OREGON MEDICAL BOARD
REPORT

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Inside This Issue

Upcoming Meetings

August 20, 9 a.m.
EMS Advisory Committee

September 2, 7:30 a.m.
Investigative Committee

September 8, Noon
Acupuncture Advisory Committee

October 7-8, 8 a.m.
Board Meeting

November 4, 7:30 a.m.
Investigative Committee

November 19, 9 a.m.
EMS Advisory Committee

Statement of Philosophy: Pain Management

This Statement of Philosophy was originally adopted by the Board in January 1993 and has been periodically amended, most recently on July 1, 2021. All Statements of Philosophy are available on the OMB website.

The Oregon Medical Board urges effective, skillful treatment of pain for all patients.

Acute Pain

For acute pain, current standards recommend a multimodal approach, possibly including multiple classes of medications and appropriate application of local or regional nerve blocking agents. If opioids are prescribed, it is recommended to use the lowest effective dose of a single agent for a duration of less than 3 days. For most patients, this should be less than 50 Morphine Equivalent Dose (MED). In cases of more severe acute pain, limit the prescription to less than 7 days. If there is a compelling reason to re-prescribe, it should be well documented. Co-prescribing of benzodiazepines with opioids is to be avoided absent a documented compelling reason.

See: Oregon Acute Opioid Prescribing Guidelines

Chronic Pain

The Board recognizes the complexity and difficulty in appropriately treating chronic pain. Addressing pain has been complicated in the not-too-distant past by well-meaning efforts to liberalize treatment of pain, including increased prescribing of opioids. Unfortunately, this has contributed to the opioid overdose crisis. Fortunately, there are now consensus statements from recognized authorities on the current standard of care. Specifically, from the United States Centers for Disease Control and Prevention and from the Oregon Pain Management Commission.

See: Center for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, Oregon Pain Management Commission, and Oregon Pain Guidance Chronic Opioid Prescribing Guidelines

When the Board receives a complaint about potential overprescribing of controlled substances, it looks not only to these guidelines, but to the opinions of local expert consultants. While it is beyond the scope of a Statement of Philosophy to advise exact parameters, practitioners would do well to note the following guidelines.

Continued on page 2

OMB Welcomes New Board Members


Anthony Domenigoni, DPM


Paula Lee-Valkov, MD

The Oregon Medical Board is pleased to welcome **Anthony Domenigoni, DPM**, and **Paula Lee-Valkov, MD**, as its newest members. Both doctors were sworn in on July 1, 2021.

Continue reading on page 5

The mission of the Oregon Medical Board is to protect the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Statement of Philosophy: Pain Management, continued

Diagnoses and the treatment plan should be clearly documented. The effectiveness of the treatment, particularly as it relates to the patient's functional status, should be regularly assessed and documented. Assessments should be ongoing, real-time, not boilerplate repetitions. These are complex patients who deserve attention.

Prescribers should not go it alone. Consultants in specialty areas including pain management and mental and behavioral health are strongly advised. Recommendations from consultants should be reviewed, documented and acted upon.

The amount of prescribed opioid should be limited. When newly treating chronic pain, there is rarely a reason to exceed 50 morphine equivalent dose (MED) of opioid, and almost never a reason to exceed 90 MED.

Polypharmacy with opioids co-prescribed with benzodiazepines, muscle relaxants, gabapentinoids, and hypnotics should be avoided. If required, the medical decision making should be documented and, due to the attendant risks, the need regularly reassessed.

The Board recognizes not all patients can be tapered to MED less than 90, but such patients deserve thorough assessment and documentation and periodic referral to appropriate specialists for co-management. As much as possible, patients should be transitioned to Medication-Assisted Treatment (MAT) – buprenorphine-based treatment. Agonist/antagonist opioid medications have a far safer profile and are often found to be equivalent if not superior to pure agonists in treating pain.

A Procedure, Alternatives, Risks, and Questions (PARQ) conference – a Material Risk Notification (MRN) – is essential. It needs to be documented. A signed agreement with the patient – a "pain contract" – is likewise essential. These should be readdressed and updated periodically, at least annually.

Examples: **Material Risk Notification** and **Patient Treatment Agreements**

Prescribers should regularly check the Oregon PDMP (Physician Drug Monitoring Program) for possible multiple prescribers. It is strongly encouraged that licensees who are prescribing chronic opioids have mechanisms for office staff to perform and document the results of these checks at every refill.

Periodic urine drug screens are essential. Board consultants generally recommend a urine drug screen (UDS) be done annually, at minimum. Any patient on chronic long-term opioids needs to be assessed for compliance, regardless of the degree of trust the prescriber may have. Even patients with a long history of compliance may find their prescriptions being diverted by others. Prescribers need to appropriately address and attempt to remediate any discrepancies discovered when checking the PDMP or a urine drug screen.

Patients on chronic methadone can develop dangerous prolongation of the QT interval in their cardiac conduction. An annual electrocardiogram (EKG) has been considered standard.

Terminal Illness

The Board believes that physicians should make every effort to relieve the pain and suffering of their terminally ill patients. Patients nearing the end of their lives should receive sufficient opioid dosages to produce comfort. The physician should acknowledge that the natural dying process usually involves declining blood pressures, decreasing respirations and altered levels of consciousness. Opioids should not be withheld on the basis of physiologic parameters when patients continue to experience pain.

Some physicians express concerns that the use of opioids in these patients may hasten death through pneumonia or respiratory depression. For these reasons, at times physicians may have limited the use of opioids in dying patients out of fear that they may be investigated for inappropriate prescribing or allegations of euthanasia.

The Board is concerned that such fear on the part of physicians may result in inadequate pain control and unnecessary suffering in terminally ill patients. The Board encourages physicians to employ skillful and compassionate pain control for patients near the end of life and believes that relief from suffering remains the physician's primary obligation to these patients.

