PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
FEBRUARY 23, 2024

Oregon
Tina Kotek, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **BOARD OFFICE & VIRTUAL VIA ZOOM**

DATE: **February 23, 2024**

TIME: **9:15 a.m. – 3:00 p.m.**

Call to Order – Chip Dunn, President **9:15 a.m.**

OPEN SESSION (Zoom option available)
https://us02web.zoom.us/j/83903086772?pwd=VFZROENUcHZTSEI0dlFVN0hqWXhGUT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 839 0308 6772 ● Passcode: 437169

Review Agenda

1. Approval of Minutes
   - December 15, 2023 Board Meeting
   - February 9, 2024 Special Board Meeting

NEW BUSINESS

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

3. Committee and Liaison Reports
   - CDCA-WREB-CITA January 2024 Annual Meeting and Educators Conference – Dr. Javier attended steering committee meeting.
   - DAWSAC 2/23/2024 Meeting - recap Chair Dr. Clark
   - OHA - Health Care Provider Incentives Program - Jill Boyd & Bill Pfunder
     - Presentation

4 Executive Director's Report
   - Board Member and Staff Updates
   - OBD Budget Status Report
   - Customer Service Survey
   - 2024 Dental License Renewal
   - Board and Staff Speaking Engagements
   - 2024 Legislative Session & feedback on LC 98/HB 4071
   - AADB Mid-Year Meeting
   - Newsletter

5. Unfinished Business and Rules
   - Memo regarding Public Rulemaking Hearing 12/15/23 & Comments on proposed Rule changes
   - SOS Filing on rule changes
   - OCHCI Guidance for Compliance with GFE Requirements

6. Correspondence

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

- Mt. Hood Community College CODA-Accreditation update
- Dr. Taggart A1c Testing Request
- ADA A1c Testing Article
- Dr. Spaniel Rule Change Request regarding HPSP

7. Other
   - OHA HWRP Updates – Slide deck
   - OHA Proposed new SOGI Questions on Surveys
   - OHA HWRP Data Collection
   - OHA Medicaid Advisory Committee Open Position - Oral Health Professional
   - Smile Direct Club articles, case background and FAQ
   - Corporate Transparency Act ADA FAQ
   - Tribes – Comment Period
   - Open Public Comment - Public comment is limited to matters on the public meeting agenda or otherwise relevant to matters that may come before the OBD. Comments will not be allowed that are longer than the time allotted by the President or are disruptive to the agency's conduct of its business.

8. Articles & Newsletters (No Action Necessary)
   - CRDTS Winter 2024 Report

EXECUTIVE SESSION **10:30 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f)(h) and (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

OPEN SESSION (Zoom option available) **2:45 p.m.**

https://us02web.zoom.us/j/83903086772?pwd=VFZROENUcHZTSEI0dlFVN0hqWXhGUT09

Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 839 0308 6772 ● Passcode: 437169

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Request for Revisions to Soft Reline Curriculum – Bonnie Marshall
    - Request for Approval of Soft Reline Curriculum – Brianna Burks
    - Request for Approval of IV Therapy/Phlebotomy course for dental assistants – The Oregon Academy of General Dentistry (OAGD)

ADJOURN **3:00 p.m.**

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

APPROVAL OF MINUTES

DRAFT

OREGON BOARD OF DENTISTRY
MINUTES
DECEMBER 15, 2023

MEMBERS PRESENT:	Chip Dunn, President Alicia Riedman, R.D.H., E.P.P. Reza Sharifi, D.M.D. Jose Javier, D.D.S. Sheena Kansal, D.D.S. Aarati Kalluri, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H., E.P.P. Michelle Aldrich, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/ Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager Samantha Plumlee, Examination and Licensing Manager
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT: VIA TELECONFERENCE*:	Mary Harrison, Oregon Dental Assistants Association; Ginny Jorgensen, Oregon Dental Assistants Association; Olesya Salathe, D.M.D., Oregon Dental Association (ODA); Barry Taylor, ODA; Karen Hall, Oregon Dental Hygienist Association (ODHA); Jen Hawley-Price, DALE Foundation; Katherine Landsberg, Dental Assisting National Board (DANB); Tony Garcia, DANB; Janelle Peterson, Karan Bershaw, Amy Coplen, Bonnie Marshall

*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 8:01 a.m. Via Zoom.

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

NEW BUSINESS

Approval of Minutes

Dr. Javier moved and Dr. Sharifi seconded that the Board approve the minutes from the October 27, 2023 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)
Olesya Salathe, D.M.D. invited the Board members to attend the ODA's January 26th Board of Trustees meeting at 9 am, in person in Wilsonville, or via Zoom. There will be a presentation from the Council of State Governments National Center for Interstate Compacts as well as representatives from the ODHA and School of Dentistry. The ODA will be meeting with the Portland Community Dental Assisting program for an onsite visit to start off 2024 with collaborations.

Oregon Dental Hygienists' Association (ODHA)
Karen Hall reported the ODHA had record attendance at their Annual Conference in November.

Oregon Dental Assistants Association (ODAA)
Mary Harrison reported that the ODAA met with the ODHA at the Annual ODHA Conference in November. The ODAA is communicating with the ODA regarding the ODA Dental Conference. The Video made with ODAA and ADEC will be available in January. The ODAA has a new webpage: www.oregondentalassistants.com with courses, job postings, ect available. The ODAA will have a membership drive in January.

COMMITTEE AND LIAISON REPORTS
Mr. Prisby gave a brief rundown on the first Dental Assistant Workforce Shortage Advisory Committee (DAWSAC) Meeting which was held on October 27. 2023. The next meeting would be February 23, 2024.

EXECUTIVE DIRECTOR'S REPORT

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

OBD Budget Status Report
Mr. Prisby shared the latest budget report for the 2023 - 2025 Biennium. The report, from July 1, 2023 through, October 31, 2023 shows revenue of $845,864.15 and expenditures of $644,137.97.

OBD - OMB updated IAA
Mr. Prisby informed the Board on the costs for select services provided by the Oregon Medical Board per the interagency agreement are going up like most state government expenses. The updated IAA agreement was included.

Customer Service Survey
Mr. Prisby disclosed the customer service surveys received from July 1, 2023 – November 30, 2023. The majority rate their experience with the OBD positively.

Board and Staff Speaking Engagements
Mr. Prisby shared that he gave an OBD "Board Updates" Presentation to the BPD Dental Hygiene Study Club via Zoom on November 20, 2023.

Dental Hygiene License Renewal Data In 2023

Mr. Prisby highlighted the details of the 2023 Dental Hygiene License Renewals and shared results compared to previous years back to 2018.

Dental Therapist License Update
Mr. Prisby gave a recap of Oregon Dental Therapy Licensure, starting when HB 2528 (2021) was signed by Governor Kate Brown in July 2021. As of November 1, 2023 there have been 17 dental therapy licenses issued by the OBD. 13 of the 17 are dual licensed providers, who also have a dental hygiene license. Only 4 solely possess a dental therapy license.

AADB Meeting Oct 2023 – Award and Summary
Mr. Prisby shared that the Citizen of the Year Award recognized an AADB member who has made significant contributions to the dental profession. Ms. Laura Richoux, RDH, Chair of the Award Selection Committee, acknowledged Lori H. Lindley, Senior Assistant Attorney General. A summary of the AADB Annual meeting was included in the meeting materials.

Oregon Tribal-State Summit – Cancelled
Mr. Prisby pointed out that the Oregon Tribal-State Summit which was to be hosted by the Cow Creek Band of Umpqua Tribe of Indians in Canyonville Dec 5 – 6 has been cancelled. Mr. Prisby anticipates this summit to be rescheduled and he plans to attend.

2024 Calendar
Mr. Prisby presented the OBD 2024 Calendar with important dates noted.

UNFINISHED BUSINESS AND RULES
The Permanent Administrative Order for changes to Rule 818-001-0087 Fees, showed that the rule becomes effective on January 1, 2024.

The public packet for the OBD Public Rule Making Hearing taking place December 15, 2023 1 pm – 1 30 pm was included with the 11 recommended rule changes. It was noted that comments and feedback may be submitted until January 19, 2024 at 4 pm to information@obd.oregon.gov.

The OBD Guidance on new Dental Implant Rules was highlighted. These rules become effective on January 1, 2024.

OTHER
A memo from Samantha Nance at Embry Merritt Womack Nance PLLC siting critical issues and legal concerns with the AADB Compact was presented to the Board. The AADB comparison of the DDH compact and the AADB compact was also presented, siting reasons why the AADB Compact should be rejected by state legislatures as flawed and defective model legislation.

A letter from Dr. Thomas E. Clark, D.M.D., requesting the Board look at changing language in Rule 818-042-0070 to allow dental assistants to remove and reinsert implant healing abutments, screws and impression copings, and to fit the check final restorations under the dentist's indirect supervision to was shared.

Dr. Aldrich moved and Dr. Javier seconded that the Board move discussion of EFDA rule 818-042-0070 to Licensing, Standards and Competency Committee for further review. The motion passed unanimously.

An email with a request for revisions to the Pit and Fissure Sealants instructor curriculum was presented along with the current Board approved course curriculum.

Dr. Alrich moved and Dr. Kalluri seconded that the Board accept the proposed changes to Bonnie Marshall's Pit and Fissure Sealant instructor curriculum. The motion passed unanimously.

The OHA Dental Pilot Project #300 'Dental Therapist Project: Dental Hygiene Model' Advisory Committee Meeting DPP #300 from November 6, 2023 was presented along with a power point presentation from OHA for data and tracking of DH measurements/outcomes.

The OHA report on Licensed Health Care Workforce Supply was presented along with a report on the Diversity of Oregon's Licensed Health Care Workforce.

An email invitation from Bernadette Molina at CODA announced a site visit evaluation at Rogue Community College in Grants Pass, January 24 -25, 2024 and OHSU Dental School, Portland, October 15-17, 2024. RSVP's to be returned by December 15, 2023.

A press release via www.roguecommunity.net provided additional information about the site visit.

Amy Coplen, program director at Pacific University School of Dentistry reported that the Pacific University Board approved the School of Dentistry to move forward with the pursuit of initial accreditation for the Dental Therapy program. Spring and Summer will be spent in preparation for a site visit in fall 2024. The curriculum is very similar to the University of Minnesota, with dental therapy courses beginning at the beginning of dental hygiene, so courses are taken simultaneously with an extra year at the end.

ARTICLES AND NEWS

A brief recap of the Oregon Wellness Program was included. All Licensees are eligible and encouraged to reach out to the OWP if they desire help with managing challenging life issues, stress and burnout related feelings.

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

OPEN SESSION: The Board returned to Open Session at 11:56 a.m.

CONSENT AGENDA

2024-0038, 2024-0066, 2024-0067, 2024-0022, 2024-0016

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

COMPLETED CASES

2023-0209, 2024-0018, 2023-0196, 2023-0197, 2023-0176

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

2024-0044
Dr. Sharifi moved and Dr. Kalluri seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure she completes all required continuing education hours, including those related to infection control within the required renewal period. The motion passed unanimously.

2024-0045
Dr. Aldrich moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure she completes all required continuing education hours, including those related to infection control within the required renewal period. The motion passed unanimously.

2024-0046
Dr. Kalluri moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure she completes all required continuing education hours, including those related to the two hours of infection control, within the required renewal period. The motion passed unanimously.

2023-0100
Dr. Kansal moved and Dr. Sharifi seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure she completes all required continuing education hours, including those related to medical emergencies, during each license renewal cycle. The motion passed unanimously.

2024-0042
Ms. Ludwig moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure (1) he responds to the Board within 10 days of a written request for information; and (2) he completes all required continuing education hours, including those related to Cultural Competency and Pain Management, within the required license renewal period. The motion passed unanimously.

Chris Y. J. Lee, D.M.D.; 2023-0208
Dr. Clark moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $12,000.00 civil penalty, by single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within 180 days of the effective date of the Order, submit documentation to the Board verifying completion of eight hours of Board approved continuing education in the area of infection control within 60 days, submit documentation to the Board verifying completion of two hours of Board approved continuing education in the area of Dental Billing and Coding within 60 days, and complete quarterly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed unanimously.

2023-0125
Ms. Riedman moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure his BLS for Healthcare provider certificate does not lapse for any length of time. The motion passed unanimously.

2023-0177
Dr. Sharifi moved and Dr. Kalluri seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he performs acceptable 1) angulation while placing dental implants, 2) crown to implant root ratios, 3) cantilever effect on final restorations, and performs acceptable all other fundamental prosthodontic principles when placing and restoring dental implants. The motion passed unanimously

2024-0048
Dr. Aldrich moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding licensee to assure he completes all required continuing education hours, including those related to infection control, cultural competency, and pain management, within the required renewal period. The motion passed unanimously.

2024-0047
Dr. Kalluri moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding licensee to assure he completes all required continuing education hours, including those related to infection control, within the required renewal period. The motion passed unanimously.

Nathan M. Tanner, D.M.D.; 2023-0164
Dr. Kansal moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; refund in the amount of $12,068.00 by single payment, in the form of a cashier's, bank, or official check made payable to patient KG and delivered to the Board within 120 days of the effective date of the Order; and pay a $2,000.00 civil penalty, in the form of a cashier's check, bank, or official check, made payable to the Oregon Board of Dentistry within 30 days of the effective date of the Order, and permanently restrict Licensee from surgically placing any and all dental implants for the remainder of his professional practice of dentistry until further order of the Board.
The motion passed unanimously.

Nathan M. Tanner, D.M.D.; 2024-0003
Ms. Ludwig moved and Dr. Kalluri seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; refund in the amount of $4,140.00 by single payment, in the form of a cashier's, bank, or official check made payable to patient AR and delivered to the Board within 60 days of the effective date of the Order; pay a $1,000.00 civil penalty, in the form of a cashier's check, bank, or official check, made payable to the Oregon Board of Dentistry within 30 days of the effective date of the Order; and unconditionally pass the PROBE: Ethics and Boundaries Program by CPEP within six months of the effective date of the order. The motion passed unanimously.

2024-0043
Dr. Clark moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure he completes all required continuing education hours,

including those related to cultural competency, within the renewal period. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

ERICA R. BROWN R.D.H.; 2023-0098
Ms. Riedman moved and Dr. Javier seconded that the Board affirm the prior Notice of Proposed Disciplinary Action incorporating a Reprimand and a $250 civil penalty. The motion passed unanimously.

Thomas L. Haymore, D.M.D.; 2021-0109 & 2021-0176
Dr. Sharifi moved and Dr. Javier seconded that the Board deny the request to present oral arguments to the board prior to the rendering of a final decision. In reference to case numbers 2021-0109 and 2021-0176 move to issue the Final Order incorporating the disciplinary costs and incorporate a reprimand, a 60-day suspension of his license to practice dentistry, effective as of issuance of the Board's final order; Licensee will not be allowed to practice dentistry or give clinical advice for the duration of the suspension; a civil penalty in the sum of $7,500 to be paid within 90 days of the effective date of the order, complete and unconditionally pass the PROBE: Ethics & Boundaries Program by CPEP within 12 months from the effective date of the order. Licensee will be responsible for the cost of the program and will report the outcome to the Board within 10 days of completion; Licensee is prohibited from practicing dentistry on co-workers until further notice of the Board; and is assessed the costs. The motion passed unanimously.

2021-0073
Dr. Aldrich moved and Dr. Javier seconded to affirm the Board's August 21, 2021 decision. The motion passed unanimously.

Request for reinstatement of an expired license – Margie Grether, R.D.H.
Dr. Kalluri moved and Dr. Javier seconded that the Board reinstate the license of Margie Grether, R.D.H. The motion passed unanimously.

Request for approval of Soft Reline Course – Lynn Murray, EFDA
Dr. Kansal moved and Dr. Javier seconded that the Board approve the proposed Soft Reline Course for Lynn Murray. The motion passed unanimously.

Proposed Changes to Exceptions language in Proposed, Amended and Final Orders
Ms. Ludwig moved and Dr. Javier seconded the Board accept the proposed changes to the exceptions language in proposed, amended and final orders. The motion passed unanimously.

> You may file written exceptions to this amended proposed order with the Oregon Board of Dentistry (Board), 1500 SW First Avenue Suite 770, Portland OR 97201. Exceptions must be received by the Board within fifteen (15) **calendar** days from the date this proposed order was issued. Exceptions shall be in writing and confined to the factual and legal issues which are essential to the ultimate and just determination of the proceeding and shall be based only on grounds that: a necessary finding of fact is omitted, erroneous, or unsupported by the preponderance of the evidence in the record; a necessary legal conclusion is omitted or is contrary to law or the Board's policy or; prejudicial procedural error occurred. ~~The Board may entertain~~

~~such oral argument as it determines necessary or appropriate to assist it in the proper disposition of the case at its regular scheduled meeting when this proposed order is considered. The Board will notify you in writing of the date, time and location of your appearance, if applicable.~~

Proposed Order and Exceptions. The ALJ will issue a proposed order in the form of findings of fact, conclusions of law and recommended agency action. You will be provided with a copy and you will be given an opportunity to make written objections, called "exceptions", to the ALJ's recommendations. **The Board will require that you provide your exceptions in writing only**. You will be notified when exceptions to the proposed order must be filed. ~~You will also be notified when you may appear and make oral argument to the Board if applicable.~~

RATIFICATION OF LICENSES

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

ADJOURNMENT

The meeting was adjourned at 12:18 p.m. Mr. Dunn stated that the next Board Meeting would take place on February 23, 2024.

_____
Charles 'Chip' Dunn
President

OREGON BOARD OF DENTISTRY
SPECIAL BOARD MEETING MINUTES
FEBRUARY 9, 2024

MEMBERS PRESENT:	Chip Dunn, President Jennifer Brixey, Vice President Alicia Riedman, R.D.H., E.P.P. Reza Sharifi, D.M.D. Sheena Kansal, D.D.S. Aarati Kalluri, D.D.S. Jose Javier, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H., E.P.P. Michelle Aldrich, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/ Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Shane Rubio, Investigator Haley Robinson, Office Manager
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General Joanna Tucker Davis, Sr. Assistant Attorney General
VISITORS PRESENT: VIA TELECONFERENCE*:	David Palmer

*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 7:32 a.m. via Zoom.

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

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.660 (2)(f),(h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

OPEN SESSION: The Board returned to Open Session. **8:10 a.m.**

Thomas Lant Haymore, D.M.D.; 2021-0109 & 2021-0176
Mr. Dunn moved and Dr. Kalluri seconded that in the matter of cases 2021-0176 and 2021-0109, the Board deny Licensee's request to Stay the Enforcement of the Final Order dated 12/26/2023. The

motion passed unanimously.

ADJOURNMENT

The meeting was adjourned at 8:15 a.m. Mr. Dunn stated that the next Board Meeting would take place on February 23, 2024.

_____

Charles ‘Chip’ Dunn
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

Health Care Provider Incentive Program (HCPIP): Loan Repayment Expansion

Presentation to Oregon Dental Board

February 23, 2024

Oregon Health Authority

Oregon Office of Rural Health

Outline

- Background on Health Care Provider Incentive Fund (HCPIF)
- Overview of HCPIP Loan Repayment incentive
- Questions and Comments

Background on Health Care Provider Incentive Fund (HCPIF)

Health Care Provider Incentive Fund: Helps practices, professionals and people

Offers Important Recruitment and Retention Tool

Provides Education Debt Relief

Increases Workforce Diversity in Local Communities

Health Care Provider Incentive Fund: Purpose

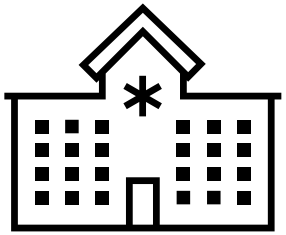
The Oregon Legislature passed House Bill 3261 (2017) that:

- **Created the Health Care Provider Incentive Fund**, which consolidated multiple provider incentives into a single pool (ORS 676.450) which also includes the **Health Care Provider Incentive Program** (HCPIP)

Oregon offers state-funded financial incentives to health care students and practicing professionals who commit to:

- Providing culturally responsive care for Oregon Health Plan (OHP)/Medicaid members and Medicare recipients Commit to practicing at a site located in rural and/or medically underserved area of Oregon

These areas and practice sites are identified through federal and state methodologies as having an insufficient number of providers to support optimal population health.



Overview of HCPIP Incentives

Incentive	Incentive recipient	Contract entity
Health Care Loan Repayment for practicing professionals in primary care, behavioral health and oral health	Practicing professionals	Practicing professionals
Primary Care Loan Forgiveness for students in training	Student	Student
SHOI-OHSU for student scholarships	Student	Educational Institution
Rural Medical Malpractice Insurance Subsidy for practicing primary care professionals in rural areas	Practicing professionals	Insurance Carrier
SHOI-Like Scholarships / Health Care Workforce Pathways	Student	Educational Institution

Overview of HCPIP Loan Repayment incentive

Overview: Loan repayment incentive

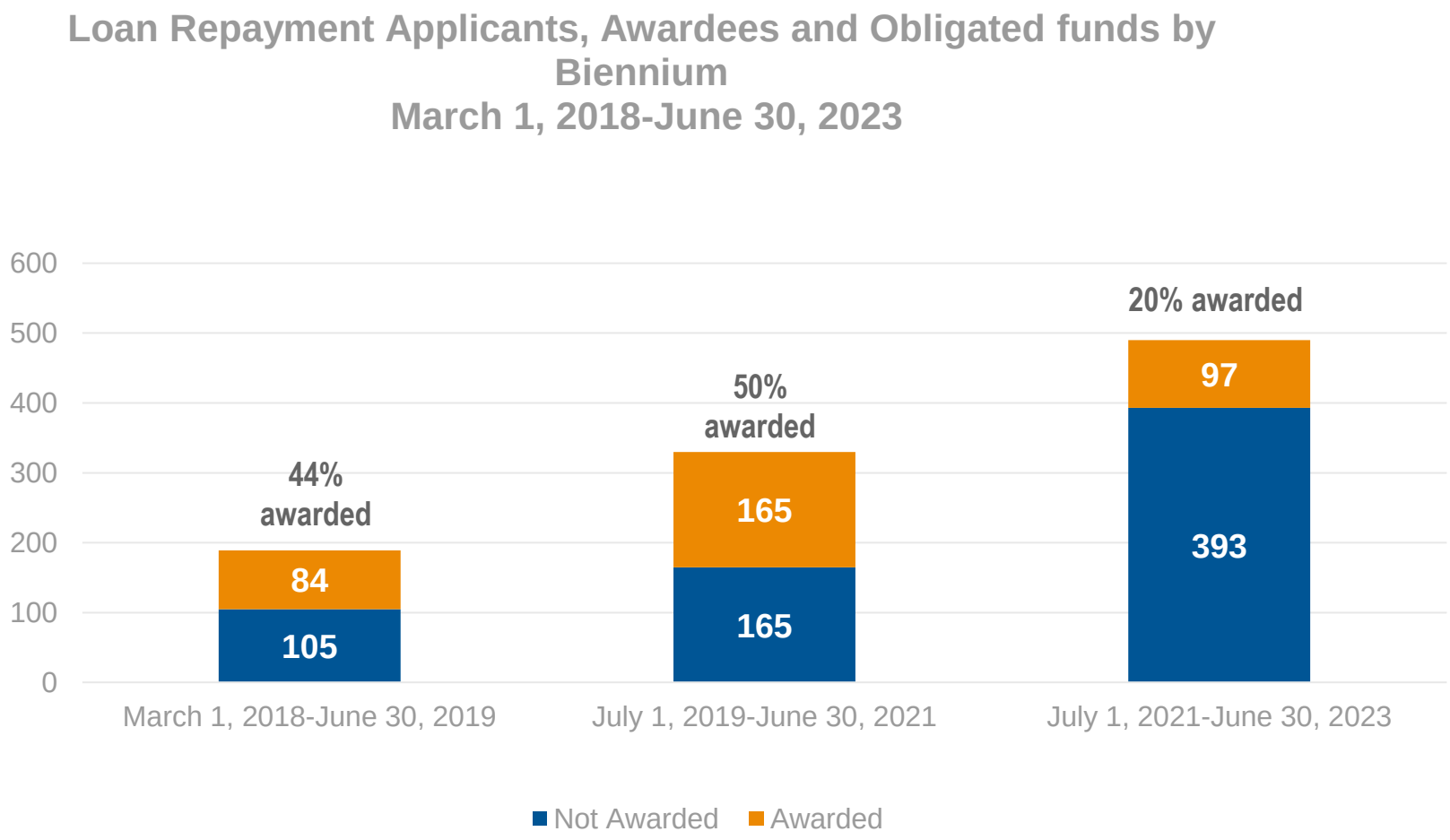
Supports practicing professionals to repay qualifying student loan debt with tax-free awards, for a three-year service commitment at a qualifying practice site

- Full-time providers:
  - Award of 100% of loan debt balance up to $29K
  - Award of 70% of loan debt balance, up to $150K per service commitment (3 years)
- Part-time providers:
  - Award of 100% of loan debt balance up to $15K
  - Award of 35% of loan debt balance, up to $75K per service commitment (3 years)

❖ 34% of recipients identify as people of color or from Tribal communities

❖ 34% speak a second language

Overview: Loan repayment incentive



Loan repayment eligibility

Eligible practice sites

- Located in a Health Professional Shortage Area (HPSA), or have a Facility HSPA; **or**
- Serve Medicaid and Medicare patients in no less than the same proportion of such patients in the county; **or**
- Provides essential health care services to an underserved population, as determined by OHA; **and**
- Have a Site Application on file with the Oregon Office of Rural Health and have received confirmation of site qualification.

Loan repayment eligibility

Eligible provider types

- **Dentists** in general or pediatric practice;
- **Expanded Practice Dental Hygienists**
- **Pharmacists**
- **Physicians (MD, DO or ND)**: Family medicine or general practice, general internal medicine, geriatrics, pediatrics, or obstetrics and gynecology
- **Nurse Practitioners**: Adult primary care, women's health care, geriatrics, pediatrics, family practice, or nurse midwifery
- **Physician Assistants**: Family medicine or general practice, general internal medicine, geriatrics, pediatrics or obstetrics and gynecology

- **Expanding in 2024**: Dental assistants (DA) and dental therapists (DT)
    - **Considerations**: length of service obligation, data tracking mechanisms for non-credentialed DAs, outreach opportunities

Questions and comments

Contact information

Jill Boyd, MPH
Health Care Provider Incentives Coordinator
Jill.M.Boyd@oha.oregon.gov

Jaime Taylor
Provider Incentives Program Support Specialist
jaime.taylor@oha.oregon.gov

Bill Pfunder
Program Manager – Incentives Program
Oregon Office of Rural Heath (ORH)
Pfunder@ohsu.edu

Thank you*!*

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
February 23, 2024

Board Member & Staff Updates

Jennifer Brixey has indicated she will not seek another term on the OBD. She joined the Board on September 28, 2018 for a partial first term, and the current term ends on April 6, 2024. We appreciate and thank Ms. Brixey for her service and support on the Board. Her lived experience, tribal background and consumer's point of view has been very valuable in OBD discussions and decisions.

Dr. Jose Javier's service on the Board will conclude on April 1, 2024. He will have completed two full terms of service, initially joining the Board on June 1, 2016. We appreciate and thank Dr. Javier for his service and support on the Board. His clinical experience in private practice, dental director of a FQHC and insight has been very valuable in OBD discussions and decisions.

Alicia Riedman, RDH, service on the Board will conclude on March 31, 2024. She first joined the Board on April 1, 2015 for a partial first term. She will have one of the longest service records of any board member (based on recent records), with almost 9 years of service on the Board. We appreciate and thank Ms. Riedman for her years of service and support on the Board. Her FQHC dental outreach program experience, compassion for oral health care in children and long tenure on the Board has been very valuable in OBD discussions and decisions.

Throughout their time on the Board they served as OBD President or Vice President at one time and Chaired various OBD Committees. They committed their time and attention to regular board meetings, special board meetings, committee meetings, rulemaking hearings, workgroups, two Strategic Planning Sessions and helped steer the OBD through the most recent worldwide pandemic. Their replacements are going through the confirmation process (when this report was written) and we anticipate welcoming the three new board members at the April 26, 2024 Board Meeting.

Discuss OBD Board Member assignments in upcoming year. Two of the professional Board Members serve as our Evaluators. They review the investigative case reports approximately 2 weeks before a board meeting with our attorney and investigators. In April when the Board elects a new President, the Evaluators will also transition as well.

Dr. Michelle Aldrich, Dr. Terrence Clark and Sharity Ludwig, RDH joined the Board on the same day (June 10, 2022). One needs to fill the Junior Evaluator position for the Board from May 2024 to April 2025. During that time period, Dr. Sheena Kansal will serve as the Senior Evaluator for the Board.

The OBD welcomed back Shane Rubio to the Investigator position on January 16, 2024. He left the OBD in June 2023 to pursue another opportunity.

We also celebrated and recognized Dr. Bernie Carter for five years of service with the OBD on February 1st. Dr. Carter previously served as our Dental Director/Chief Investigator, and is now working part time as our dental investigator.

