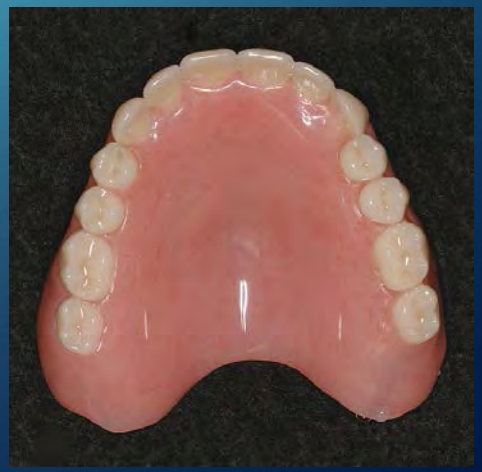
THE DENTURE

MAXILLARY VS. MANDIBULAR

- **THE MAXILLARY DENTURE**



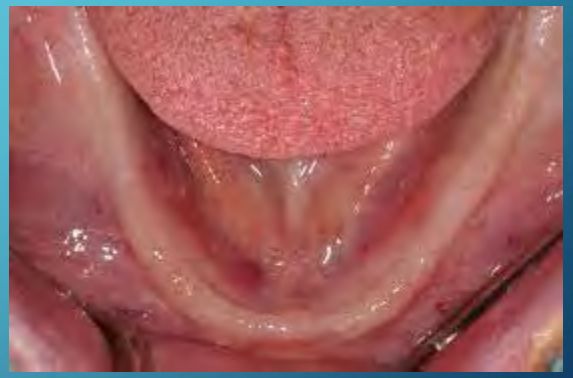
- **Surface Area**
- **Suction Increases**
- **Occlusal Force**
- **Bone Resorption is less**
- **Fabrication**
- **Adaption easier**



THE DENTURE

MAXILLARY VS. MANDIBULAR

- **THE MANDIBULAR DENTURE**



- **Tongue, Frenum and Attachments**
- **Less Surface Area**
- **Suction Issues**
- **Thinner/Less Bone**
- **More Bone Resorption**
- **Fabrication/Adaption**

SOFT RELINES
DIFFERENT TYPES OF PATIENTS

Limited Access Patients- Not in the Dental office

1. **Prescription from Dentist**
2. **EFDA Credentials**
3. **Patients seen outside dental office**

- Home bound
- Confined
- Unable to be transported
- Hospitalized
- Nursing home or care center
- Home health services

OBJECTIVE OF SOFT RELINES

- A Temporary Measure
  - Length of time varies per patient
- Relieve Soreness
  - Most common during healing process of recent EXTs
- Allow the Patient to Chew
  - Denture fit does not slip
- Speech Improvement
  - More stable

TYPES OF DENTURE LINERS

- Temporary Liners
- Soft Relines
- Dental Lab Processed Relines (Hard Relines)
- OTC Reline Products

TYPES OF DENTURE LINERS

TEMPORARY LINERS

- **Length of Time**
- **Can Be Placed Many Times**
- **Tissue Compression**
- **Eases Faulty Occlusion**
- **Rehabilitate tissues (tissue conditioning)**
- **Ingredients**
- **Products for Temporary Liners**
  - Mixing the Product

TYPES OF DENTURE RELINES

SOFT RELINES

- Temporary Measure
  - Length of time: can be worn for 3-6 months, but as tissue heals can be replaced sooner if needed
  - Harder to remove the longer it is in the denture
- Relieves soreness
- Able to chew easier
- Speech/Comfort
- What Happens Next?
- Ingredients
  - Polymethylmethacrylate powder and ethyl alcohol liquid

TYPES OF DENTURE RELINES

LABORATORY PROCESSED RELINES (HARD RELINE)

- **Impression in/using Denture** (Polyvinyl or polyether)
- **Option: Liner Worn Overnight (soft reline)**
- **Better for long term fit and comfort**
- **Done after healing is finished (at least 6 months post Exts.)**
- **Sent out to lab to complete Hard reline of Denture**
- **Timing for the Patient**