Evolving Standards

Finally, the Board knows the expectations of care can and do shift over time as the understanding of these complex situations shifts. While the Board makes every effort to update statements such as this, the final adjudication of an investigation of potential overprescribing will rest upon the recognized standards at the time. ✚

- Adopted January 1993
- Amended April 1999
- Amended July 2004
- Amended April 2011
- Amended January 2013
- Amended April 2016
- Amended July 1, 2021

Under ORS 677.190(24) the Oregon Medical Board may may suspend or revoke a license to practice medicine for prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

From the Desk of the Medical Director

David Farris, MD | Medical Director, Oregon Medical Board

Chronic Opiates

In my first 12 months as Medical Director, the Board opened investigations on 19 complaints of potential overprescribing of chronic opiates, and the pace has not slowed. As with any allegation of inappropriate patient care, these are reviewed by expert consultants to determine whether the prescribing practices meet the standard of care. In an effort to help licensees avoid these complaints and to improve patient care, I'd like to relate recurring themes and relevant facts.

First, a significant portion of practitioners facing complaints have not updated their practice patterns since the days we were encouraged to liberalize prescribing for pain, the "fifth vital sign." It is incumbent upon all practicing licensees to seek ongoing education and remain current with new practice standards for the safety of our patients.

Encouragingly, a number of licensees who have undergone review of their prescribing practices and subsequent Board-required education have ultimately reported obvious and significant improvements in their patients' results. Many patients on long-term high-dose opiates are more functional once they safely taper to lower doses or are transitioned to agonist/antagonist (buprenorphine) therapy. Several practitioners have expressed gratitude to the Board for being directed to better practices.

One very prominent internist told me, "Today was never the day to discuss tapering. There was always something else going on: Upcoming surgery. Family stress. But when the Board's investigation process started, today became the day. The visits were longer. There were tears. But ultimately, my patients were not only safer, but doing better." Another practitioner summarized this phenomenon simply: "I had to grow a spine." The Board recognizes that chronic pain is a complex issue, requiring difficult discussions and careful shared decision making with patients.

Unlike most areas of medicine, there are readily available documents describing the current expectations for chronic opiate prescribing, such as the CDC's **Prescribing Guidelines**. Additionally, the OMB has newly updated its Statement of Philosophy for Pain Management, featured on the front page of this issue and available **online here**. The following education modules are also highly recommended:

- **PBI Education** – RX-21 Extended
- **PACE/UCSD** – Physician Prescribing Course
- **CPEP** – Basics of Chronic Pain Management, Prescribing Controlled Drugs: Critical Issues and Common Pitfalls
- **Case Western Reserve University** – Intensive Course in Controlled Substance Prescribing
- **WILM** – Prescribing Practices & Management of Chronic Pain & Substance Use Disorder

Calling All OMB Consultants

If you are or were a consultant to the Board, you likely just received a renewal contract by email. Consultant contracts expire after 24 months. Please do complete and return it even if we did not ask you to participate in the last biennium. When I need a consultant, my search function looks for "active" consultants and I would hate to miss you. ✚

The 34th Annual Chronic Pain Management Conference

Presented by the Foundation for Medical Excellencec in cooperation with the College of Physicians and Surgeons of British Columbia

The 34th Annual Chronic Pain Management Conference will be held on Friday, September 17, 2021.

This one-day virutal, interactive conference equips clinicians to work with the most difficult chronic pain patients - patients with complex chronic pain. These patients' pain frequently erodes non-medical domains of function, such as social, work and family relationships. This one-and-a-half-day course builds the knowledge base and skills necessary to work productively with these patients. There is a focus on recognition of substance misuse and addiction as prescribed medication sometimes leads to decreasing function in these patients. Because this work can be challenging, attention is also directed to maintaining clinician well-being and emotional balance. Optional half-day sessions are offered in cognitive behavioral therapy and advanced intereviewing skills.

Registration information is available at **TFME.org**. ✚

Topic of Interest: Physician Assistant Modernization Bill

In 2021, the Oregon Legislature passed **House Bill 3036**, which modernizes physician assistant practice in Oregon. The bill's effective date of June 23, 2021, allows the Oregon Medical Board to start working on implementation of the bill. The actual changes to PA practice provided in HB 3036 are operational in phases on January 15, 2022, and July 15, 2022 (see HB 3036 sections 9, 20, and 21).

The OMB is currently reviewing and developing a plan for implementation of HB 3036. Rulemaking will start in fall 2021 and continue through July 2022. There will be opportunities for stakeholder input and feedback during the process.

HB 3036 Summary
The summary below does not include every provision of HB 3036, but highlights areas that will be addressed in OMB rulemaking. Section numbers are provided for reference to HB 3036, along with operational dates for each section. Please review HB 3036 for detailed information.

Operational January 15, 2022

- Updates PA requirements to dispense prescription drugs.
- Removes requirement that PAs include supervising physician information on each prescription.
- Removes requirement that PAs practice within the scope of practice of a supervising physician.
- Updates the degree of autonomous judgment that a PA may exercise and allow that to be determined at the PA's primary practice location according to the community standard of care and the PA's education, training, and experience.
- Adds a telemedicine license for PAs, which authorizes those licensees to provide care to Oregon patients via telemedicine when the PA is physically located outside of the state.

Operational July 15, 2022

- Adds definitions for collaboration, collaboration agreement, and employer. Removes definitions for practice agreement, supervision, supervising physician, and supervising physician organization (SPO).
- Removes requirement for PAs to practice under a supervising physician or SPO.
- Allows PAs to enter a collaboration agreement with an Oregon physician or the PA's employer.
- Allows PAs to continue practicing under a current practice agreement or practice description until the PA enters into a collaboration agreement. Requires PAs to transition to a collaboration agreement when the PA's license is due for renewal or December 31, 2023, whichever is later.

Information about HB 3036 and the Board's implementation process, including rulemakings and public input opportunities will be available on the Board's **HB 3036 webpage**.

Please email **elizabeth.ross@omb.oregon.gov** with comments or questions about HB 3036 and the implementation process. ✚

Update: Inital Licensure Personal History Questions

The Oregon Medical Board's initial licensure application asks five questions related to physical, mental, and emotional health conditions that may impair an applicant's ability to practice safely and competently. The Board reviews and modifies these questions periodically. At the April 1, 2021, meeting, the Board directed staff to revise these questions to inquire about any impairing conditions experienced within the previous six months as opposed to conditions experienced within the past two years. These revisions to the initial licensure application are effective as of July 1, 2021.