OBD Licensing Manager, Samantha Plumlee's last day was February 16, 2024. She joined the OBD in March 2018 and made a positive impact on administrative work and served as licensing manager for the last 3 years. She was also a great resource for many OBD meetings, presentations and production of OBD Newsletters. The open position will be posted on the state's employment website and we will follow the state's rules and policies to recruit and hire her replacement.

OBD Budget Status Report

Attached is the latest budget report for the 2023 - 2025 Biennium. This report, which is from July 1, 2023 through, December 31, 2023 shows revenue of $912,506.27 and expenditures of $901,789.81. **Attachment #1**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2023 – January 31, 2024. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #2**

2024 Dental License Renewal

The 2024 dental license renewal began in late January and will conclude on March 31 for those Oregon dentists whose license expires in 2024.

Board and Staff Speaking Engagements

Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at OIT in Salem on Monday, February 5, 2024.

Dr. Angela Smorra attended Sunset Oral Surgery Study Club in Portland on Thursday, February 8, 2024. She briefly reviewed pathways dental professionals have to become instructors for Radiological Proficiency, Pit & Fissure Sealants, Placing Subgingival Materials, or Soft Relines.

2024 Legislative Session & LC 98/HB 4071

The 2024 Legislative Session began on February 5, 2024. LC 98 was circulated a few weeks ago and feedback was requested on it. **Attachment #3**

American Association of Dental Boards Mid-Year Meeting

The AADB Mid-Year Meeting is scheduled for April 11 – 12, 2024 in Rosemont, Illinois. Any Board Members interested in attending should confirm with me so I can assist with logistics and approve travel authorization. I would like to attend the meeting and ask for the Board to approve my request to attend it this spring. **Attachment #4 ACTION REQUESTED**

Newsletter

We will produce a late spring newsletter with updates on new board members, rule changes, the Oregon Wellness Program and other important news for our Licensees.

Agency 834

Appn Year			2025		
			Monthly Activity	Biennium to Date	Budget
Fund	Budget Obj	Budget Obj Title			
3400	1000	REVENUES	29,508.53	912,506.27	3,972,405.00
	2500	TRANSFER OUT	0.00	3,153.15	267,000.00
	3000	PERSONAL SERVICES	80,930.00	547,689.29	2,273,180.00
	4000	SERVICES AND SUPPLIES	24,647.75	354,100.52	1,968,770.00
3400 Total			**135,086.28**	**1,817,449.23**	**8,481,355.00**
Grand Total			**135,086.28**	**1,817,449.23**	**8,481,355.00**

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	06
Rpt Fiscal Mm Name	DECEMBER 2023
Load Date GI	1/12/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	1000	REVENUES	0205	OTHER BUSINESS LICENSES	22,085.00	754,945.00	3,495,149.00
				0210	OTHER NONBUSINESS LICENSES AND FEES	650.00	3,400.00	14,900.00
				0410	CHARGES FOR SERVICES	63.00	7,152.00	148,355.00
				0505	FINES AND FORFEITS	1,991.00	116,830.70	240,000.00
				0605	INTEREST AND INVESTMENTS	4,579.53	27,904.93	60,000.00
				0975	OTHER REVENUE	140.00	2,273.64	14,001.00
			REVENUES Total			**29,508.53**	**912,506.27**	**3,972,405.00**
		2500	TRANSFER OUT	2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	3,153.15	267,000.00
			TRANSFER OUT Total			**0.00**	**3,153.15**	**267,000.00**
		3000	PERSONAL SERVICES	3110	CLASS/UNCLASS SALARY & PER DIEM	49,869.37	351,036.60	1,403,771.00
				3115	BOARD MEMBER STIPENDS	3,818.00	16,805.00	46,900.00
				3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,585.00
				3170	OVERTIME PAYMENTS	(32.02)	244.29	6,669.00
				3180	SHIFT DIFFERENTIAL	0.00	1.00	0.00
				3190	ALL OTHER DIFFERENTIAL	629.69	3,585.93	41,510.00
				3210	ERB ASSESSMENT	10.95	81.03	404.00
				3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	9,430.99	66,481.41	255,636.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	06
Rpt Fiscal Mm Name	DECEMBER 2023
Load Date GI	1/12/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	3000	PERSONAL SERVICES	3221	PENSION BOND CONTRIBUTION	2,356.81	18,672.53	80,296.00
				3230	SOCIAL SECURITY TAX	4,482.78	28,548.00	116,198.00
				3241	PAID FAMILY MEDICAL LEAVE INSURANCE	234.41	1,290.16	5,391.00
				3250	WORKERS' COMPENSATION ASSESSMENT	8.67	67.46	351.00
				3260	MASS TRANSIT	302.79	2,129.05	9,521.00
				3270	FLEXIBLE BENEFITS	9,817.56	58,746.83	301,948.00
			PERSONAL SERVICES Total			**80,930.00**	**547,689.29**	**2,273,180.00**
		4000	SERVICES AND SUPPLIES	4100	INSTATE TRAVEL	0.00	3,715.32	55,194.00
				4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,220.00
				4150	EMPLOYEE TRAINING	0.00	6,297.15	58,929.00
				4175	OFFICE EXPENSES	553.30	4,134.32	99,149.00
				4200	TELECOMM/TECH SVC AND SUPPLIES	528.22	3,624.40	27,088.00
				4225	STATE GOVERNMENT SERVICE CHARGES	44.05	43,810.17	94,114.00
				4250	DATA PROCESSING	366.22	34,673.81	163,405.00
				4275	PUBLICITY & PUBLICATIONS	0.00	488.54	16,145.00
				4300	PROFESSIONAL SERVICES	11,741.00	119,389.55	458,367.00
				4315	IT PROFESSIONAL SERVICES	0.00	0.00	161,038.00
				4325	ATTORNEY GENERAL LEGAL FEES	0.00	49,141.90	338,907.00
				4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	120.00	766.00
				4400	DUES AND SUBSCRIPTIONS	0.00	1,042.90	11,331.00
				4425	LEASE PAYMENTS & TAXES	8,191.40	48,671.22	206,576.00
				4475	FACILITIES MAINTENANCE	0.00	0.00	634.00

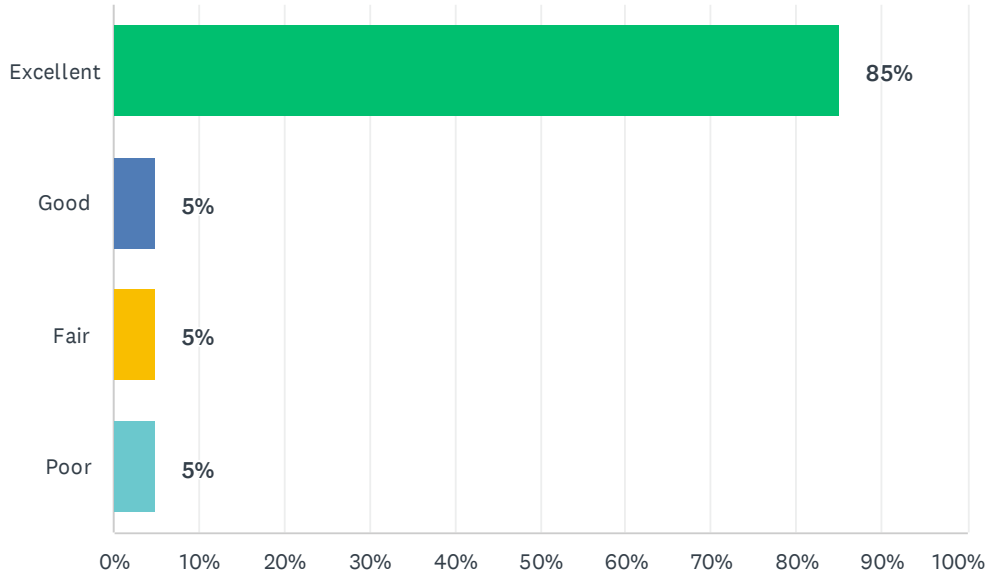
Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	06
Rpt Fiscal Mm Name	DECEMBER 2023
Load Date GI	1/12/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	4000	SERVICES AND SUPPLIES	4575	AGENCY PROGRAM RELATED SVCS & SUPP	60.60	7,856.95	142,660.00
				4650	OTHER SERVICES AND SUPPLIES	3,162.96	27,705.89	94,383.00
				4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	6,343.00
				4715	IT EXPENDABLE PROPERTY	0.00	3,428.40	25,521.00
			SERVICES AND SUPPLIES Total			**24,647.75**	**354,100.52**	**1,968,770.00**

DAFR9210 Agency 834 - month end

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

Answered: 20 Skipped: 0

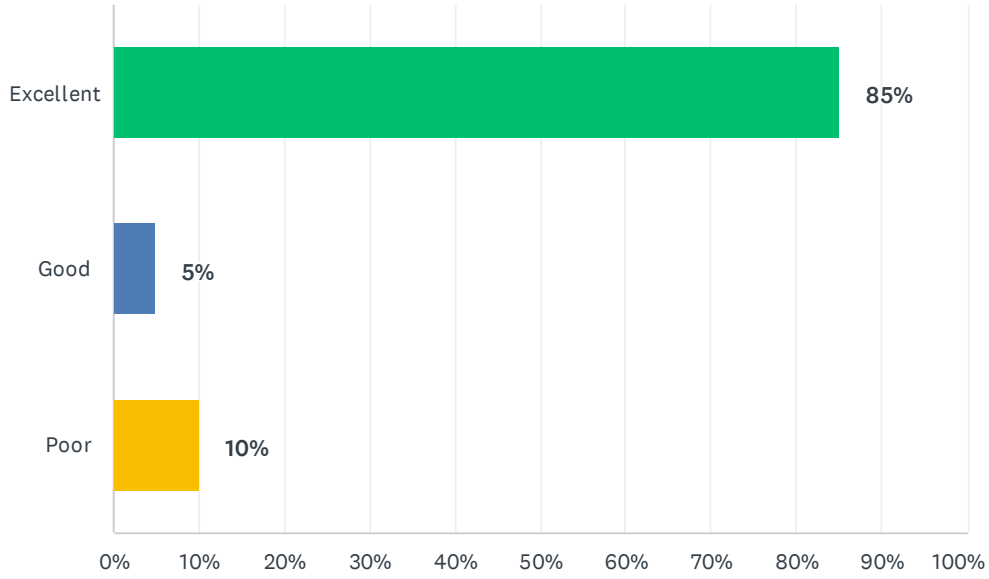


ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Good	5%	1
Fair	5%	1
Poor	5%	1
TOTAL		20

Attachment #2

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

Answered: 20 Skipped: 0

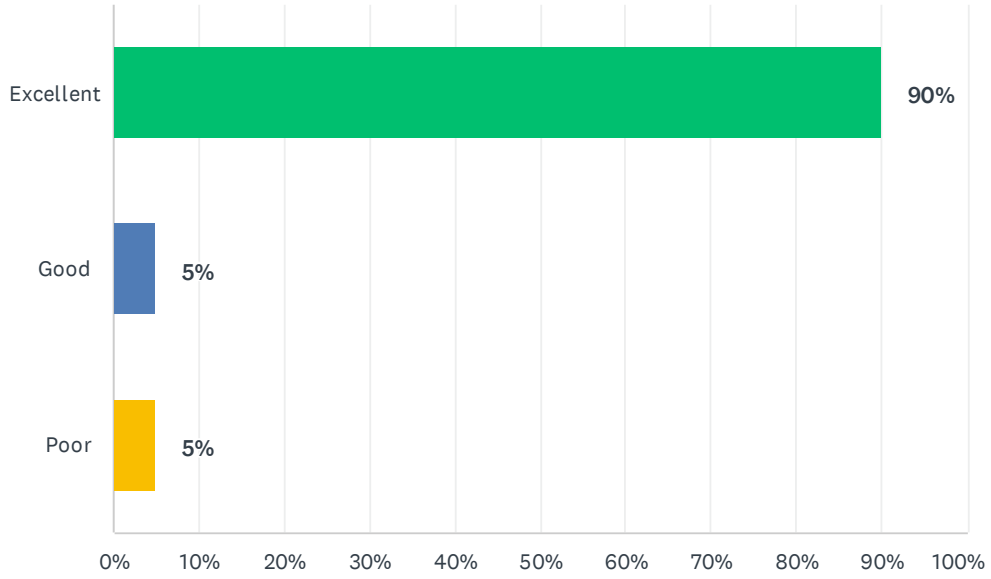


ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Good	5%	1
Poor	10%	2
TOTAL		20

Attachment #2

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

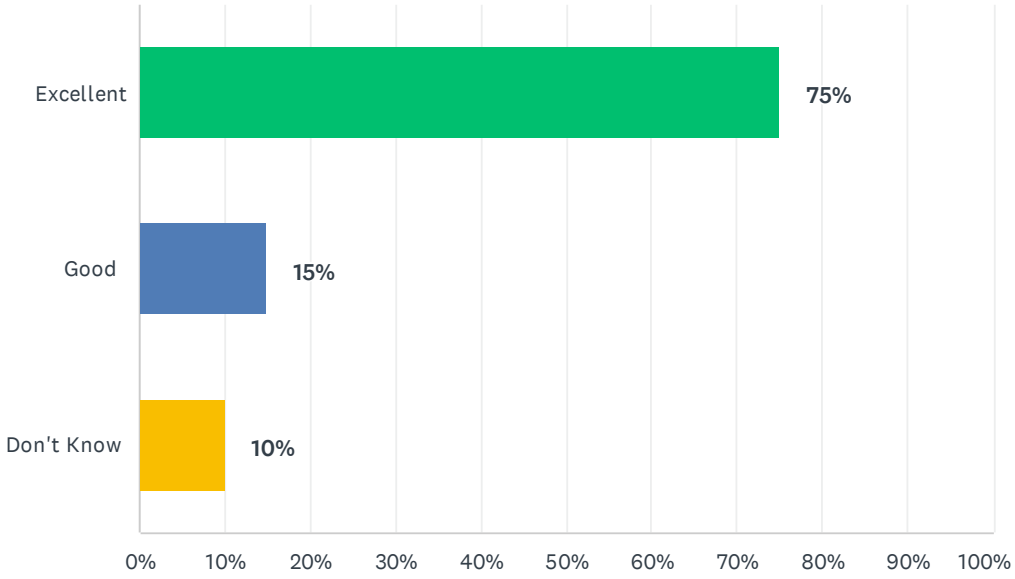
Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	90%	18
Good	5%	1
Poor	5%	1
TOTAL		20

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

Answered: 20 Skipped: 0

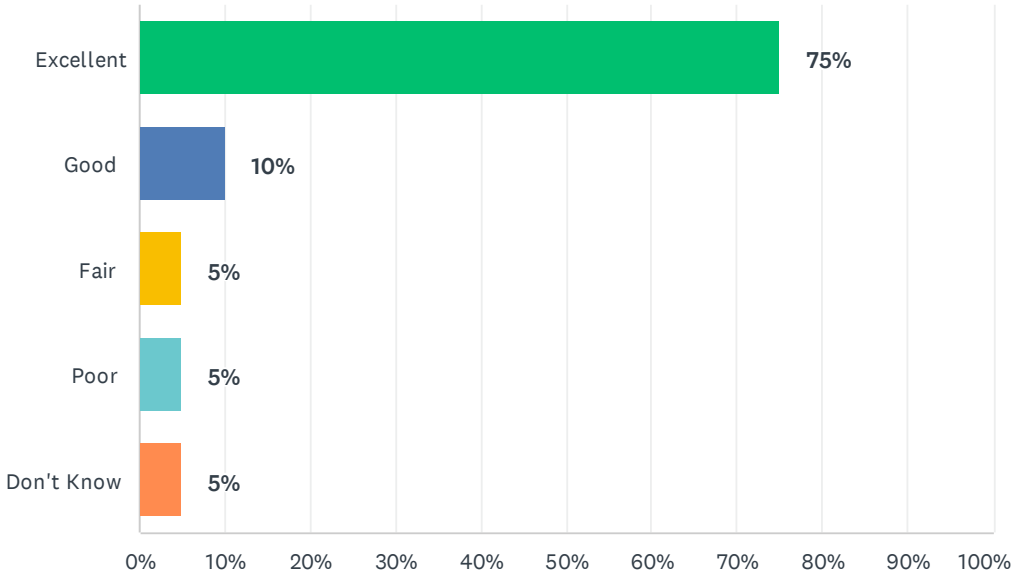


ANSWER CHOICES	RESPONSES	
Excellent	75%	15
Good	15%	3
Don't Know	10%	2
TOTAL		20

Attachment #2

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

Answered: 20 Skipped: 0

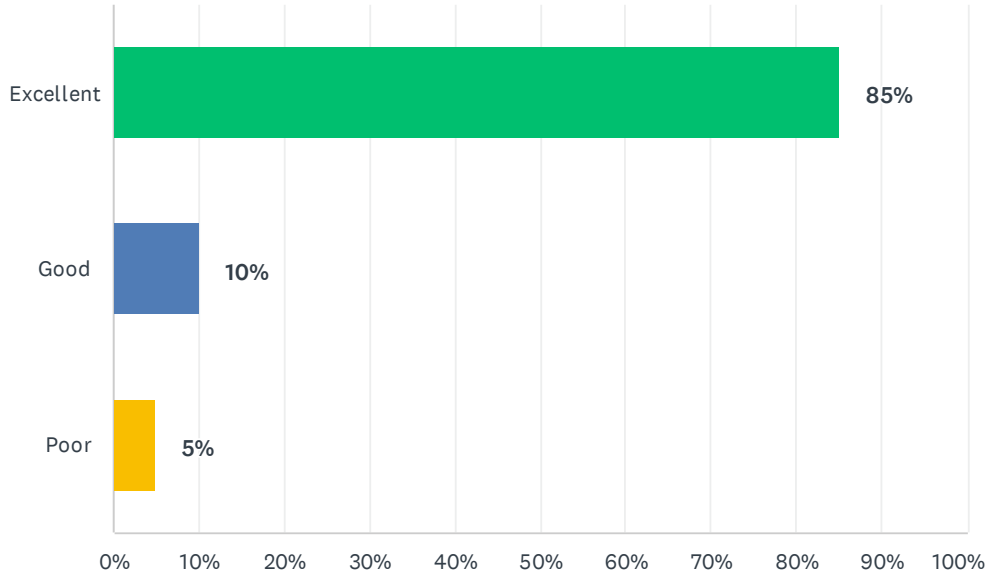


ANSWER CHOICES	RESPONSES	
Excellent	75%	15
Good	10%	2
Fair	5%	1
Poor	5%	1
Don't Know	5%	1
TOTAL		20

Attachment #2

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

Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Good	10%	2
Poor	5%	1
TOTAL		20

Attachment #2

2024 Session Calendar

JANUARY						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8 LC Return	9 TF Day	10 Leg Day	11 Leg Day	12 Leg Day Drop LC	13
14	15 MLK Day	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

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

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

Leg. Days	
State Holiday	
Leg. Counsel Deadlines	Deadlines for bills to be returned by LC and introduced (after these deadlines only measures from the Sen. President, House Rules, and JWM Committee may be introduced)
Session Deadlines	Deadlines for bills to be posted for work sessions, then voted out of policy committees in the first and second chambers. Does not apply to House Rules, Senate Rules, House Revenue, Senate Finance and Revenue, or Joint Committees including Ways and Means.
House & Senate Floor Sessions	Senate and House floor sessions on all weekdays. Additional floor sessions will be announced by the Senate President or House Speaker as necessary.
Important Election Date	

Attachment #3

Feedback on LC 98 from Stephen Prisby, Executive Director for the Oregon Board of Dentistry (OBD) compiled on January 18, 2024.

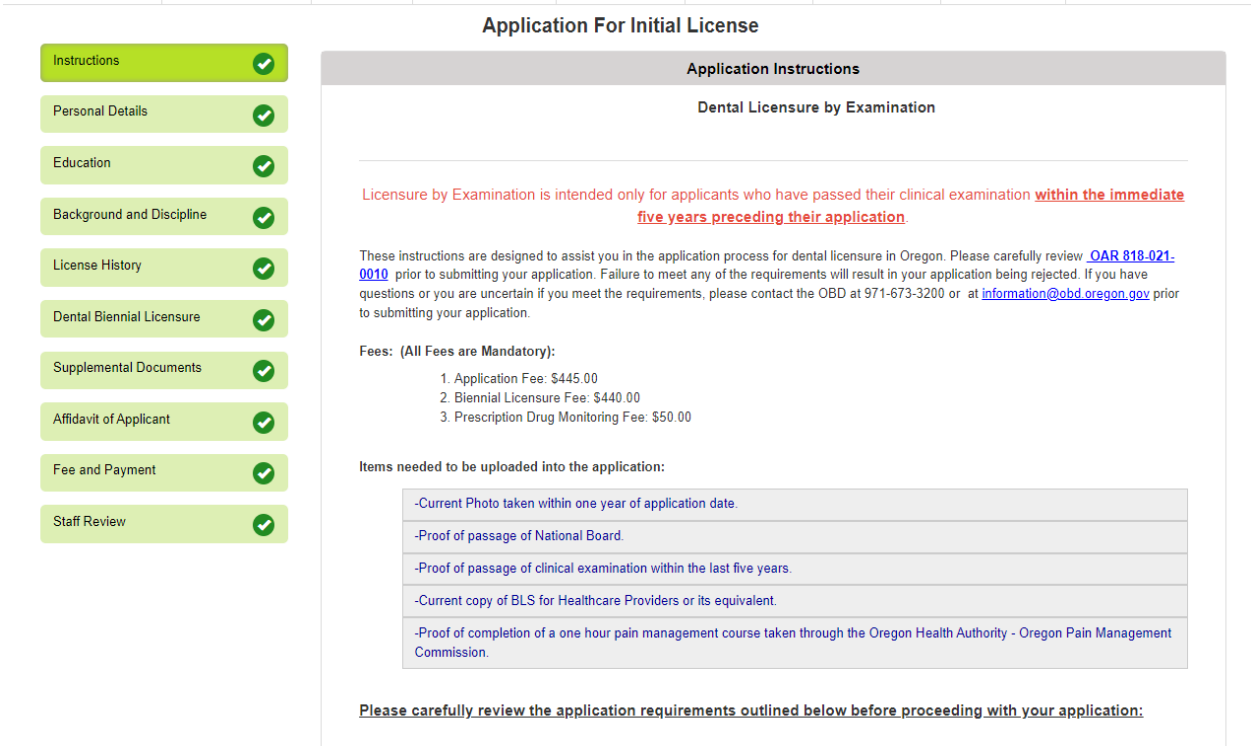
Our Board has 7.5 Full Time Employees and 10 volunteer Board Members. The OBD licenses about 400 people every year. Our licensing and renewal is on-line and has been for a few years now. Our total license population is about 8000. We are funded by our Licensees: any change to our operations, service expectations or new work may need additional resources, which could lead to fee increases.

Here are the statistics on licensure going back to 2013:

Licenses Issued per year											
Per year	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Dental Licenses	126	168	183	196	170	221	224	192	180	172	190
Dental Hygiene Licenses	206	210	221	239	224	196	202	188	188	206	195
Dental Therapy Licenses										4	14
Total Licenses issued	**332**	**378**	**404**	**435**	**394**	**417**	**426**	**380**	**368**	**382**	**399**

The licensing portal screen shot is provided. These items are uploaded by the applicant for licensure. As the applicant gathers and completes the items, they go into the application database for each individual. The Licensing Manager conducts verification of the items including education, clinical exam results, Oregon State Police Background check information, check on National Data Bank Practitioner information, other state's licensure if applicable, etc…

The applicants are directed that they may begin the process even before they complete dental/dental hygiene school or move to Oregon (or for any reason), to get the process started and cut down on any delays.



We have one dedicated licensing manager and other administrative staff assist when questions arise or as needed to support the manager.

We engage with most of our applicants coming right out of school (approx. 60% of applicants), and this will be their first health care license. Those applicants are the easiest and the quickest to get licensed. Those that have long work histories and have been licensed in other states (approx. 40% of applicants) will logically take longer to process, and ensure they meet all statutory and rule criteria to license them in Oregon.

Applicants do not need to live in Oregon and can start the application process a few months before they graduate or move to Oregon.

We acknowledge that some people can have a delayed process and not be issued a license within the standard 6 – 8 weeks. Factors that typically delay a license being issued in a regular timeframe could be due to the applicant having a criminal background, incomplete information, court records not shared, education outside the US, failing clinical exams, other states delayed in providing licensing or disciplinary information, failing the Board's Jurisprudence Exam, and sometimes documents are still mailed into the Board.

On the staff side, with only one licensing manager obviously they need time off and there can be a lot of work and demands, especially in later spring when most schools graduations occur. We believe that a few days at a time, or a one week delay is acceptable. Licenses are issued year-round once all items and criteria are met, and there is no delay. Our Board ratifies my decision as the executive director, to license everyone and no regular applicants are delayed by the board convening for meetings. A few applicants each year need special review due to criminal history and/or board actions from other states. Those go to the full Board for review and the Board decides whether to license them or not.

We would have challenges implementing LC 98 and from a consumer protection view be very concerned about the safety of Oregonians. A rush to allow someone to practice in Oregon without due diligence in an age of ever sophisticated fraud and lawlessness, could be a recipe for patient harm. A few bad practitioners could negatively impact the dental profession, regulators in Oregon and ultimately the Governor and the Legislature. Dentists are highly compensated - typically earning close to $150,000/year right out of school. A few days or weeks delay to ensure they meet all criteria seems reasonable & prudent. The OBD would need to revamp a number of rules, policies, forms, webs links/instructions and protocols to implement any sort of temporary authorization or license.

I checked with colleagues at Washington State and they issue temporary licenses to dental hygienists, not dentists. They indicated it still takes a few weeks to process and ensure people meet the criteria for the temporary license offered in Washington State.

Other states regulatory apparatuses are not as robust or as well run as Oregon. I know this first hand as I have been with the OBD since 2012 and served as executive director since 2015. I

have served as President of the American Association of Dental Administrators and have interacted with many state Board executive directors on various issues throughout the years.

Draft LC 98 directs state boards to "determine that other state's authorization requirements are substantially similar". We do not currently have processes in place to do this. Scrutinizing each state's licensure requirements to determine if they are similar to our own would create an immense burden on our small staff.

Draft LC 98 requires that the applicant Provides to the health professional regulatory board, in a manner determined by the health professional regulatory board, sufficient proof that the applicant is in good standing with the issuing out-of state entity. This would be nearly impossible to achieve this within the 10 day timeframe. In a lot of states, it takes longer than 10 days to receive proper verification of good standing. The current estimate to receive license verifications is around 2 - 4 weeks.

Our Licensees can work in a variety of health care settings. There are still many that work in small offices/clinics where there may only be a dentist and one or two other employees. It is these small office settings with zero or very limited oversight that we must be cognizant of to ensure Oregonians are being treated by a competent and legally qualified health care provider. Other direct clinical health care practitioners like medical doctors and nurses typically work in more largely staffed health care settings and are subject to more colleagues' observations of their care and administrative & clinical oversite.

Draft LC 98 directs the agency to issue a temporary authorization within 10 days. That time frame would be challenging for us to achieve even if we waived or disregarded most criteria for licensure that currently stand in statute and rule. This timeframe would not only be challenging, but near impossible for people who hold licenses in other states. Obtaining license verifications from other states can take 2 – 4 weeks, especially for people who hold licenses in multiple states.

Draft LC 98 uses undefined terms like "adequately demonstrates intent to reside, in this state." This would, again, create undue burden on board staff. This is not something that we currently require, so it would become the board staff's responsibility to implement a new process for verifying this information.

Draft LC 98 directs the board to define new criteria for competency, substantially similar, sufficient proof of good standing, competency. Draft LC 98 contradicts itself by directing the board to define new criteria for competency. The existing licensing requirements exist to do just that, yet LC 98 would require us to waive those requirements and issue licenses without first obtaining the documentation required to verify competency. Additionally, our licensing requirements are largely based on educational background, not licensure in other states. LC 98 does not allow us to verify an applicant's educational background, so this would lead to people being issued a temporary license who do not meet the requirements for a permanent general

dental license. This would result in unqualified providers practicing for up to one year in Oregon. After the temporary license expires they would be required to stop working in Oregon, which only creates more hardship for those individuals. There is no provision or guidance to prevent someone from repeating the temporary process over and over, start one year, stop and repeat in subsequent years.

Also not clear if the Board could charge any fees for a temporary license or authorization. So this could have a negative impact on our Board and most that are funded by its licensees.

Once the Board issues a temporary license or authorization we would convey certain rights to them, and this could lead to legal issues and additional costs in utilizing our assigned DOJ AAG.

Thank you for allowing me to share my candid feedback. Please follow up or reach out any time for anything I can assist on.

Sincerely,

Stephen Prisby
OBD Executive Director
971-673-3200
Stephen.Prisby@obd.oregon.gov

LC 98
2024 Regular Session
1/4/24 (SCT/ps)

D R A F T

SUMMARY

Digest: Tells health care boards to give short-term permission to work. Starts January 1, 2025. (Flesch Readability Score: 60.7).

