PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
AUGUST 20, 2021

Oregon
Kate Brown, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM (Audio Only)**

DATE: **August 20, 2021**

TIME: **8:00 a.m. – 3:30 p.m.**

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

OPEN SESSION (Via Zoom, audio only)
*** This is when the public may connect on the Board Meeting at this phone #1-253-215-8782, Meeting ID: 826 9621 1678, Passcode: 812684**

Review Agenda

1. Approval of Minutes
   - June 18, 2021 - Board Meeting
   - OLD BUSINESS

NEW BUSINESS

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

3. Committee and Liaison Reports
   - 2021-22 Committee and Liaison Assignments
   - WREB Liaison Report – Yadira Martinez, R.D.H.
   - AADB Liaison Report – Alicia Riedman, R.D.H.
   - ADEX Liaison Report – Vacant
   - CDCA Liaison Report – Amy B. Fine, D.M.D.
     - The CDCA Annual Steering Committee Meeting 7.22.21
   - 2021 CRDTS Workshop and Annual Meeting
   - CRDTS/WREB Merger Announcement
     - FAQ Document
   - June 18 Rules Oversight Committee Meeting Minutes- Chair, Alicia Riedman, R.D.H.
     - The recommendations from this committee, were combined with recommendations related to dental hygiene interim therapeutic restorations in Tab 5
   - DERB & HERB Special Meeting

4. Executive Director's Report
   - Board member and Staff Updates
   - OBD Budget Status Report
   - Customer Service Survey
   - Dental Hygiene License Renewal
   - Agency Head Financial Transactions Report July 1, 2020 – June 30, 2021

Notes:
(1) A working lunch will be served for Board members at approximately 11:30 a.m.
(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

- 2021 Legislative Wrap Up
- HB 2359
- TriMet 2021-2022 Contract
- HSPS – Year 11 Reports
- 2021 Third Party Audit Results for HPSP
- Board Best Practices Self-Assessment & Score Card
- Oregon Buys Newsletter
- Strategic Planning Update
- Newsletter

5. Unfinished Business and Rules
   - Dental Hygiene Bill HB 2627 (2021) – ITR Rules and Requirements
     - Recommendations for Board to consider and move forward to rulemaking hearing and approve ITR Curriculum
     - OBD-OHA Meeting Packet, 6.30.2021
     - OBD-OHA Meeting Packet, 7.28.2021
   - Pain Management training requirement – HB 2078
     - Draft Rule OAR 818-021-0060
   - Memo – Board Review New Rules and attachments
   - DRAFT- Dental Therapy Rules Oversight Committee Creation
   - Dental Therapy Bill - HB 2528 (2021)
     - Draft Mockup of updated DPA with references to Dental Therapy

6. Correspondence
   - Request from Dr. Irving Anders for Board reconsideration
   - Request for approval of Restorative curriculum – Dixie State University
   - Request for approval of Local Anesthesia course – Salt Lake Community College

7. Other
   - Strategic Planning – Introduction and overview with our facilitators (in person 25 minute overview)
   - CODA 2021 Summer Meeting to be Virtual
   - JCNDE – 2020 Technical Report DLOSCE
   - Interstate Compact Kickoff Meeting

8. Articles & Newsletters (No Action Necessary)
   - ADEA Advocate – June 22, 2021
   - HPSP Newsletter
   - DANB 2020 Salary Survey Report
   - HPSP Post Pandemic Newsletter
   - OHA Announces New Dental Director
   - OHA Vaccine Requirements for Healthcare Workers

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

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

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

LUNCH **11:30 a.m.**

OPEN SESSION **2:00 p.m.**

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Daniel Martinez Tovar, R.D.H. Request to be WREB Examiner

OTHER BUSINESS

EXECUTIVE SESSION

The Board will meet in Executive Session pursuant to ORS 192.660(2)(i), to conduct the annual review and performance evaluation of the Executive Director. No final action will be taken in Executive Session.

Performance Review Executive Director

18. Conduct performance evaluation of Executive Director

OPEN SESSION **3:15 p.m.**

ADJOURN **3:30 p.m.**

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APPROVAL OF MINUTES

DRAFT 1

OREGON BOARD OF DENTISTRY
MINUTES
JUNE 18, 2021

MEMBERS PRESENT:	Alicia Riedman, R.D.H., President Jose Javier, D.D.S., Vice President Reza Sharifi, D.M.D. Amy B. Fine, D.M.D. Sheena Kansal, D.D.S. Gary Underhill, D.M.D Yadira Martinez, R.D.H. Chip Dunn Aarati Kalluri, D.D.S.
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop "Bernie" Carter, D.D.S., Dental Investigator Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager (portion of meeting) Shane Rubio, Investigator (portion of meeting) Samantha VandeBerg, Office Specialist (portion of meeting) Ingrid Nye, Examination and Licensing Manager (portion of the meeting)
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT VIA TELECONFERENCE*:	Jen Lewis-Goff, Oregon Dental Association (ODA); Lisa Rowley, R.D.H., Oregon Dental Hygienists' Association (ODHA); Calie Roa, D.M.D.; Lori Govar, Health Professionals' Services Program (HPSP); Kate Manelis, HPSP

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

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

President Alicia Riedman, R.D.H., welcome 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 April 16, 2021 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)
Ms. Lewis-Goff reported that the ODA is continuing to work with Oregon OSHA regarding dental and business regulations in regards to the pandemic. They are finishing their work for the legislative process this session, including a few dental-specific budget requests. She also reported that the ODA is continuing to advocate for additional funding for the OHA Dental Director position. She congratulated the newest members of the Board.