It is the hope of the Board that changes to these questions may encourage providers to seek appropriate care, destigmatize mental health issues, and ultimately address the growing concern of mental and behavioral health conditions within the medical community. ✚

Vaccine Education App Combats Misinformation, Hesitancy

The Pediatric Infectious Diseases Society (PIDS) has launched **The Comprehensive Vaccine Education Program** to help combat vaccine misinformation and hesitancy.

The program will offer two ways to do this — the first is a web-based educational curriculum, and the second is a mobile app that provides up-to-date vaccine information, called **The Vaccine Handbook App**.

Visit **PIDS.org** for more information. ✚

OMB Welcomes New Board Members

Anthony Domenigoni, DPM

Dr. Anthony Domenigoni is a podiatric physician at Kaiser Permanente in Clackamas, OR, and is board certified in both Foot and Rearfoot & Reconstruction Surgery. He obtained his undergraduate degree from the University of Oregon before attending the Dr. William M. Scholl College of Podiatric Medicine in Chicago, IL. Dr. Domenigoni completed residency training, as well as the Kaiser/Legacy Podiatry Residency Program, in Portland. He continues to actively participate in resident training at Kaiser Permanente and currently serves as the Surgical Lead for the Department of Medical Informatics and the Chief of the Podiatry Department.

Outside of his medical practice, Dr. Domenigoni enjoys staying active with exercise including hiking, biking, and skiing. He also enjoys reading, watching movies, and walking his dog with his spouse and two daughters.

Dr. Domenigoni succeeds Dr. Andrew Schink of Eugene as the podiatric physician on the Board.

Paula Lee-Valkov, MD

Dr. Paula Lee-Valkov is a board-certified radiologist who has practiced in The Dalles, OR since 2006. She currently practices with a small Adventist Radiology group, which serves east Portland, The Dalles, and Kailua, HI.

Dr. Lee-Valkov attended MIT and earned her Bachelor of Science in Civil and Environmental Engineering and her Masters in Environmental Health Sciences. She went on to earn a Doctorate in Medicine at Baylor College of Medicine in Houston, TX. She completed her internship at Alameda County Medical Center in Oakland, CA, and her residency at Tulane University in New Orleans, LA.

Dr. Lee-Valkov served on the Mid-Columbia Medical Center Quality Committee, Credentials Committee, Cancer Committee, and the Breast Center Stewardship Committee. She also served on the Medical Executive Committee as the 2018 Chief of Medical Staff. Since 2008, Dr. Lee-Valkov has been a board member for the Mid-Columbia Health Foundation, which acts as the philanthropic arm to Mid-Columbia Medical Center, helping to ensure the community's access to quality local health care.

Outside of medicine, Dr. Lee-Valkov enjoys spending time with her family, stand-up paddle boarding, kayaking, biking, playing her ukulele, and she has actively been trying to bring her Trinidadian "peppa" sauce to the local food market.

Dr. Lee-Valkov succeeds Dr. Jim Lace of Salem. ✚

Public Health & Pharmacy Formulary Advisory Committee

The Oregon Board of Pharmacy is seeking applicants to become members of the Public Health & Pharmacy Formulary Advisory Committee. The following opportunities are available for appointment on December 1, 2021:

- Two Pharmacist member positions
- One Advanced Practice Registered Nurse member position
- Two Physician member positions

If you are qualified and interested in being considered for a position as a Formulary Advisory Committee member, email the Governor's Office of Executive Appointments (executive.appointments@oregon.gov) or call 503-376-6829. The application packet is available online here.

For questions or inquiries related to the Public Health & Pharmacy Formulary Advisory Committee, contact pharmacy.formulary@bop.oregon.gov or visit the Board of Pharmacy's website. ✚

Statement of Philosophy: Cultural Competency

The Oregon Medical Board's mission is to regulate the practice of medicine in a way to promote access to safe, quality care for all Oregon citizens. Oregonians are growing increasingly diverse, and inequities in access to quality health care are apparent. Achieving equity of health outcomes requires that we first acknowledge that current inequities are not acceptable, that we gain a better understanding of what contributes to inequity, and that we commit to addressing inequities.

The Oregon Medical Board recommends the following as a basis for inspiring positive change for the benefit of all patients:

1. Focus on self-reflection and culturally competent practice
Licensees are encouraged to engage in self-reflection, understand their own conscious and unconscious biases, and consider the impact on the provider-patient relationship. The extent to which providers engage in self-reflection, consider how their own cultural view and biases influence patient care, and then adjust their practice, depends heavily on provider self-motivation to make change. Initiatives to embed cultural competency into all areas of practice, professional development, policies, and processes are essential.

2. Acknowledge systemic racism
Some patients may have difficulty engaging with health professionals or with the treatment prescribed due to systemic issues. It is important to acknowledge that systemic racism and privilege exist in the health sector in order to meaningfully address this problem. Providers can reflect on their own cultural views and biases as a first step, then work to influence and support positive changes in their institutions and organizations.

3. Collect and use data for equity monitoring
Health care providers need access to robust and accurate data to identify inequities and address problematic structures and processes.

4. Overcome structural barriers to individualize care
Short clinical visits focused on only the patient's immediate needs results in a relationship which is largely transactional. To strengthen the provider-patient relationship and provide culturally competent care, providers must consider the individual patient's practices, values, and beliefs. Tailoring the clinical visit to the individual can ensure the patient's input is respected and valued.

All Oregon Medical Board licensees are required to complete cultural competency continuing education to care effectively for patients from diverse cultures, groups, and communities. Participating in cultural competency continuing education is a way to gain a better understanding of Oregon's socially and culturally diverse communities and to foster a commitment to addressing health care inequities. ✚

- Adopted October 2013
- Amended, April 1, 2021

The Oregon Medical Board holds licensees to recognized standards of ethics of the medical profession, specifically for this philosophy: American Medical Association's Code of Medical Ethics: Opinion 9.121 Racial and Ethnic Health Care Disparities; American Association of Physician Assistants' Guidelines for Ethical Conduct for the PA Profession: The PA and Individual Professionalism-Competency; and Oregon Association of Acupuncturists' Code of Ethics: 1.1 Competence.