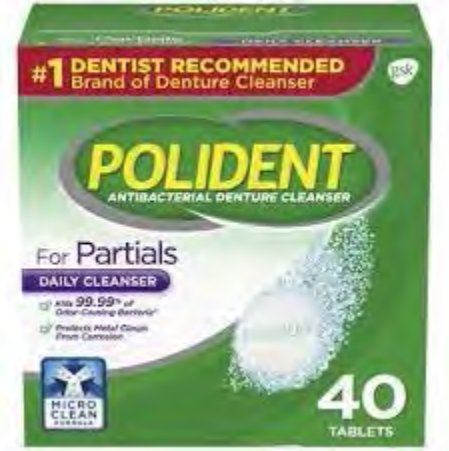
Typically, a 2-day process that they are w/o denture

TYPES OF DENTURE RELINES

OTC DENTURE PRODUCTS

- **Difficult to Use**
- **Need Professional Diagnosis**
- **Hard to Read Directions**
- **Categories of OTC Products**
  - Adhesives
  - Liners or Relines
  - Repair Kits
  - Replacement Teeth
  - Cleaners
  - Home Remedies

OTC DENTURE PRODUCTS



SOFT RELINE PROCEDURE

- **Medical History**
  - Medications
  - Indications/Contraindications
  - Review at each appointment
- **Dental History**
  - Patients' Chief complaint
  - Prescribed/evaluation by a Dentist
  - Options given
  - rehabilitate

SOFT RELINE PROCEDURE

PREP, MIXING, PLACEMENT

- **Seat and Fit Denture**
  - Check occlusal relationship
  - Establish centric
  - Is there discomfort?
- **Explaining the Procedure**
  - Do one denture at a time
  - Start with MAX for best results
- **Follow Asepsis Protocol**

PROCEDURE

PREP, MIXING, & PLACEMENT

- **Measure Material** (manufactures directions)
- **Coat Denture Surfaces w/lubricant**
- **Mix Material/Consistency**
- **Seat the Denture**
- **Have Patient Bite into Occlusion – make sure opposing is in if its an opposing FD**
- **Muscle Trim (facial expressions)**
- **Instruct to bite to keep in place, Wait 3 Minutes**
- **Remove Denture and Rinse**
- **Trim Excess and Smooth Periphery**
- **Reseat**
- **Repeat on Mandibular denture** (if present and needed)

HOME CARE INSTRUCTIONS

- ***First 24 Hours***
  - Do not use denture brushes
  - Rinse cold water
  - Eat and drink normally
  - Restrict alcohol intake
  - Do not touch or pick at lining
  - Soak with teeth side down

HOME CARE INSTRUCTIONS

- ***After 24 Hours***

- Normal Routine
- Keep Very Clean with light gentle brushing
- Remove at night and place in water
- Report any Loose Material or Cracks
- Excess Alcohol Shortens Life of the Liner, alcohol soluble

CHART ENTRY

- **Note the Procedure in the Chart**
  - Who Prescribed and Why?
  - What Material Was Used
  - What Aftercare Instructions Were Give
  - To Whom Were the Instructions Given
- **What are the Future Plans for the Dentures**
- **Your Name** (initials)

REVIEW FOR TODAY

- Difference between a soft and hard reline and their purpose
- Ethyl alcohol and alcohol problems
- Must be prescribed, checked, and adjusted as needed
- What are the characteristics: color and consistencies of products?
- Importance of home care

Soft liner/ Tissue conditioner Syllabus

Winding Waters Dental Clinic

_____ Review of tissue conditioner power point

_____ Review of clinics tissue conditioner instruction/safety sheet

_____ Exam passed with 90% or greater

_____ Review of tissue conditioner alternative materials

_____ Trim doctor placed tissue conditioner 3x with dentist present

_____ Place tissue conditioner and trim 3x with dentist present

All the above satisfactorily completed

_____

Date: _____

Tissue Conditioners

Index

Introduction

✓In 1967 Kydd and Mandley stated that tissue lining materials permit wider dispersion of forces and hence, aid to decrease the force per unit area transmitted to the supporting tissues.