Oregon Dental Hygienists' Association (ODHA)
Ms. Rowley congratulated President Alicia Riedman on her first meeting as Board President.

Oregon Dental Assistants Association (ODAA)
Nothing to report at this time.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report
Ms. Martinez reported that WREB with be merging with CDCA. There will be additional information on this provided at the August 20, 2021 Board Meeting.

AADB Liaison Report
Ms. Riedman reported that she, Dr. Jose Javier, Stephen Prisby and Lori Lindley plan to attend the AADA and AADB annual meetings in San Antonio, TX.

CDCA Liaison Report
Nothing to report.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates
Mr. Prisby stated that he was pleased to introduce our newest Board Member, reappointments to the Board and Staff Member.

The Senate voted and officially confirmed Dr. Sheena Kansal to the Oregon Board of Dentistry. Her term began April 19, 2021 and ends March 31, 2025. OBD Staff welcomed her with new Board Member orientation on May 7, 2021.

Dr. Sheena Kalia Kansal is a pediatric dentist and an owner of Hollywood Children's Dentistry located in northeast Portland. She completed her undergraduate studies and Doctor of Dental Surgery (DDS) in Alberta, Canada. She practiced general dentistry for six years in Canada before relocating to Portland and completing a two-year specialty program in Pediatric Dentistry at OHSU in 2008. She has been practicing dentistry for over 20 years and is, currently, serving communities in Portland and surrounding areas.

The Senate voted and officially confirmed Chip Dunn to another term on the Oregon Board of Dentistry. His next term began April 1, 2021 and ends March 31, 2025.

The Senate also voted and officially confirmed Alicia Riedman, RDH to another term of service on the Oregon Board of Dentistry. Her next term began April 1, 2021 and ends March 31, 2024. Note it is not a four-year term, since statute dictates that no more than three board members' terms can be scheduled to end in any given year.

Dr. Angela Smorra is the OBD's new Dental Investigator. Her hire date was May 1, 2021. Dr. Smorra completed her undergraduate training at University of Arizona and then moved to Oregon to attend OHSU School of Dentistry. She comes to the OBD with 15 years of general dentistry practice in a public health setting at a local FQHC. She completed a GPR residency at the Portland VA Hospital, has served as a volunteer adjunct faculty member with the OHSU Department of Community Dentistry since 2009, and loved working as a preceptor for OHSU dental students during their external rotations. Angela has always been passionate about providing care to the underserved and those with limited access to care. She is looking forward to her next career chapter with the Oregon Board of Dentistry and serving the state of Oregon. Angela enjoys spending time outdoors with her husband, performing chemistry experiments with her son, and walking her Australian shepherd.

In early April, agency directors were asked to nominate employees for a special acknowledgement as part of Public Service Recognition Week, May 2 - 8, 2021. Mr. Prisby nominated Haley Robinson, OBD Office Manager, as someone who is a true Ambassador of Public Service and who has persevered in the face of adversity and exemplified resilience in service to Oregon this past year.

As part of the acknowledgement of Haley's positive impact on our agency and the citizens of Oregon, she was invited to attend a reception with Governor Brown on a Zoom call, on May 6, 2021. This event was a celebration with other honored state employees, and an opportunity to interact with the Governor.

Mr. Prisby will also recognize Haley for her five-year work anniversary with the OBD which is on June 20, 2021.

OBD Budget Status Report

Mr. Prisby presented the budget report for the 2019 - 2021 Biennium. This report, which is from July 1, 2019 through April 30, 2021, shows revenue of $3,619,541.34 and expenditures of $2,963,508.72. The current budget biennium ends June 30, 2021 and the budget is tracking exceptionally well with spending and revenues in line with our expectations even with the pandemic. The OBD is being represented by DAS in negotiating terms for the lease of OBD office suite #700 in our current location. The current lease expires on July 31, 2021.

FY 2020 Gold Star Certificate & Criteria

The State Controller's Office has once again issued the OBD a Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information for FY 2020 in a timely manner. Mr. Prisby also referenced the criteria attached to the achieve that certification.

OBD 2021-2023 Budget Status Update

The OBD's Budget Bill – SB 5511 has made its way through the legislative process and was awaiting the Governor's approval at the time of this report.

Customer Service Survey
Mr. Prisby presented the legislatively mandated survey results from July 1, 2020 through May 31, 2021. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements
Mr. Prisby gave a "Board Updates" virtual presentation to third year dental students at the OHSU School of Dentistry in Portland on Tuesday, April 13, 2021.