- ORS 677.190(1)(a) and ORS 677.188(4)(a)

Coming Soon: License Renewal Season

Between October and December this year, nearly all Oregon physicians and physician assistants will renew their medical licenses. During this three-month period, the Board will be busy renewing approximately 20,000 licenses while continuing to process new applications to practice in Oregon. As we approach license renewal season, here's what you can do to prepare:

Watch for email and postcard reminders to renew. Beginning in early October, you may log in to the OMB's **Applicant and Licensee Services page** to initiate the renewal process. You are required to ensure all information is complete and accurate, making this a great opportunity to update your mailing and practice addresses, employment or hospital privileges, languages spoken, and other state licenses.

Review your CME requirements and organize certificates in anticipation of the OMB's random CME audit. Licensees are notified during the renewal process if they will be audited. Remember, CME requirements are automatically met with maintenance of board certification. If you participate in ongoing maintenance of certification with an accepted certifying board, OMB staff will attempt to verify certification directly with the specialty board, and you will not be required to provide additional CME documentation. For more information about CME requirements, including the number of hours required, acceptable CME providers, possible exemptions, and penalties for failure to comply, please review OAR 847-008-0070. More information is available the Board's **Continuing Education webpage**.

Licensing staff is available for any questions you may have. The Licensing Call Center can be reached at 971-673-2700, Monday through Friday, from 9 a.m. – noon and 1 p.m. – 3 p.m. ✚

Reminder: Mandatory Cultural Competency Continuing Education Requirements

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

In 2019 (HB 2011), the Oregon Legislature mandated cultural competency continuing education for health care professionals as of **July 1, 2021**. Under the new requirement, Oregon Medical Board licensees must complete cultural competency continuing education as a condition of licensure.

- **Licensees required to comply:** All Oregon physicians, physician assistants, and acupuncturists whose license is at a practicing status must meet this requirement. The only exceptions are licensees in residency training and volunteer camp licensees. Licensees with a "retired" status do not have to meet the requirement because their license is not at a practicing status.
- **Number of hours:** Licensees must complete an average of at least one hour of cultural competency education per year during an audit period. An audit period is two renewal cycles (i.e. every four years for most licensees). Required hours will be based on the number of years licensed during the audit period; any portion of a year licensed will require one hour of cultural competency education. For example, a licensee who has been licensed for 3.5 years during the audit period will be required to obtain four hours of cultural competency education. Hours may be obtained at any time during the audit period. For example, either one four-hour experience, or four one-hour courses taken annually, would satisfy the requirement.
- **Educational opportunities:** The cultural competency continuing education may (but does not have to) be accredited continuing medical education (CME). The law was written to allow a wide array of courses or experiences, which may include: courses delivered in-person or electronically, experiential or service learning, cultural or linguistic immersion, volunteering in a rural clinic, an employer's cultural competency training, attending an event with members of an underserved community to discuss health care access issues, or courses approved by the Oregon Health Authority.
- **Tracking completion:** Licensees may, but are not required to, track educational hours on a **Board-provided record keeping form**. During license renewal, licensees will attest to completing the required hours by checking a box and reporting the number of hours obtained. The Board will audit for compliance every other renewal cycle with the first audit being conducted during the Fall 2023 renewal cycle. The cultural competency audit will be included within the existing audit for CME compliance. Beginning in 2023 (and every other renewal cycle thereafter), audited licensees will be asked to also produce documentation of their cultural competency educational experiences. Documentation may be a course certificate, the OMB record keeping form, or other documentation.

For the first audit period during the Fall 2023 renewal cycle, licensees will be required to report two hours of cultural competency education.

Information about this requirement, the rulemaking, links to OHA approved courses, and the record keeping form are available on the Board's **Cultural Competency webpage**. ✚

The 38th Annual Oregon Rural Health Conference will be back in-person this October, with over three hundred providers, administrators, policy-makers, consumers, and public health experts coming together to explore topics of vital importance to Oregonians living in rural communities.

In light of the ongoing COVID-19 pandemic, this year's conference will feature various precautionary measures to ensure the safety of guests and speakers, as well as conference and hotel staff, including socially distanced seating and capacity limitations.

For more information or to register for the conference, visit the **Oregon Office of Rural Health's website**. ✚

Critical Access Hospital in Oregon Uses Advisory Council and Trainings to Improve Cultural Competency

Allee Mead | Web Writer, Rural Health Information Hub

This article was originally published in **The Rural Monitor** *and reprtined here with permission.*

St. Charles Madras is a Critical Access Hospital (CAH) that serves Jefferson County in Oregon. Its service population is about one-third American Indian people, one-third Latino people, and one-third White people. However, the nursing staff at St. Charles Madras is predominantly White, with only one Latina nurse and one American Indian nurse.

St.. Charles Madras staff realized through employees' and patients' feedback that they weren't doing enough to provide culturally competent care to its American Indian and Latino patients. Some providers said they were worried about how their care might interfere with a patient's cultural preferences, and patients shared anecdotes of times when healthcare staff treated them with disrespect or a lack of understanding of their cultures.

For example, Chief Nursing Officer Candy Canga-Picar, DNP, shared one nurse's story of an American Indian patient who had lost her baby during childbirth. The patient and the family were upset to see that the baby had not been wrapped in white cloth, a symbolic color in this family's culture. The nurse was also surprised when the patient shaved her own head, a sign of grieving. "The whole experience created unnecessary tension between the nurse and the family due to lack of understanding of each other's culture," Canga-Picar said.

Canga-Picar was born in the Philippines and immigrated to the United States in the early 1990s to work as a registered nurse. When she was working on her doctorate, she completed a capstone project to promote racial equity in healthcare. Canga-Picar found evidence-based training and education in cultural competency and brought these findings to St. Charles Madras.

To improve cultural sensitivity and understanding, the hospital applied for a Small Rural Hospital Improvement Project (SHIP) grant via the Oregon Office of Rural Health to create a pilot project to better serve its American Indian and Latino patients. The project collects feedback from patients and community leaders and uses employee trainings to improve cultural competency.

The SHIP Program

The Small Rural Hospital Improvement Program (SHIP) is administrated by the Federal Office of Rural Health Policy (FORHP) within the Health Resources and Services Administration (HRSA). SHIP funds State Offices of Rural Health (SORHs) to in turn support rural hospitals with 49 or fewer beds in three categories: value-based purchasing, Accountable Care Organizations, and payment bundling.