Requires health professional regulatory boards to issue a temporary authorization to practice a health profession to eligible applicants within 10 days of receiving an application for licensure. Defines "health profession" and "health professional regulatory board."

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to health care licensing; and prescribing an effective date.

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

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

(a) "Health profession" means a health care service:

(A) For which an individual must possess a license to provide the health care service; and

(B) Over which a health professional regulatory board has oversight.

(b) "Health professional regulatory board" means a state agency that licenses individuals to provide a health care service to clients or patients that are humans.

(2) A health professional regulatory board shall, within 10 days of receiving an application for licensure, issue to the applicant a temporary authorization to practice the health profession regulated by the health professional regulatory board if the applicant:

(a) Holds a current authorization to practice the health profession issued by another state and the health professional regulatory board

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

determines that the other state's authorization requirements are substantially similar to or exceed those of the health professional regulatory board;

(b) Provides to the health professional regulatory board, in a manner determined by the health professional regulatory board, sufficient proof that the applicant is in good standing with the issuing out-of-state entity;

(c) Has demonstrated competency, as determined by the health professional regulatory board by rule, over the health profession regulated by the health professional regulatory board;

(d) Agrees to complete within one year of the date the health professional regulatory board receives the application any applicable continuing education requirements; and

(e) Resides, or adequately demonstrates an intent to reside, in this state.

(3) A temporary authorization issued under subsection (2) of this section is valid until the earlier of the following dates:

(a) One year from the date of issuance; or

(b) The date on which the applicant receives the license for which the applicant applied to the health professional regulatory board.

SECTION 2. (1) Section 1 of this 2024 Act becomes operative on January 1, 2025.

(2) A health professional regulatory board may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the health professional regulatory board to exercise, on or after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the health professional regulatory board by section 1 of this 2024 Act.

SECTION 3. This 2024 Act takes effect on the 91st day after the date on which the 2024 regular session of the Eighty-second Legislative Assembly adjourns sine die.

House Bill 4071

Sponsored by Representatives DIEHL, PHAM H, Senator BONHAM; Representatives BOICE, CONRAD, CRAMER, DEXTER, GOODWIN, HELFRICH, HIEB, LEVY B, LIVELY, MANNIX, MCINTIRE, OSBORNE, OWENS, RESCHKE, SCHARF, WALLAN, YUNKER, Senators DEMBROW, FINDLEY, HANSELL, HAYDEN, JAMA, LINTHICUM, SMITH DB, SOLLMAN, WEBER (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: Tells health care boards to give short-term permission to work. Starts January 1, 2025. (Flesch Readability Score: 60.7).

Requires health professional regulatory boards to issue a temporary authorization to practice a health profession to eligible applicants within 10 days of receiving an application for licensure. Defines "health profession" and "health professional regulatory board."

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to health care licensing; and prescribing an effective date.

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

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

(a) "Health profession" means a health care service:

(A) For which an individual must possess a license to provide the health care service; and

(B) Over which a health professional regulatory board has oversight.

(b) "Health professional regulatory board" means a state agency that licenses individuals to provide a health care service to clients or patients that are humans.

(2) A health professional regulatory board shall, within 10 days of receiving an application for licensure, issue to the applicant a temporary authorization to practice the health profession regulated by the health professional regulatory board if the applicant:

(a) Holds a current authorization to practice the health profession issued by another state and the health professional regulatory board determines that the other state's authorization requirements are substantially similar to or exceed those of the health professional regulatory board;

(b) Provides to the health professional regulatory board, in a manner determined by the health professional regulatory board, sufficient proof that the applicant is in good standing with the issuing out-of-state entity;

(c) Has demonstrated competency, as determined by the health professional regulatory board by rule, over the health profession regulated by the health professional regulatory board;

(d) Agrees to complete within one year of the date the health professional regulatory board receives the application any applicable continuing education requirements; and

(e) Resides, or adequately demonstrates an intent to reside, in this state.

(3) A temporary authorization issued under subsection (2) of this section is valid until the earlier of the following dates:

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(a) One year from the date of issuance; or

(b) The date on which the applicant receives the license for which the applicant applied to the health professional regulatory board.

SECTION 2. (1) Section 1 of this 2024 Act becomes operative on January 1, 2025.

(2) A health professional regulatory board may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the health professional regulatory board to exercise, on or after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the health professional regulatory board by section 1 of this 2024 Act.

SECTION 3. This 2024 Act takes effect on the 91st day after the date on which the 2024 regular session of the Eighty-second Legislative Assembly adjourns sine die.

2024 Mid-Year

Preliminary Meeting Program

Thursday, April 11th

5:00 p.m. - 6:00 p.m.	**Registration**

Friday, April 12th (1:00 pm - 6:15 pm)

11:00 a.m. - 6:00 p.m.	**Registration**
12:00 p.m.	**AADB Attorney Round Table Meeting** *This closed session is for Attorneys who represent State/Territory Dental Boards.*
1:00 p.m. - 1:15 p.m.	**AADB President's Opening Remarks** Dale Chamberlain, DDS, AADB President *Recognition of the AADB Board of Directors* *Name Change* *Update*
1:15 p.m. - 1:30 p.m.	**Executive Director's Welcome & Report** Kimber Cobb, RDH, Interim Executive Director
1:30 p.m. - 2:30 p.m.	**DANB Presentation** Katherine Landsberg
2:30 p.m. - 3:30 p.m.	**AADB Dental & Dental Hygiene Compact Update**
3:30 p.m. - 3:45 p.m.	**Exhibits & Networking Break**
3:45 p.m. - 5:00 p.m.	**Spa Dentistry: Procedures & Practice Protocols**
5:00 p.m. - 5:45 p.m.	**Spa Dentistry: Model Regulations & limitations/prohibitions**
6:15 p.m.	**Presidential Reception - cash bar** *Please join President Dale Chamberlain, DDS, the AADB Board of Directors, AADB team, and invited speakers for light hors d'oeuvres and drinks.*

Saturday, April 13th (8:00 am - 1:00 pm)

8:00 a.m. - 10:00 a.m.	**Registration**
8:00 a.m. - 9:00 a.m.	**Hot Breakfast Buffet**
9:00 a.m. - 9:30 a.m.	**AADB Member Hygienist Caucus Meeting** Diane Klemann, RDH AADB Dental Hygiene Board Member *This closed session is for AADB member hygienists*
9:30 a.m. - 10:15 a.m.	**Regional Caucus Meetings** *North Caucus* *South Caucus* *East Caucus* *West Caucus*
10:15 a.m. - 10:30 a.m.	**Exhibits & Networking Break**
10:30 a.m. - 10:45 p.m.	**Sponsorship Recognition**
10:45 a.m. - 11:45 a.m.	**Attorney Roundtable** Lori Lindley, Senior Assistant Attorney General Oregon Board of Dentistry
11:45 a.m. - 12:15 p.m.	**Caucus Reports** **North:** Frank Maggio, DDS, AADB Caucus Chair **South**: Melodie Jones, DMD, AADB Caucus Chair **East**: TBD **West**: TBD
12:15 p.m. - 1:00 p.m.	**AADB State Dental Board Forum: State/Jurisdictions Board Issues - Frank Maggio, DDS** AADB Member and Moderator AADB Lawyers Committee Board of Director Members
1:00 p.m.	**Adjournment**

Caucuses by State

North

Illinois
Indiana
Iowa
Michigan
Minnesota
Missouri
Nebraska
North Dakota
Ohio
South Dakota
Wisconsin

South

Alabama
Arkansas
Florida
Georgia
Kentucky
Louisiana
Mississippi
North Carolina
Puerto Rico
South Carolina
Tennessee
Virginia
Virgin Islands

East

Connecticut
Delaware
District of Columbia
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont
West Virginia

West

Alaska
Arizona
California
Colorado
Hawaii
Idaho
Kansas
Montana
Nevada
New Mexico
Oklahoma
Oregon
Texas
Utah
Washington
Wyoming

UNFINISHED BUSINESS & RULES

Oregon
Tina Kotek, Governor

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

TO: Oregon Board of Dentistry Board Members
FROM: Stephen Prisby OBD Executive Director
DATE: January 22, 2024
SUBJECT: Public Rulemaking Hearing and Feedback

I served as the OBD's Hearings Officer for a public rulemaking hearing on December 15, 2023 at 1 pm, held via Zoom.

There were a few observers but no one testified or submitted any comments or feedback on the proposed rule changes.

The public comment period was open from November 9, 2023 to January 19, 2024. No public comment or feedback was received on these proposed rule changes.

OREGON BOARD OF DENTISTRY
PUBLIC RULE MAKING HEARING

December 15 at 1 pm – 1:30 p.m.* to be conducted via Zoom

Comments and feedback may be submitted until
January 19, 2024 at 4 p.m. to
information@obd.oregon.gov

***The public meeting will end early if no one is present or plans to submit comments on the rule changes proposed.**

1. **818-012-0005 Scope of Practice**
2. **818-021-0060 Continuing Education — Dentists**
3. **OAR 818-026-0010 Definitions**
4. **OAR 818-026-0050 Minimal Sedation Permit**
5. **OAR 818-026-0055 Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation**
6. **OAR 818-038-00XX Additional Functions of Dental Therapists – proposed New rule**
7. **OAR 818-042-0020 Dentist, Dental Therapist and Dental Hygienist Responsibility**
8. **OAR 818-042-0100 Expanded Functions — Orthodontic Assistant (EFODA)**
9. **OAR 818-042-0114 Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)**
10. **OAR 818-042-0115 Expanded Functions — Certified Anesthesia Dental Assistant**
11. **OAR 818-042-0117 Initiation of IV Line and Phlebotomy Blood Draw**

MEETING NOTICE

PUBLIC RULEMAKING HEARING

Oregon Board of Dentistry
1500 SW 1st Ave.,
Portland, Oregon 97201

ZOOM MEETING INFORMATION
https://us02web.zoom.us/j/81334374385?pwd=bE00NFRrMTJtSlhkVUoyMUpMRU11UT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 813 3437 4385 ● Passcode: 810816

December 15, 2023
1:00 p.m. – 1:30 p.m.

818-012-0005
Scope of Practice
(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.
(5) A dentist may place ~~endosseous~~ **dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited ~~graduate~~ **postdoctoral** dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
(6) A dentist placing ~~endosseous~~ **dental** implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).

818-021-0060
Continuing Education — Dentists
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist's name, course title, course completion date, course provider name, and continuing education hours completed.
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(6) At least two (2) hours of continuing education must be related to infection control.
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).
(8) A dentist placing ~~endosseous~~ **dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective January 1, 2024).

OAR 818-026-0010
Definitions
As used in these rules:
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
(2) "Anxiolysis" means the diminution or elimination of anxiety.
(3) “General Anesthesia” means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
(4) “Deep Sedation” means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
(5) “Moderate Sedation” means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by non-intravenous **and/or non-intramuscular** pharmacological methods, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous **and/or non-intramuscular** pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous **and/or non-intramuscular** pharmacological method in minimal sedation.
(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(8) “Maximum recommended dose” (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.
(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.
(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.
(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.
(a) ASA I “A normal healthy patient”.
(b) ASA II “A patient with mild systemic disease”.

(c) ASA III “A patient with severe systemic disease”.
(d) ASA IV “A patient with severe systemic disease that is a constant threat to life”.
(e) ASA V “A moribund patient who is not expected to survive without the operation”.
(f) ASA VI “A declared brain-dead patient whose organs are being removed for donor purposes".
(14) “Recovery” means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia monitor until discharge criteria is met.

OAR 818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation **or nitrous oxide sedation** at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may

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

OAR 818-035-0030
Additional Functions of Dental Hygienists
(1) In a ddition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:
(a) Make preliminary intra-oral and extra-oral examinations and record findings;
(b) Place periodontal dressings;
(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;
(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;
(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.
(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.
(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.
(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(i) Perform all aspects of teeth whitening procedures.
(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:
(a) Determine the need for and appropriateness of sealants or fluoride; and
(b) Apply sealants or fluoride.
(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

OAR 818-038-00XX
Additional Functions of Dental Therapists
(1) In addition to functions set forth in ORS 679.010, a dental therapist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

OAR 818-042-0020

Dentist, Dental Therapist and Dental Hygienist Responsibility

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.

(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.

(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services.

(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

(6) Dental assistants may take physical impressions and digital scans.

OAR 818-042-0100
Expanded Functions — Orthodontic Assistant (EFODA)
(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:
(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;
(b) Select or try for the fit of orthodontic bands;
(c) Recement loose orthodontic bands;
(d) Place and remove orthodontic separators;
(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/ or retainers after their position has been approved by the supervising licensed dentist;
(f) Fit and adjust headgear;
(g) Remove fixed orthodontic appliances;
(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; **and**
(i) Cut arch wires.~~; and~~
~~(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.~~
(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:
(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/ or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.
(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

OAR 818-042-0114

Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)

~~(1)~~ Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:

~~(2)~~ **(1)** Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.

OAR 818-042-0115
Expanded Functions — Certified Anesthesia Dental Assistant
(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.
(c) Perform phlebotomy for dental procedures.
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.

OAR 818-042-0117
Initiation of IV Line and Phlebotomy Blood Draw
(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

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

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 818
OREGON BOARD OF DENTISTRY

FILED
11/09/2023 10:27 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: The Board intends to amend 10 rules and adopt one new rule.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 01/19/2024 4:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Stephen Prisby
971-673-3200
stephen.prisby@obd.oregon.gov

1500 SW 1st Ave
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 12/15/2023
TIME: 1:00 PM - 1:30 PM
OFFICER: Stephen Prisby

HEARING LOCATION
ADDRESS: OBD via Zoom, 1500 SW 1st Ave, Portland, OR 97201
SPECIAL INSTRUCTIONS:
Zoom info on hearings notice and other board documents

NEED FOR THE RULE(S)

The Board's Committees have reviewed the updated rule changes and then the Board agreed to move these OAR to the public rulemaking process for more feedback before considering them at the February 2024 Board meeting.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Board and Committee meeting agendas, minutes and correspondence.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

This is an unknown and difficult for the Board to measure or quantify. Board and Committee members represent diversity in Oregon and were integral in the discussions leading to the proposed rule changes.

FISCAL AND ECONOMIC IMPACT:

The Board anticipates little or no meaningful impact on our Licensees with these proposed rule changes.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

The Board anticipates little or no meaningful impact on our Licensees with the these proposed rule changes.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Board and Committee members represent diversity in Oregon in practice size. facility type and ownership as well. Small and large business interests are involved in Board rulemaking activities.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
818-012-0005, 818-021-0060, 818-026-0010, 818-026-0050, 818-035-0030, 818-038-0022, 818-042-0020, 818-042-0100, 818-042-0114, 818-042-0115, 818-042-0117

AMEND: 818-012-0005

RULE SUMMARY: The reference to dental implant training requirements are being refined for clarity.

CHANGES TO RULE:

818-012-0005
Scope of Practice ¶

(1) No dentist may perform any of the procedures listed below:¶
(a) Rhinoplasty;¶
(b) Blepharoplasty;¶
(c) Rhytidectomy;¶
(d) Submental liposuction;¶
(e) Laser resurfacing;¶
(f) Browlift, either open or endoscopic technique;¶
(g) Platysmal muscle plication;¶
(h) Otoplasty;¶
(i) Dermabrasion;¶
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and¶
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.¶
(2) Unless the dentist:¶
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or¶
(b) Holds privileges either:¶
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or¶
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).¶
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.¶
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist

may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.¶
(5) A dentist may place ~~endosseous~~dental implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical dental implant course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited ~~graduate~~postdoctoral dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).¶
(6) A dentist placing ~~endosseous~~dental implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-021-0060

RULE SUMMARY: The reference to dental implant training requirements are being refined for clarity.

CHANGES TO RULE:

818-021-0060
Continuing Education - Dentists ¶

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.¶
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.¶
(3) Continuing education includes:¶
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.¶
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)¶
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist's name, course title, course completion date, course provider name, and continuing education hours completed.¶
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.¶
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.¶
(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(6) At least two (2) hours of continuing education must be related to infection control.¶
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).¶
(8) A dentist placing ~~endosseous~~dental implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period (Effective January 1, 2024).
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(9)

AMEND: 818-026-0010

RULE SUMMARY: Minimal sedation will now include reference to non-intramuscular methods and recovery is defined in the rule as well.

CHANGES TO RULE:

818-026-0010
Definitions ¶

As used in these rules: ¶
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication. ¶
(2) "Anxiolysis" means the diminution or elimination of anxiety. ¶
(3) "General Anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.¶
(4) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. ¶
(5) "Moderate Sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. ¶
(6) "Minimal Sedation" means minimally depressed level of consciousness, produced by non-intravenous and/or non-intramuscular pharmacological methods, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous and/or non-intramuscular pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous and/or non-intramuscular pharmacological method in minimal sedation. ¶
(7) "Nitrous Oxide Sedation" means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command. ¶
(8) "Maximum recommended dose" (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use. ¶
(9) "Incremental Dosing" means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).¶
(10) "Supplemental Dosing" means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.¶
(11) "Enteral Route" means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.¶
(12) "Parenteral Route" means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.¶
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.¶
(a) ASA I "A normal healthy patient".¶
(b) ASA II "A patient with mild systemic disease".¶
(c) ASA III "A patient with severe systemic disease".¶
(d) ASA IV "A patient with severe systemic disease that is a constant threat to life".¶
(e) ASA V "A moribund patient who is not expected to survive without the operation".¶
(f) ASA VI "A declared brain-dead patient whose organs are being removed for donor purposes".¶
(14) "Recovery" means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia

monitor until discharge criteria is met.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(7), 679.250(10)

AMEND: 818-026-0050

RULE SUMMARY: The rule is clarifying that no permit holder shall have more than one person under nitrous oxide sedation at the same time.

CHANGES TO RULE:

818-026-0050
Minimal Sedation Permit ¶

Minimal sedation and nitrous oxide sedation.¶
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:¶
(a) Is a licensed dentist in Oregon;¶
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and¶
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or¶
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.¶
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:¶
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;¶
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;¶
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;¶
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;¶
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;¶
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;¶
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and¶
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.¶
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:¶
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;¶
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;¶
(c) Certify that the patient is an appropriate candidate for minimal sedation; and¶
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.¶
(4) No permit holder shall have more than one person under minimal sedation <u>or nitrous oxide sedation</u> at the same time.¶
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.¶
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.¶
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special

skill or knowledge derived from training and experience.)¶
(8) The patient shall be monitored as follows:¶
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.¶
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.¶
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:¶
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;¶
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;¶
(c) The patient can talk and respond coherently to verbal questioning;¶
(d) The patient can sit up unaided;¶
(e) The patient can ambulate with minimal assistance; and¶
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.¶
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.¶
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.¶
(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(7), 679.250(10)

AMEND: 818-035-0030

RULE SUMMARY: The rule is adding optional additional functions including intravenous access, phlebotomy and blood draw with successful completion of a Board approved course.

CHANGES TO RULE:

818-035-0030
Additional Functions of Dental Hygienists ¶

(1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:¶
(a) Make preliminary intra-oral and extra-oral examinations and record findings;¶
(b) Place periodontal dressings;¶
(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;¶
(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;¶
(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.¶
(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.¶
(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.¶
(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.¶
(i) Perform all aspects of teeth whitening procedures.¶
(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:¶
(a) Determine the need for and appropriateness of sealants or fluoride; and¶
(b) Apply sealants or fluoride.¶
(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist: ¶
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit. ¶
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j)

ADOPT: 818-038-0022

RULE SUMMARY: The new rule is adding optional additional functions including intravenous access, phlebotomy and blood draw with successful completion of a Board approved course.

CHANGES TO RULE:

818-038-0022
Additional Functions of Dental Therapists
In addition to functions set forth in ORS 679.010, a dental therapist may perform the following functions under the indirect supervision of a licensed dentist:¶
(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.¶
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679

AMEND: 818-042-0020

RULE SUMMARY: The rule clarifies that dental assistants may take physical impressions and digital scans.

CHANGES TO RULE:

818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility ¶

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.¶
(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.¶
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services. ¶
(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.¶
(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.¶
(6) Dental assistants may take physical impressions and digital scans.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0100

RULE SUMMARY: The rule is deleting reference to taking impressions and other orthodontics.

CHANGES TO RULE:

818-042-0100
Expanded Functions - Orthodontic Assistant (EFODA) ¶

(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:¶
(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;¶
(b) Select or try for the fit of orthodontic bands;¶
(c) Recement loose orthodontic bands;¶
(d) Place and remove orthodontic separators;¶
(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/or retainers after their position has been approved by the supervising licensed dentist;¶
(f) Fit and adjust headgear;¶
(g) Remove fixed orthodontic appliances;¶
(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; and¶
(i) Cut arch wires~~; and~~¶
~~(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.~~¶
(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:¶
(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.¶
(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7)

AMEND: 818-042-0114

RULE SUMMARY: A number is being removed, no change to language or intent of rule.

CHANGES TO RULE:

818-042-0114
Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)
(1) Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:¶
(2) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.
Statutory/Other Authority: ORS 676
Statutes/Other Implemented: ORS 676, ORS 679.600

AMEND: 818-042-0115

RULE SUMMARY: The rule is adding that the certified dental assistant can perform phlebotomy for dental procedures.

CHANGES TO RULE:

818-042-0115
Expanded Functions - Certified Anesthesia Dental Assistant ¶

(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:¶
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.¶
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.¶
(c) Perform phlebotomy for dental procedures.¶
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1), 679.250(7)

AMEND: 818-042-0117

RULE SUMMARY: The rule is adding that the certified dental assistant may perform phlebotomy procedures after completing a Board approved course.

CHANGES TO RULE:

818-042-0117
Initiation of IV Line-and Phlebotomy Blood Draw ¶

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.¶
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1), 679.250(7)

Guidance Document for Compliance with "Good Faith Effort" (GFE)

Guidance Document for Compliance with "Good Faith Effort" (GFE) Requirements of Oregon House Bill 2359 and OAR 950-050-0160

Introduction

Oregon House Bill 2359 clarified requirements that health care providers, language service providers, and Coordinated Care Organizations (CCOs) must work with Health Care Interpreters (HCIs) from Oregon's central registry. The Oregon Administrative Rules (OARs) further outlined the requirements and exceptions for working with credentialed (qualified or certified) HCIs from the central registry.

One allowable exception for working with an HCI from the central registry is when there is no available HCI from the central registry for a specific interpreting session. In these circumstances, the interpreting appointment may be scheduled with an interpreter who is not on the central registry once a "good faith effort" (GFE) to schedule with an HCI from the central registry has been made and that effort is fully documented. While the OARs provide some detail around what constitutes a good faith effort, they also note that the Oregon Health Authority (OHA) may release additional guidance in the future. This document is intended to provide that additional guidance on demonstrating GFE for working with HCIs from the central registry.

Overview

The Oregon Council on Health Care Interpreters (OCHCI) is a 15-member council appointed by the Director of OHA to advise OHA on administrative rules and policy standards for the HCI Program. OCHCI members have been meeting over the past several months to discuss and develop additional guidance to clarify the good faith effort requirements outlined in the rule.

The OCHCI has prepared this document to provide guidance, primarily to the health care providers and the health systems where they work, on how to demonstrate compliance with HB 2359 requirements for working with HCIs in the central registry. These providers and health systems include most health care providers working in Oregon and are further described in OAR 950-050-0010(10). In addition, much of this guidance is also applicable to language service providers (OAR 950-050-0170), Coordinated Care Organizations (OAR 410-141-3590), and others who have responsibility for scheduling and assigning HCIs.

The focus of this document is on the good faith effort provisions outlined in OAR 950-050-0160(1)(b), which addresses the situation where a provider is unable to obtain an HCI from the central registry. Health care providers and health systems are required to make good faith efforts to work with HCIs from the central registry and create and maintain records of these efforts. The information outlined here covers the necessary steps for creating policies and procedures for assigning interpreters from the central registry, making efforts to reduce reliance on interpreters who are not on the central registry, and strategies for increasing the utilization rate of interpreters from the central registry. The OARs require:

950-050-0160

Health Care Provider Requirements

(1) Beginning July 1, 2022, for onsite interpreting and no later than July 1, 2023, for remote interpreting, health care providers shall work with qualified or certified health care interpreters from the Authority's health care interpreter central registry when arranging for or providing services to a person with LEP or who prefers to communicate in a language other than English or who communicates in signed language. Exceptions are allowed when the provider:

…

(b) Has made a good faith effort to obtain a health care interpreter from the central registry and has found that none are available to provide interpreting. In this circumstance, the health care provider may work with the non-registered interpreter for that visit or episode of care. For each visit or episode of care that a provider works with a non-registered interpreter, the provider shall create and maintain records of the good faith efforts made by the provider to work with an interpreter from the central registry. Evidence of good faith efforts shall be made available to the Authority and relevant provider licensing and certification boards upon request. The Authority may release additional guidance on good faith efforts in the future. At a minimum, providers shall develop and maintain policies, processes, and outcomes describing:

> (A) The steps the provider takes to work with an interpreter from the central registry for a health care appointment;
>
> (B) The efforts the provider makes to reduce reliance on interpreters who are not on the central registry; and
>
> (C) How the provider efforts are increasing the number of health care interpreting appointments scheduled with interpreters from the central registry;

Guidance

The OARs require health care systems to complete several steps prior to working with an interpreter who is not on the central registry. Those required steps are detailed in the OARs cited above. This guidance document follows that OAR framework and outlines how health care systems and others can meet the requirements to develop and maintain policies, processes, and outcomes for each of the subsections (1)(b)(A), (1)(b)(B), and (1)(b)(C) of OAR 950-050-0160.

(A) Steps to Work with an Interpreter from the Central Registry

Establishing Policies and Processes. Health care systems should develop and maintain comprehensive language service policies and processes for scheduling and working with HCIs from the central registry. These policies must include clear steps to be followed for every health care appointment. Key components include:

1. Early Identification of Language Needs:

- Identify the patient's language needs at the earliest opportunity.
- Incorporate language preference questions into pre-appointment communications or intake forms.
- Ask patients their preferred language when they call to schedule an appointment.

2. Working with HCIs from the Central Registry:
    - Prioritize working with interpreters listed in the central registry and require the same of contracted vendors.
        - Language companies
            - Route calls to credentialed interpreters first.
            - Make appointments on portals visible to credentialed interpreters first or only visible to credentialed interpreters up to the day before the appointment. For same-day appointments, notify credentialed interpreters first.
            - To continue providing health care interpreting services to people in Oregon, require interpreters to obtain a state credential within a set period to continue to work with the company.

    - Clearly outline the process for requesting interpreters from the central registry and steps to follow when an interpreter from the central registry is not available.

3. Recordkeeping:
    - Maintain records of accessing interpreter information from the central registry for each appointment. Accessing or checking the central registry may be accomplished by making an inquiry at: https://hciregistry.dhsoha.state.or.us/Search or by downloading central registry data and incorporating it into another scheduling system on a regular basis – at least once a month, and utilizing that scheduling system to identify and assign interpreting appointments.
    - Document the date and time of the request, language required, responses received, and whether the interpreting appointment was assigned to an HCI from the central registry (include HCI's central registry number in these cases) or with an interpreter who is not listed in the central registry.

4. Follow-up Procedures:
    - Establish procedures for following up on requested HCI to ensure timely confirmation of interpreting appointments.
    - Document any difficulties encountered with assigning an interpreter from the central registry and the steps taken to resolve them.
    - Document any challenges encountered in complying with the requirements and proactively report these challenges to the appropriate regulatory body

(e.g., OHA's Health Licensing Office, Health Facility Licensing & Certification Program, Medicaid program, or other independent health licensing boards). This sharing of information can help foster a collaborative relationship with regulatory bodies and enhance systems improvement.

(B) Efforts to Reduce Reliance on Interpreters who are not on the Central Registry
Health care systems must actively work to minimize reliance on interpreters not listed in the central registry. Efforts should include integrating the following into the health care system's existing language access plan:

1. Training and Education:
    - Train staff on the importance of working with HCIs on the central registry.
    - Educate health care professionals about the potential risks of working with interpreters who are not included on the central registry.
    - Educate patients on benefits of working with trained interpreters; have patients sign waiver when declining interpreting services and suggest a trained interpreter sit in on encounters.
    - Educate patients on their language access rights.
    - Implement measures to encourage working with HCIs on the central registry such as incentives or recognition programs.
    - Acknowledge harms of past and present failure to provide consistent access to competent interpreters, and work to rebuild trust with patients who are speakers and signers of languages other than English, many of whom have had negative experiences in the past due to lack of access to interpreting services or low quality of interpreting services.