✓For practical purposes, denture base materials are made of rigid materials.

✓The dentist must recognize that the prolonged contact of these bases with the underlying tissues is bound to elicit changes in the tissues.

✓Mucosal health may be promoted by hygienic and therapeutic measures and tissue-conditioning techniques may be applied when appropriate.

Composition

- ✓Tissue conditioners are composed of polyethylmethacrylate and a mixture of aromatic ester and ethyl alcohol.
- ✓Tissue conditioners are available as three component systems
  - ✓Polymer(Powder)
  - ✓Monomer(Liquid)
  - ✓Liquid plasticizer(Flow control)
- ✓A gel is formed when these materials are mixed, with the ethyl alcohol having a greater affinity for the polymer.

Uses of Tissue Conditioners

- ✓Tissue treatment
- ✓Temporary obturator
- ✓Baseplate stabilization
- ✓To diagnose the outcome outcome of resilient liners
- ✓Liners in surgical splints
- ✓Trial denture base
- ✓Functional impression material

Adjuncts for Tissue Healing

✓Advantage of using tissue conditioner is that they prepare the selected oral structures to withstand all the stress from the prosthesis.

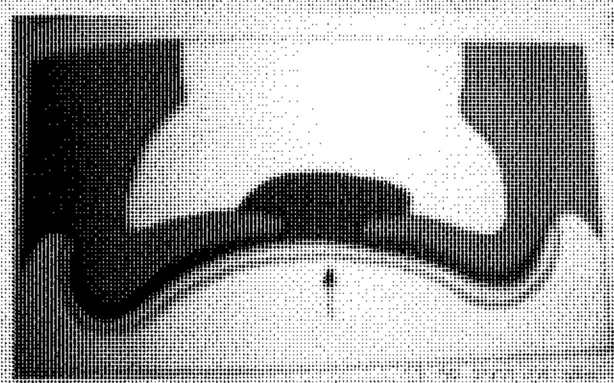
✓Tissue conditioners are generally used to preserve the residual ridge.

✓Also used to heal irritated hyperemic tissues prior to denture fabrication.

Temporary Obturator

✓Tissue conditioners may be added as a temporary obturator over existing complete or partial denture.

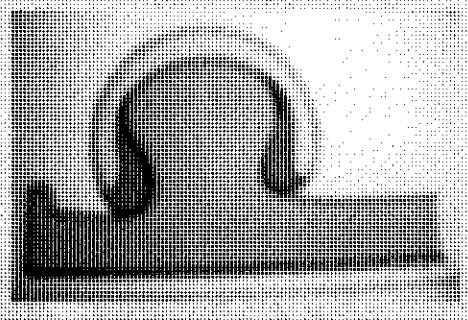
✓This may be done directly in mouth or indirectly after an impression of the surgical area has been made.



Stabilization of Baseplates & Surgical Splints or Stents

✓When undercuts are present on an edentulous cast, an acrylic temporary denture base cannot be used as it may get locked into the undercut and break the cast during removal.

✓In such cases tissue conditioners of stiffer consistency may be used to stabilize the record bases and prevent breakage of the cast.



Adjuncts to an Impression or as a Final Impression Material

- These materials are used when it is difficult to determine the extent of the denture base due to presence of movable oral structures.
- These materials record the extension of the denture in a dynamic form that will later help in preparing an impression tray for the final impression.

Adjunct to determine the
Potential Benefits of a Treatment Modality

✓Sometimes patients with well constructed dentures develop chronic soreness and find it difficult to wear the dentures comfortably.

✓Tissue conditioners can be used to determine if this problem can be resolved with the use of resilient liner.