SHIP awardees are located in 46 states that have qualifying hospitals. About 1,600 hospitals participate each year, and SORHs receive about $12,000 per participating hospital. Hospitals are given the option to pool their funds as a network at the state level or to determine their own projects.

Oregon has 32 SHIP-eligible hospitals, 25 of which are CAHs. Oregon offers a network option, but a majority of the hospitals do not choose it. Rebecca Dobert has been Field Services Program Manager at the Oregon Office of Rural Health since 2016, and she said there's never been more than a third of the hospitals taking the network option.

Most SHIP hospitals in Oregon like St. Charles Madras complete independent projects. This approach, Dobert said, "does give them the leeway to work with me to design projects that really meet their need."

Every participating SORH sends reports to HRSA. Salamatu "Sallay" Barrie, a HRSA project officer for the SHIP program, works to see which cohort of her grantees stand out as a promising practice, and that's where Dobert told her about St. Charles Madras' work.

Barrie recognized the promising practice in the cultural competency aspect, the evidence-based training, and the story that the data were able to tell about St. Charles' improved patient satisfaction scores.

St. Charles Madras: Advisory Councils, Trainings, and Artwork

At St. Charles Madras, Canga-Picar reached out to the Chief Physician Officer and the Chief Nursing Executive and worked with a local Indian Health Service (IHS) clinic provider and nurse manager who introduced her to leaders from the Confederated Tribes of Warm Springs.

These healthcare staff and tribal leaders served on a panel for a cultural summit, funded by the SHIP grant, held at the local performing arts center. The summit featured a lecture on transcultural care, and the panel discussed American Indian cultures and history as well as ways providers can adjust their care to better align with a patient's beliefs and traditions.

Establishing trust with the tribal leaders took a while. Our hospital leadership team worked diligently to remain transparent and humble and listened to their concerns.

"Establishing trust with the tribal leaders took a while," Canga-Picar said. "Our hospital leadership team worked diligently to remain transparent and humble and listened to their concerns."

Canga-Picar said the number of inpatient providers who completed the initial cultural competency training and education surpassed the goal set at the start of the pilot project. About 110 providers and community members attended the conference.

In addition, the hospital's nurse leadership and human resources worked together to rewrite nursing job descriptions to include requirements about participating in cultural competency activities. St. Charles Madras also updated its artwork in and around the hospital to better reflect its patient population. For example, the outdoor healing garden has an artistic rendering of a piece of rock art in the Columbia River Gorge called "She Who Watches" along with a sculpture of three salmon, which represent abundance, renewal, fertility, and prosperity.

Tribal leaders also participate in the newly formed Patient Family Advisory Council (PFAC), which also includes leaders from the Latino communities. This formal group meets regularly with healthcare providers to weigh in on policy and program decisions. "The PFAC is the voice of our patients and family members to assist the hospital in improving the quality of care," Canga-Picar said. The PFAC developed five hospital policies around cultural considerations for American Indian patients.

"I loved that Candy and St. Charles really took the intent of the program and applied it to help quantify and ameliorate a gap in the quality of care being provided to a significant portion of their patient demographic. It was a simple, evidence-based approach that accomplished quite a complex task.

"I loved that Candy and St. Charles really took the intent of the program and applied it to help quantify and ameliorate a gap in the quality of care being provided to a significant portion of their patient demographic," Dobert of the Oregon SORH said. "It was a simple, evidence-based approach that accomplished quite a complex task."

Results and Success Stories

The PFAC also advised the hospital to switch from a mailed patient satisfaction survey to a telephone survey, as many community members in the service area would rather share their opinions and experiences verbally instead of in writing. Hospital staffers have already seen an increase in the number of people who respond to their surveys, from a small number of people to around 25 per fiscal quarter.

Dobert at the Oregon SORH encourages big-picture thinking among SHIP awardees and reminds them that seemingly "mundane" tasks like collecting HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) surveys from patients are important for quality improvement. SHIP awardees must publicly report HCAHPS scores.

HCAHPS scores for St. Charles Madras show an increase in survey participants who said they'd recommend the hospital: from 60.9% in 2018 to 67.1% in 2019 to 69.9% in 2020. The hospital also saw a drop in the number of patient complaints — from 59 to 13.

Dobert remembers Canga-Picar saying that community members told her this pilot project was the first time anyone had not only asked for their input but then made changes based on that feedback. "I don't think the value of that can be overstated ever. It's also far past time," Dobert said.

Dobert added, "If we don't get the answers from the people we're serving, we don't know how to serve them." She sees this attention to patients' feedback as a crucial part of St. Charles Madras' work: "Starting with attaining a simple, genuine assessment of where the hospital was not meeting the needs of a patient population, they have been able to have significant impacts across the facility and beyond."

It's not just patients appreciating St. Charles Madras' work. A health equity council in central Oregon reached out to Canga-Picar to learn more about her pilot project, and the Oregon Medical Board asked for a presentation about this work. The Oregon Office of Rural Health asked Canga-Picar about replicating this project throughout the state. In 2019, Canga-Picar received the Transformational Pioneer Award from the Northwest Organization of Nurse Leaders; she was nominated by her administrator.

Dobert said her state has many highly engaged SHIP awardees, but St. Charles Madras' "work was a standout from the beginning" and demonstrates "the quintessential value of SHIP."

It's being able to promote patient advocacy and empowerment…It's not just somebody coming in and saying, 'This is what we need to do.' It's making sure that community is part of that process

Barrie noted how the hospital brought together tribal leaders and healthcare providers to develop new policies and programs. "It's being able to promote patient advocacy and empowerment…It's not just somebody coming in and saying, 'This is what we need to do.' It's making sure that community is part of that process," Barrie said. ✚

Statement of Philosophy: Use of Unlicensed Healthcare Personnel in Acupuncture

In providing safe, effective, and efficient care, an Oregon-licensed acupuncturist may be assisted by unlicensed healthcare personnel. Acupuncturists must use caution when employing unlicensed personnel, including ensuring adequate training and appropriate supervision and avoiding delegation of the practice of acupuncture.