2. Incorporating Language Services into Care Delivery:
    - Integrate language services into standard care delivery processes.
    - Explore technologies that facilitate identifying and assigning HCIs from the central registry.
    - Include provisions in contracts with any contracted vendors responsible for assigning or providing interpreting to require working with HCIs from the central registry or document good faith efforts to do so.
    - Consider percentage of language service providers' workforce that are on the central registry when negotiating contracts.
    - Include language emphasizing the routing of calls and appointments to HCIs on the central registry BEFORE seeking interpreters who are not on the central registry.

3. Regular Audits and Assessments by the Health Care System and CCOs:
    - Conduct regular audits of interpreter utilization and the rates of assigned HCIs on the central registry versus those who are not.
        - CCOs and health systems: Compare internal audits with language company audits.

- CCOs: compare health system encounter tracking data (T1013 codes, encounter notes) with language access reports.

- Implement assessments to identify opportunities for improvement in reducing reliance on interpreters who are not on the central registry.

(C) Increasing Rate of Central Registry HCI Appointments

Health care systems should be actively working to increase their rate of health care interpreting appointments scheduled with HCIs from the central registry. The OCHCI has adopted the target from OHA's Metrics and Scoring Committee which identified that Oregon's benchmark goal should be that:

> 75% of all health care interpreting appointments are provided with HCIs from the central registry. The OCHCI recognizes that given the need to schedule emergency and on-demand interpreting sessions in some cases, a 100% rate is likely not possible. In addition, the OCHCI acknowledges that this percentage rate is likely significantly higher than the current rate for most health care systems. However, given the goal of assuring that all people have meaningful access to health care services in Oregon, the OCHCI believes the 75% rate is the appropriate aspirational goal.

The health care system must regularly monitor and assess the effectiveness of their improvement strategies to assure that the rate is increasing. To ensure ongoing, meaningful improvement, health care systems should set an annual improvement target for increasing their rate of working with HCIs from the central registry. Health care systems can identify their annual improvement target by comparing their baseline performance (typically the previous year's performance) with the state's aspirational goal and then calculating a 10 percent reduction between the baseline and the aspirational benchmark.

For example, suppose a health care system's baseline performance for working with HCIs from the central registry was 45%. The gap between that baseline and the benchmark is 30% [75% aspirational goal – 45% baseline = 30%]. To show meaningful progress towards the benchmark, the health care system should work towards reducing that gap by at least 10% over the course of the next year. That means that the improvement target would be a 3% increase [ten percent of 30% = 3%] and the health care system would need to raise their rate of working with HCIs from the central registry to 48% [45% baseline + 3% improvement = 48%]. Stated as a formula:

$$X = \frac{\text{Benchmark] – [Health care system baseline]}}{10}$$

$$\text{Improvement Target} = \text{[Health care system baseline] + [X]}$$

Improvement strategies may include:

1. Collaboration with the Oregon HCI Program and Oversight Entities:
    - Establish open communication channels with the program and oversight entities.
    - Collaborate on strategies to increase the availability of interpreters for commonly requested languages as well as languages of lesser diffusion.
        - Regular forums for discussion between patients who are speakers and signers of languages other than English, interpreters, CCOs, language companies, OHA, and health licensing boards to discuss best practices, challenges, and strategies, to ask each other questions, and to gain clarity on who is doing what to promote collaboration and avoid duplicating efforts.

    - CCOs: Inform patients who are speakers and signers of languages other than English and health care interpreters of contract negotiations between CCOs and language companies. Solicit their feedback and consider it when making contracting decisions. At a minimum, email all interpreters on the central registry to inform them when contract negotiations are set to begin and provide forums for interpreters to give feedback and ask questions. For example, respond to questions within 30 days.

2. Workforce Enhancements:
   The following suggestions are intended to positively impact the health care system's ability to hire and maintain a robust, qualified, stable, and content workforce. Adequate compensation and professional support not only attract top-tier talent during the recruitment phase but also serves as a cornerstone for retaining skilled professionals. A content and secure workforce is inherently more engaged, leading to increased productivity, creativity, and loyalty.

    - Engage in community outreach to promote the central registry and encourage interpreters to become credentialed and listed on the central registry.
    - Support costs of interpreter training and continuing education required to be included and maintained on the central registry.
    - Encourage interpreters with national certification to apply to become listed on the central registry. The OCHCI has developed a streamlined process for nationally credentialed interpreters to be included on the Oregon central registry.
    - CCOs: get workforce information from language companies in RFPs (e.g., number of interpreters for each language, fill rate for each language, etc.) Contract with enough language companies/interpreters to be able to

include language companies or interpreters specializing in languages with low historical CCO fill rates (in the case of interpreters their certified/qualified languages; in the case of language companies the languages they show high numbers of interpreters and high fill rates for).

- Publicize financial incentives for HCIs on the central registry
    - Provide a pay rate enhancement to interpreters on the central registry versus those who are not.
    - Pay a two-hour minimum for interpreting sessions.
    - Pay travel time and mileage for in-person interpreting sessions.
    - Pay an on-call rate for HCIs on the central registry who are actively waiting in a queue for remote interpreting calls.
    - CCOs:
        - Publicize incentives for credentialed interpreters being paid to language companies (2-hour minimums, travel pay, mileage reimbursement, etc.) so that interpreters contracted with the language companies can receive those when taking jobs with the contracted language companies, increasing the likelihood that they will accept jobs.
        - Correlate language company pay to interpreter pay. This connection can reward language companies that pay rates high enough to support credentialed interpreters.
        - Reimburse provider network for language companies without CCO contracts when the companies contracted with the CCO can't find an interpreter in the patient's preferred language.
        - Reimburse provider network for central registry interpreter services provided by language companies without CCO contracts when the language companies contracted with the CCO can't find an interpreter on the central registry.

3. Feedback Mechanisms:
    - Establish mechanisms for feedback from patients who are speakers and signers of languages other than English, health care systems, interpreters, and others to address any challenges or barriers to central registry utilization. Ensure that these feedback mechanisms are accessible to speakers and signers of languages other than English and respond to feedback in a timely manner. For example, within 30 days unless more time is necessary to investigate before taking action. In these cases, provide updates to the complainant every 30 days.
    - Engage in and respond to regular reviews and audits of health care providers and health care systems by oversight entities such as licensing boards, health plans, and OHA.

Conclusion

Demonstrating compliance with the good faith effort requirements of HB 2359 and OAR 950-050-0160 requires a systematic approach to language access in health care. By following the steps and recommendations outlined here, health care providers and health systems, language service providers, CCOs, and others can create an effective framework that ensures the availability of interpreters and continually increases the rate in which interpreting sessions are provided by credentialed HCIs from the central registry.

Finally, utilizing the guidance outlined in this document, health care providers and others can effectively demonstrate compliance with good faith effort requirements, fostering improved communication and patient care by working with credentialed interpreters from the central registry. Regular self-assessment and collaboration with regulatory bodies will ensure ongoing compliance and continuous enhancement of language access.

Thanks to the Oregon Council on Health Care Interpreters (OCHCI) for development, review, and approval of this guidance document. OCHCI members include:

Alina Stircu
Law Student, Lewis & Clark Law School, Health Care Interpreter

Amelia Pacheco
Indigenous Interpreter & Case Manager Collectivo de Interpretes Indigenas de Oregon - Pueblo Unido

Ana Catalina Jones*
Testing and Training Manager, Language Line Solutions

Felicity Ratway*
PhD Student OSU Public Health; Health Care Interpreter; HCI Instructor

Liban Satu
Founding Director of Risen Community Organization

Loie Feuerle*
Oregon Society of Translators and Interpreters, Curriculum Development Subject Matter Expert

Maria Michalczyk*
Oregon Healthcare Interpreters Association (OHCIA), President Emeritus; National Council on Interpreting in Heath Care, Board President, Registered Nurse

Michaelle Gearheart
Certification & Training Coordinator for Court Language Access Services for Oregon Judicial Department

Norma Ramirez
Director of Programs and Community Development, EUVALCREE

Sanjoy Dutt*
Health Care Interpreter

**Special thanks to these OCHCI members who made up the Good Faith Effort (GFE) workgroup and to David Simnitt, Principle with DS Consulting, who facilitated and coordinated the GFE workgroup. OHA and the HCI Program appreciate their extensive expertise and the many hours these members generously dedicated to developing this important GFE Guidance Document.*

CORRESPONDENCE

MEETING MINUTES

MHCC DENTAL HYGIENE PROGRAM ADVISORY BOARD, FALL MEETING

Thursday, November 30, 2023
5:30 – 7:00pm

I. Welcome and Announcements

Betsy Julian (Interim Vice President of Instruction) stopped by prior to meeting start and thanked attendees for their support. She shared the challenges, time, energy and efforts and gave gratitude to the team of individuals that were part of the clinic renovation project. Attendees toured the new facility.

II. Reports from College, Division

- Betsy Julian, Interim Vice President of Instruction
  There were no reports from the college to share.
- Daniel Wenger, Interim Dean of Health Professions Division
  There were no reports from the division to share.

III. Program Reports; Academic and Clinical Reports

- Jennifer Aubry, Program Director
  Admissions: 89 applicants in last cycle (DH23). 82 applications were complete. Application scores have increased over the last few years. This past year the application score was 36, up from 35 (DH22) and 33 (DH21). Average GPA of admitted students has also increased. This past year was 3.68, up from 3.62 (DH22) and 3.43 (DH21).
  Program information sessions: First for new school year was 11/14. Another will be held 12/13, 2-3:30pm.
  Observation hours: Interested students may contact the clinic or program director to schedule a time to complete observation hours for the application or to have the opportunity to visit the program and observe dental hygiene students/coursework.
  Application Cycle DH24: Applications are due 1/26. Application is now online through MHCC website. Interviews will be in April and acceptance letters will be issued in May.
  Program faculty: several new faculty/staff were hired since last meeting to meet the needs of the modified coursework schedule during the remodel. Four faculty and two dentists have continued/will continue teaching this school year.
- Amber Phillips, Second Year Clinical Coordinator
  - Board Exams and Graduates; Employment (Class of 2023)
    Clinical board exams: all passed. National board exams: 15 of 18 passed. Two have since taken the exam and passed. One remains to retake.
    Regional exams: This year program students will be taking CRDTS (Central Regional Dental Testing Service) exams. LA (Local Anesthesia) exams will be at Pacific University in February. Hygiene and Restorative exams will be held at MHCC in May.

- Ilya Babiy, First Year Clinical Coordinator
  Class of 2025: Ilya reported the new cohort is a diverse class that ranges in all areas of demographics. Seven languages are spoken. The cohort is working very well together and have great participation. 15 of the students attended the ODHA (Oregon Dental Hygienists' Association) conference in Salem this year.
- Renee Alexandre, Restorative Clinic Lead
  No restorative curriculum reports to share.
- Jennifer Aubry, Community Outreach Coordinator
  St. Lucia: 14 students + 2 faculty attended Great Shape 1000 Smiles project.
  Sandy: 10+ seniors and 8+ juniors attended clinic in October 2023.
  Philippines: Ilya and Elizabeth (faculty) are planning a mission trip in March 2024 with senior and junior students.
  Mexico: Ilya shared a possible mission trip in February 2024. More information to come.
  June: Program is investigating and planning to hold a Saturday clinic to meet community member needs that are not able to seek regular dental care in our clinical course setting.
  Summer 2024: Students are just beginning to share their interest in attending Great Shape 1000 Smiles mission in St. Lucia, Jamaica or Grenada this next summer.
- Garrett Parfitt (2024) and Crystal Childers (2025), Student Class Representatives
  Class of 2024: Garrett talked about the transition to the new clinic. Stated it was hard, but doable. Took a couple weeks to get used to the new facility/equipment, but classmates are enjoying the space and having their own units.
  Class of 2025: Crystal talked about the transition into the dental hygiene program. Shared appreciation of the availability of instructors and resources. She stated she feels very supported. And felt like she hit the ground running when classes started. Cohort is getting ready for finals and putting in a lot of practice on typodonts. Shared that most of her class has already completed all of their fall term skill checks.

IV. Old Business

- Accreditation Site Visit Recommendations – Clinic/Lab Renovation Project
  Program recommendations have been met and current accreditation status, received Aug 2023, is "approval without reporting requirements."
  Next site visit is Fall 2027. Self-study/preparation will begin WI/SP26.
- Clinical Rotation Site Updates
  The temporary use of the multiple off-site locations as major sites has halted. However, a minor site report was submitted for Gateway Grace this summer and students will continue to complete clinical rotations at Good News, Gateway Grace, and Wallace Dental.

V. New Business

- Open House: February 22
  Hours: 5-8pm. Open to all community members/public. Planning process is just beginning. Program student club and ASG (Associated Student Governement) have

shown interest in supporting and planning. Advisory board members were encouraged to share with company partners, colleagues, etc.

- New program equipment/curriculum
  Program received Perkins funding for an intraoral scanner and 3D printer. Senior students will be trained winter term and complete at least one experience on a patient by their graduation date. For future cohorts, curriculum will be reviewed at annual end-of-year meeting and incorporated into program coursework/curriculum.
  Program received one-time funding to acquire Biolase dental hygiene lasers. Training has been scheduled for January 2024 for faculty and senior students. Students will complete at least two experiences on a patient before graduation. Next cohort will complete training fall term and will complete at least three experiences (one/term) on patients.
- New Clinical Rotation Site
  A minor educational activity site report will be submitted December 2023 for clinical rotations to Virginia Garcia. Students will begin going in January. Site supervisor will be a VG RDH, Rachel, who has been working with Pacific students for several years. At least two locations have been identified: Hillsboro and Cornelius. Hopeful this new rotation will add more pedo patient experiences for students. Excited for the additional opportunity and experience and working with even more community members.

Tentative date for next meeting: May/June 2024

Meeting minutes drafted by Jennifer Aubry and reviewed by Ed Chang on 12/5/2023 prior to emailing to members.

From:
To:
Subject:
Date:

Hello,

In December 2018, when Dr. Beck and Dr. Fine agreed that dentists and hygienists may perform in-office A1c screening tests, I imagine that the intent of the motion is to clarify that A1c testing is, indeed, within the scope of a dental practice. Unfortunately the motion has had a further obfuscating effect, because the language is unclear as to whether or not a dental assistant can perform the test under the supervision of the dentist or hygienist.

I would submit that a dental assistant should be allowed to perform the test, since it is the same capillary blood draw procedure that patients do at home for themselves when testing blood glucose. Additionally, in accordance with CMS regulations, anyone at my clinic who performs the test are CLIA certified for the A1c test, so the dental assistant would have the same certification as the dentist and hygienist for that procedure.

Regards,
Colin

Colin Taggart, DMD
Dentist & Interim Dental Director
One Community Health
office: 541-256-4342 / cell: 503-936-8264

ONE COMMUNITY HEALTH
CARING FOR ALL, CARING WITH HEART
CUIDANDO A TODOS, CUIDANDO CON EL CORAZÓN

D0411 – ADA Guide to Point of Care Diabetes Testing and Reporting

Developed by the ADA, this guide is published to educate dentists and others in the dental community on this procedure and its code first published in *CDT 2018* and effective January 1, 2018.

Introduction

Simple chair-side screening for dysglycemia via finger-stick random capillary HbA1c glucose testing can be used to rapidly identify high-risk patients. Chair-side screening and appropriate referral may improve diagnosis of pre-diabetes and diabetes.

A code for the finger-stick capillary HbA1c glucose test procedure can foster its broader adoption. This test is relevant to dentists as diabetes is a risk factor related to periodontal disease. It is akin to caries risk testing that relates to tooth decay and remedial restorative procedures and preventive procedures. Hb1Ac testing enables a dentist to amend the patient's treatment planning depending on whether the results are the first indicator of a new diabetic condition, or if the results indicate a change in the existing diabetic condition.

The full CDT Code entry (Nomenclature only; no Descriptor):

D0411 HbA1c in-office point of service testing

The following pages contain a number of Questions and Answers, all intended to provide readers with insight and understanding of the procedure and its reporting, including points to consider before offering this service to your patients.

Questions and Answers

1. What is HbA1c?

   Hemoglobin A1c, also known as glycated hemoglobin, is a measure of the amount of glucose attached to red blood cells and directly relates to the average blood glucose levels. Patient fasting is not required prior to an HbA1c test.

2. When should I suggest that a patient receive an HbA1c Point of Care Test (POCT)?

   There are a number of factors that could place a patient at risk of diabetes, some of which may already be in their dental records, and include:

   - Obesity or being overweight
   - Ethnic background (diabetes happens more often in Hispanic/Latino Americans, African-Americans, Native Americans, Asian-Americans, Pacific Islanders, and Alaska natives)
   - Sedentary lifestyle (exercise less than three times a week)
   - Family history (parent or sibling who has diabetes)

   A resource that will help identify patients who might be candidates for the D0411 procedure is the Point-of-care prediabetes identification (click on hyperlink to open) guide prepared jointly by the American Diabetes Association, the American Medical Association, and the Centers for Disease Control.

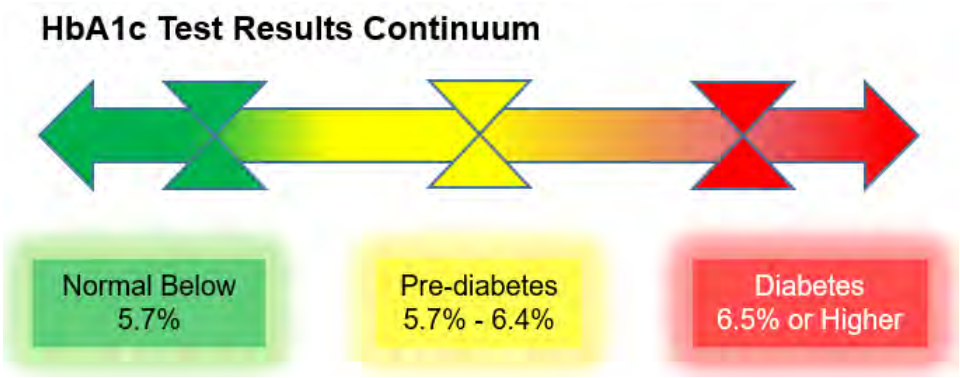
3. How is the procedure delivered?

   There are established protocols for acquiring and assaying the small sample of blood for POCT to measure HbA1c. Protocol steps include: a) finger selection; b) massaging, cleaning and drying the site; c) skin puncture with a lancet; d) wiping away the first blood before collecting the sample without "milking the finger" site; e) placing the sample into the analyzing device; and f) reading the results.

   Every blood donor has experienced skin puncture with a lancet. There can be some variations in steps e) and f), dependent on the test kit used.

4. What do the analysis results indicate?

   The HbA1c analyzing device displays a percent figure. There is a recognized range of percentages that is used to indicate whether the patient is considered normal, pre-diabetic or diabetic, as illustrated:



5. What should I do if my patient's HbA1c test result is at the pre-diabetes or diabetes percentage?

   A dentist should assess how this information affects the patients current and future treatment plans. In addition to informing the patient of the outcome, it would be appropriate to recommend they contact their physician for a definitive diagnosis. A third action would be to determine whether the patient's dental benefit plan provides coverage for additional prophylaxis procedures, if indicated.

6. How would the procedure's findings help my treatment planning for the tested patient?

   The screening result could lead to a definitive diagnosis of diabetes by a physician. A diagnosis of diabetes may indicate that the patient could benefit from more frequent prophylaxes than a person without such a diagnosis to maintain their oral health. Some dental benefit plans cover "extra" prophylaxis procedures for patients with diabetes.

7. Are there rules or regulations regarding in office HbA1c testing, documented with CDT Code D0411?

   Yes, be sure to check your state's Dental Practice Act to determine if testing is within the scope of your license. There are also federal, and state, regulations concerning laboratories that may affect your business decision to provide this service.

8. What federal or state regulatory requirements must I satisfy before offering this procedure to my patients?

   There is an overarching federal regulation – Clinical Laboratory Improvement Amendments of 1988 (CLIA). Any dental practice that performs tests on human tissues, including blood, is considered a laboratory according to CLIA. This means that the practice requires certification by the state and the Centers for Medicare and Medicaid Services (CMS) before collecting and testing the blood sample.

   The "finger-stick" point of service test considered to be of low complexity by the Food and Drug Administration (FDA), and is in the "waived" category of laboratory procedures. This means that CMS will issue two-year Certificate of Waiver (COW) to a dental office that performs this test. The COW fee is $150, and the dental office must perform only the waived test following the manufacturer's current instructions without changes. A COW holder is subject to announced or unannounced on-site inspections by CMS.

   Federal regulations establish the requirements threshold. Local or state laws may be more stringent – there may be specific regulations concerning practice personnel who may administer the test; biohazard safety, including handling and disposing of medical waste.

   For example, New Jersey's State Board of Dentistry ruled that it is within the scope of practice for New Jersey licensed dentists to perform in-office A1C diabetes screening tests for at-risk patients. The board noted that: a) such testing is not presumed to be the standard of care; and b) for A1C screenings beyond the normal range, dentists should refer patients to a physician for a formal evaluation, diagnosis, and treatment.

   The following chart illustrates how a dental practice would be considered a laboratory under CLIA, and the applicable federal regulations. A red arrow points to where the D0411 procedure falls (Simple or Waived Tests), indicating that the dental practice is required to have the $150 two-year COW.

CLIA Flowchart

Is your dental practice considered a laboratory under CLIA?

Do you utilize human tissue samples or specimens at your office?
(i.e., saliva, blood, plaque, hard or soft tissue biopsy)

No. We do not and never have.

→ **You are probably not a laboratory.** If you do not take or send out samples, you are likely not affected by CLIA.

Yes, but we only take the samples in office, and send them to an outside lab for testing.

→ **You are probably not a laboratory.** If you use an outside laboratory to get results, that facility is a laboratory and you should check the CLIA registry online to guarantee that the laboratory is certified and follows federal, state and local law.

Yes. We perform tests to diagnose, prevent, treat, and assess patient health.

→ **You are most likely a laboratory.** Next, look at the FDA categories of test complexities to see what level(s) apply to you.

Local and state laws may override CLIA – check with your attorney. Your state dental association may also have information.

Simple or Waived Tests (i.e., blood glucose, cholesterol)
If the test is a simple laboratory procedure with an insignificant risk of erroneous results, you may be eligible for a certificate of waiver after your laboratory has been certified through the CLIA process. See the FDA website for a complete list of tests that have been waived. "Waived" does not mean you don't have to do anything; you still need to obtain certification, follow the manufacturer's instructions for test performance, and maintain the appropriate records.

Moderate Complexity/PPM (e.g., INRatio2 device or microscopic examinations)
If the test is of moderate complexity or is a provider-performed microscopy procedure, you may be eligible for a Certificate for PPM. You need to apply to the CLIA program and designate the applicable waiver. See five types of certificates and CLIA enrollment.

High complexity
See the FDA website for more information.

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

9. What are a dentist's ethical obligations to deliver this procedure to patients (e.g., all patients; those presenting with signs or symptoms or medical history)?

   Within dentistry there is no consensus that HbA1c screening is considered a standard of care. In fact the New Jersey State Board of Dentistry has explicitly stated that this screening is not presumed to be a standard of care.

   From another perspective, the American Diabetes Association has published its *Standards of Medical Care in Diabetes 2016*, which addresses HbA1c testing. Links to this information, and others pertaining to diabetes, dentistry and oral health are published on the American Dental Association's web site – http://www.ada.org/en/member-center/oral-health-topics/diabetes

   A dentist should provide a patient with sufficient information about the procedure, including its relevance to both oral and general health, so that she or he can make an informed decision.

10. How do I close the referral loop – informing the patient's physician – of the finger-stick findings?

    If the HbA1c screening is delivered the findings should be conveyed to the patient's physician or appropriate health care provider. Before doing so be sure to have an information release form signed by the patient on file. These referrals must be tracked and documented. Failure to do so may lead to liability issues.

11. What should I do with the results if the patient does not have a physician or other health care provider who can act on the information?

    The patient should be informed of the screening's findings, be directed towards resources containing more information, and encouraged to become a physician's patient of record for their other health needs. These actions must be noted in the patient's dental records.

12. What is the likelihood of false measures since this is a screening type procedure and not a full lab test?

    The likelihood of false results is considered extremely low. This and the test's simplicity are factors that led the FDA to place this type of test into the "waived" category of laboratory procedures. They are also reasons why test kits are sold over-the-counter to individuals who wish to self-monitor.

13. What are the additional overhead costs and ongoing administrative activities that must be in place in order to offer this screening service?

    Before incorporating HbA1c screening a dental practice should consider factors that contribute to total cost. These include personnel time, consumable products and durable goods, additional training of personnel, additional safety and biohazard supplies, record keeping associated with good laboratory practices and the maintenance and storage of these records, certification fees, counseling and education of patients, and referral/tracking of referrals of patients.

14. What components of the D0411 procedure may be delegated to staff and which may only be performed by the dentist

    As with any procedure, the practitioner providing the service is determined by state law and licensure. Direct or indirect supervision by a dentist may, or may not, be a requirement.

15. What documentation should I maintain in my patient records, and what will be needed on a claim submission when reporting D0411?

    The patient's records would include the same information about services provided as is done with other dental procedures – plus notations of the activities described in the answers to questions 4, 9 and 10 above, as applicable.

    A dental claim would be coded and completed in the same manner as other dental procedures (e.g., date of service, CDT Code, full fee).

16. What dental benefit plan coverage – commercial or governmental – is anticipated?

    As with any procedure documented with a CDT Code there is no guarantee of coverage by a patient's dental benefit plan. At least one third-party payer, Delta Dental of New Jersey, is promoting delivery of HbA1c screening by its network dentists for their patients.

17. What factors should I consider when determining my full fee for the D0411 service?

    Dentists and other practitioners in the dental community acquire their skills and expertise through training and experience. It is up to each individual to determine the value of their time and the time required to provide the service when determining their full fee. Other unique factors such as the cost of acquiring and maintaining a supply of the finger-stick test materials may also be considered.

Questions or Assistance?

Call 800-621-8099 or send an email to dentalcode@ada.org

Notes:

- This document includes content from the ADA publication – *Current Dental Terminology (CDT)* ©2017 American Dental Association (ADA). All rights reserved.
- Version History

Date	Version	Remarks – Change Summary
07/17/2017	1	Initial publication

Good Morning Haley,

Thank you so much for taking the time to chat last week about the OBD Diversion program and possible alternatives to care for dentists.

I appreciate you sharing resources from the OBD to better frame a request for a rule change.

I have talked to Uprise Health about the differences between the Oregon Medical Board allowances and the Oregon Dental Board. I have attached their website's "Potential Participants" section to demonstrate the differences.

I want to make a formal request to allow Dentists the option for "Self-Referral." Under the section for the OMB, Potential Participants, it reads, " Self-Referral - If not currently under investigation by the Board, licensees may choose to self-refer to HPSP for monitoring if they have a substance use disorder and/or mental health disorder. Licensees who self-refer to HPSP and successfully complete five years of monitoring, without having any non-compliance events, will graduate the program without Board involvement."

I understand there will be a meeting to review requests in the near future. If you could let me know when the meeting is scheduled, I would like the opportunity to attend.

Thanks again and let me know if you need anything else from me.

Julie

Julie Spaniel DDS (she/her/hers)
President Washington County Dental Society
ADA Wellness Ambassadors
ADA Dental Wellness Advisory Council
President-elect Academy for Private Dental Practice
ODA Chair Wellness Ambassadors

Dr Julie Spaniel
Founder/President One World Brigades 501(c)3
Summerwood Dental Associates
Office: 503-906-8600 Cell: 802-598-1112
10835 SW Lower Boones Ferry Road
Tigard, Oregon 97224

uprisehealth

Potential Participants

Each participating Oregon licensing board has different HPSP eligibility requirements. Currently the Oregon Medical Board, Board of Nursing, Board of Dentistry, and Board of Pharmacy participate in HPSP. Click on the tab for the appropriate board to learn more.

OSBN | OBD | OMB | OBP

Monitoring for the Oregon Board of Dentistry

HPSP is an alternative to disciplinary action or may be part of a disciplinary action by the Oregon Board of Dentistry for any licensee who has come to the attention of the board and has a substance use disorder and/or mental health disorder. Participation in HPSP is confidential for all licensees enrolled in the program and information is released only with signed consent from the licensee or in accordance with state or federal law.

Licensees may enter HPSP under one of the following categories:

Board Referral – Licensees may be referred to HPSP by the Oregon Board of Dentistry as a result of impaired professional practice or behavior and must have a substance use disorder and/or mental health disorder.

Monitoring Services Include:

- Random Toxicology Testing
- Worksite Monitoring (If not self-employed)
- Agreement Monitors
- Weekly reporting by licensees
- Independent Third Party Evaluations
- Medical Review Officer oversight
- Interactive Voice Response (IVR) system for daily testing requirements
- Care Coordination
- Safe practice evaluations

Still have questions? Please feel free to call us at (888)802-2843 or email at hpsp@uprisehealth.com

uprisehealth

Potential Participants

Each participating Oregon licensing board has different HPSP eligibility requirements. Currently the Oregon Medical Board, Board of Nursing, Board of Dentistry, and Board of Pharmacy participate in HPSP. Click on the tab for the appropriate board to learn more.