Dr. Bernie Carter gave a "Board Enforcement & what you need to know to stay out of trouble"" virtual presentation to third year dental students at the OHSU School of Dentistry in Portland on Tuesday, April 20, 2021.

Ingrid Nye gave a License Application virtual presentation to the graduating Dental Hygiene Students at Lane Community College in Eugene on Monday, May 3, 2021.

Ingrid Nye gave a License Application virtual presentation to the graduating Dental Hygiene Students at Mt. Hood Community College in Gresham on Monday, May 17, 2021.

Ingrid Nye gave a License Application virtual presentation to the graduating Dental Hygiene Students at Pacific University in Hillsboro on Wednesday, June 9, 2021.

2021 Legislative Session
Mr. Prisby presented a bill tracker report of legislation he was tracking on behalf of the OBD and will have an update on select bills at this meeting. He gave updates on a number of the bills that have an impact on Licensees or the OBD.

Memo - Delegated Duties for Executive Director & Staff
Every June the new President of the OBD takes the gavel for the first regular Board meeting after being voted President at the April Board Meeting for a 1-year term of office. Every June Mr. Prisby submits to the Board for reauthorization, a memo outlining delegated duties to himself as executive director and OBD staff along with his job description.

Dr. Fine moved and Dr. Underhill seconded that the Board approve the delegated duties as presented. The motion passed unanimously.

OBD Bylaws
The OBD Bylaws were adopted in 2018 and were included for review.

AADA & AADB Annual Meetings
The AADA and AADB will hold in person meetings this fall in San Antonio, Texas. This is welcome news and the Board has resources to send President Alicia Riedman, Dr. Jose Javier and Lori Lindley to the AADB Meeting. Mr. Prisby currently serves as President-Elect of the AADA. Mr. Prisby requests that the Board approve his attendance at both meetings.

Dr. Fine moved and Dr. Javier seconded that the Board approve Mr. Prisby's attendance at the AADB & AADA annual meetings in San Antonio, TX. The motion passed unanimously.

2022 OBD Meeting Dates & Calendar
The Board adopted the 2022 OBD Board Meeting dates at the April 16, 2021 Board Meeting.

CORRESPONDENCE

Dental Scope of Practice Question Regarding Botox – Dr. Calie Roa
Dr. Calie Roa submitted correspondence to the Board requesting clarification on the scope of practice for dentists administering Botulinum Toxin Type A. No motion was made.

OTHER ISSUES

HPSP Presentation – Lori Govar, Director of IBH Monitoring
Ms. Govar and Ms. Manelis provided a presentation to the Board via teleconference, providing updates and a general overview of the program for the Board.

ARTICLES AND NEWS (Informational Only)

- ADEA – The Impact of the COVD-19 Pandemic on US Dental Schools
- HPSP Newsletter May 2021
- CODA Call for Nominees

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 1:35 p.m.

CONSENT AGENDA

2021-0177, 2021-0113, 2021-0156, 2021-0157, 2021-0144, 2021-0158, 2021-0146, 2021-0100, 2021-0139, 2021-0153, 2021-0147, 2021-0155, 2021-0124, 2021-0174, 2021-0140, 2021-0145
Dr. Javier moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

COMPLETED CASES

2021-0088, 2021-0167, 2021-0123, 2021-0148, 2021-0099, 2021-0135, 2021-0069, 2021-0031, 2021-0152, 2021-0078, 2021-0129, 2021-0142, 2021-0093, 2021-0138, 2021-0042
Dr. Javier moved and Mr. Dunn seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

2021-0051
Dr. Sharifi moved and Dr. Underhill seconded that the Board close the matter with a strongly worded Letter of Concern, reminding Licensee to assure that he clearly documents his rationale

when prescribing a patient with medication when allergic reactions to those medications have been reported by the patient on their medical history. When performing an implant uncovering procedure for placement of a healing abutment, it is the standard of practice to perform a radiographic examination of the endosseous implant as well to review the seating of the healing abutment. Also, the Licensee should follow and adhere to the most up-to-date Oregon Opioid Prescribing Guidelines in regards to pain management regimens. The motion passed unanimously.

2021-0028
Dr. Kalluri moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he conducts biological monitoring testing on a weekly basis, and for Respondent #2, move to close the matter with a finding of No Violation.

EDWARDS, JAMES D.D.S.; 2021-0175
Ms. Martinez moved and Mr. Dunn seconded that the Board issue a Notice of Proposed License Revocation. The motion passed unanimously.

2021-0136
Dr. Kansal moved and Ms. Martinez seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all clinical advice is within his scope of practice. The motion passed unanimously.

2021-0090
Dr. Fine moved and Mr. Dunn seconded that the board close the matter with a Letter of Concern reminding Licensee to assure that she pays close attention to detail, confirming clinically and radiographically, an acceptable therapeutic decision, when performing extraction of teeth. In addition, a letter is to be sent to the dental director of the organization assuring the organization supports confirming clinically and radiographically an acceptable therapeutic decision, when performing extraction of teeth. The motion passed unanimously.