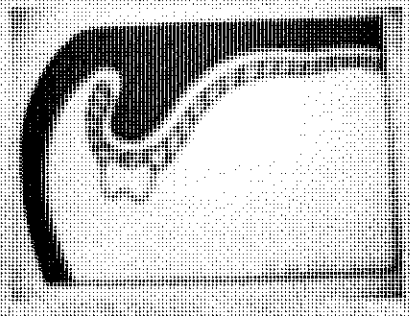
Procedure for Applying Tissue Conditioners

✓The following steps must be considered while applying tissue conditioners on a denture.

Preparation of the dentures

✓The tissue part of the denture base, which crosses an undercut, should be reduced.

✓The tissue surface of the denture, which covers the crest of the ridge, should be reduced by 1 mm.



- ✓It should be remembered that the dentures should allow sufficient room for the placement of the tissue conditioner in order to promote the recovery of displaced and traumatized tissues.
- ✓Mixing & placement of the tissue conditioner
- ✓Tissue conditioners are available as three component systems
  - ✓Polymer(Powder)
  - ✓Monomer(Liquid)
  - ✓Liquid plasticizer(Flow control)
- ✓The mixing ratio can be changed according to consistency required. A ratio of 1.25 parts of polymer, 1 part monomer and 0.5cc plasticizer is usually recommended. The plasticizer should be added to the monomer.
- ✓The ingredients are mixed to form a gel, which is applied in sufficient thickness to the tissue surface of the denture.
- ✓The denture is inserted and border movements are carried out to mould the setting material.

Care & maintenance

✓Tissue conditioners should not be cleaned by scrubbing with a hard brush in order to prevent tearing of the material. The use of soft brush under running water is recommended.

✓The greatest virtue of tissue conditioners is their versatility and ease of use.

✓The biggest flaw is that they are also misused.

✓Their longevity against wear is very limited and they tend to harden and roughen within 4 to 8 weeks due to the loss of plasticizer. Hence, they require observation.

Conclusion

✓ Although tissue conditioners can be easily used but the prolonged contact of these bases may elicit changes in the underlying tissues, they may traumatize the oral tissues.

References

- ✓Boucher's Prosthodontic Treatment For Edentulous Patients – George A. Zarb, Charles L. Bolender, Gunnar E. Carlsson
- ✓Essentials of Complete Denture Prosthodontics – Sheldon Winkler
- ✓Prosthodontics for Elderly – Ejvind Budtz, Jorgensen, Dr. Odont

Dentsply Sirona

Lynal®

Tissue Conditioner & Temporary Reliner

DIRECTIONS FOR USE

For dental use only. USA: Rx only.

1. PRODUCT DESCRIPTION

Lynal Tissue Conditioner and Temporary Reliner is a self-curing, resilient methacrylate/plasticized acrylic formulation intended for use as a soft lining material for short-term use in removable dentures. Lynal Tissue Conditioner and Temporary Reliner is classified as and complies with ISO 10139-1, short-term Type B, class 2.

1.1 Delivery forms

Lynal Tissue Conditioner and Temporary Reliner is available in:
Powder - 120g bottle
Liquid - 90mL bottle for hand mixing
Liquid Separator - 15mL bottle with integrated brush cap

1.2 Composition

Powder: Polyethylmethacrylate, Aspartame
Liquid: Ethyl Alcohol, Citrate ester plasticizer, Spearmint oil flavoring
Liquid Separator: Mineral oil, spearmint oil

1.3 Indications

1. Tissue Conditioner and temporary reliner when denture-bearing soft tissues have been distorted by trauma or infection.
2. Functional impression material when a complete denture is to be rebased or remade.
3. Soft liner, especially for aged patients or patients with impaired tissue health.

1.4 Contraindications

Lynal Tissue Conditioner and Temporary Reliner is contraindicated for use with patients who have a history of severe allergic reaction to methacrylate resins.