OSBN | OBD | OMB | OBP

Monitoring for the Oregon Medical Board

HPSP is an alternative to disciplinary action or may be part of a disciplinary action by the Oregon Medical Board for any licensee who has come to the attention of the board and has a substance use disorder and/or mental health disorder. Participation in HPSP is confidential for all licensees enrolled in the program and information is released only with signed consent from the licensee or in accordance with state or federal law.

Licensees may enter HPSP under one of the following categories:

Board Referral – Licensees may be referred to HPSP by the Oregon Medical Board as a result of impaired professional practice or behavior and must have a substance use disorder and/or mental health disorder.

Self-Referral – If not currently under investigation by the Board, licensees may choose to self-refer to HPSP for monitoring if they have a substance use disorder and/or mental health disorder. Licensees who self-refer to HPSP and successfully complete five years of monitoring, without having any non-compliance events, will graduate the program without Board involvement.

Monitoring Services Include:

- Random Toxicology Testing
- Worksite Monitoring
- Agreement Monitors
- Weekly reporting by licensees
- Periodic Monitoring Consultants-monthly/quarterly
- Group Monitoring Consultants-weekly group for two years
- Independent Third Party Evaluations
- Medical Review Officer oversight
- Interactive Voice Response (IVR) system for random toxicology testing check-in
- Care Coordination
- Safe practice evaluations (self-referrals only)

Still have questions? Please feel free to call us at (888)802-2843 or email at hpsp@uprisehealth.com

OTHER ISSUES

Health Care Workforce Reporting Program Updates

Andy Davis, Meredith Halling, Piper Block

November 30, 2023

Stay up-to-date on Oregon's licensed health care workforce

Oregon Health Authority

HEALTH POLICY & ANALYTICS DIVISION

Office of Health Analytics

Agenda

- Introductions (5 mins)
- Upcoming changes:
  - Addition of burnout section (2024) (25 mins)
  - Addition of Sexual Orientation and Gender Identity (SOGI) section (2025) (5 mins)
- General feedback
  - Uses/needs from HWRP products and data (5 mins)
  - Questions/Comments (5 mins)

Introductions

Oregon Health Authority

The HWRP captures information about Oregon's licensed health professionals

Board license renewal

5-8 minute questionnaire

OHA processes and analyzes data

- **Data elements collected**: Provider demographics and background, practice patterns, future plans
- **Products:** Oregon's Licensed Health Care Workforce Supply report and Diversity report, Occupational Profiles Dashboard, Health Care Workforce Needs Assessment (OSU report using HWRP data)

Why collect data on burnout?

Available data indicates **high prevalence of burnout**[1] among the health care workforce

Burnout has a **high financial cost**[2] for institutions and a **high personal cost**[3] for individuals

Collecting data on burnout as a part of the HWRP survey will:

- Allow us to determine what members of the licensed workforce are at highest risk
- Provide a baseline for comparison for future interventions or policies

1. Rotenstein LS, Torre M, Ramos MA, Rosales RC, Guille C, Sen S, Mata DA. Prevalence of burnout among physicians: A systematic review. JAMA. 2018 Sep 18;320(11):1131-50.
2. Hamidi MS, Bohman B, Sandborg C, Smith-Coggins R, De Vries P, Albert MS, Murphy ML, Welle D, Trockel MT. Estimating institutional physician turnover attributable to self-reported burnout and associated financial burden: a case study. BMC Health Services Research. 2018 Dec;18:1-8.
3. Williams ES, Rathert C, Buttigieg SC. The personal and professional consequences of physician burnout: a systematic review of the literature. Medical Care Research and Review. 2020 Oct;77(5):371-86.

Burnout data collection plan

Structure:

- Two questions added to standard HWRP license renewal survey
- After completing standard survey, respondents will be asked if they are willing to answer extra questions (~ 5 - 10 minutes)

Timeline:

- To be implemented January 2024

Burnout screening measure

Non-proprietary, single-item burnout measure, responses on a five-category ordinal scale :

"Overall, based on your definition of burnout, how would you rate your level of burnout?"

1) I enjoy my work. I have no symptoms of burnout.
2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.
3) I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.
4) The symptoms of burnout that I'm experiencing won't go away. I think about frustration at work a lot.
5) I feel completely burned out and often wonder if I can go on in this role. I am at the point where I may need some changes or may need to seek some sort of help.

Collected with standard HWRP license renewal survey

Contributing factors to burnout

[If answer of 2 or above on burnout screen, then ask:]

"On a scale from 1 – 10, how much do you feel the following contributes to your feelings of burnout?"	
Work schedule	Vacation policies
Electronic health record	Social connection with colleagues
Payer-related paperwork	Compensation model
Productivity targets	Opportunities for professional development
Workplace discrimination	Experiences of verbal or physical abuse
Behavior of senior leaders	Overqualification for assigned tasks
Other: [open text box]	

Collected with standard HWRP license renewal survey

Opt-in study: Questionnaires

Construct	Survey measure/source	# items
Burnout, stress, & compassion satisfaction	ProQOL	30
Financial stability	OWP 1-item	1
Career choice satisfaction	Shanafelt et al.	1
Work-life balance	Shanafelt et al.	1
Work Discrimination and Harassment	Williams et al.	9
Exposure to violence at work	Workplace Violence	5
	Total:	47

This set of questionnaires offered on a voluntary basis

Sexual Orientation and Gender Identity (SOGI)

- To be implemented in 2025
- Required Demographic Questions (current draft here)
- **1. Please describe your gender in any way you prefer:**
- **2. What is your gender? (check all that apply)**

  □ Girl, Woman □ Boy, Man □ Non-binary □ Questioning □ Not listed. Please specify: _____ □ I don't know what this question is asking □ Agender/No gender □ Don't know □ I don't want to answer
- **3. Are you transgender?**

  □ Yes □No □ Questioning □ I don't know what this question is asking □ I don't want to answer
- **4. Please describe your sexual orientation or sexual identity in any way you want:**
- **5. How do you describe your sexual orientation or sexual identity? (check all that apply)**

  □ Same-gender loving □ Same-sex loving □ Lesbian □ Gay □ Bisexual □ Pansexual □ Straight (attracted mainly to or only to other gender(s) or sex(s)) □ Asexual □ Queer □ Questioning □ Don't know □ Not listed. Please specify: _____ □ I don't know what this question is asking □ I don't want to answer

Uses/needs for HWRP products/data

- HWRP Website
- Health Care Workforce Dashboard
- Oregon's Health Care Workforce Supply
- The Diversity of Oregon's Licensed Health Care Workforce

Using HWRP Data:

- Health Care Workforce Needs Assessment (OHA/OHPB)
- Postsecondary Healthcare Education Shortage in Oregon (HECC)

HWRP Contact Information

Main Website:

https://www.oregon.gov/oha/hpa/analytics/pages/health-care-workforce-reporting.aspx

- Andy Davis, Research Analyst, HWRP
  andy.davis@ oha.oregon.gov
- Meredith Halling, Research Analyst, HWRP
  meredith.halling@ oha.oregon.gov
- Sara Grusing, BHWi Research Analyst
  sara.e.grusing@oha.oregon.gov
- Piper Block, Manager, Research and Data Unit
  piper.block@oha.oregon.gov

Questions / Discussion

OHA SOGI DRAFT Data Collection Recommendations

November 2023

In 2018 the Oregon Health Authority Office of Equity and Inclusion convened the Sexual Orientation and Gender Identity (SOGI) Data Collection Workgroup. The group consists of internal and external stakeholders who interact with the LGBTQ+ community and health systems in a myriad of ways, many of whom also identify as LGBTQ+ themselves. The group was stratified into six subcommittees, each focusing on a different level of implementation, beginning with medical settings, and then other settings involving eligibility and service settings. From this work, there were two sets of recommendations developed. These recommendations need to go through an extensive rulemaking advisory process that we hope to convene in February 2023. Note that translations in other written languages will be done later based on best practice in conveying the same meaning and intent, as well as modifications for children and teens that are age appropriate.

Figure 1 below contains five SOGI demographic questions recommended to be included for most settings, including medical/clinical settings; these are the minimum standards recommended by the committee at this time.

Figure 1. Required Demographic Questions

1. Please describe your gender in any way you prefer:
_____

2. What is your gender? (check all that apply)
☐ Girl, Woman ☐ Boy, Man ☐ Non-binary ☐ Agender/No gender ☐ Questioning
☐ Not listed. Please specify: _____ ☐ Don't know
☐ I don't know what this question is asking[1] ☐ I don't want to answer

3. **Are you transgender?**
☐ Yes ☐No ☐ Questioning ☐ Don't Know
☐ I don't know what this question is asking ☐ I don't want to answer

4. Please describe your sexual orientation or sexual identity in any way you want:
_____

5. How do you describe your sexual orientation or sexual identity? (check all that apply)
☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Pansexual ☐ Straight (attracted mainly to or only to other gender(s) or sex(s))
☐ Asexual ☐ Queer ☐ Questioning ☐ Don't know
☐ Not listed. Please specify: _____
☐ I don't know what this question is asking ☐ I don't want to answer

[1] "Don't know" means the person doesn't know (such as a parent answering for a child); "I don't know what this question is asking" more to capture comprehension difficulties with the question and/or response options.

Figure 2 has a menu of recommendations with the goal of respectful communications for data-matching/ verifications that might occur in systems involving insurance and or eligibility for services. *These questions may be required if applicable to the specific data system or programmatic requirements.*

Figure 2. Logistical Questions Applicable for Social Services and or Eligibility Systems (DRAFT)

Names

1. What full name do you want to us to use? (Text field) _____
Is this your legal name? ☐ Yes ☐ No **If not, please list your legal name:** _____

This question format may be suitable for clinical/medical settings involving insurance and billing
1b. Are there any other names we should know about, such as on your insurance card?
☐ Check here if there are other names we should know about
Legal name: _____
Name on insurance card: _____ Name on billing record: _____

Name on relevant previous medical records: _____
Name on other relevant records (Please specify): _____

Pronouns and Titles

2. What pronouns do you want us to use? (select all that apply)
☐ They/Them ☐ She/Her ☐ He/Him ☐ No pronouns, use my name ☐ Don't know
☐ Not listed. Please specify: _____ ☐ I don't know what this question is asking
☐ I don't want to answer

Only ask the below question if the organization specifically uses titles (e.g., in correspondence)
3. What title want us to address you by?
☐ Mx. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Please use my name and no titles ☐ Don't know
☐ Not listed. Please specify: _____ ☐ I don't want to answer

Sex- It is anticipated that if you need to ask about sex (not gender) you will probably just need to ask 1 or 2 of the questions below – depending on WHY you need this information.

4. When you were born what sex was assigned to you? (Pick one)
☐ Male ☐ Female ☐ Intersex ☐ Unspecified ☐ Not listed. Please specify: ___
☐ Don't know ☐ I don't know what this question is asking ☐ I don't want to answer

5. What is your current legal sex in your state? (Pick one) (OR simply: What is your current sex?)
☐ Male ☐ Female ☐ X ☐ Intersex ☐ Non-binary ☐ Unspecified ☐ Don't know
☐ Not listed. Please specify: _____ ☐ I don't know what this question is asking

If you need to verify or match based on a state-issued ID:

6. Do you have a state-issued ID?
☐ No ☐ Yes. If yes, please specify state associated with ID: _____
☐ Don't know ☐ I don't know what this question is asking ☐ I don't want to answer

6b. If Yes, what is the sex on your state-issued ID?
☐ F – Female ☐ M – Male ☐ X -Non-Binary ☐ U - Unspecified ☐ Not listed. Please specify:
☐ Don't know ☐ I don't know what this question is asking ☐ I don't want to answer

If you are using sex to verify identity with the SSA and/or cannot report a response other than M/F then:

7. For federal reporting purposes if we were only given a binary option of M (Male) or F (Female), which one would you like us to use? ☐ Female ☐ Male
OR: **We respect and honor your gender. We use federal data to verify your information, like what you use for social security or on your passport.[2] They only offer two options – male or female. Please select the sex that matches your current federal information.** ☐ Female ☐ Male

[1] "Don't know" means the person doesn't know (such as a parent answering for a child); "I don't know what this question is asking" more to capture comprehension difficulties with the question and/or response options.

[2] Note that sex is not necessarily the same across different government reporting systems. Just because SSA says "this" does not mean that Selective Service agrees. This question should be tailored to match the verification system(s) used (if applicable).

Appendix A includes additional questions for medical settings following best practices but are *not* suggested to required data collection elements sent to OHA.

Appendix A: Best Practice Recommendations to Assure Quality Medical Care

SEXUAL HEALTH

1. Are you sexually active? Yes□ No □
   If No, have you been sexually active in the past year? Yes□ No □
2. If yes to question 7: Are your sexual partners (Check all that apply):
   - □ A person with a penis
   - □ A person with a vagina
   - □ A person with intersex genitalia
   - □ A person who had genital reassignment surgery
   - □ Don't know
   - □ I don't know what this question is asking
   - □ I don't want to say

YOUR BODY

3. Are you (Check all that apply):
   - □ A person with breasts
   - □ A person with a cervix
   - □ A person with ovaries
   - □ A person with a uterus
   - □ A person with a vagina
   - □ A person with a penis
   - □ A person with a prostate
   - □ A person with testes
   - □ A person with intersex genitalia
   - □ A person who had genital reassignment surgery
   - □ Don't know
   - □ I don't know what this question is asking
   - □ I don't want to say

AND *provide comment box* so that person is also asked by the clinician about terms they would prefer for their body parts.

D. TRANS HEALTH

4. Are you currently taking gender-affirming hormones and/or hormone blockers? Yes□ No □
If you are **not** currently taking hormones, are you interested in starting hormones? Yes□ No □
4b. If Yes to Question 4: When did you start? _____What is your current dose and frequency? _____
5. Have you experienced any complications with hormones? Yes□ No □ Not Applicable □
5b. If yes to Question 11, what complications have you had? _____
What questions or concerns do you have about starting gender-affirming hormones?

_____

6. Have you had any other gender-affirming surgeries/treatments in the past? Yes□ No □
   If Yes, which ones? _____
6b. If Yes to Question 6: Have you experienced any complications with gender-affirming surgeries/treatments? Yes□ No □
If Yes, what complications have you had? _____
If Yes, have you would you like to speak with someone with expertise in complications for this kind of surgery? Yes□ No □

Two burnout questions to add to all boards standard HWRP license renewal survey:

“Overall, based on your definition of burnout, how would you rate your level of burnout?”

1. I enjoy my work. I have no symptoms of burnout.
2. Occasionally I am under stress, and I don’t always have as much energy as I once did, but I don’t feel burned out.
3. I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.
4. The symptoms of burnout that I’m experiencing won’t go away. I think about frustration at work a lot.
5. I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.

[If answer of 2 or above on burnout screen, then ask:]

“On a scale from 1 to 10, how much do you feel the following contribute to your feelings of burnout?”

Work schedule
Electronic health record
Payer-related paperwork
Productivity targets
Workplace discrimination
Behavior of senior leaders
Vacation policies
Lack of social connection with colleagues
Compensation model
Lack of opportunities for professional development
Experiences of verbal or physical abuse
Overqualification for assigned tasks
Insufficient staffing
Other: [Open text response]
Other: [Open text response]
Other: [Open text response]

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

Career choice satisfaction:

‘‘If given the opportunity to revisit your career choice, would you choose to become a [profession type] again?’’

Definitely yes, Probably, neutral, Not sure, Probably not, Definitely not

Work-life balance:

‘‘My work schedule leaves me enough time for my personal/family life.’’

Strongly agree, Agree, Neutral, Disagree, Strongly disagree

Financial Security:

“How easy is it for your household to make ends meet every month?”

Extremely difficult, Somewhat difficult, Neither easy for difficult, Somewhat easy, Extremely easy

Citations:

Shanafelt TD, Balch CM, Bechamps GJ, et al. Burnout and career satisfaction among American surgeons. *Ann Surg.* 2009;250(3):463–471.

Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med.* 2012;172(18):1377–1385.

Chronic Work Discrimination and Harassment (Abbreviated)

Measure: Here are some situations that can arise at work. Please tell me how often you have experienced them during the past 12 months.

Discrimination

1. How often do you feel that you have to work twice as hard as others to get the same treatment or evaluation?
2. How often are you watched more closely than other workers?
3. How often are you unfairly humiliated in front of others at work?

Harassment

1. How often do your supervisor or coworkers make slurs or jokes about racial or ethnic groups?
2. How often do your supervisor or coworkers make slurs or jokes about women?
3. How often do your supervisor or coworkers make slurs or jokes about the LGBTQ+ community?

Harassment from patients (recommended addition for HWRP study)

1. How often do your patients make slurs or jokes about racial or ethnic groups?
2. How often do your patients make slurs or jokes about women?
3. How often do your patients make slurs or jokes about LGBTQ+ community?

Response scale:

1- Once a week or more
2- A few times a month
3- A few times a year
4- Less than once a year
5- Never

Measure information:

Developed for the Chicago Community Adult Health Study (CCAHS)

Citation: Sternthal, M., Slopen, N., Williams, D.R. “Racial Disparities in Health: How Much Does Stress Really Matter?” Du Bois Review, 2011; 8(1): 95-113.

RWJF report findings: https://www.statnews.com/wp-content/uploads/2023/05/rwjf473632.pdf

Workplace Violence (WPV) Questionnaire

1) In the last year, how often have you experienced the following while at work:
   - Physical Violence (being hit, pushed, spit on, bitten)
   - Threats of physical assault (verbal or written threats intending harm)
   - Emotional abuse (insults, gestures, humiliation)
   - Verbal sexual harassment (repeated, unwanted questions or remarks of a sexual nature)
   - Sexual assault (any forced physical sexual contact or sexual acts)

   Never, Once or twice in the past year, Several times in the past year, About once a month, Several times times a month, At least once a week, Every day

2) In the past year, have you witnessed any type of workplace violence without being directly involved?

   No (0), Yes (1) (for each

3) In the past year, have you learned about any of your team/coworkers experiencing any type of workplace violence?

   No (0), Yes (1)

4) How do you feel physical violence or the threat of physical violence in your practice is changing over time?

   Decreasing, Same, Increasing, Not sure

5) How much of the time do you feel safe at work?

   Never, Some of the time, Not sure, Most of the time, Always

Sources: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7824770/ , https://www.mdpi.com/1660-4601/20/6/4805

From: Cogswell Thomas <THOMAS.COGSWELL@oha.oregon.gov>
Sent: Tuesday, January 30, 2024 1:25 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Subject: OHA Medicaid Advisory Committee Open Position - Oral Health Professional

Hi, Stephen –
I received your contact information from Amy Umphlett at the Oregon Health Authority (OHA). Our agency is currently recruiting for three positions on the Medicaid Advisory Committee, one of which is for an oral health professional. I wanted to reach out to see if you might be able to share the announcement below through your Oregon Board of Dentistry network.

OHA Medicaid Advisory Committee Open Positions
Contact: Sarah Wetherson (mac.info@odhsoha.oregon.gov, 503-793-1920).
Oregon's Medicaid Advisory Committee (MAC) is recruiting candidates to fill multiple open positions including:

- **One** oral health professional;
- **One** physician living or practicing outside of the Willamette Valley; and
- **One** person with professional or lived experience with Oregon's long term services and supports (LTSS) program.

Please click on the following recruitment announcements for additional information:

- English: https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC%20Recruitment%20Announcement%202024_ENG.pdf
- Spanish: https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC%20Recruitment%20Announcement%202024_ES.pdf

The MAC is a federally mandated body that advises the Oregon Health Policy Board (OHPB), the Oregon Health Authority (OHA), and the Oregon Department of Human Services (ODHS) about the operation of Oregon's Medicaid program through a consumer and community lens.

Thank you!

Tom Cogswell
Project Coordinator
Community Advisory Council (CAC) lead
OREGON HEALTH AUTHORITY
Health Policy and Analytics Division
Transformation Center
thomas.cogswell@oha.oregon.gov
Cell: (971) 304-9642
http://www.transformationcenter.org

Click here to view **Community Advisory Council (CAC)** resources:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx

Click below to be added to the Transformation Center's **distribution list for events, resources & learning opportunities**:
https://www.surveymonkey.com/r/OHATransformationCenterTA

SmileDirectClub is shutting down. Where does that leave its customers?

FILE - Dental assistants go over appointments at SmileDirectClub's SmileShop located inside a CVS store April 24, 2019, in Downey, Calif. SmileDirectClub is shutting down, just months after the struggling teeth-straightening company filed for bankruptcy, leaving existing customers in limbo. On Friday, Dec. 8, 2023, the company said it was unable to find a partner willing to bring in enough capital to keep the company afloat, despite a months-long search. (AP Photo/Jae C. Hong)

AP

BY WYATTE GRANTHAM-PHILIPS

Updated 12:27 PM PST, December 13, 2023

NEW YORK (AP) — Just months after filing for bankruptcy, SmileDirectClub announced it was shutting down its global operations and halting its teeth-aligner treatments.

That leaves existing SmileDirectClub customers with a lot of questions and few available answers. The company is offering no more customer care support and few details about possible refunds are available yet. Multiple dental organizations and orthodontists also caution patients about safety concerns arising from "direct-to-consumer" dentistry.

Here's what you need to know.

WHAT IS THE COMPANY AND WHY IS IT CLOSING SHOP?

SmileDirectClub — which served over 2 million people since its 2014 founding — once promised to revolutionize the oral-care industry by selling clear dental aligners that were marketed as a faster and more affordable alternative to braces. It sold its aligners directly to consumers by mail and in major retailers.

When SmileDirectClub's stock began trading on the stock market in 2019, the company was valued at about $8.9 billion. But the stock plummeted in value over time as the company proved to be unprofitable year after year. In 2022, SmileDirectClub lost $86.4 million.

With its stock price tumbling, SmileDirectClub was pressured to spend on acquiring customers to demonstrate its business could grow, said Eric Snyder, chairman of bankruptcy at the Wilk Auslander law firm.

"And then you combine that with the legal battles they had (and pushback) from orthodontics industry ... all those things together just made it really hard for them to stay competitive," he added. "They've been losing just tremendous amounts of money over the last couple of years."

SmileDirectClub filed for Chapter 11 bankruptcy protection in September while reporting nearly $900 million in debt. And at the end of last week, it confirmed it was shutting down operations after being unable to find a partner willing to bring in enough capital to keep the company afloat.

WHAT ABOUT EXISTING CUSTOMERS?

In a Friday FAQ about it shutting down operations, SmileDirectClub confirmed that its telehealth aligner treatment is no longer available.

That leaves existing customers in limbo. Customer orders that haven't shipped yet have been canceled and "Lifetime Smile Guarantee" no longer exists, the company said. SmileDirectClub added that Smile Pay customers are expected to continue to make payments, leading to further confusion and frustration online.

Customer-care support has also ceased. SmileDirectClub apologized and urged consumers to consult their local dentist or orthodontist for further treatments. The Nashville, Tennessee, company said that more details about refund requests will arrive "once the bankruptcy process determines next steps and additional measures customers can take."

When contacted by The Associated Press for additional information, a spokesperson said the company couldn't comment further.

Now that SmileDirectClub is out of business, must to liquidate, Snyder noted. He said he's skeptical about compensation making its way to customers — but notes that people who signed up or made payments after the company's September bankruptcy filing will likely be prioritized.

"Unfortunately, I think they're going to be out of luck. ... (But) if there's any money, it'll go to the newest customers," Snyder said. And even when a company goes out of business, consumers still paying off services they already received will still owe that amount, he noted.

Snyder also doesn't expect there to be further legal implications around the end of the "Lifetime Smile Guarantee," for example, noting that such warranties are "only as good as the life of the company offering it."

It's unclear how many active customers SmileDirectClub had before shutting down, but American Association of Orthodontists President Dr. Myron Guymon speculates that tens of thousands of people could be affected.

"That's got to be very frustrating for them to have spent time and money in a treatment, and then all of a sudden the rug gets shoved out underneath their feet," Guymon said.

He and others advised those people to seek the care of a professionally trained orthodontic specialist, such as those listed on AAO's website.

WHAT ARE ORTHODONTISTS SAYING?

Over the years, dental associations around the world have been urging caution or expressing opposition to direct-to-consumer aligners — what some call "DIY" dentistry.

These types of aligner treatments don't require in-person visits to a dentist or orthodontist, but typically ask consumers to take molds of their teeth or a digital scan instead. This can lead to key aspects of a patient's oral condition being overlooked and potentially lead to health consequences, some experts say.

"It's very easy to cause harm if you're not properly monitoring the case," Dr. Thikriat Al-Jewair, chair of the Department of Orthodontics at the University at Buffalo, said. "I cannot overstate the importance of seeing an orthodontist to monitor the care. (Moving teeth) is a very complex process and also very individualized."

Al-Jewair added that many former direct-to-consumer aligner patients end up coming to orthodontic practices for reevaluation. In these cases, she said, gum disease, bite problems and other issues often arise.

It's important to note that SmileDirectClub isn't the only direct-to-consumer aligner provider on the market today. The treatment's appeal and perceived benefits boil down to

convenience and affordability — still, Al-Jewair notes, past demographic research has found that the majority of patients seeking direct-to-consumer aligners came from higher economic backgrounds.

SmileDirectClub has previously specified that each of its customers' treatment plans and health histories were reviewed by licensed doctors, who could also request additional information or reject some for the company's teledentristy care. But this kind of business model, which again isn't isolated to one company, still brings up concerns for the AAO, Guymon noted. In addition to not by requiring an initial in-person evaluation, he said, supervising doctors are not always identified to patients.

"Our concern has always been that the lack of direct supervision, the lack of a patient-doctor relationship (and the fact) that the patient didn't know who to call if they had problems, was not in the public's best health and interests," he said.

That doesn't mean there isn't a place for telehealth in the dental world, Guymon and others said, noting that remote monitoring between treatments, for example, can help patients with convenience and some cost barriers of orthodontic care.

"We absolutely support teledentistry and many of our members use it, but just within certain safety guidelines," said Trey Lawrence, AAO's VP, general counsel and head of the association's advocacy team. "Patients can check in with their dentist (remotely), but also maintain knowing who your dentist is and being seen in-person before you start something more permanent, like orthodontic treatment."

AXIOS Dec 12, 2023

SmileDirectClub's sudden collapse leaves teeth alignment patients stranded.

Nathan Bomey, author of Axios Closer

The sudden collapse of SmileDirectClub has stranded users of its clear-plastic, removable teeth aligners — in some cases just weeks after they were given a discount for paying up front.

Why it matters: Customers experiencing problems with their treatment will not be able to get new aligners, treatment, or other support from the company.

Catch up fast: SDC filed for bankruptcy protection in September, and subsequently failed to find a buyer during the Chapter 11 process.

- A company attorney told a judge Friday that it had become clear that the "Hail Mary" sale process would not be successful, and that SDC had abruptly begun winding down operations.
- The company effectively shut down, canceling undelivered orders and ending customer support.

As of just weeks ago, however, and about a month after its bankruptcy filing, SDC was still offering discounts to prospective customers who paid up front instead of paying over time, Axios has learned.

- A deal offered in an email campaign on October 30, shared with Axios by a customer, shows the company offered aligners for $995 to anyone who paid in full by Nov. 4 or $1,750 for anyone who signed up for the company's SmilePay monthly plan.
- "You have to act really fast to get these historic savings," CEO David Katzman told recipients in the email, adding that "this is truly a once-in-a-lifetime chance to get a smile you love at a savings that may never be repeated."

Of note: Email campaigns with discount offers were part of the company's normal sale strategy, and SDC has long offered an up-front payment discount on its website, advertising a price of $2,050 on its website last summer.

Joey Echeverria, a Nashville-area government employee, tells Axios that he signed up for the October 30 up-front deal and paid $995.

- He got an email in early December saying his aligners had been made. As of Monday he hadn't yet received them, and a tracking link he received redirected him to the company's going-out-of-business FAQ.
- "So I have no idea if my braces even shipped," he says. "Even if they did ship, do I even want to do it because they could be messed up. If they are messed up, I have no customer support, I have no guarantee. So I'm out a thousand dollars."

SDC customer Chantelle Jones, of Gloucestershire in the United Kingdom, told the BBC she's in the middle of treatment: Her top teeth are finished being straightened, but she hasn't received aligners for her bottom teeth.

- "I'm not sure if I'm going to get any money back," she said.

What they're saying: SDC media representatives and the company's bankruptcy attorney, Spencer Winters, did not respond to multiple requests for comment.

- The company addresses the subject of refunds on its website, saying in an FAQ response, "There will be more information to come once the bankruptcy process determines next steps and additional measures customers can take."
- Customers who signed up for the monthly payment plan are expected to continue to make all monthly payments until made in full, it says.

Realigning expectations

As a general rule of thumb, customers are considered unsecured creditors in bankruptcy cases — which means they don't get paid anything unless there's money left after the debtor pays its secured lenders.

- "By all appearances it looks bleak for customers," McKool Smith bankruptcy attorney John Sparacino, who is not involved in the case, tells Axios.
- "I have to assume that general unsecured creditor claims are going to get probably zero out of this process — and unfortunately customers fall in that category."