2021-0143
Mr. Dunn moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all required continuing education is completed with the licensing period. The motion passed unanimously.

2021-0160
Dr. Underhill moved and Ms. Martinez seconded that the Board move to enroll Licensee in the HPSP and close the matter with No Further Action. The motion passed unanimously.

NICACIO, PABLO, D.D.S.; 2021-0121
Dr. Sharifi moved and Mr. Dunn seconded that the Board issue a Notice of Proposed Disciplinary Action and offer License a Consent Order incorporating a reprimand and a $500.00 civil penalty to be paid within 30 days. The motion passed unanimously.

POELMAN, DAVID CLARK, D.D.S.; 2021-0110
Dr. Kalluri moved Ms. Martinez seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, complete three hours of Board approved continuing education in record keeping within 30 days, and pass the Oregon

Board of Dentistry Jurisprudence Exam within 60 days of the effective date of the Order. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

HSU, RICHARD PAO-YUAN, D.M.D.; 2020-0033
Ms. Martinez moved and Dr. Underhill seconded that the Board accept Licensee's request and remove the Emergency Suspension from his dental license. The motion passed unanimously.

2019-0039
Dr. Kansal moved and Mr. Dunn seconded that the Board issue an Order of Dismissal dismissing Licensee's Interim Consent Order dated 2/3/21. The motion passed unanimously.

YONAN, PETER M., D.M.D.; 2021-0087
Dr. Fine moved and Dr. Underhill seconded that the Board accept Licensee's proposal and offer Licensee a Consent Order incorporating a reprimand and a $1,000.00 civil penalty to be paid within 30 days. The motion passed unanimously.

LICENSE & EXAMINATION ISSUES

Request for reinstatement of a retired license – Michelle Webb Pippert, R.D.H.
Mr. Dunn moved and Ms. Martinez seconded that the Board approve the reinstatement of retired license for Michelle Webb Pippert, R.D.H. The motion passed unanimously.

Request for reinstatement of a retired license - Kenneth J. Huff, D.D.S.
Dr. Underhill moved and Ms. Martinez seconded that the Board approve the reinstatement of retired license for Kenneth J. Huff, D.D.S. The motion passed unanimously.

Request to waive statutory requirement for 3500 hours of licensed clinical practice – Irving Anders, D.M.D.
Dr. Sharifi moved and Ms. Martinez seconded that the Board deny the request to waive the statutory requirement for 3500 hours of licensed clinical practice. The motion passed unanimously.

HPSP Program Requirements
Ms. Martinez moved and Dr. Sharifi seconded that the Board send the discussion of the length of the HPSP program requirements to the Licensing, Standards and Competency Committee. The motion passed unanimously.

Request for Investigative Summary Case 2021-0016
Dr. Kalluri moved and Ms. Martinez seconded that the Board release the investigative summary for 2021-0016 as requested. The motion passed unanimously.

Request for Investigative Summary Case 2021-0073
Ms. Martinez moved and Mr. Dunn seconded that the Board release the investigative summary for 2021-0073 as requested. The motion passed unanimously.

RATIFICATION OF LICENSES

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

ADJOURNMENT

The meeting was adjourned at 1:52 p.m. Ms. Riedman stated that the next Board Meeting would take place on August 20, 2021.

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Alicia Riedman, R.D.H.
President

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Oregon Board of Dentistry Committee and Liaison Assignments

April 2021 - April 2022

STANDING COMMITTEES

Communications

Purpose: To enhance communications to all constituencies

Committee:

Jose Javier, D.D.S., Chair
Yadira Martinez, R.D.H., E.P.P.
Jennifer Brixey
Aarati Kalluri, D.D.S.
Alayna Schoblaske, D.M.D., ODA Rep.
Lesley Harbison, R.D.H., ODHA Rep.
Linda Kihs, CDA, EFDA, OMSA, MADAA, ODAA Rep.

Subcommittees:

- Newsletter – Alicia Riedman, R.D.H., E.P.P., Editor

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

Yadira Martinez, R.D.H., E.P.P., Chair
Jose Javier, D.D.S.
Alicia Riedman, R.D.H., E.P.P.
Jennifer Brixey
David J. Dowsett, D.M.D., ODA Rep.
Lisa Rowley, R.D.H., ODHA Rep.
Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Gary Underhill, D.M.D., Chair
Alicia Riedman, R.D.H., E.P.P.
Sheena Kansal, D.D.S.
Chip Dunn
Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

Subcommittees:

Evaluators

- Jose Javier, D.D.S., Senior Evaluator
- Reza Sharifi, D.M.D., Evaluator

Licensing, Standards and Competency

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

Committee:

Amy B. Fine, D.M.D. Chair
Reza Sharifi, D.M.D.
Aarati Kalluri, D.D.S.
Jennifer Brixey
Daren L. Goin, D.M.D., ODA Rep.
Susan Kramer, R.D.H., ODHA Rep.
Ginny Jorgensen, CDA, EFDA, EFODA, AAS, ODAA Rep.