2. GENERAL SAFETY NOTES

Be aware of the following general safety notes and the special safety notes in other chapter of these directions for use.

CAUTION

Safety alert symbol
This is the safety alert symbol. It is used to alert you to potential personal injury hazards. Obey all safety messages that follow this symbol to avoid possible injury.

2.1 Warnings

1. Lynal Tissue Conditioner and Temporary Reliner contains polyethylmethacrylate and ethyl alcohol which may be irritating to skin and eyes and may cause allergic contact dermatitis in susceptible persons. Do not breathe vapors. Use only in well ventilated areas.
   - Avoid eye contact to prevent irritation and possible corneal damage. In case of contact with eyes, rinse immediately with plenty of water and seek medical attention.
   - Avoid skin contact to prevent irritation and possible allergic response. In case of contact, reddish rashes may be seen on the skin. If contact with skin occurs, immediately remove material with cotton and wash thoroughly with water and soap. In case of skin sensitisation or rash, discontinue use and seek medical attention.
   - Avoid ingestion/swallowing of material to prevent irritation or obstruction. If accidental swallowing occurs, drink lots of water. This material is not hazardous when small quantities are ingested. Larger quantities may cause bowel obstruction. Seek medical attention in the event of digestive irregularities.
2. Danger: Extremely flammable. Lynal Tissue Conditioner and Temporary Reliner liquid contains Ethyl Alcohol. Use only in well ventilated areas. Keep away from heat, sparks and open flame.
3. Lynal Tissue Conditioner and Temporary Reliner powder contains aspartame and should not be used with patients who have a history of phenylalanine metabolic disorder. In the event of exposure, PKU patients that are or may be pregnant should seek medical advice.

2.2 Precautions

1. This product is intended to be used only as specifically outlined in the Directions for Use. Any use of this product inconsistent with the Directions for Use is at the discretion and sole responsibility of the practitioner.
2. Wear suitable protective eyewaar, mask, clothing and gloves. Protective eyewear is recommended for patients.
3. To prevent the containers from exposure to spatter or spray of body fluids or contaminated hands it is mandatory that the containers are handled with clean/disinfected gloves. As additional precautionary measure, containers may be protected from gross contamination but not from all contamination by applying a protective barrier.
4. The Lynal Tissue Conditioner and Temporary Reliner containers should be tightly closed immediately after use. Replace original cap tightly after each use.
5. Lynal Tissue Conditioner and Temporary Reliner should be used with properly fitted dentures. To reduce gagging, choking or swallowing, do not overfill dentures.
6. All products should be used at room temperature. Higher temperatures reduce work times and laboratory bench set times (faster), lower temperatures increase them (slower).
7. Interactions
   - Lynal Tissue Conditioner and Temporary Reliner will adhere to most denture base materials and resin denture teeth. Use Lynal Tissue Conditioner and Temporary Reliner Separator on areas where adhesion of material is not desired.
   - Eugenol containing materials should not be used in conjunction with this product because they may interfere with hardening and cause softening of the polymeric components of the material.

2.3 Adverse Reactions

- Eye contact: irritation and possible corneal damage.
- Skin contact: irritation or possible allergic response. Reddish rashes may be seen on the skin.
- Product contains aspartame, and may cause hyperphenylalaninemia in susceptible individuals. Hyperphenylalaninemia may have harmful effects on developing fetus. (See Warnings)
- Inhalation of vapors: varying degrees of damage to the affected tissue and also increased susceptibility to respiratory illness.
- Bowel obstruction or other digestive distress may result from ingestion of mixed material. (See Warnings)

2.4 Storage

Lynal Tissue Conditioner and Temporary Reliner should be kept out of direct sunlight and stored in a well ventilated place at temperatures between 10-24°C/50-75°F. Allow material to reach room temperature prior to use. Protect from moisture. Do not freeze. Do not use after expiration date.