Zoom out: The demise of SDC marks a dark turn in the furious market for teeth straightening — a competition involving dentists, the orthodontics lobby, state dental boards, a slew of upstart companies and the market leader, Align Technology's Invisalign.

- SDC went public in 2019, but its stock never returned to its IPO price of $23 despite heavy advertising and an early-pandemic boom in sales for the business, which was mostly conducted through the mail and digital communication.
- "They've been facing demand pressure for a couple of years now," Jefferies analyst Brandon Couillard, who tracks the teeth alignment industry, tells Axios. And "the amount that it required for them to acquire a new customer never came down for the business to be sustainable."

Yes, but: At least one competitor is already offering help to SDC customers.

- OrthoFX, which received FDA approval for its aligners earlier this year, said it's launching a hotline to provide free consultation to SDC patients.
- OrthoFX also said it would provide "special financial assistance and flexible payment plans" to SDC customers.

What others are saying: The American Dental Association, which represents dentists, said in a statement that it maintains its opposition to the SmileDirectClub model of direct-to-consumer dentistry.

- The ADA said it "encourages any individual who will no longer have access to customer service — or is considering other DTC dental products or services — to speak with a dentist in their area."

KROLL

SmileDirectClub, Inc.

Case No. 23-90786

Case Background

On September 29, 2023, SmileDirectClub, Inc. and eight (8) affiliated debtors (collectively, the "Debtors") each filed a voluntary petition for relief under Chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the Southern District of Texas. The cases are pending before the Honorable Christopher M. Lopez, and are jointly administered under Case No. 23-90786.

Important Information & Dates

Plan & Disclosure Statement

On October 30, 2023, the Debtors filed their Chapter 11 Plan of Reorganization and the Disclosure Statement related thereto. The Bankruptcy Court will hold a hearing to consider conditional approval of the Disclosure Statement on November 20, 2023 at 3:30 p.m. (prevailing Central Time).

Please click below to view and download the Debtors' Plan & Disclosure Statement:

Plan & Disclosure Statement

Deadline to File Claims

The Bankruptcy Court has set the following deadlines for filing proofs of claim:

- General Bar Date: November 27, 2023 at 5:00 p.m. (CT)
- Governmental Bar Date: March 27, 2024 at 5:00 p.m. (CT)

Click on "Submit a Claim" above to download a proof of claim form and for more information regarding filing a claim against the Debtors. Please click here to download the Bar Date Order and here to download the Bar Date Notice.

Meeting of Creditors

In accordance with Section 341 of the Bankruptcy Code, the meeting of creditors was held on November 2, 2023. Please click here to view and download the Notice of Commencement-341 Meeting of Creditors.

First Day Hearing

A hearing on the Debtors' First Day Motions was held on October 2, 2023, before the Honorable Christopher M. Lopez, United States Bankruptcy Court for the District of Southern District of Texas. A final hearing on certain of the First Day Motions was held on November 7, 2023.

Dates

SEPTEMBER	MARCH
29	27
2023	2024
Petition Date	Governmental Ba…

- Parties

Debtors' Counsel

- Kirkland & Ellis LLP (New York)

  601 Lexington Avenue
  New York, NY 10022
  https://www.kirkland.com/
  Phone: 212.446.4800
  Fax: 212.446.4900

  Joshua A. Sussberg, P.C.

- Kirkland & Ellis LLP (Chicago)

  300 North LaSalle Street
  Chicago, IL 60654
  Phone: 312.862.2000
  Fax: 312.862.2200

  Spencer A. Winters
  Rachael M. Bentley

- Jackson Walker LLP

  1401 McKinney Street
  Suite 1900
  Houston, TX 77010
  https://www.jw.com/
  Phone: 713.752.4200
  Fax: 713.752.4221

  Matthew D. Cavenaugh
  Rebecca Blake Chaikin
  Emily Meraia

United States Trustee and Court Information

- United States Bankruptcy Court, Southern District of Texas

  United States Courthouse
  515 Rusk Avenue
  Houston, TX 77002
  https://www.txs.uscourts.gov/offices/houston-division
  Phone: 713.250.5500

- Office of the United States Trustee

  515 Rusk Street
  Suite 3516
  Houston, TX 77002
  https://www.justice.gov/ust-regions-r07/region-7-southern-district-texas-houston-division
  Phone: 713.718.4650
  Fax: 713.718.4670

  Alicia Lenae Barcomb
  Ha Minh Nguyen

- Debtors

Case Number	Debtor Name	Petition Date
23-90786	SmileDirectClub, Inc.	September 29, 2023
23-90784	SmileDirectClub, LLC	September 29, 2023
23-90785	Ortho Lab Services, LLC	September 29, 2023
23-90787	Access Dental Lab, LLC	September 29, 2023
23-90788	CAMF II, LLC	September 29, 2023
23-90789	SDC Financial LLC	September 29, 2023
23-90790	SDC Holding, LLC	September 29, 2023
23-90791	SDC Plane, LLC	September 29, 2023
23-90792	SmileFarm, LLC	September 29, 2023

smile
DIRECT CLUB

Customer FAQ

SmileDirectClub has made the incredibly difficult decision to wind down its global operations, effective immediately. For new customers interested in SmileDirectClub services, thank you for your interest, but aligner treatment is no longer available through our telehealth platform. For existing customers, we apologize for the inconvenience, but customer care support is no longer available. Thank you for your support and letting us improve over 2 million smiles and lives.

I placed an order for SmileDirectClub aligners, but have not yet received my aligners. What should I do?
Unfortunately aligner treatment is no longer available through the SmileDirectClub platform. All orders that have not yet shipped have been cancelled at this time, and you will not receive your aligners.

Should I continue to conduct my 60-day check-ins? Is my treating doctor still available to complete my treatment?
We apologize for the inconvenience, but aligner treatment is no longer available through the SmileDirectClub platform. If you wish to continue treatment outside of our platform, please consult your treating doctor or your local dentist with any questions around future aligner treatment.

I'm on the SmilePay Plan. Do I need to keep paying for my aligners?
HFD is the service provider for your SmilePay payment plan. For questions regarding your financial obligations please contact HFD at 1-877-874-3877, support@gohfd.com or visit their website at www.gohfd.com/.

Is the Lifetime Guarantee still in place?
No. Effective immediately the Lifetime Smile Guarantee no longer exists.

How do I ask for a refund?
There will be more information to come once the bankruptcy process determines next steps and additional measures customers can take.

Corporate Transparency Act

INFORMATION FOR DENTAL PRACTICES

NEW LAW EFFECTIVE 1/1/2024

What is the Corporate Transparency Act (CTA)?

The CTA was enacted by Congress in 2021 to combat the use of businesses as money-laundering operations. It requires certain businesses to report information to the Financial Crimes Enforcement Unit (FinCEN) about their ownership.

When does the CTA go into effect?

The CTA will take effect on January 1, 2024.

Is my dental practice affected by the CTA?

Your dental practice must file under the CTA if it meets either of the following criteria:

- The practice employs fewer than 20 people
- The practice generates less than $5 million (gross receipts) in revenue annually

My practice meets one or both of these criteria. What do I need to do?

Beginning January 1, 2024, you can visit fincen.gov/boi to file your report. FinCEN is not accepting reports until this date.

What information will I need to report?

Existing dental practices will need to report information on both the practice itself and its 'beneficial owners'.

For the business:

- Practice's legal name
- Any trade names
- Practice's current address
- The jurisdiction (state, territory, or District of Columbia) in which the business was formed
- The business's Tax ID Number (TIN)

For the beneficial owners:

- Name
- Date of birth
- Residential address
- An ID number from one of the following forms of identification: driver's license, passport, or state ID
- A copy of the form of identification used

How long do I have to collect this information?

Existing dental practices must file this information before January 1, 2025.

Who is a 'beneficial owner'?

According to the statute, a 'beneficial owner' need not necessarily own shares or have a financial stake in the business. A beneficial owner:

- Owns or controls at least 25% of the business

  OR

- Exercises substantial control over the business.

FinCEN's final rule clarifies that 'substantial control' includes senior officers of a business, as well as anyone with significant influence over important decisions (even if that person has no formal decision-making power). That also extends to any contractual or financial relationships you may have.

Because the definition in the final rule is so broad and includes anyone with significant influence over decisions, a beneficial owner for your practice may include (depending on circumstances):

- Board, committee, or advisory panel members
- Contractors or lenders with decision-making influence
- Consultants, including IT consultants
- Landlords
- Mentors

The final rule clarifies that standard legal or accounting services do not constitute beneficial ownership.

If you are uncertain whether a particular person qualifies as a beneficial owner, it may be best to include them out of an abundance of caution. The ADA recommends consulting legal counsel when making determinations on beneficial ownership.

I will be forming a new dental practice in 2024. What do I need to do?

Within 90 days of forming your new practice, go to fincen.gov/boi and file your report. New businesses must report all the same information as existing businesses. New businesses must also provide information on the person filing their report, as well as the person who directed or ordered the filing (if the two are different). The information new businesses will have to provide for their filers is the same as the information they must provide for their beneficial owners. Only new businesses need report information on their filers.

My practice is a subsidiary of a larger organization. What do I need to do?

If your practice is owned entirely by entities that are exempt from this statute (in other words, it is owned by organization(s) that have more than $5 million in revenue annually AND employ more than 20 people) then the

subsidiary is also exempt, and there is no need to file. However, if any part of the practice is owned by an entity that would be required to file a report under this statute, then the subsidiary must also file a report.

Subsidiaries should keep in mind that any beneficial owners of their parent company are also beneficial owners of the subsidiary company.

I am an employee of a dental practice. What do I need to do?

Nothing—unless you are significantly involved in making business or financial decisions for the practice. In that case, you may be asked to provide your information as a beneficial owner.

I filed, but my practice's information has changed. What should I do?

It is your responsibility to maintain an accurate report for your organization. If there is a change to any of the information you reported, you must update your report to FinCEN within 30 days.

I made a mistake on my report! What should I do?

If you notice an error on your report, you must correct the error with FinCEN within 30 days of when you initially noticed the error. Since the filing window will be open for an entire year, it may be best to take your time and ensure that all the information in your report is accurate before filing.

What happens if I don't comply with the CTA?

Failing to file a report, knowingly providing false information, or refusing to provide you information if you are a beneficial owner can all carry both civil and criminal penalties.

Civil penalties include fines of up to $500 per day until the violation is fixed. Criminal penalties include fines of up to $10,000 and/or imprisonment for up to two years.

For more information contact the ADA Member Service Center at (800) 621-8099 or via email at msc@ada.org or try out the Live Chat function online.

NEWSLETTERS & ARTICLES OF INTEREST

The CRDTS Report

Over 50 Years of Testing Excellence

Central Regional Dental Testing Service, Inc. Winter 2024

President's Message

Otto Dohm, DDS
President

CRDTS 2024

This is often the time for reflection upon the past and anticipation for the future. It is important to reflect on the past and assess the effectiveness of our efforts and make mid-course corrections as necessary. I would like to take this opportunity to thank everyone involved with this organization for their dedication and efforts to a common cause. It is remarkable to see a group of people with common goals and values work so hard as a team and it is a tribute to the foundation that this organization was built upon and the adherence to those guiding principles. It seems that many today question whether hard work and principles are traits that matter in our society; I think it is clear that these things do matter, and the evidence is obvious within this organization.

CRDTS as an organization continues to develop and provide testing services to state boards across the country. The organization continues to grow in membership each year. The development of our exams provides reliable, valid mechanisms that State Boards can rely upon to evaluate the competency of potential professional licensees within their jurisdiction. The development of these exams is an ongoing process that allows CRDTS to modify and adjust the content to keep pace with a changing profession while ensuring the validity of the exam process. The fact that CRDTS is governed by a committee made up of representatives of State Boards ensures that the needs of the states are met and allows for input into the exam process by the ultimate end user of the product, this is something unique in this industry. We are able to develop this product to meet the needs of the boards while doing everything possible to make the exam process less onerous for the candidates that must take these exams. The effort to accommodate the candidate and reduce the stress of a high stakes exam is evident by on-site retakes and the options of testing center exams at varied dates that a candidate may choose. I think that by any evaluation CRDTS has the premier set of exams from the State Board perspective as well as the candidate's and has done remarkably well accounting for both sides.

Otto Dohm, DDS
President

Volume 20, Issue 1

Sheli Cobler, Executive Director

DENTAL AND DENTAL HYGIENE COMPACTS – WHAT IS IN THE fine print... And WHAT IS THE IMPACT on Dentistry?

There is so much to know and so many questions that arise when reading through the proposed dental and dental hygiene compacts that unfortunately, it is impossible to unpack it all in one small article. Thus, this article will highlight just a few things to consider.

The impact the compacts, as written, could have on the dental profession creates concern for CRDTS as an agency that has been providing excellence in dental and dental hygiene testing for more than half a century, and for many of our Members. There is no doubt that portability for dental professionals is desired and important. There is no doubt that with the right language dental and dental hygiene compacts could enhance portability options for dental professionals.

However, if not carefully written the dental and dental hygiene interstate compacts may negatively impact the standard of care established by states. While portability is important, the mission of state dental boards is to protect the safety and welfare of the public. If state dental boards cannot enforce the requirements for dental and dental hygiene licensure in their respective states, the quality of dentistry may be at risk. Furthermore, with some minor tweaks, the matter of portability can be improved with the licensure through credentialing laws that are already in place in 49 of the 50 U.S. states. A compact will only complicate the matter further.

For example, 43 of the 50 states that accept clinical licensure examinations as a pathway toward licensure require a psychomotor hand skills component by law or rule. These laws were put into place to protect the safety and welfare of the public. With the Council on State Governments (CSG) Dental and Dental Hygiene (DDH) Compact, participating states must "Require for licensure that applicants successfully complete a Clinical Assessment" (Section 3, A. 10. DDH Compact). Great. However, Clinical Assessment is defined as, "an examination or process required for licensure as a Dentist or Dental Hygienist as applicable that provides evidence of clinical competence in dentistry or dental hygiene." (Section 2. D. DDH Compact). There is no requirement that the assessment include a hand skills component.

Only six states currently accept the Dental Licensure Objective Structured Clinical Examination (DLOSCE) which is a computer based **written-only** examination with **no hand skills assessment** developed by the American Dental Association (ADA)/Joint Commission on National Dental Examinations (JCNDE). This means that if a licensee from a state that does not require a hand skills assessment participates in the compact and requests privilege in a state that **does** require a hand skills assessment, the participating state must grant that privilege and **does not have the authority to require a hand skills assessment** before that licensee practices in the respective state. If the overwhelming majority of state's have included the requirement for a hand skills assessment for licensure in their laws, it would seem not only appropriate but absolutely necessary that the state legislators look to the state dental boards for guidance about the effect this compact language may have on the standards set forth in a respective state's laws. Unfortunately, in many cases the dental boards are not being consulted and bills introducing the legislation are moving forward this very legislative session.

The CSG partnered with the Department of Defense, the American Dental Association (ADA), and the American Dental Hygienist's Association (ADHA) to write the compact language and in January of 2023, before most dental professionals or even members of state dental boards knew anything about the proposed compact, the compact was lobbied and was enacted into three states. It continues to be heavily lobbied and is being introduced into legislation in the 2024 legislative session in ten or more states. In order to come into effect, the CSG DDH Compact must be enacted into law in seven states.

It is concerning that laws may be passed that impact the dental profession without the input of the very professionals charged with enforcing those laws. Some state dental board members are learning about the language of the compacts AFTER the legislation has been introduced or even adopted. How is it that state dental boards, those bodies that must enforce the laws that protect the public, are not the first to be asked for a position on legislation that will impact their responsibility and authority?

Proposed as an alternative to the CSG DDH Compact, is the AADB Dental and Dental Hygiene Compact (AADB Compact). The AADB compact was discussed at the most recent AADB Annual Meeting. Authors of the compact were noted to be employees of the CDCA/WREB/CITA testing organization and a couple of board attorneys from states that accept only the ADEX examination which is administered solely by CDCA/WREB/CITA. The AADB Compact requires that participants in the compact have successfully completed the ADEX exam. Those having completed a different clinical examination may be grandfathered in if taken prior to January 2024. Currently, 41 of the 50 states in the U.S. accept more than one clinical licensure examination,

continued on page 3

DENTAL AND DENTAL HYGIENE COMPACTS – WHAT IS IN THE fine print… Continued...

thus a very small minority of states will be able to enter such a compact without having their current laws and rules impacted. Portability and an easier method of licensure is said to be the main idea behind the compacts. However, if that were the case, it seems counter-productive to ask the majority of the U.S. to ignore their own state's laws in favor of one testing agency. A monopoly, I'm sure we can agree, is a dangerous thing. Competition is what drives higher standards, accountability, and cost control. Certainly, there is a better solution to enhanced opportunities for portability among dentists and dental hygienists than the compromise of laws that are already in place for the purpose of public safety.

CRDTS has been providing a standard of excellence in dental and dental hygiene testing since 1968. The leadership of the organization consists of a group of dental and business professionals who are passionate about the dental profession and believe that licensure examinations are critical in ensuring competency for new dental and dental hygiene graduates. I've heard it said by many examiners that before they became examiners they didn't know if the clinical licensure exams were beneficial but after examining and seeing the 1-3% of students that are not quite ready to practice, they too became passionate about the importance of the exams as a means of assessing minimal competency for the benefit of protecting the safety of the public.

As an agency that has no financial interest in either of the currently proposed dental and dental hygiene compacts, the goal is to help raise awareness of details in the language of the proposed compacts. Our mission is to serve and assist licensing boards with their mission to protect the health, safety and welfare of the public.

Whether you are a dentist or dental hygienist, board member or educator, it is important that you know the impact a compact could have on the dental profession.

Sheli Cobler
CRDTS Executive Director

Deena Kuempel, DDS
President Elect

CRDTS - ALWAYS LOOKING FOR WAYS TO HELP STATE BOARDS AND PRACTITIONERS

Hello from balmy Iowa. Christmas and New Year have passed and there is NO SNOW on the ground. Just like our environment, CRDTS is ever changing. Many of you may think of CRDTS as only a dental testing resource. We are working diligently at this time to help state boards by developing and supplying resources for needed remediation of licensed individuals and licensees that may have been away from practice for some time and wish to update their clinical skills prior to their return to practice.

We are doing this with a significant investment in leading haptic technology and partnerships with other outstanding businesses to assure assessment and assistance in clinical hand skills and management issues (record keeping, standard of care concerns) practitioners may face and need remediation with for state boards to assure public safety.

We are doing this for the benefit of both practitioners and state boards. A definite effort is being made to keep fees at a level so that it is not prohibitive to consider for the practitioner to update and prove competency in their skills. Another service this can provide for states is the ability to assure that foreign trained practitioners are at the same level as CODA approved program graduates.

Just as we have made changes going to manikin-based exams, we are being forward thinking about using haptic technology in licensure testing. This technology is being used more every year at universities in their clinical training, so using it for licensure testing will be consistent with their educational experiences. This may also allow for a standard of acceptability to be programmed and the clinician's work to be scanned into the program to be evaluated electronically.

Needless to say, none of this happens without the dedication and commitment of the many committee members and staff members. We hear you when you have needs, and we are here to help find the best solutions and serve you with the kind of teamwork that you deserve.

Thank you again for being a part of CRDTS and we are here to help you anyway that we can.

Deena Kuempel, DDS
President Elect

DENTAL NEWS

Mark Edwards, DDS, Director of Dental Examinations

Rod Hill, DDS, ERC Committee Chair

Here's hoping that your 2024 year is off to a prosperous start. CRDTS Dental ERC has been busy continuing to modify simulated patient examination typodonts as well as simulated patient content, criteria, and policy. Following careful psychometric review and analysis of simulated patient examination scoring and candidate performance statistics from 2019-2023, Dr. Brett Foley from Alpine Testing Solutions has supported a modification to the scoring system of the dental examination. Beginning in the 2023-2024 dental testing year (Class of 2024), candidates will be scored in a conjunctive manner, meaning they will have to achieve a 75% or greater score on each procedure within each part of the CRDTS exam in order to pass the overall exam.

In collaboration with Acadental, additional teeth with simulated caries have been developed, and a new periodontal typodont will be evaluated for implementation in the Class of 2025 testing cycle. Additionally, CRDTS is being financially and environmentally prudent in the recycling of typodonts, which is an effort to reduce the net cost to candidates taking the CRDTS exam.

CRDTS continues to embrace and explore new avenues and the impact of technology in dental and dental hygiene licensure assessment, education, and remediation. CRDTS continues to work in a collaborative relationship with SIMtoCARE to develop and refine virtual haptic technology to be used in education and remediation at our independent testing site in Topeka, KS. Additionally, CRDTS maintains a partnership agreement with Acadental relative to utilizing Teo virtual reality technology as a remediation tool for distance learning via 3-D evaluation and critique of licensee work.

CRDTS dental leadership will attend the 2024 Southern Deans and Dental Examiners Annual Conference in Charleston, SC on January 19-21, and will be an exhibitor at the American Student Dental Association (ASDA) meeting in Denver, CO on February 23-25, and the American Dental Education Association (ADEA) meeting in New Orleans, LA on March 9-12. These events provide excellent opportunities to share the CRDTS vision and mission with both students and educators as we continue to spread the word on services that CRDTS can offer in dental examination for initial licensure as well as in remediation/retraining and reeducation.

Again, the Dental leadership team is open to your thoughts and ideas on how we can most effectively serve the parties who we represent. From state dental boards in their mission to protect the health, safety and welfare of the public, to dental candidates and dental schools, CRDTS continues to develop and implement fair, valid and reliable scoring criteria and examination policy.

Mark Edwards, DDS
Director of Dental Examinations

Rod Hill, DDS
ERC Committee Chair

FRESH OFF THE PRESS FROM THE DENTAL HYGIENE DEPARTMENT

Hello All!

CRDTS' 2024 exam year is looking bright! Please take time to visit crdts.org and view our 2024 manuals and orientations. We are excited to develop new relationships and continue to foster our existing ones with our scheduled Dental Hygiene Programs. As many of you have already experienced, CRDTS is all about the personal touch. We are known for our friendliness and our timely responses to your questions. We are here for you - students, faculty, and state boards - to answer any questions that may arise about the exam or scheduling. CRDTS will work with you to meet your testing needs.

You may have heard that California Governor Newsom signed AB1257 late last year and it goes into effect January 2024. One of the provisions of this bill is that the California students who graduate from a CODA accredited and CA Board-approved California dental hygiene program and apply for their initial license within three years of graduating will not be required to complete a clinical examination. CRDTS will continue to test in California to meet the portability needs of candidates who may be going to other states. All out-of-state applicants who apply for a dental hygiene license in CA will be required to submit a passing clinical examination score to apply toward licensure unless applying through the Licensure by Credential pathway. Currently, all states (except California) require applicants for initial dental hygiene licensure to pass a clinical licensure examination. We have many student Q&A sessions scheduled for 2024 programs. Let us know if you would like one scheduled for your program and we will make it happen. CRDTS has a lot to offer, and this is why our exam is highly popular and continues to grow. Thank you for your dedication to our profession and your loyalty to CRDTS.

Kind Regards,

Kelly Mandella, RDH,
Director of Dental Hygiene Examinations
Trelawny Saldana, RDH
Assistant Director of Dental Hygiene Examinations
Janine Sasse-Englert, RDH
Dental Hygiene Exam Review Committee Chair

WHAT 0 TO 60 MEANS TO THE CRDTS CARE PROGRAM

Have you ever been in a fast car? I mean a REALLY fast car. You know, the kind that can go from 0 to 60 in just a couple of seconds. If you have, you know the exhilarating feeling of starting from a dead stop, and in moments, you are speeding down the road.

It was mid-2022 when the first whispers of a new CRDTS remediation/reeducation program were spoken and the idea of creating a new arm of the organization that focused on working with State Dental Boards to create custom remediation solutions for Licensees was brand new. CRDTS recognized the need and understood the organization has the expertise to create a program, and the board supported the initiative to develop a program to assist the State Dental Boards in this way. Thus, the leadership and Subject Matter Experts diligently worked to develop an option for remediation that State Dental Boards could utilize and licensees could take advantage of for individual needs. Today, only sixteen months after the first ideas were put down on paper, CRDTS is quickly becoming known as the premier organization for remediation and reeducation programs for dentists and dental hygienists. For those involved in the conception, creation, and administration of the CARE Programs, I cannot think of a better analogy than to say this program has gone from 0 to 60, and we couldn't be happier to be in the driver's seat for this exciting journey.

During the August CRDTS Annual Meeting, I had the opportunity to talk with many of my examiner colleagues and realized that although CRDTS has been immersed in this new adventure, many of you have heard only bits and pieces of what we are doing, and others were completely unaware of these programs. I would like to take this opportunity to share some of the exciting things we have been doing with CRDTS CARE.

Why would CRDTS get involved with remediation?

CRDTS has worked very hard over the last 50+ years of dental testing to build relationships with State Dental Boards. During conversations with leaders from State Boards, we realized that they were searching for a reliable, trusted partner that could provide dental and dental hygiene education for their Licensees needing to prove competence in dental and dental hygiene practice. Who better to create learning opportunities for these individuals, than an organization with an abundance of highly skilled clinicians, and educational leaders?

continued on page 6

What 0 to 60 means to the CRDTS CARE Program Continued...

Who does CRDTS CARE Programs help?

CRDTS currently has two categories of individuals to whom we provide education; Licensees who have been board-ordered to complete an education program to maintain their license and Licensees who are looking to reinstate a lapsed license. Every situation is unique, so the CRDTS CARE Team creates custom programming that takes into consideration the needs of each licensee.

Where does CRDTS hold the Remediation and Reeducation Programs?

In 2022, CRDTS opened our Learning Center/Clinic right in the same building as CRDTS Central Office. This space currently has four operatories and is equipped with everything clinicians need for their customized, one-on-one, hands-on skills practice. Along with these operatories, Licensees get hands-on practice using our very own SIMtoCARE Dente', virtual haptic technology. CRDTS is proud to partner with SIMtoCARE to develop virtual haptic technology that enhances education. Having the opportunity to work with a hygiene reeducation case in this environment, I was thrilled with the private, stress-free, and comfortable atmosphere this space provides the licensee to work and learn, and the feedback from licensees has been very positive.

How does CRDTS provide "Custom Remediation and Re-Education Programs"?

One of my favorite job responsibilities is to work directly with each licensee to understand their situation and help them navigate the path to licensure. For some, the need for remediation is due to a state's board order requiring them to complete a program of didactic and hands-on skills practice. For these individuals, we work directly with the dental board to create customized education that will address the areas of deficiency. Many of the dental hygiene Licensees reach out to CRDTS because life has led them away from the practice of dental hygiene and they are looking to reinstate a lapsed license. Many state dental boards require these hygienists to complete a dental hygiene reeducation program, and others require successful completion of the CRDTS dental hygiene examination. In a time when many states are experiencing a dental hygiene shortage, it is exciting to see so many hygienists returning to practice, and even more exciting to be a part of their re-licensure journey.

What happens after the 0 to 60?

It has been a whirlwind getting to this point of our new CARE Remediation and Reeducation Programs. However, CRDTS has no intention of slowing down. To stay with our analogy, we have our foot firmly on the gas, and are moving down the road of solidifying our reputation as the go-to organization for remediation and reeducation programs for dental professionals. We are accomplishing this by staying in front of State Dental Boards, presenting information on our CARE programs to the individuals tasked with ensuring the safety of our dental patients. We continue to build our learning library and are working with our Subject Matter Experts to ensure that we are not only helping Licensees complete necessary requirements, but also continue the relationship to ensure that the refreshed concepts, skills, and procedures are put into daily practice. We are proud to partner with SIMtoCARE continuing to develop technology driven education, which we have found to be a great way to provide repetitive learning opportunities in both dentistry and dental hygiene. We continue to nurture our relationship with SPEAR Education and EBAS, to allow for robust learning opportunities and the ability to provide the ethics testing that state boards are mandating for Licensees. Finally, the CRDTS CARE Team is working to build additional programming that will help further meet the requests of our Dental State Boards, and the needs of our Licensees.

We invite you to join us on this CARE Programs "road trip" by helping to spread the word about these exciting new offerings. As examiners, educators, and state dental board members, we all have opportunities to inform Key Opinion Leaders and decision makers that CRDTS provides both fair, trusted and reliable examinations for future dental professions AND remediation and reeducation programs for Licensees across the country.

Catrice Opichka, RDH
RDH Programs Coordinator

LICENSE RATIFICATION

RATIFICATION OF LICENSES

As authorized by the Board, licenses to practice dentistry, dental therapy and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify the issuance of the following licenses. Complete application files will be available for review during the Board meeting.