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Alicia Riedman, R.D.H., E.P.P., Chair
Jose Javier, D.D.S.
Yadira Martinez, R.D.H., E.P.P.
Chip Dunn
Philip Marucha, D.D.S., ODA Rep.
Sharity Ludwig, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

Anesthesia

Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.

Committee:

Reza Sharifi, D.M.D., Chair
Sheena Kansal, D.D.S.
Julie Ann Smith, D.D.S., M.D., M.C.R.
Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Normund Auzins, D.M.D.
Ryan Allred, D.M.D.
Jay Wylam, D.M.D.
Michael Doherty, D.D.S.
Eric Downey, D.D.S.

LIAISONS

American Assoc. of Dental Administrators (AADA) — Stephen Prisby, Executive Director
American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Stephen Prisby, Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Jose Javier, D.D.S.
- Hygiene Liaison – Alicia Riedman, R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Amy B. Fine, D.M.D.
- Dental Exam Committee – Amy B. Fine, D.M.D.

Commission on Dental Competency Steering Committee (CDCA)

- Amy B. Fine, D.M.D.
- Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Association – Sheena Kansal, D.D.S.
Oregon Dental Hygienists' Association Alicia Riedman, R.D.H., E.P.P.
Oregon Dental Assistants Association – Alicia Riedman, D.M.D.
Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Amy B. Fine, D.M.D.
- Hygiene Exam Review Committee – Yadira Martinez, R.D.H., E.P.P.

Administrative Workgroup

Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director. Also to work on and make strategic planning recommendations to the Board.
Committee:

- Alicia Riedman, R.D.H., E.P.P., Chair
- Gary Underhill, D.M.D.
- Aarati Kalluri, D.D.S.
- Chip Dunn

Subcommittee:

Budget/Legislative – *(President, Vice President, Immediate Past President)*

- Alicia Riedman, R.D.H., E.P.P
- Jose Javier, D.D.S.
- Yadira Martinez, R.D.H., E.P.P.

CDCA Steering Committee July 22nd, 2021

Report by Patricia Parker, DMD (Alternate)

Most discussion during the meeting was about the merger of CDCA with WREB. The new name/logo is below:

The first year of the merger will be a transition year in which both exams will still be given in their original form (CDCA uses the ADEX exam and WREB has their own exam). Starting July, 2022 there will be an integrated ADEX exam that will be given by all members of CDCAWREB

Changes were discussed for the 2022 exams including Hygiene exams and Compodont (non-patient based exams utilizing Compodont teeth for restorative, endo and hygiene).

On August 17th at 7pm there will be a Webinar presentation that Boards can join or someone from CDCAWREB will come to OBD to give a presentation.

The governing bodies of CDCA and WREB will also merge with existing leaders integrating into leadership roles in the new organization.

From: Renee Gideon <renee@crdts.org>
Sent: Wednesday, June 16, 2021 10:09 AM
Subject: CRDTS Annual Meeting Invitation

Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd \|Topeka, KS 66604
(785) 273-0380\|info@crdts.org

You are cordially invited to attend the 2021 CRDTS Workshop and Annual Meeting
August 26-28, 2021
Loews Vanderbilt Hotel, 2100 West End Ave.
Nashville, TN 37203

Please refer to the expenditure and reimbursement policy below before making reservations.
Registration is available through July 26th, 2021

Meeting registration is available on our website, www.crdts.org/annual_meeting.aspx

Hotel Reservation is available https://www.loewshotels.com/vanderbilt-hotel/crdts-annual-meeting

Make travel arrangements via Concur online for examiners or via Corporate Travel Management
(866) 903-1739 or demail@travelandtransport.com

Expenditure & Reimbursement Policy

CRDTS will reimburse two nights lodging and airfare. Roundtrip mileage reimbursement at the IRS rate, not to exceed coach airfare amount. All other travel expenses will be the responsibility of the attendee.

- **State Board Members, State Board Executive Directors, Dental & Hygiene School Representatives (one per school) and All Active CRDTS Examiners & Proctors will be reimbursed for lodging, airfare, and/or mileage as outlined above.**

- **Committee Members with scheduled meetings will be reimbursed for their hotel nights and per diem for their meeting(s).**

Renee' Gideon
Office & Accounts Manager
Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd|Topeka, KS|66604
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From: Stephanie Beeler <sbeeler@cdcaexams.org>
Sent: Wednesday, August 4, 2021 11:17 AM
To: Stephanie Beeler <sbeeler@cdcaexams.org>
Subject: CDCA, WREB Announce Merger

Dear State Boards of Dentistry Members and Executive Directors,

The Commission on Dental Competency Assessment and the Western Regional Examining Board, the two leading dental competency assessment organizations in the United States, are pleased to announce that the final steps to complete the previously announced merger have been completed.