An acupuncturist may not allow unlicensed healthcare personnel to practice acupuncture as defined in ORS 677.757. Unlicensed healthcare personnel may not diagnose, provide point location or needle insertion, perform manipulation, render advice to patients, or perform other procedures requiring a similar degree of judgment or skill.

Unlicensed healthcare personnel may perform administrative, clerical, and supportive services under adequate supervision by a licensed acupuncturist. Supportive services may include, but are not limited to, the operation of an e-stim machine after the acupuncturist has placed needles, attached leads, and set frequency. Operation in this context includes turning on the machine, adjusting intensity for patient comfort, turning off the machine, and unclipping the machine from needles so long as the unlicensed healthcare personnel is trained to do so. Unlicensed healthcare personnel may also remove needles after receiving appropriate training and supervision from a licensed acupuncturist.

Unlicensed healthcare personnel should clearly identify themselves to patients. This should include clear identification on badges as well as direct communication with patients.

In order to fulfill its mission to protect the health, safety, and wellbeing of Oregonians, the Oregon Medical Board asks Oregon-licensed acupuncturists to follow these guidelines and to be mindful of patient safety when using the assistance of unlicensed healthcare personnel. ✚

- Adopted July 1, 2021

The Oregon Medical Board holds licensees to recognized standards of ethics of the medical profession, including the Oregon Association of Acupuncturists' Code of Ethics: Rule 2.3 Staff, and the National Certification Commission for Acupuncture and Oriental Medicine's 2016 Code of Ethics.

- ORS 677.190(1)(a) and ORS 677.188(4)(a)

Oregon Children's Advocacy Centers

For over 25 years, Oregon Child Abuse Solutions (OCAS) has partnered with local communities and their experts, including law enforcement, the Department of Human Services (DHS), and medical professionals, to strengthen solutions for child abuse.

OCAS operates a statewide network of Children's Advocacy Centers (CACs) that minimize trauma for children when there are concerns of abuse. CACs are nonprofits, often situated in a trauma-informed, child-friendly environment which helps children feel safe and comfortable, and employ child abuse medical professionals, forensic interviewers, prevention educators, family advocates, and therapists. All professionals within the CACs are mandatory reporters and responsible for reporting abuse 24/7.

By partnering with child welfare, law enforcement, medical, and mental health providers, CACs help families through investigations without requiring them to travel to traumatic places like emergency rooms and police stations. CACs help ensure collaborative response and reduce the number of times children have to talk about their abuse. CACs also provide additional services for children and community members, such as community trainings and mental health support.

There are currently 20 CACs throughout Oregon, with more in development, collectively serving approximately 8,000 children each year, 78% of whom are 12 years old or younger. The most common allegations brought to the Centers are sexual or physical abuse, witness to violence, neglect, and drug endangerment.

For training opportunities and resources, including information on how to prevent and recognize the signs of abuse, visit the **CAC's website**. ✚

REALD for Phase 3 Providers

Last year, the Oregon State Legislature passed House Bill 4212 sections 40-43, which requires licensees of the OMB to collect race, ethnicity, language, and disability (REALD) data from patients during a COVID-19 encounter.

The phased implementation of REALD data collection began in October 2020 with hospitals and health care providers within a health system or working in a federally qualified health center. Phase 2 began in March of this year and included health care facilities and providers working in or with individuals in a congregate setting.

Starting October 1, 2021, all health care providers in Oregon must begin collecting and reporting REALD data in accordance with current REALD standards and Oregon Disease Reporting rules. These include:

- Phase 1 and Phase 2 providers who have not yet begun REALD data collection and reporting for COVID-19 encounters;
- Other health care providers defined in House Bill 4212 (1st Special Session) who do not work in a Phase 1 or Phase 2 health care setting.

Any Phase 3 providers who cannot start reporting data on October 1, 2021, must submit a compliance plan to OHA. You can learn more about how OHA will assess compliance here.

You can learn more about how OHA will assess compliance on the OHA's REALD for Providers page. Visit the OMB's REALD Topic of Interest page for rules, guidelines, and other implementation resources.

Oregon Administrative Rules

Rules proposed and adopted by the Oregon Medical Board.

The OMB and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended in response to evolving standards and circumstances. OARs are written and amended within the agency's statutory authority granted by the Legislature.

Rules go through a First and Final Review before being permanently adopted. Temporary rules expire 180 days after adoption unless permanently adopted through the rulemaking process. Official notice of rulemaking is provided in the Secretary of State Bulletin. The full text of the OARs under review and the procedure for submitting comments can be found at **omb.oregon.gov/rules**.

PROPOSED RULES

First Review. Written comments for all rulemakings due by 5 p.m. on August 24, 2021, via email to elizabeth.ross@omb.oregon.gov.

All Licensees

847-010-0130: Establishes requirements for Oregon Medical Board licensees to use medical chaperones.

The proposed rule requires board licensees to utilize a medical chaperone for all breast, genital, and rectal examinations performed in outpatient and inpatient settings for all genders and ages by January 1, 2023. This proposed rule was recommended by the Oregon Medical Board's Workgroup on Sexual Misconduct to adopt the American College of Obstetricians and Gynecologists (ACOG) recommendation for medical chaperones. ***The Board will take public oral comments on the proposed rule at a public hearing via videoconference on Tuesday, August 24, 2021 at 10:00 a.m. and written comments will be accepted until 5 p.m. on August 24, 2021. Please see the rulemaking information sheet for proposed rule language and how to participate in the public hearing via videoconference.***

Videoconference Public Hearing on OAR 847-010-0130 Proposed Rule
Tuesday, August 24, 2021, 10 a.m.

Zoom Meeting	By Phone: 253-215-8782
Meeting ID: 892 0560 4517	Meeting ID: 892 0560 4517
Passcode: gW83q4te*	Passcode: 856670386

847-008-0065: Amendment to allow licensees to practice under a variation of their legal name.

The proposed rule amendment allows licensees to practice under a variation of their legal name if the licensee notifies the Board of this name variation. Without this rule amendment, licensees must practice under their first, middle, and last name without use of initials. Licensees

who are known professionally by their legal middle name or maiden name are out of compliance with the current rule. Patients must be able to identify their providers and locate providers on the Oregon Medical Board's Licensee Search website. The proposed rule amendment requires licensees to notify the Board of the legal name variation in order to ensure that the name is recorded correctly in the Board's database, allowing the public to search for their provider on the Board's website.