DENTAL HYGIENISTS

H8756	AUXIER, ELIZABETH A	12/8/2023	RDH
H8757	ZIEGLER, KRISTA ROSE	12/13/2023	RDH
H8758	AN, SEUNGWON	12/13/2023	RDH
H8759	MENDEZ-MARTINEZ, VANESSA	12/13/2023	RDH
H8760	MARINELLO, AMBER	12/14/2023	RDH
H8761	MARSHALL-SVOBODA, NATALIE JEANINE	1/2/2024	RDH
H8762	RAZA, ASYA	1/5/2024	RDH
H8763	WAIT, ABIGAILE	1/24/2024	RDH
H8764	HART, BROOKE	1/31/2024	RDH

DENTISTS

D11921	GUPTA-JOHNSON, DEEPTI	11/30/2023	DMD
D11922	HALE, LAURA LEE	12/5/2023	DDS
D11923	KEYSALOV, DMITRY AFANASSI	12/6/2023	DDS
D11924	FERRER, VESNA-LEA	12/20/2023	DDS
D11925	BEHLKE, WILLIAM JOHN	12/20/2023	DMD
D11926	HOORFAR, MERSAD	12/27/2023	DMD
D11927	LUTAAYA, ALFRED	1/2/2024	DMD
D11928	RAINA, GAYATRI	1/5/2024	DMD
D11929	WILLIARD, MARY	1/8/2024	DDS
D11930	MISHRA, RASHMI	1/10/2024	
D11931	BONG, JESSICA	1/18/2024	DDS
D11932	DOWNES, MATTHEW	1/23/2024	DMD
D11933	MCCOMBS, SEAN	1/24/2024	DDS
D11934	HABIB, BISHWY	1/29/2024	DDS
D11935	BALACKY, PETER	1/30/2024	DDS
D11936	CHAVELEH, ANDREA	1/31/2024	DDS
D11937	MENDOZA, MARIO	1/31/2024	DMD
D11938	BAKER, THANAKORN	1/31/2024	DDS

DENTAL THERAPISTS

DT0019	ROSARIO, REINA ROSE	1/31/2024	DT, RDH

LICENSE, PERMIT & CERTIFICATION

PLUMLEE Samantha * OBD

From: OBD Info * OBD
Sent: Tuesday, November 21, 2023 2:17 PM
To: PLUMLEE Samantha * OBD
Subject: FW: Proposed changes for Sealant and Soft reline
Attachments: Ut#5 Soft Denture Relines 2023.docx; 1. OREGON BOARD OF DENTISTRY sealants.docx

---

From: Bonnie Marshall <mgrammabuns50@gmail.com>
Sent: Tuesday, November 21, 2023 2:13 PM
To: OBD Info * OBD <information@obd.oregon.gov>
Cc: Bonnie Marshall <mgrammabuns50@gmail.com>
Subject: Proposed changes for Sealant and Soft reline

> You don't often get email from mgrammabuns50@gmail.com. Learn why this is important

Thank you for reviewing the following attachments for changes to my Sealant and Soft Reline classes

Sincerely,
Bonnie Marshall
503.209.8450

OREGON BOARD OF DENTISTRY
BOARD APPROVED COURSE FOR TEMPORARY SOFT DENTURE RELINE

Bonnie Marshall
13908 NE River Bend Dr.
Battle Ground, Washington 98604
Mgrammabuns50@gmail.com
503.209.8450

Proposal:
I, Bonnie Marshall, would like to make changes to the Temporary Soft Denture Reline class that I am certified to teach. (Changes will be in red)

PREREQUISITES:

1) **The attendees must be an Oregon Expanded Function Dental Assistant.**
2) **The attendee must provide a copy of their EFDA certification with the course registration.**

SUGGESTED TEXTS:
Finkeiner and Johnson, Comprehensive Dental Assisting: Mosby Bird and Robinson, Modern Dental assisting, 12th edition, Elsevier, or any text used by Dental Assisting Programs.

COURSE FORMAT:
This course should be presented in a lecture/lab/clinic format and should be completed within 3 (three) months. All tests and lab, and clinic forms should be transmitted to the instructor within 3(three) months to receive a certificate of completion.

LECTURE
The lecture/didactic portion of this course can be presented either in person or through a webinar or zoom presentation by the approved instructor.
To include the following regarding purpose, techniques, and safety issues for placement of temporary soft denture relines:

1) OAR Div. 42 rule regarding placement of Temporary Soft Denture Relines
    a. Current patient history.
    b. Noted allergies.
    c. Medications
    d. Other health considerations
2) Infection control issues
    a. Principles of disease transmission
    b. Universal precautions
3) OSHA regulations
4) The Denture Patient
    a. Purpose
5) The Dynamics of a Denture

   a. The Maxillary Denture
   b. The Mandibular Denture
6) Extraction vs Preventative options
7) Limited access of care for patients
8) Objective of Soft Relines
9) Types of Denture Liners
10) Procedure and Materials
11) Preparation, Mixing and Placement Procedure
12) Chart Entry
13) Terminology
14) Current and future trends

WRITTEN EXAM:

Class participants must take a 25 question, multiple choice exam with a minimum passing score of 80% prior to commencing the lab portion of the course.
If the EFDA dental assistant is enrolled in a webinar or zoom class, the instructor must maintain and record of the successful passage of the exam for the attendee to continue with the in-office lab work.

LAB:

Attendees should be provided with knowledge and skills to perform placement of temporary soft denture relines. The following criteria and instruction apply to the EFDA dental assistant enrolled in a webinar or zoom class:

1) The instructor must provide a video and zoom instructions (performance criteria) prior to the lab work.
2) The office that the EFDA dental assistant is employed by must record and document the successful accomplishment of the mixing and placement of temporary soft denture reline materials on three (3) dentures, under direct supervision, prior to moving on to the clinical portion of the course. The evaluation must be done by the dentist of record, or a certified temporary soft denture reline dental assistant and transmitted to the instructor of record. (Attachment #1)

Clinical:

The following criteria and instruction apply to the EFDA dental assistant enrolled in a webinar or zoom class:

1) The dentist of record or temporary soft denture reline certified dental assistant will work directly with the EFDA dental assistant to accomplish the successful completion of the in-office clinical portion of the class.
   a. The EFDA dental assistant must successfully place five (5) temporary soft denture relines, under direct supervision of the dentist of record or a certified temporary soft denture reline dental assistant.

2) Upon completion of the form (attachment 2), the form must be transmitted to the class instructor with a copy of the dentist of record or a certified temporary soft denture reline dental assistant license.
3) Upon receiving the forms, the instructor will review the documentation and transmit the "Temporary Soft Denture Reline Certificate" to the attendee of the class.
4) The instructor will maintain records of documentations for 5 years.

Intent:

Upon approval of the changes to previous approved "Temporary Soft Denture Reline" course, I, Bonnie Marshall, intend to work closely with the Oregon Dental Assistants Association to offer this class throughout the State of Oregon.

Rational:

This class will offer EFDA's the opportunity to accomplish their Temporary Soft Denture Reline class wherever they are employed in the state without the need to travel and will allow dentists, offices, and patients to benefit from their successful completion of this course.

ATTACHMENT #2 - 2017 APPROVED CURRICULUM

TEMPORARY SOFT DENTURE RELINE COURSE

RECEIVED
MAR 24 2017
Oregon Board of Dentistry

Instructor: Bonnie Marshall, CDA, RDA, EFDA, EFODA, MADAA, BS

Class Length: Three (3) Hours

Course Requirements:
Attendees must

a. have the Oregon Expanded Duties Certificate prior to attending the class and show proof of.
b. attend the entire course.
c. successfully pass a Soft Reline written exam.
d. successfully complete the Soft Reline lab portion of the course.

The Temporary Soft Denture Reline course will be conducted as follows:

a. Lecture/Power point (outline attached)
b. Lab (performance objectives attached)
c. Written Exam

Upon completion of the above course, attendees will receive a certificate issued by the instructor.

Qualifications:
Bonnie Marshall attended a class on Temporary Soft Denture Relines on April 23, 2005 (copy of certificate enclosed).

Bonnie Marshall performed temporary soft denture relines for patients under direction of a dentist at Kaiser Dental Offices.

Bonnie Marshall taught Temporary Soft Denture Reline classes within the CODA approved program at Portland Community College and the Dental Assisting Program at Charter College in Vancouver Washington.

Bonnie L Marshall
Thank you... This is a request for approval as a Temporary Soft Denture Reline Instructor

Oregon Dental Assistants Association

Bonnie Marshall

has successfully completed a three hour course approved by the Oregon Board of Dentistry for Expanded Function Temporary Soft Denture Relines

Sheri Billetter, CDA, EFDA, BS
Dated: April 23, 2005

TEMPORARY SOFT DENTURE RELINE OUTLINE

Temporary Soft Relines for Dentures

A. The Denture Patient
   1. Emotions of the Denture Patient - Be sensitive
      a. Very conscious of their appearance
      b. Apologetic for tooth loss
      c. Very angry about loss
         (1) Blame someone else - (parents, insurance, dentist)
         (2) Blames childhood dentist - did not do their job
         (3) Patient takes blame - too late now
      d Very sad about loss
         (1) Cancer
         (2) Radiation
         (3) Resorption of bone
      e. Unconcerned - could care less
      f.. Constant discomfort
         (1) Gag feflex
         (2) Soreness
   2. Complications of Mastication
      a. Can not chew properly
      b. Denture(s) float
      c. Denture(s) tip or rock
      d. Biting of the cheek or tongue
      e. Hard to chew - must take very small bites

B. The Denture
   1. A Failure of Dentistry
      a. Difficult to Make & Expense
      b. Reduced Chewing Capability
         (1) Reduced by 5-15%
         (2) Will never be like real teeth
      c. Can't Go Back - Option: Implants
         (1) Implants
         (2) Bone loss too great
         (3) Very expensive
         (4) Possible bone implants first
      d. Constant Changes in Soft and Hard Tissues
         (5) A processed denture remain the same
         (6) Tissues swell, dehydrate, resorb
         (7) Tissues affected by weight loss/gain
      e. Natural Dentition vs. Porcelain or Plastic Teeth
         (8) Porcelain teeth wear natural teeth and are the primary

causative factor for bone resorption.

(9) Plastic teeth are less hard than porcelain and kinder to natural dentition.

2. The MaxillaryDenture
   a. Surface area is larger than mandibular
   b. Suction increased due to palatal coverage
   c. Occlusal force is spread over the entire arch
   d. Bone resorption is less than mandibular
   e. Easier to fabricate
   f. Teeth are not very sharp, less long term bone loss

3.The Mandibular Denture
   a. Tongue and frenum attachments pull - denture lifts
   b. Less surface area for chewing and strength
   c. No suction
   d. Thinner bone and less bone
   e. More bone resorption
   f. Harder to fabricate, teeth flatter

C. Dynamics of Dentures
   1. Bone Resorption
      1. **Maxillary Anterior Ridge**
         Maxillary bone resorption occurs in the anterior
         Shorter maxillary lip line
         Lip line is literally lost - older ladies with "painted lips"
      2. **Mandibular Posterior Ridge**
         Mandibular jaw position extends forward
         Patients move mandible forward to chew and hold denture in place.
   2. Over Closing
   3. Digestion and the Alimentary Tract

D. Extraction vs. Preventative Options
   1. Tooth Extractions
      1. Clinical crown removed
      2. Roots removed
      3. Roots left
   2. Bone recontoured to make smooth ridge
   3. Over Closure
      a. Loss of lip line
      b. TMJ problems
   4. Preventative Options
      1. Implants
      2. Mandibular partial dentures

3. Leave cuspids if possible
4. Leave healthy roots - overdentures
5. Conservative implant use - no more than 3 mandibular

E. Limited Access Patients - Not in the Dental Office
   1. Prescription
      a. Must be prescribed by the dentist then checked after placement.

   2. Expanded Function Duty
      b. Was an RDH expanded function until OBD approved for expanded function dental assistants in January 2002.
   3. Patient's Seen Outside the Dental Office
      a. Home bound
      b. Confined
      c. Unable to be transported
      d. Hospitalized
      e. Nursing home or Care Center
      f. Home Health Services

F. Objective of Soft Relines
   1. A Temporary Measures
   2. Relieves Soreness
      a. The most common reason fo relines
   3. Allow the Patient to Chew
      a. Inability to chew because dentures slip
   4. Speech Improvement
      a. Dentures more stable
   5. Stroke
      a. Loss of muscle function
   6. Cancer
      a. Weight loss
   7. Comfort
   8. Tissue Conditioning
      a. Improves Tissue for New Dentures
   9. Temporary During Construction of Implant
      a. Soft reline over an implant cap

G. Types of Denture Liners
   1. Temporary Liners
      a. Length of Time
         (1) Manufactures suggest up to 6 weeks
         (2) 2-3 weeks is the best and much easier t remove
      b. Can be Placed Many Times
      c. Helps Lessen Tissue Compression

d. Eases Faulty occlusion - stops sliding
e. Ingredients:
(1) Zinc undulate in a base and ethyl alcohol liquid
Helps reduce candidiases and ease xerostomia based yeast infections. Post-op is critical.
(2) *** Alcoholic beverages breaks this product down quickly since it already contains alcohol.
f. Products for Temporary Liners:
b. Coe Soft
c. Coe Comfort
d. Fixx
e.

2. Soft Relines
a. Length of Time
(1) Lasts 3-6 months
b. Harder to Remove
(1) Needs a laboratory bur or lathe
c. Need a plan for a new denture - what happens in 6 months
d. Ingredients
(1) Polyethylmethacrylate powder and ethyl alcohol liquid
e. Soft Reline Products - Coe Soft
(1) Mixing the Product
a. Dispense according to manufacturers directions
b. Mix to form a soft plastic mass
c. Results are a very firm liner in the denture
(2) What happens:
(a) Ethyl alcohol evaporates during the first 24 hrs.
(b) Replaced by water in the saliva.
(c) This H 20 evaporates and leaves a firmer base
(d) *** The patient must avoid alcohol during this time or the process gets messed up.

3. Laboratory Processed Relines
d. Impression in the denture
e. Liner worn overnight
f. Timing for the Patient: A 2 Day Process
(1) When to leave - morning
(2) When to pick up - late afternoon
(3) Day will be based on the "denture"

4. OTC Denture Products
a. Difficult to Use
Local pharmacies will have "tons" of products available - go see what is available so you have a brand names in mind
b. Need Professional Diagnosis

Some patients will try to fix their own - then never get another dental exam

c. Hard to Read Directions

d. Use Non-professional Products

e. Categories of OTC Products
Adhesives
Liners
Repair Kits
Replacement Teeth
Cleaners
Home Remedies

H. Procedure - Medical History Evaluation

1. Medical History

a. Medications - do they effect denture use

b. Contra indications

c. Indications

2. Dental History

a. Dental Prescription (by the dentist)

b. Daily Care

Who does this?	Patient, CNA, care giver?
Cleaning methods:	LeKleen machines at Freds or Safeway
No saliva:	Does the patient use biotene for xerostomia
Mouth wash:	Do not use Listerine - too high in alcohol content will evaporate even faster.

b. Thorough oral Cancer Examination

c. Mentally Compromised - have assistance

e. Questions to Ask
How old are the dentures
Determine the need for a reline, rebase or new denture
Old - dentures, slow progressive bone loss - how sloppy
New- Ill fitting, para functional habit
Other disease complications:
Stroke, cancer, systemic, malnutrition (can't eat = weight loss = dentures fit even less well.

I. Initial Try In Procedure

1. Seat & Fit the Denture in the Mouth

a. Check occlusal relationship

(1) Always replicate centric relationship

b. Ask about discomfort

c. Have the patient say a sentence with "s" in it (sun, shasta etc.)

2. Identification of Denture
   a. State Law Requires Identification
      (1) For a patient placed in a care facility.
   b. Make Sure the Denture Belongs to the Patient
   c. Denture should have the Patients Name in it
      (1) (Roughen with an emery board or vulcanite bur, type name on paper, cut and place on roughened surface, coat with clear acrylic or place clear bonder and cure.
   d. Care Facilities
      (1) Staff is unaware of non identified dentures
      (2) Staff could get dentures mixed up
   e. Kits Available
      (1) Do with acrylic or bonder.
3. Explaining the Procedure to the Patient or Care giver
4. Follow asepsis protocol
   (1) Clean denture or partial in solution (baggie) in ultrasonic cleaner before attempting to place any material.

J. Preparation, Mixing & Placement Procedure
*** DO ONE DENTURE AT A TIME***

1. Measure Material (follow mfg. directions)
   [*] Maxillary = 3 level measures of powder to 12 cc of liquid
   [*] Mandibular = 2 level measures of powder to 8cc of liquid

   **These are now ready to place in the mixing container - either the red mixing container provided or a paper cup.

2. Coat the Denture Surfaces
   a. (Labial and buccal) that you do not want the reline material to adhere to with Coe lubricant or a separating medium.
3. Begin with the Maxillary Denture first:
4. Mixing the Material
   a. Add powder to liquid slowly and mix to a thin taffy like consistency - not drippy
   b. Mix slowly for 30 seconds - do not incorporate air bubbles
   c. Do not mix for longer than 30 seconds
   d. Working quickly - Spread the mixture into the denture, bring up over the edges and smoothly and in a rolling manner.
5. Seat the Denture Carefully
6. Instruct the Patient to Bite into Occlusion - gently muscle trim
7. After 3 minutes Instruct the Patient
   (1) to form an "o" to muscle trim the area

8. Gently Remove Denture
9. Rinse under Cold Water
10. Trim Away Excess Material
    a. To smooth peripheral edges cut away with scissors or scalpel then
    b. Smooth edges with hot spatula
    c. This is all - a minimal finishing! Do not use stones or a lathe, - this will scorch and ruin the reline.
11. Reseat the Denture and Have Patient Bite into Occlusion
12. Instruct the Patient to Gently Hold Centric for 5 minutes.
13. Repeat Procedure on Mandibular Denture - (if needed)
14. Caution the Patient not to Use Harsh Abrasives for Cleaning

K. Home Care Instructions

1. First 24 hours
    a. Do not use a denture brush - soft tooth brush only (gently)
    b. Rinse in cold water
    c. Eat and drink normally
    d. Restrict alcohol consumption
    e. Do not touch with fingers
    f. Soak with teeth side down
2. After 24 hours

    a. Normal routine
    b. Keep very clean
    c. Report any loose material or cracks
    d. Excess alcohol consumption shortens life of the liner

Chart Entry

Note procedure in the chart

Who prescribed and why
What material was used
What aftercare instructions were given and to whom

b. What are future plans for the denture
c. Your name (initials)

PERFORMANCE OBJECTIVE

Attendee Name _____ Date_____

Procedure: **Temporary Soft Denture Relines**

Objective:
a) The attendee will state the purpose for the two types of soft denture relines.
b) The attendee will demonstrate preparation of the denture for the tissue conditioner or soft reline in a laboratory setting.
c) The attendee will demonstrate safe and effective placement of the denture.
d) The attendee will demonstrate proper technique for trimming excess material and preparing for delivery.
e) The attendee will demonstrate aseptic handling of the denture before, during and after the procedure.

Selection: a) Maxillary b) Mandibular
Product: a) Soft Denture Reline b) Tissue Conditioner

Criterion: The attendee will complete the module at a competency level of 85% or more for sucessful pasaage If the attendee does not obtain 85% or more a retake will be required.

IE=Instructor Evaluation	A=Acceptable 1 Point X=Unacceptable 0 Point	A	X	IE
PERSONAL PROTECTIVE EQUIPMENT:				
1. Mask, gloves, safety glasses, appropriate PPE				
ARMAMENTARIUM:				
2. Complete tray set-up, mirror, explorer, cotton rolls, 2X2 gauze, spatula, reline or conditioning material, mixing containers, scissors, wax spatula, mouth wash.				
INITIAL:				
3. Attendee checked the occlusion and fit of the denture.				
4. Attendee placed the denture in a zip-lock baggie with sparkyl to disinfect.				
5. Attendee roughened the tissue side of the denture with lab bur.				
6. Attendee prepared material as selected by the faculty for either a soft reline or tissue conditioner.				
PREPARATION:				
7. Attendee dispensed proper amount of polymer and monomer.				
8. Attendee mixed according to manufactures directions. Mixing for ____ seconds until a thin homogenous mass is established.				
9. Attendee placed material in denture covering the entire tissue area.				
10. Attendee used spatula to roll material over the peripheral border.				

PROCEDURE:			
11. Denture is placed on typodont and held in a gently yet firm manner.			
12. Denture is removed after ____ minutes, rinsed IN _____ water, and reinserted for____ minutes.			
13. Denture is removed, rinsed and disinfected for adjustments.			
14. Scissors are used to trim away gross excess.			
15. Once gross excess is removed, a wax spatula is **slightly heated** and used to smooth the cut edges at the periphery of the denture.			
16. The denture is disinfected and reseated on the typodont again.			
17. Attendee stated how to disinfect the denture prior to returning to a live patient.			
18. Attendee maintained professionalism throughout the procedure.			
19. Attendeee followed appropriate infection control throughout procedure.			
Comments:			
TOTALS			

_____% Pass_____ Fail_____

18=95%
17=89%
16=84% Successful Passage Required
15= Not Passing

Revised 3/20/17 BLM

Request for Approval of Soft Reline Course – Brianna Burks, 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."

To whom it may concern from the Board of Dentistry,

My name is Brianna Burks, I have been a dental assistant for 8 years now. Within my 8 years of being an assistant I have shadowed a denturist for 6 ½ of those years learning and watching all the steps in relation to removable appliances, became EFDA certified, x-ray certified, and spent 1 year managing a dental office. I am back to being an assistant and currently in school to be a denturist. I am attending the American Denturist Association program online. I became certified in placement of reline material about 5 years ago and have brought that certification with me to the different offices I have worked at. I am very eager to spread my knowledge to become a certified teacher in this placement to teach others how to place the best, most efficient reline material in a removeable appliance.

Thank you for your time and consideration,

Best Regards,

Brianna Burks

Soft Reline Course

Course Goal/Objective: Coe-Comfort/Coe-Soft reline course is designed to provide Expanded Functions Dental Assistants only with the principles of how to place a coe-soft or coe-comfort reline material in an existing removable appliance such as dentures, flippers, and partials. The goal of this course is to build a foundation that will help the dental assistants to be successful in placing the coe-soft reline material, understand the different techniques involved in trimming the excess material, and post-operative instructions.

The objective of this course is to have all expanded function assistants certified and proficient in placements of soft relines in removable prosthetics.

The Board approved course should offer instruction on the purpose, techniques, and safety considerations of placing a soft reline material in a removable appliance and the Expanded Function Dental Assistant's role as the operator under 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(9))"

PREREQUISITES

1. The attendee must be an Oregon Expanded Functions Dental Assistant.
2. The attendee must provide a copy of their EFDA certification with course registration.
3. Pass written exam with an 80%

Course Format

The course should be presented in a 3-part format lab/lecture/clinical for a total of at least 3 hours.

There will be a hands-on demonstration on how to mix the reline material properly and placement inside of a removable appliance. Will also demonstrate how to manipulate the cheeks and make sure the patient is correctly biting down while reline material is setting up. Then will demonstrate how to trim the excess material away.

Lecture: To include the following in regards to purpose, techniques, and safety issues for placement of soft reline materials.

1. OAR. Div. 42 rule regarding placement of soft reline material by an EFDA.

2. Patient health history review
    a. Is the history current
    b. Noted allergies
    c. Medications
    d. Other health considerations
3. Infection control issues
    a. Principles of disease transmission
    b. Need for safety glasses for the patient and EFDA
    c. Universal precautions
4. OSHA regulations
    a. Operator injury
    b. Spill cleanup
5. Use of dental equipment and instruments
    a. Use of appropriate fulcrum
    b. Use of correct instruments
6. Understanding anatomical tooth surfaces and oral anatomy
    a. Tooth surfaces
    b. Tooth margins
    c. Surrounding periodontium and gingival tissue
    d. Anatomic anatomy
7. Indications/Contradictions for reline material
    a. Tissue health
    b. Correct placement of reline material
    c. Trimming of excess material using a 15 blade or periosteal with a torch
    d. Appropriate technique used for placement and trimming of material

Written Exam: Class participants must take a 15 question, multiple choice examination with a minimum passing score of 80% prior to commencing the lab portion of the course.

Clinical: After successfully completing the lecture and written examination, attendees shall show proof of having placed soft reline material in 1-2 patients under the indirect supervision of a dentist.

Coe-Soft/Comfort Additional Information

Coe-Soft is a resilient self-cure reline material used when the patient requires a soft, temporary liner in upper or lower dentures. Polymerizes in or out of the mouth in approximately 15 minutes and will normally last about 3-6 months in the appliance.

Coe-Soft liner will stay soft for the first 24-48 hours and will continue to shape to the oral tissues over the next couple of days after placement. It is important to not use any adhesive for the first two days. It will stay soft longer depending on diet, smoking, and cleaning techniques. As the gums heal, the patient may need to have the lining material replaced once or twice post-surgery before getting hard reline done or final appliance made.

Caution#1 – Improper powder/liquid ration may cause undesired sensitivity and inconsistent mixture of the material.
Caution#2 – Personal protective equipment (PPE) such as gloves, face masks, and safety eyewear should always be worn.

Features and Benefits:

- It does not contain monomers
- Contains zinc undecylenate - (Zinc Undecylenate is a natural or synthetic fungistatic fatty acid, antifungal Zinc Undecylenate is used topically in creams against fungal infections, eczemas, ringworm, and other cutaneous conditions. The zinc provides an astringent action, reducing rawness and irritation.)
- It is free of exothermic heat or burning sensations
- Does not have an unpleasant taste or odor (varies between patients)
- Provides a soft, cushion lining between the gums and the denture that temporarily calms the tissue during healing
- Offers improved patient comfort
- Perfect for post-surgical applications, in immediate denture placement after extractions

Cleaning the Appliance with a lining material on it:

- It is important to remove debris, so it doesn't become embedded in the soft liner. The lining material is a porous substance that will absorb saliva, debris or anything it comes into contact with)
- Cleaning the denture teeth with a soft toothbrush 2 times a day (Morning/Evening)
- The patient may use either soap or a denture cleaning material during cleaning (tablets that dissolve in water). – DO NOT LEAVE DENTURE IN TABLET SOLUTION OVERNIGHT
- Keeping liner clean will aid in tissue healing and prevent irritation
- Improper cleaning of appliance can cause denture stomatitis (fungal/yeast infection in the oral cavity, commonly known as thrush)

COE-SOFT™

GB

RESILIENT DENTURE LINER

Prior to use, carefully read the instructions. For use only by a dental professional in the recommended indications.

CONTRAINDICATIONS:

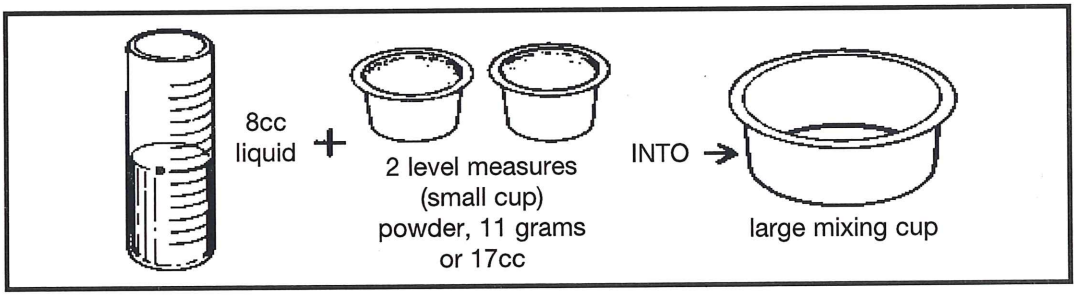
Patients who have shown sensitivity to the material. In case of allergy refer to a physician.

RECOMMENDED INDICATIONS:

A temporary lining for acrylic dentures. For use in chairside procedures.

DIRECTIONS FOR USE:

1. ***Preparation of the denture:*** Relieve and roughen the area of the denture to be relined. Clean and dry the denture thoroughly. Coat labial and buccal surfaces of the denture with COE LUBRICANT. Do not apply coating within 3mm (1/8 inch) of the peripheral border. If the denture has plastic teeth also protect them with COE LUBRICANT. Note: COE-SOFT will not adhere to surfaces coated with COE LUBRICANT.
2. ***Preparation of COE-SOFT:*** Recommended powder / liquid ratio is 11g powder to 8ml liquid. Pour the liquid into the large mixing cup. Then add the powder slowly. Stir mixture thoroughly for 30 seconds. A suitable spatula is provided for this purpose. To avoid introducing bubbles into the mixture, do not spatulate for more than 30 seconds. Do not whip.