WREB's member states, represented by their members of the Dental Exam Review Board (DERB) and Hygiene Exam Review Board (HERB), met on July 21 and heard the details of the proposed merger. They voted unanimously to support the merger.

The CDCA's General Assembly met on August 3 and also voted unanimously to approve the Plan of Merger along with linked Constitution and Bylaws changes that support the new organization and fully incorporate WREB examiners.

Effective immediately, the new organization will be known as CDCA-WREB. Together the agency will simplify the needs of boards, licensure candidates, and schools as we continue to serve the oral health professions.

"We come together with 100 years combined experience between the two organizations…when you look at the simplification for educators and consistency for the students, it's going to be a great marriage for the two organizations to come together," proclaimed CDCA Board of Directors Chairman, Dr. Harvey Weingarten.

WREB President, Dr. Robert Lauf agreed, stating that, "Portability is definitely the key to this union. We are very excited in providing a national examination for the dental and dental hygiene programs."

Please click the video link to view the full comments from CDCA-WREB leadership. To share, or view the full story online, click here.

Stephanie Beeler
Multimedia, Communications and Strategic Projects Leader
443.270.3090

The CDCA is now CDCA-WREB
Click **cdcaexams.org or wreb.org** to learn more

CDCA WREB

FAQs:
Please see the following, which offers detailed responses to questions we've previously received. We hope this is helpful to you, and we certainly look forward to seeing everyone this evening!

Q: How will the influx of new members into the combined organization break down?

Membership at a Glance:
CDCA members already affiliated with WREB: 66

CDCA (existing total: 1052)
Member Dentists 476
Member Hygienists 172
Consultant Dentists 242
Consultant Hygienists 162

Proposed additions:
WREB (unique: 158)
Member Dentists: 43
Member Hygienists: 24
Consultant Dentists: 46
Consultant Hygienists: 45
* Newly added WREB voting members would become approximately 10% of the voting membership.

Q: Won't participation opportunities be lessened with an increase of examiners?
This is not expected to be the case. While additional examiners will be a part of the combined organization, there will also be many additional exams to serve for both Dental and Dental Hygiene examinations. Sites that historically offered WREB examinations will transition to ADEX examination locations by 2023.

Q: What examination will be delivered by CDCA-WREB?
CDCA-WREB will offer both the WREB and ADEX examinations through 2022 to best facilitate the needs of candidates and schools. Following this transition year, CDCA-WREB will administer the ADEX examination for Dental and Dental Hygiene for 2023 and beyond. CDCA-WREB will also offer other non-ADEX assessment examinations that are currently offered by WREB and/or CDCA to best support state board needs.

Q: How will states/licensure candidates/schools be impacted by this merger?
We expect that this combination will simplify steps and processes for most states, schools and licensure candidates while also assisting in developing further consensus for a common licensure standard. Portability of the ADEX examinations is the highest compared to other licensure pathways. In fact, the ADEX dental exam is now accepted in every US jurisdiction that requires an independent 3rd party licensure exam. The CDCA-WREB staff teams in both the eastern and western offices look forward to coming together in a smooth transition as part of a shared mission in support of the oral health professions.

Q: After the proposed combined transition Board of Directors sunsets in January of 2024, there will be 2 newly added members at large positions permanently added. Why are both new positions dentists?
Both combining organization's Boards wanted to fit Board representation to best reflect the membership. At this time, member dentists/dental hygienists are approximately 76%/24% of voting members. With 7 Board members at large, 5 dentists (71%) and 2 dental hygienist (29%) generally reflects these percentages. Other elected board positions are undesignated and open to all.

From: Beth Cole <bcole@wreb.org>
Subject: Special Meeting of DERB and HERB

Good Morning,

Please mark your calendars to attend a Special Combined meeting of the WREB Dental Exam Review Board and the Hygiene Exam Review Board on Wednesday evening, July 21, 2021 at 6 pm PDT. This meeting will be held virtually. The agenda will include an update on the proposed merger between CDCA and WREB. The meeting is expected to last 90 minutes. Leadership from both organizations will be in attendance to answer questions.

An invitation with log in information will be sent as we get closer to the actual meeting date.

Thank you!

Beth

Beth Cole
Chief Executive Officer, Western Regional Examining Board
23460 N 19th Ave Suite 210 Phoenix, AZ 85027
623-209-5411 | bcole@wreb.org | wreb.org

Rules Oversight Committee Meeting
Minutes
June 18, 2021

MEMBERS PRESENT:	Alicia Riedman, R.D.H., E.P.P., Chair Jose Javier, D.D.S. Yadira Martinez, R.D.H., E.P.P. Chip Dunn Phillip Marucha, D.M.D. - ODA Rep. Sharity Ludwig, R.D.H., - ODHA Rep. Mary Harrison, CDA, EFDA, EFODA, FADAA - ODAA Rep.
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop Carter, D.D.S.., Dental Director/Chief Investigator Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager Ingrid Nye, Licensing Manager
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Jennifer Lewis-Goff, ODA; Lisa Rowley, R.D.H., ODHA, Joe Weiss, American Academy of Implant Dentistry, Frank Recker

Call to Order: The meeting was called to order by the Chair at 2:02 p.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

MINUTES

Ms. Martinez moved and Ms. Harrison seconded that the minutes of the August 2, 2019 Rules Oversight Committee meeting be approved as presented. The motion passed unanimously.