847-010-0073: Medical incompetence and unprofessional or dishonorable conduct definitions and incorporation of recognized ethics standards.
The proposed rulemaking further defines "medical incompetence" to clarify that evidence of medical incompetence also includes failure to pass a competency exam/program or complete a course/program when required by the Board or a health care facility. The proposed rulemaking breaks out the nine separate types of conduct within definition of "unprofessional or dishonorable conduct" in ORS 677.188(4). The rulemaking clarifies that a licensee may not knowingly contact the complainant, or allow any person authorized to act on behalf of the licensee to knowingly contact the complainant, until the licensee has requested a contested case hearing and the Board has authorized the taking of the complainant's deposition. Lastly, the proposed amendment incorporates by reference the ethics standards of the board's regulated professions and defines financial conflicts of interest.

847-001-0024: Enrolling specified licensees in the National Practitioner Data Bank's continuous query.
The proposed rule amendment requires the Board to enroll active licensees alleged to have engaged in sexual misconduct in the National Practitioner Data Bank's Continuous Query for two years from the date of the last allegation. Enrolling licensees for two years will provide continuous monitoring and ensure the Board receives timely notice of any additional actions.

847-065-0055: Health Professionals' Services Program licensee reporting responsibilities.
The proposed rule amendment would require Health Professionals' Services Program (HPSP) licensees to report any citation for the use or possession of any DEA scheduled substances including but not limited to citations for Class E violations. The proposed rule amendment also clarifies that a current license status includes active and lapsed license statuses.

Physician
847-015-0040: Collaborative Drug Therapy Management.
The proposed amendment removes the requirement that a collaborative drug therapy protocol be filed with the Oregon Board of Pharmacy. The protocol only needs to be kept on file in the pharmacy and made available to the Oregon Board of Pharmacy and the Oregon Medical Board upon request. The proposed rule amendment aligns with the Oregon Board of Pharmacy's rule, OAR 855-019-0260.

Acupuncture
847-070-0050: Updating Oregon Association of Acupuncturists name.
The proposed rule amendment updates the association name from "Oregon Association of Acupuncture and Oriental Medicine" to "Oregon Association of Acupuncturists."

ADOPTED RULES

All Licensees
847-001-0032, 847-001-0024: Termination of Corrective Action Agreement and Truthful Response.
The rule amendment delegates the authority to terminate a Corrective Action Agreement (CAA) to the Executive Director or Medical Director if all terms are successfully completed. CAAs are designed to modify or monitor an identified issue, often requiring educational courses. The CAA may be terminated once a licensee completes all of the agreement's terms. Delegating the authority provides the licensee faster resolution. Secondly, the rule amendment clarifies the board's expectation that licensees and applicants truthfully respond to the board's investigative inquiries.

Acupuncture
847-070-0020: Acupuncturist Use of the Title of "Doctor" in Practice.
The rule amendment clarifies that as provided in ORS 676.110, an Oregon licensed acupuncturist who has earned a doctoral degree in acupuncture may use the title of "doctor" in connection with the practice of acupuncture, if the doctoral degree program holds federally recognized accreditation and the specific doctoral degree is designated in all professional communications as required by ORS 676.110(2). See the Board's webpage for **Acupuncturist Using the Title "Doctor"** for more information.

TEMPORARY RULE

EMS Providers
847-035-0030: EMTs, Advanced EMTs, EMT Intermediates, and Paramedics to prepare and administer COVID-19 immunizations.
The temporary rule aligns with the State of Oregon EMS Medical Director protocol dated May 26, 2021, allowing Emergency Medical Technicians (EMT), Advanced EMTs, EMT Intermediates, and Paramedics to prepare and administer COVID-19 immunizations under the direction of their supervising physician and within the agency's supervising physician's standing order. The temporary rule is valid from June 15, 2021 until December 11, 2021.

Board Actions

April 16, 2021 - July 15, 2021

Many licensees have similar names. When reviewing Board Action details, please review the record carefully to ensure that it is the intended licensee.

INTERIM STIPULATED ORDERS

*These actions are not disciplinary because they are not final orders, but are reportable to the national data banks.**

CORDES, Kathleen K., MD, MD16009
Eugene, OR

On June 8, 2021, Licensee entered into an Interim Stipulated Order to cease prescribing opioid and benzodiazepine medications except for patients enrolled in hospice or receiving end of life care pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

KLOS, Martin M., MD, MD18059
Springfield, OR

On May 26, 2021, Licensee entered into an Interim Stipulated Order to voluntarily limit his prescribing of scheduled opiate medications to buprenorphine only and only in outpatient settings pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

ORTIZ, Orlando R., MD, MD201294
Portland, OR

On June 22, 2021, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

THOMAS, Paul N., MD, MD15689
Portland, OR

On June 3, 2021, Licensee entered into an Interim Stipulated Order to voluntarily limit his practice to acute care; refrain from engaging in consultations or directing clinic staff with respect to vaccination protocols questions, issues or recommendations; and refrain from performing any research involving patient care pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

YAMASE, Melvin H., MD, MD15185
Canby, OR

On June 11, 2021, Licensee entered into an Interim Stipulated Order to voluntarily cease new opioid prescriptions, not increase the dosage of current opioid prescriptions, and identify all current patients on potentially dangerous regimens who must be seen and evaluated for possible taper, transfer, or co-management with a second physician pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

NON-DISCIPLINARY BOARD ACTIONS

*These actions are not disciplinary and are not reportable to the national data banks.**

CORRECTIVE ACTION AGREEMENTS

These agreements are not disciplinary orders and are not reportable to the national data banks unless they relate to the delivery of health care services or contain a negative finding of fact or conclusion of law. They are public agreements with the goal of remediating problems in the Licensees' individual practices.*

FIORILLO, Joseph A., MD, MD29086
Eugene, OR

On July 1, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved professionalism course.