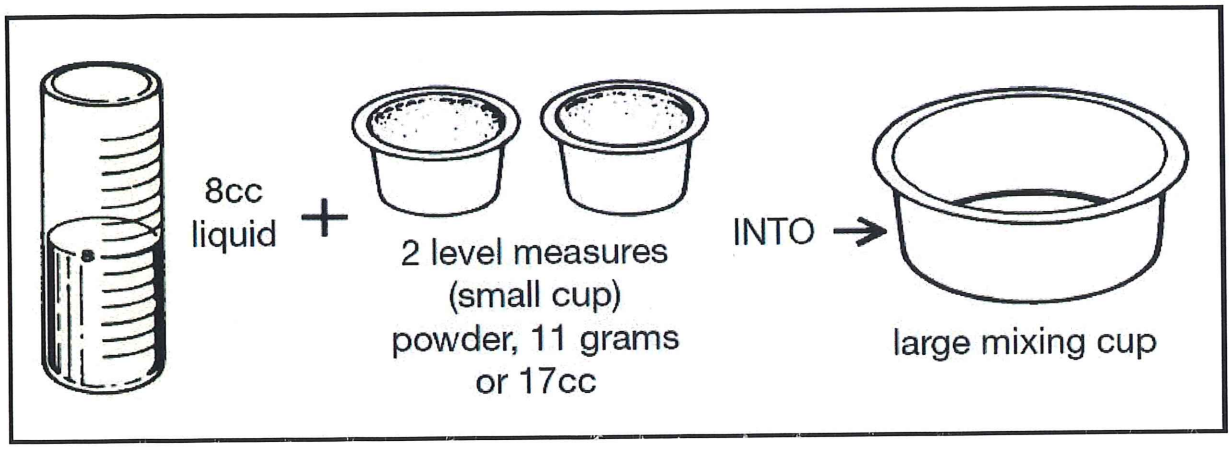
3. ***Application:*** Spread the mixture of COE-SOFT over the area to be relined. Seat the denture in the manner of taking an impression and instruct the patient to close lightly into occlusion. After 3 minutes instruct the patient to move lips and cheeks so that a muscle trimmed periphery is obtained. Remove the denture and rinse under cold water. Trim away excess material. Re-seat the denture and instruct the patient to close FIRMLY into occlusion, and to hold this position for 5 minutes. Remove the denture and rinse again in cold water.
4. ***Finishing:*** When curing is complete, trim away excess. For smoothing the edges use a hot spatula.
5. ***Patient Advice:*** Advise the patient NOT to use a brush or abrasive (such as toothpaste) on the lining. Cleaning is best achieved by holding it under cold running water and wiping with wet cotton.

STORAGE:

Store in a dry location at room temperature (70° to 77°F; 21° to 25°C). (3 year shelf-life guarantee).

PACKAGES:

344001 COE-SOFT Professional Package
344002 COE-SOFT Powder, 6oz (170g)
344091 COE-SOFT Liquid, 6oz (177ml)
344003 COE-SOFT Economy Package
344004 COE-SOFT Powder, 5lb (2.27kg)
344092 COE-SOFT Liquid, 32oz (946ml)



III. Application:

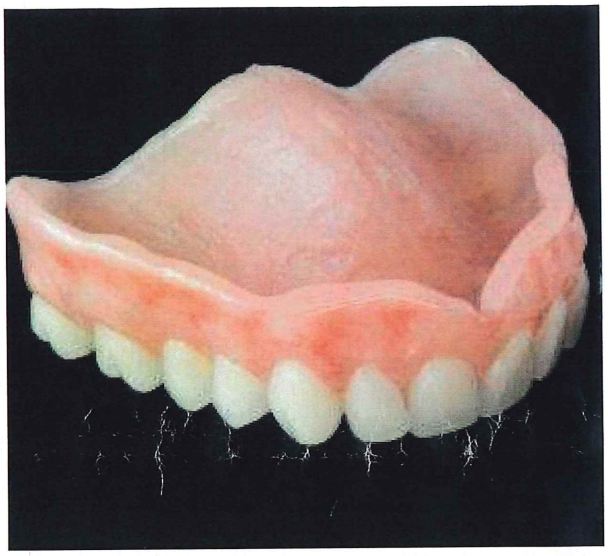
Spread the mixture of COE-SOFT over the area to be relined. Seat the denture in the manner of taking an impression and instruct the patient to close lightly into occlusion. After 3 minutes instruct the patient to move lips and cheeks so that a muscle trimmed periphery is obtained. Remove the denture and rinse under cold water. Trim away excess material. Re-seat the denture and instruct the patient to close FIRMLY into occlusion and to hold this position for 5 minutes. Remove the denture and rinse again in cold water.

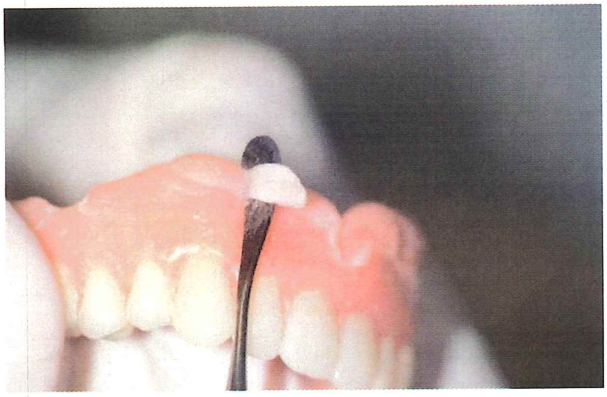
IV. Finishing:

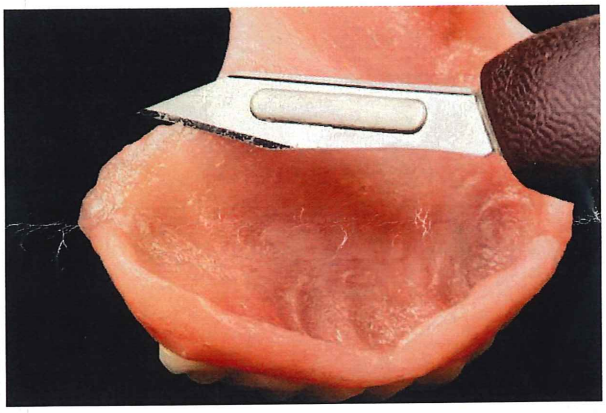
When curing is complete, trim away excess. For smoothing the edges use a hot spatula.

V. Patient Advice:

Advise the patient NOT to use a brush or abrasive (such as toothpaste) on the lining. Cleaning is best achieved by holding it under cold running water and wiping with wet cotton.







Common Asked Questions by the Patient

Why do I need a soft reline in my appliance?

- Most denture wearers can wear a ridged denture base adequately, but a careful examination has shown that the anatomical irregularities of your mouth prevent a rigid denture from being acceptable. Having a soft reline material not only provides the denture to fit better and more snug to the contours of the ridge but helps eliminate discomfort the denture may be providing to the gum tissue.

What is the soft reline material being placed in my appliance?

- The soft reline material is a specially compounded dental plastic. This plastic is designed to make your appliance more comfortable and efficient when functioning.

How long will this reline material last in my appliance?

- Most patients find that this cushion will remain soft and comfortable for a few months. It will start off soft and as time goes on, the material hardens. At around 3 months the lining material may start to peel away from the appliance in which a new reline material is needed.

How should I clean my appliance with the reline material in place?

- The patient will want to clean their appliance 2 times a day. Keeping the appliance clean will help prevent tissue irritation and potential causes of denture stomatitis. A soft bristle toothbrush is recommended in aid for cleaning dentures. It is recommended to not leave an appliance with soft reline material in a cleaning solution overnight. When the appliance is not in the mouth it is recommended to be left in a cup of water.

What are the disadvantages of the soft reline material?

- The reline material is porous and not color stable. Meaning over time the reline material will become saturated by the saliva produced in the mouth causing distortion of the color. It has a low resistance to abrasion, a short-term resiliency, and lack of bond strength. Due to lack of bond strength, the liner will start to peel away from the denture, reason why it will need to be replaced a few times over the duration of the healing time. The reline material will need to be replaced also due to the change in gums from healing

Soft Reline Performance Check Off List

- ☐ Trimming away any excess material on the intaglio surface from extraction sites, for ideal ridge healing
- ☐ Excess material being trimmed away that has leaked over the vestibule on the facial/buccal flange.
- ☐ Excess is trimmed to align with the posterior palatal seal : i.e. - soft reline material does not extend further than point of acrylic on denture.
- ☐ No air bubbles present in reline material
- ☐ Material even across the palate
- ☐ Reline material does not alter the patients bite
- ☐ Borders of reline material mimics the natural anatomy of the vestibules and frenums

Soft Reline Exam

1. What are some of the reasons a soft liner is placed in a denture?

    a. To help the denture fit better while the mouth is healing and the ridge is changing shape.

    b. To condition unhealthy tissue in preparation for impressions for a reline or new denture.

    c. If a patient is having chronic soreness while wearing their denture

    d. All of the above

2. How much time does it take for the ridge shape to stabilize after extractions?

    a. Up to 12 months

    b. 3 months

    c. 6 months

    d. 1-2 months

3. At what point will the hard liner be indicated?

    a. When the soft liner is old

    b. At the dentist discretion when ridge shape has stabilized

    c. 1 year

    d. When the patient is ready

4. For how long are soft liners placed after immediate denture delivery?

    a. For as long as the patient is having discomfort

    b. Until definitive reline or fabrication of definitive complete denture

    c. 6 months

    d. No more than 2 months

5. What instructions do you follow to know how to mix the materials?

a. It depends on the dentist

b. Whatever your trainer told you

c. Manufacturer's instructions

d. COE soft instructions

6. What is the powder to liquid ratio for COE- Soft liner?

a. 8 cc of liquid to 11 grams of powder

b. 7 cc of liquid to 10 grams of powder

c. 11 cc of liquid to 8 grams of powder

d. 10 cc of liquid to 7 grams of powder

7. How many minutes do you wait until removing the denture from the mouth with COE-Soft?

a. 8 minutes

b. 5 minutes

c. 3 minutes

d. 1 minute

8. True or False: When mixing, you must add the powder to the liquid.

a. True

b. False

9. For how long do you stir the COE-Soft?

a. 15 seconds

b. 20 seconds

c. Until smooth

d. No more than 30 seconds

10. What surfaces do you apply lubricant to on the denture?

a. To the inside of the denture

b. Labial and buccal surfaces

c. On the incisal edges of the teeth

d. On the peripheral boarder

Short Answer Questions

11. What instructions do you give a patient after completing a soft reline?

12. What do you instruct the patient to do after seating the denture in their mouth after mixing the soft liner material?

13. Name 2 items that you can use to trim excess material.

14. Why are border molding movements important for the fit of the soft liner?

15. If the patient has an upper and lower denture, which one should you reline first?

SODAE PROGRAM

CERTIFICATE

OF COMPLETION

THIS CERTIFICATE IS AWARDED TO

Brianna Burks

This certificate is awarded for completion of the Dental Reline Course.

01/07/2021

DATE ISSUED

SODAE

Dental Assisting Program

TEACHER SIGNATURE

OREGON BOARD OF DENTISTRY

Dental Assistant Expanded Functions Dental Assistant
Issued: March 16, 2021

001079
CERTIFICATE NUMBER

Radiological Proficiency
Issued: August 12, 2020

Brianna Paige Burks

Certificate Print Date: March 17, 2021

January 8, 2024

Samantha Plumlee
Oregon Board of Dentistry
Licensing/Examinations
1500 SW 1st Ave. Suite 770
Portland, Oregon 97201

Ms. Plumlee,

The Oregon Academy of General Dentistry is seeking approval for our Comprehensive Training in Parenteral Moderate Sedation course as a board approved IV/Phlebotomy course for dental assistants.

Along with this letter please find the attached requested documents including the course description, syllabus and the CV of our course director, Ken Reed. Also attached are verifications of Dr. Reeds dental license and general anesthesia permits in both Oregon and Arizona.

Thank you for considering our course for board approval and please let me know if you have any questions.

Katy Hester

Katy Hester
Oregon AGD Program Director
503.228.6266
cedirector@oragd.org

OREGON ACADEMY of GENERAL DENTISTRY

Course Description:

Safely and confidently treat your anxious or fearful adult patients by performing IV moderate sedation. This comprehensive certifying course includes lectures and clinical training by the renowned Drs. Kenneth Reed, Amanda Okundaye, Andrea Fonner, and Stanley Malamed. Didactic discussion includes pharmacology, patient evaluation, airway management, monitors and monitoring, ECG interpretation, geriatrics, medical emergencies, post-operative analgesics and venipuncture techniques. At the final session before clinic participants will practice managing anesthesia related emergencies on a high fidelity human simulator, which will provide you with valuable hands on experience. During the clinical portion of the course, participants will start IVs and administer sedative agents and perform clinical dentistry - just like you will in private practice.

Unlike other programs, we prepare participants for real-life clinical practice by having them simultaneously perform both the sedation and dentistry on a minimum of twenty patients. We allow participants to choose procedures with which they are most comfortable and we supply the appropriate, pre-screened patients for this course.

Couse Objectives:

- Discuss the appropriate patient to receive parenteral moderate sedation
- Explain the pharmacology of the benzodiazepines, opioids, adjunctive and reversal agents
- Describe venipuncture technique
- Outline a plan for the prevention, recognition and treatment of medical emergencies that may occur with sedation

Course Syllabus:

<u>Day One:</u>
Introduction (2 hours)
History of Dental Anesthesia (0.5 hours)
Definitions (1 hour)
Drugs, Death & Dentistry (1.5 hours)
Physical Evaluation- The Healthy Patient (2 hours)

<u>Day Two:</u>
Physical Evaluation- The Patient with Known Systemic Disease (4 hours)
Pharmacology of the Benzodiazepines (2 hours)
Pharmacology of the Opioids (1.5 hours)

<u>Day Three:</u>
Respiratory Depression and Apnea (1 hour)
Local Anesthesia (2 hours)
Adjunctive Agents (1.5 hours)

Airway Management (1.5 hours)
Monitoring and Monitors (1.5 hours)

Day Four:
ECG Interpretation (2 hours)
Documentation Standards for Moderate Sedation (1 hour)
Venipuncture Techniques (1.5 hours)
Complications of Venipuncture (0.5 hours)

Day Five:
Enteral Sedation (1.5 hours)
IV Sedation Techniques (1.5 hours)
Nitrous Oxide (1 hour)
Geriatrics (1.5 hours)
General Anesthesia Provider Options (0.5 hours)

Day Six:
Pharmacology of Emergency Drugs (1.5 hours)
Pediatrics (1.5 hours)
Medical Emergencies (4 hours)

Day Seven:
Medical Emergencies (2 hours)
Practical Aspects of IV Sedation (1 hour)
Post-Operative Analgesics (2 hours)
Case Selection & Assessment (1.5 hours)
State Board Exams (0.5 hours)
Introduction to Sim Man (0.5 hours)

Days Eight – Eleven:
Review of Didactic Materials/Clinic Orientation/Monitor Training (4 hours)
Clinic (43 hours)*
*during the clinic, assistants will provide chairside assistance and monitoring of vitals for a minimum of 20 patients with their doctor.

Course Location:

The course is held at the Oregon AGD Foundation Center: The Center | OAGD (oagdfoundation.org)

Oregon AGD Foundation Center
13333 SW 68th Pkwy. Ste. 010
Tigard, Oregon 97223

Course Format:

The course is held live and in person with no hybrid option.

Total Number of CE Hours:

The total number of hours for the course is 103, which breaks down into 60 didactic hours and 43 clinical hours. Renewal participants may attend as many of the didactic days as they wish. There are no separate courses offered within the overall course.

Faculty Bios:

Faculty bios for Dr. Ken Reed, Stanley Malamed, Amanda Okundaye, Andrea Fonner and Jason Brady can be found on Dr. Reed's website: Learn IV Sedation

Additional Information:

Dr. Ked Reed-

Dental License: Oregon, Arizonia

General Anesthesia Permit: Oregon, Arizonia

Certificates of Specialty: Dental Anesthesia, Periodontics

Dr. Stanley Malamed-

Dental License: New York

Certificate of Specialty: Dental Anesthesia

Dr. Amanda Okundaye-

Dental License: Nevada

General Anesthesia Permit: Nevada

Certificate of Specialty: Dental Anesthesia

Dr. Andrea Fonner-

Dental License: Washington

General Anesthesia Permit: Washington

Certificate of Specialty: Dental Anesthesia

Dr. Jason Brady-

Dental License: Arizona

General Anesthesia Permit: Arizona

Certificate of Specialty: Dental Anesthesia

*Oregon AGD obtains temporary dental permits for the state of Oregon for all clinic dates for those instructors not licensed in the state of Oregon.

Course Director CV:

FULL NAME, Degree:	**Kenneth L. Reed, DMD**

EDUCATIONAL BACKGROUND including certifications received, residencies or fellowships attended (Begin: college level)

Name of School, City and State	**Yr. of Grad.**	**Certificate or Degree**	**Area of Study**
University of Arizona	1986	B.A.	General Studies
Oregon Health Sciences University, School of Dentistry	1989	DMD	Dentistry
Oregon Health Sciences University, School of Dentistry	1991	Certificate	Periodontology
Oregon Health Sciences University, School of Dentistry	1991	---	Anesthesiology
American Dental Society of Anesthesiology	1998	Fellowship	General Anesthesia
Lutheran Medical Center (now NYU Langone)	2013	Certificate	Anesthesiology

LICENSURE

State License (Do not include license number)	**From (Year)**	**To (Year)**

Oregon	1989	Present
Arizona	1990	Present

BOARD CERTIFICATION

Certifying Organization	Specialty	Date certified
American Dental Board of Anesthesiology	Anesthesiology	2015

TEACHING APPOINTMENTS ((Begin with current and include other teaching/mentoring experiences)

Name of Institution, City and State	Rank	Subjects/Content Areas Taught/ Administrative Responsibilities	From (Year)	To (Year)
NYU Langone, Brooklyn NY	Associate Program Director	Dental Anesthesiology	2013	Present
NYU Langone, Brooklyn NY	Attending in Anesthesiology & Periodontics Graduate Periodontics	Sedation and Anesthesia	2013	Present
Faculty of Medicine and Dentistry University of Alberta Edmonton, Alberta, Canada	Clinical Instructor	Anesthesia & Pharmacology	2011	Present
School of Dentistry The Oregon Health Science University. Portland, OR.	Affiliate Assistant Professor	Parenteral Moderate Sedation	2011	Present
Lutheran Medical Center, Department of Dental Medicine, Brooklyn NY (now NYU Langone)	Attending in Anesthesiology Graduate Pediatric Dentistry	Sedation and Anesthesia	2010	Present

The University of Nevada Las Vegas School of Dental Medicine Las Vegas, NV.	Associate Professor in Residence	Anesthesia & Pharmacology	2009	2015
Lutheran Medical Center, Department of Dental Medicine, Brooklyn NY (now NYU Langone Hospitals)	Assistant Director Advanced Education in General Dentistry	Anesthesia & Pharmacology	2000	2013
The Ostrow School of Dentistry of the University of Southern California. Los Angeles, CA.	Clinical Associate Professor Endodontics, Oral and Maxillofacial Surgery and Ortho	Anesthesia & Pharmacology	1999	2015
Pima Community College	Adjunct Faculty	Anesthesia & Pharmacology	1993	2006

CURRENT TEACHING RESPONSIBILITIES

Name of Institution, City, State	**Clinical Training Site (Health Center) City, State**	**Type Residency Program (AEGD, GPR, Peds, etc.)**	**Please Check All That Apply**		
			Program Admin	**Didactic**	**Clinical**
NYU Langone, Brooklyn, NY	AZ/CA	Anesthesia	X	X	X
Faculty of Medicine and Dentistry University of Alberta Edmonton, Alberta, Canada	Edmonton, Alberta, Canada	Dental School	X	X	X
School of Dentistry The Oregon Health Science University. Portland, OR.	Portland, OR	Dental School	X	X	X

NYU Langone, Brooklyn NY	Arizona	Pediatric Dental		X	X

HOSPITAL APPOINTMENTS (Begin with current)

Name of Hospital	City	State	From (Year)	To (Year)
None				

PRACTICE EXPERIENCE (Begin with current)

Location (City and State)	Type of Practice	From (Year)	To (Year)
Los Angeles, CA	Anesthesia	2013	2018
Tucson, AZ	Anesthesia	1991	Present

CE COURSES TAKEN (Pertinent or in last 5 years)

Course Title	Course Content / Provider	Month and Year
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2020
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2020
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2019
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2019
Sedation and Anesthesia Update	American Dental Society of Anesthesiology	10/2019
Annual Session	American Dental Society of Anesthesiology	04/2019
High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2018
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2018
Annual Session	American Dental Society of Anesthesiology	04/2018

High Fidelity Human Simulation for General Anesthesia Providers	American Dental Society of Anesthesiology	02/2017
General Anesthesia and Deep Sedation Review Course	American Dental Society of Anesthesiology	02/2017
Annual Session	American Dental Society of Anesthesiology	04/2017

MEMBERSHIP, OFFICES OR APPOINTMENTS HELD IN LOCAL, STATE OR NATIONAL DENTAL OR ALLIED DENTAL ORGANIZATIONS, INCLUDING APPOINTMENTS TO STATE BOARDS OF DENTISTRY AND CODA

Name of Organization	Position Held Title or Appointment	From (Year)	To (Year)
American Dental Board of Anesthesiology	Secretary	2021	Present
American Dental Board of Anesthesiology	Director	2021	Present
American Dental Society of Anesthesiology	President	2015	Present
American Dental Society of Anesthesiology	President Elect	2013	2015
American Dental Society of Anesthesiology	Vice-President	2011	2013
American Dental Society of Anesthesiology	Board of Directors	2003	2011
American Dental Association	Consultant	2011	Present
American College of Dentists	Fellow	2010	2019
American Dental Association	Chair ADA Standards Committee Working Group on Syringes, Cartridges, and Needles	2006	2016

OREGON ACADEMY of GENERAL DENTISTRY

PUBLISHED WORKS: (List articles in which you were the principal author that appeared in refereed journals or text books, by author(s), title, publication, and date. If list is very extensive, include **the most recent five years**)

Author(s)	Title	Publication	Date
Reed, KL Okundaye, AJ.	Working with a Dentist Anesthesiologist.	Wright's Behavior Management in Dentistry for Children, Second Edition	2021
Reed, KL Okundaye, AJ.	Management of Emergencies Associated with Sedation for The Pediatric Dental Patient.	Wright's Behavior Management in Dentistry for Children, Second Edition	2021
Malamed SF, Reed KL, Okundaye AJ & Fonner AM.	Local and Regional Anesthesia in Dental and Oral Surgery	Complications of Regional Anesthesia: Principles of Safe Practice in Local and Regional Anesthesia	2017
Fonner, AM & Reed, KL.	Post-Operative Pain Management Strategies for Acute Dental Pain	Decisions in Dentistry	2017
Fonner, AM & Reed, KL.	Responding to Cardiac Arrest	Decisions in Dentistry	2016
Stevens, RL & Reed, KL.	Anesthetic Adversity: Failed Sedation	Anesthesia Complications in the Dental Office	2015
Reed, KL.	Section Editor, Section 3: Oral and Maxillofacial Surgery/Pain Control 2.0	Mosby's Review for the NBDE Part II, Second edition	2014
Okundaye, AJ, Reed, KL, Fonner, AM.	Why Capnography?	The Pulse	2014
Reed, KL Okundaye, AJ	Working with a Dentist Anesthesiologist	Behavior Management in Dentistry for Children	2014
Reed, KL Okundaye, AJ	Management of Emergencies Associated with Pediatric Dental Sedation	Behavior Management in Dentistry for Children	2014
Fonner, AM. Reed, KL.	Be Prepared - How to Manage a Medical Emergency in the Dental Office	Dimensions of Dental Hygiene	2013
Reed, KL., Malamed, SF., Fonner, AM	Local Anesthesia Part 2: Technical Considerations.	Anesthesia Progress	2012
Becker, DE. & Reed, KL	Local Anesthetics: Review of Pharmacological Considerations	Anesthesia Progress	2012
Reed, KL	TCI (Target Controlled Infusion).	The Pulse	2011
Stevens RL, Reed KL	The Impact of Regulation on Enteral Sedation in Dentistry	Dental Anesthesiology: A Guide to the Rules and Regulations of the United States of America	2011
Reed, KL	Allergy & Anaphylaxis	Inside Dentistry	2011
Malamed, SF., Reed, KL., Poorsattar, S	Needle Breakage: Incidence and Prevention.	Dental Clinics of North America	2010
Reed, KL	Basic Management of Medical Emergencies: Recognizing a Patient's Distress	JADA	2010

Reed KL.	The History and Current Status of Anesthesiology in Dentistry	NV Dent Assn J	2009
Reed KL.	The Geriatric Patient	Sedation: A Guide to Patient Management	2009
Reed KL.	The Physically Compromised Patient	Sedation: A Guide to Patient Management	2009
Reed KL.	Neurologic Illnesses and Other Conditions	Sedation: A Guide to Patient Management	2009

RESEARCH AND GRANT ACTIVITY:

Name	Awarded By	Years (s)
N/A		

HONORS OR AWARDS:

Name	Awarded By	Year
Fellow	American Dental Society of Anesthesiology	1998
Distinguished Teaching Award	Pima Community College	1993

SERVICE TO THE PROFESSIONAND COMMUNITY: Include consulting services, community involvement, invited speaker, continuing education courses taught, military career, or any other dentally related activities. If appropriate, can add description

Service or Activity	Organization	Year
CE Courses Taught	Over 10,000 hours of CE provided in anesthesia related topics	1991-Present
Member, Anesthesia Committee	Arizona State Board of Dentistry	2011-2015, 1997-2006
Bare Bones Basic Emergency Drug Kit	ADA Seminar Series	2011
Course Faculty Airway Management Course	ADA	2010-2015
Assistant Editor	Anesthesia Progress	2004-Present
Scientific Advisory Panel	Journal of Endodontics	2004-2010
Advisory Board, Dental Hygiene	Pima Community College	2003-2006
Editorial Review Board	Anesthesia Progress	2001-Present

SERVICE TO THE PROFESSIONAND COMMUNITY: Include consulting services, community involvement, invited speaker, continuing education courses taught, military career, or any other dentally related activities. If appropriate, can add description

Delegate	American Dental Society of Anesthesiology	2000-2007
Journal Reviewer	Indian Journal of Critical Care Medicine	2013-2016
Journal Reviewer	Journal of Oral and Maxillofacial Surgery, Medicine and Pathology	2012-2016
Journal Reviewer	Journal of Dentistry	2012-2016
Journal Reviewer	JADA	2011-2016
Journal Reviewer	Special Care in Dentistry	2008-2016
Journal Reviewer	Anesthesia Progress	1997-Present
Journal Reviewer	General Dentistry	1993-2012
Mission Piot	Flying Samaritans	2004-Present
Board of Directors	Flying Samaritans	2012-Present
Volunteer Pilot	Veteran's Airlift Command	2009-Present
Volunteer Pilot	Homeland Security Emergency Air Transportation System	2008-Present
Arizona Wing, Aviation safety Officer	Angel Flight West	2019-Present
Southern Arizona Area Coordinator	Angel Flight West	2006-Present
FAA Safety Team	FAA	2008-Present
Certified Parliamentarian	American Institute of Parliamentarians	2022-Present
Professional Registered Parliamentari	National Association of Parliamentarians	2021-Present

ARIZONA
Arizona State Board
of Dental Examiners

DENTAL PROFESSIONAL PROFILE PAGE

Information Current as of 1/8/2024 2:00:17 PM

Home Search

General

Kenneth L. Reed DMD	
12090 N. Thornydale Road	
Suite 110 #286	
Marana, AZ 85658	
(520) 370-3693	

License Number:	**D04183**
License Status:	**Active**
License Type:	**Dentist License**
License Issued:	**09/06/1990**
Expiration:	**08/31/2024**

Additional Certifications

Dental General Anesthesia Permit

Status:	**Active**
Expiration:	**12/31/2028**

Education

School:	Oregon Health Sciences Univ.
Graduation Date:	06/09/1989

Disciplinary Board Actions

There are no disciplinary actions

Non-Disciplinary Board Actions

There are no nondisciplinary actions

Practitioner Name	Speciality Details	Location	Public Health	Action

Full Name : REED, KENNETH L

Primary Office Address : 13333 SW 68th Parkway, #010

City, State Zip : Tigard, OR 97223

Degree : D.M.D.

Licenses :

License Number	Status	License Date	Expiration Date	Restrictions	Case Number
D6566	Active	06/28/1989	03/31/2025		

Permits :

Permit	Issue Date
General Anesthesia	08/16/2013

Endorsements :

Endorsement Type	Endorsement Attained Date

Specialities :

Specialty	Issue Date
Certified in the Specialty of Dental Anesthesiology	01/07/2020
Certified in the Specialty of Periodontics	06/08/1991

Board Action / Malpractice :

Action Type	Document Link

Collaborative Agreement :

Collaborative Provider	Document

← Close detail

REED, MICHELLE MARIE		View Details
REED, REBECCA M	MEDFORD OR 97504	View Details
REED, ROBERT D	PALM DESERT CA 92260	View Details
REED, STACY D	TUALATIN OREGON 97062	View Details
Reed, Talysa		View Details
REED-HARMEL, CHELSEA M	WOODLAND HILLS CA 91367	View Details
REEDAL, THOMAS M	BEAVERTON OR 97003	View Details
REEDER, SHERYL M		View Details