OAR 818-001-0000 – Notice of Proposed Rule Making

Ms. Martinez moved and Dr. Javier seconded that the Committee recommend the Board send OAR 818-001-0000 Notice of Proposed Rule Making to a public rulemaking hearing as presented. The motion passed unanimously.

818-001-0000
Notice of Proposed Rule Making
Prior to the adoption, amendment, or repeal of any permanent rule, the Oregon Board of Dentistry shall give notice of the proposed adoption, amendment, or repeal:
(1) By publishing a notice in the Secretary of State's Bulletin referred to in ORS 183.370 at least 21 days prior to the effective date.
(2) By mailing, **emailing or electronic mailing** a copy of the notice to persons on the mailing list established pursuant to ORS 183.335(8) at least 28 days before the effective date of the adoption, amendment, or repeal.

(3) By mailing, **emailing or electronic mailing** a copy of the notice to the following persons and publications:
(a) Oregon Dental Hygienists' Association;
(b) Oregon Dental Assistants Association;
(c) Oregon Association of Dental Laboratories;
(d) Oregon Dental Association;
(e) The Oregonian;
(f) Oregon Health & Science University, School of Dentistry;
(g) The United Press International;
(h) The Associated Press;
(i) The Capitol Building Press Room.

OAR 818-001-0002 – Definitions

Dr. Javier moved and Ms. Martinez seconded that the Committee recommend the Board send OAR 818-001-0002 Definitions to a public rulemaking hearing as amended and to ensure the language is amended consistently in the Dental Practice Act. The motion passed unanimously.

818-001-0002
Definitions

As used in OAR chapter 818:
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(5) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(6) "Hygienist" means a person licensed pursuant to ORS 680.010 to 680.170 to practice dental hygiene.
(7) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(8) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(9) "Licensee" means a dentist or hygienist.
(10) "Volunteer Licensee" is a dentist or dental hygienist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.
(11) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(12) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) "Dental Anesthesiology" is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.

(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Orthodontics and Dentofacial Orthopedics" is the area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(h) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(i) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(j) "Prosthodontics" is the branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
(13) “Full-time” as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry or dental hygiene.
(14) For purposes of ORS 679.020(4)(h) the term “dentist of record” means a dentist that either

authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
(15) “Dental Study Group” as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(16) “Physical Harm” as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(17) “Teledentistry” is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
(18) “BLS for Healthcare Providers or its Equivalent” the **BLS/**CPR certification standard is the American Heart Association’s BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial **BLS/**CPR course must be a hands-on course; online **BLS/**CPR courses will not be approved by the Board for initial **BLS/**CPR certification: After the initial **BLS/**CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A **BLS/**CPR certification card with an expiration date must be received from the **BLS/**CPR provider as documentation of **BLS/**CPR certification. The Board considers the **BLS/**CPR expiration date to be the last day of the month that the **BLS/**CPR instructor indicates that the certification expires.

OAR 818-001-0082 – Access to Public Records
Dr. Javier moved and Mr. Dunn seconded that the Committee recommend the Board send OAR 818-001-0082 Access to Public Records to a public rulemaking hearing as amended. The motion passed unanimously.

818-001-0082
Access to Public Records
(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased upon receipt of a written request. The Board may withhold copies of public records until the requestor pays for the copies.
(3) The Board follows the Department of Administrative Service’s statewide policy (107-001-030) for fees in regards to public records request; in addition, the Board establishes the following fees:
(a) $0.10 per name and address for computer-generated lists on paper ~~or labels~~; $0.20 per name and address for computer-generated lists on paper ~~or labels~~ sorted by specific zip code;
(b) Data files ~~on diskette~~ **submitted electronically** or **on a device** ~~CD~~:
(A) All Licensed Dentists — $50;
(B) All Licensed Dental Hygienists — $50;
(C) All Licensees — $100.
(c) Written verification of licensure — $2.50 per name; and
(d) Certificate of Standing — $20.

OAR 818-012-0005 – Scope of Practice
Ms. Martinez moved and Dr. Marucha seconded that the Committee recommend the Board send OAR 818-012-0005 Scope of Practice to a public rulemaking hearing as presented. The motion passed unanimously.

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

(#) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical 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 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).

(#) A dentist placing endosseous 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, 2022.)

OAR 818-012-0070 – Patient Records
Ms. Martinez moved and Dr. Javier seconded that the Committee recommend the Board send OAR 818-012-0070 Patient Records to a public rulemaking hearing as presented. The motion passed unanimously.