CONSENT AGREEMENTS FOR RE-ENTRY TO PRACTICE

*These actions are not disciplinary and are not reportable to the national data banks.**

DOUGLASS, Kristen M., MD, MD21722
Clackamas, OR

On July 12, 2021, Applicant entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to practice under the supervision of a pre-approved physician mentor for 2,000 hours, to include reports to the Board by the mentor; pass the Special Purpose Examination within six months; and obtain certification from the American Board of Pediatrics.

MARSH, Brenda J., MD, MD196987
Portland, OR

On May 24, 2021, Applicant entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to practice under the supervision of a pre-approved physician mentor for 500 hours, to include reports to the Board by the mentor, and complete 100 hours of CME.

PURSELL, Jennifer J., LAc, AC01192
Portland, OR

On May 3, 2021, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to complete an 80-hour mentorship with a Board-approved clinical supervisor and complete 30 hours of continuing education.

SCHUMACHER, John P., MD, MD20852
Portland, OR

On April 20, 2021, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of pre-approved physician mentor for 500 hours.

TRIMAS, Mandi A., LAc, AC199307
Portland, OR

On May 24, 2021, Applicant entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to complete an 80-hour mentorship with a Board-approved clinical supervisor and complete 30 hours of continuing education.

DISCIPLINARY ACTIONS

*These actions are reportable to the national data banks.**

FIKS, Vladimir B., MD, MD19358
Portland, OR

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and repeated acts of negligence. This Order assesses a $7,500 civil penalty; prohibits Licensee from obtaining, purchasing, leasing, or using any equipment for vestibular or balance testing; and prohibits Licensee from performing allergy testing and treating chronic environmental allergies by desensitization injections.

HYSON, Morton I., MD, MD175174
Las Vegas, NV

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for fraud or misrepresentation in applying for or procuring a license to practice in this state; and failure to report to the Board any adverse action taken against Licensee by another licensing jurisdiction as required. With this Order, Licensee surrenders his medical license while under investigation and agrees to not reapply for an Oregon medical license for at least two years.

JOHNSON, Cory T., MD, MD24075
Klamath Falls, OR

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. This Order revokes Licensee's Oregon medical license and prohibits him from reapplying for an Oregon medical license for at least two years.

KILBOURN, Roger S., DO, DO177082
Pendleton, OR

On June 3, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and prescribing controlled substances without following accepted procedures for examination of patients or for record keeping. With this Order, Licensee retires his medical license while under investigation.

KING, Ronald L., PA, PA160674
Portland, OR

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and willful violation of any rule adopted by the Board or Board order. With this Order, Licensee surrenders his physician assistant license while under investigation.

LATULIPPE, Steven A., MD, MD22341
Dallas, OR

On May 6, 2021, the Board issued a Final Order affirming the suspension of Licensee's medical license for the safety and welfare of Licensee's patients and the public. This Order is in effect until the termination of the declared public health emergency or until otherwise ordered by the Board.

LEE, Peter G.S., MD, Applicant
Los Angeles, CA

On July 1, 2021, Applicant entered into a Stipulated Order with the Board for fraud or misrepresentation in applying for or procuring a license to practice in this state. With this Order, Applicant withdraws his application to practice medicine in the State of Oregon while under investigation and agrees to not apply for Oregon licensure for at least two years.

LOVIN, Jeffrey D., MD, MD17100
San Diego, CA

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for failure to report an official action taken against Licensee within 10 working days; unprofessional or dishonorable conduct; fraud or misrepresentation in applying for or procuring a license to practice in this state; disciplinary action by another state of a license to practice as required; and failure to comply with a Board request. With this Order, Licensee surrenders his medical license while under investigation.

MCWEENEY, Thomas P., MD, MD16875
Tualatin, OR

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; fraud or misrepresentation in applying for or procuring a license to practice in this state; repeated negligence in the practice of medicine; violation of a Board order; and failure to report to the Board any adverse action taken against Licensee by a health care institution or professional or medical society or association. This Order limits Licensee's orthopedics practice to an office-based, outpatient, non-surgical practice only.

WARNE, Clinton L., MD, MD23217
Portland, OR

On May 6, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order, Licensee retires his Oregon medical license while under investigation.

ZINSER, Michael A., PA, PA184071
Kalispell, MT

On July 1, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and prescribing controlled substances without a legitimate medical purpose. With this Order, Licensee retires his physician assistant license while under investigation and agrees to not reapply for an Oregon physician assistant license for at least two years.

PRIOR ORDERS MODIFIED OR TERMINATED

HAYES, Whitney K., LAc, AC150217
Portland, OR

On July 1, 2021, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's July 11, 2019, Stipulated Order.

KEIPER, Glenn L., Jr., MD, MD20444
Eugene, OR

On July 1, 2021, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's January 7, 2021, Stipulated Order.

THOMAS, Paul N., MD, MD15689
Portland, OR

On June 3, 2021, the Board issued a Withdrawal of Order of Emergency Suspension for Reconsideration. This Order withdraws for reconsideration the Board's December 4, 2020, Order of Emergency Suspension.

Current and past public Board Orders are available on the OMB's website.

**National Practitioner Data Bank (NPDB) and Federation of State Medical Boards.*

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Office Hours

Monday - Friday, 8 a.m. - 5 p.m.
(closed 12 p.m. - 1 p.m.)

Office Closures

Notice: OMB staff are available by phone and email; however, the OMB offices are currently closed to the public. Please contact OMB staff at 971-673-2700 or info@omb.oregon.gov. Questions about COVID-19? Visit omb.oregon.gov/COVID-19.

Monday, Sept. 6 - **Labor Day**

Thursday, Nov. 11 - **Veterans Day**

Thursday & Friday, Nov. 25 & 26 - **Thanksgiving**

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Visit omb.oregon.gov/subscribe to register for any of the following notices from the Oregon Medical Board:

- Administrative Rules
- Board Action Report
- EMS Interested Parties
- *OMB Report* Quarterly Newsletter
- Public Meeting Notice
- Quarterly Malpractice Report

Applicant/Licensee Services

For new license applications, renewals, address updates, practice agreements, and supervising physician applications: omb.oregon.gov/login

Licensing Call Center

Hours: 8 a.m. - 3 p.m.
Phone: 971-673-2700
Email: licensing@omb.oregon.gov

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Oregon Medical Board Members

Statement of Purpose

*The **OMB Report** is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.*