3. STEP-BY-STEP INSTRUCTIONS

3.1 Tissue Conditioning

1. Clean denture with brush and detergent solution. Disinfect denture according to manufacturer's or dental laboratory's instructions. Relieve pressure areas and undercuts by grinding. Thoroughly rinse and dry denture surface.
2. Using the brush-cap, apply Separator for Lynal Tissue Conditioner and Temporary Reliner only to areas where bonding is not desired e.g., external denture base and denture tooth surfaces. Do not use brush on contaminated (non-disinfected) denture surfaces.
3. Allow materials to reach room temperature before use. At room temperature, measure 10mL of powder in measuring vial. Using pipette, dispense 4.0mL of liquid into mix cup. Replace container caps. Add powder to liquid and stir for 30 seconds. Recommended powder/liquid ratio is 3g/2mL. A slight increase in the amount of powder used will produce a stiffer mix. Up to 0.5mL liquid may be added to produce a thinner mix if desired.
4. Cover tissue surface of denture with Lynal Tissue Conditioner and Temporary Reliner mixture. To overcome the initial tackiness of the mix during placement in the denture, the operator may moisten his fingers.
5. Insert denture with Lynal Tissue Conditioner and Temporary Reliner material into mouth approximately 2 or 3 minutes from start of mix. Remove undesired excess beyond denture, e.g., retromolar areas. Instruct patient to close gently in normal occlusion and remain in rest position for a minimum of 2 minutes. Then have the patient read aloud and perform functional movements. Alternatively, the operator can perform border molding manipulation as per usual techniques. These exercises should take approximately 2 minutes.
6. Remove denture from mouth in approximately 7 to 8 minutes from start of mix. Check for proper coverage, especially in border areas. Trim excess with a sharp instrument.
7. Recall patient after a few days. Following the above directions, a new mix may be added to deficient areas. Continue treatment until tissues have returned to normal. **Technique Tip:** Study models may be used to record progress of conditioning procedure. Pour cast immediately to preserve maximum detail.
8. Following completion of tissue conditioning, proceed to section 3.2 Functional Impression, section 3.3 Soft Lining, or standard rebasing or remaking impression techniques.

3.2 Functional Impression-Taking

1. The general directions above in Steps 3.1.,1-6 should be followed.
2. The application may remain in the mouth for as little as 1 hour, but no longer than 24-48 hours. Longer periods may produce distorted impressions.
3. Pour cast directly into impression without the Separator. Prepare rebase or new denture in the usual manner.

3.3 Temporary Soft Lining

1. The general directions above in section 3.1 steps 1-6 should be followed. Lynal Tissue Conditioner and Temporary Reliner will act as a soft liner for varying periods of time, up to 28 days.
2. Periodically recall patient and evaluate liner.
3. Lynal Tissue Conditioner and Temporary Reliner should be completely removed by grinding with an acrylic bur, and replaced as outlined above, when any of the following occur:
   - Material loses resilience
   - Material exhibits surface discoloration
   - Material causes patient discomfort

3.4 Maintenance of Lynal Tissue Conditioner and Temporary Reliner treated dentures

1. Immediately following application and trimming, prior to delivery to the patient, dentures should be cleaned by rinsing in a gentle stream of clear water. Lined denture may be disinfected with an intermediate-level, tuberculocidal surface disinfectant according to disinfectant manufacturer's instructions. Immersion in disinfectant solutions is not recommended.
2. After 1 day in the mouth Lynal Tissue Conditioner and Temporary Reliner treated dentures can be cleaned by gentle brushing with a soft-bristled brush and clear water. Do not use commercially available chemical cleansers. Do not immerse denture in cleaning solutions.

Instructions for Disinfecting Product containers, measures, mixing cups and spatula

Warnings	• Intermediate level disinfection is appropriate for the Product containers, measures, mixing cups and spatula. It is not recommended to submerse product containers into disinfection solutions. Product contamination may occur. It is not recommended to submerse measures, mixing cup or spatula into disinfection solutions. Discoloration and deterioration may occur. Do not autoclave Product containers, measures, mixing cups and spatula. Vigorous wiping of containers can destroy the label. Wipe containers gently.
Limitations on Reprocessing	• Repeated processing has minimal effect on the Product containers, measures, mixing cups and spatula. The Product containers, measures, mixing cups and spatula can be subjected to the cleaning and disinfection process until containers are empty or material has expired, and which time materials should be properly discarded and replaced. Cold liquid disinfection/sterilization, chemical vapor sterilization, and dry heat sterilization methods have not been tested or validated for efficacy and are not recommended for use.
Point of Use	• Remove excess soil with disposable cloth / paper wipe. Prior to Cleaning and Disinfection, replace original caps on containers. Remove excess material with a soft paper tissue and alcohol of 70%. It is recommended that the Product containers, measures, mixing cups and spatula be reprocessed as soon as is reasonably practical following use.
Containment and Transportation	• No particular requirements.
Cleaning and Disinfection: Automated	• Methods have not been tested or validated for efficacy and are not recommended for use.
Cleaning and Disinfection: Manual	• The Product containers, measures, mixing cups and spatula have to be cleaned by scrubbing with hot water and soap or detergent. The product containers must be cleaned with a single-use cloth soaked in hot water and detergent. After cleaning thoroughly wipe all device surfaces with a single-use cloth in combination with a water-based, bactericidal, virucidal and fungicidal disinfection solution approved according to local regulations and use according to disinfectant solution manufacturer's Instructions for Use. Make sure disinfectant solution is compatible with cleaning solution. Pay special attention to device seams and insertions. Use of phenolic-, iodophor- or organic solvent (e.g. alcohol) based or containing products may over time cause surface staining. Remove disinfectant solution residue with a cloth soaked with water. Dry device with a lint-free single-use cloth.
Packaging	• No particular requirements.
Sterilization	• Methods have not been tested or validated for efficacy and are not recommended for use.
Drying	• Allow the Product containers, measures, mixing cups and spatula to fully dry before storage.
Maintenance	• If the Product containers, measures, mixing cups or spatula are discolored, damaged, worn, or distorted they should be discarded. No additional maintenance or lubrication is recommended.
Storage	• Store the Product containers, measures, mixing cups and spatula at room temperature, away from moisture or excessive humidity. Product containers, measures, mixing cups and spatula should be disinfected and dried prior to storage.
Manufacturer Contact	• Within the United States, call DENTSPLY at 1-302-422-4511. For areas outside the United States, contact your local DENTSPLY representative.

4. HYGIENE

CAUTION

Cross-contamination - Infection

- Do not reuse single use products. Dispose of in accordance with local regulations.
- Reprocess reusable products as described below.

4.1 Cleaning and disinfection Instructions

- To prevent containers from exposure to spatter or spray of body fluids or contaminated hands, or oral tissues, use of a protective barrier is recommended to avoid package contamination. The use of protective barriers is an additional precautionary measure against gross contamination but not against all contamination.
- For manual cleaning: Use a new clean pair of examination gloves. Discard gloves according to local regulations and disinfect hands with an appropriate bactericidal, virucidal, and fungicidal hand disinfectant solution according to local regulations. Use according to disinfectant solution manufacturer's Instructions for Use.

CAUTION

Cross-contamination - Infection

- Applicator brush cannot be reprocessed. Dispose of contaminated bottle in accordance with local regulations.

Do not attempt to clean or disinfect Liquid Separator applicator brush stem or bristles. If brush stem or bristles become contaminated, resealing bottle without contamination of contents will not be possible. Properly dispose of brush, bottle and material.

5. LOT NUMBER AND EXPIRATION DATE

1. Do not use after expiration date. ISO standard uses: "YYYY-MM."
2. The following numbers should be quoted in all correspondences:
   - Reorder number
   - Lot number on package
   - Expiration date

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