818-012-0070
Patient Records
(1) Each licensee shall have prepared and maintained an accurate and legible record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:
(a) Name and address and, if a minor, name of guardian;
(b) Date description of examination and diagnosis;
(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or ~~"SOAP" (Subjective Objective Assessment Plan) or their~~ **its** equivalent.
(d) Date and description of treatment or services rendered;
(e) Date, description and documentation of informing the patient of any recognized treatment complications;
(f) Date and description of all radiographs, study models, and periodontal charting;
(g) **Current** ~~H~~**h**ealth history; and
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(2) Each licensee shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.
(3) Each licensee shall maintain patient records and radiographs for at least seven years from the date of last entry unless:
(a) The patient requests the records, radiographs, and models be transferred to another licensee who shall maintain the records and radiographs;
(b) The licensee gives the records, radiographs, or models to the patient; or
(c) The licensee transfers the licensee's practice to another licensee who shall maintain the records and radiographs.
(4) When a dental implant is placed the following information must be given to the patient in writing and maintained in the patient record:
(a) Manufacture brand;
(b) Design name of implant;
(c) Diameter and length;
(d) Lot number;
(e) Reference number;
(f) Expiration date;
(g) Product labeling containing the above information may be used in satisfying this requirement.
(5) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.
(6) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

OAR 818-012-XXXX – Compliance with Governor's Executive Orders
Dr. Javier moved and Ms. Martinez seconded that the Committee recommend the Board send OAR 818-012-XXXX Compliance with Governor's Executive Orders to a public rulemaking hearing as presented. The motion passed unanimously.

818-012-XXXX - Compliance with Governor's Executive Orders

(1) During a declared emergency, unprofessional conduct includes failing to comply with any applicable provision of a Governor's Executive Order or any provision of this rule.
(2) Failing to comply as described in subsection (1) includes, but is not limited to:
(a) Operating a business required by an Executive Order to be closed under any current Executive Order.
(b) Providing services at a business required by an Executive Order to be closed under any current Executive Order.
(c) Failing to comply with Oregon Health Authority (OHA) guidance implementing an Executive Order, including but not limited to:
(A) Failing to satisfy required criteria in OHA guidance prior to resuming elective and non-emergent procedures;
(B) Failing to implement a measured approach when resuming elective and nonemergent procedures in accordance with OHA guidance;
(d) Failing to comply with any Board of Dentistry guidance implementing an Executive Order;
(3) No disciplinary action or penalty action shall be taken under this rule if the Executive Order alleged to have been violated is not in effect at the time of the alleged violation.
(4) Penalties for violating this rule include: up to $5,000 per violation pursuant to ORS 679.140(10). Any such penalties shall be imposed in accordance with ORS 679.140.

OAR 818-015-0007 – Specialty Advertising
Ms. Martinez moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-015-0007 Specialty Advertising to a public rulemaking hearing as presented. The motion passed unanimously.

818-015-0007
Specialty Advertising
(1) A dentist may only advertise as a specialist in an area of dentistry which is recognized by the Board and in which the dentist is licensed or certified by the Board.
(2) The Board recognizes the following specialties:
(a) Endodontics;
(b) Oral and Maxillofacial Surgery;
(c) Oral and Maxillofacial Radiology;
(d) Oral and Maxillofacial Pathology;
(e) Orthodontics and Dentofacial Orthopedics;
(f) Pediatric Dentistry;
(g) Periodontics;
(h) Prosthodontics;
(i) Dental Public Health;

(j) Dental Anesthesiology**;**
(k) Oral Medicine;
(l) Orofacial Pain.
(3) A dentist whose license is not limited to the practice of a specialty under OAR 818-021-0017 may advertise that the dentist performs or limits practice to specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists except those licensed pursuant to 818-021-0017: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."

OAR 818-021-0012 – Specialties Recognized
Ms. Martinez moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-021-0012 Specialties Recognized to a public rulemaking hearing as presented. The motion passed unanimously.

818-021-0012
Specialties Recognized
(1) A dentist may advertise that the dentist is a dentist anesthesiologist, endodontist, oral and maxillofacial pathologist, oral and maxillofacial surgeon, oral and maxillofacial radiologist, **oral medicine dentist, orofacial pain dentist,** orthodontist and dentofacial orthopedist, pediatric dentist, periodontist, prosthodontist or dental public health dentist, only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.
(2) A dentist may advertise that the dentist specializes in or is a specialist in dental anesthesiology, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, oral and maxillofacial radiology, **oral medicine, orofacial pain,** orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics or dental public health only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.

OAR 818-021-0060 – Continuing Education - Dentists
Ms. Martinez moved and Dr. Marucha seconded that the Committee recommend the Board send OAR 818-021-0060 Continuing Education – Dentists to a public rulemaking hearing as amended. The motion passed unanimously.

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 includes an examination and the dentist passes the examination.
(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) 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. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.
(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 implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period.

OAR 818-021-0080 – Renewal of License
Dr. Javier moved and Ms. Martinez seconded that the Committee recommend the Board send OAR 818-021-0080 Renewal of License to a public rulemaking hearing as amended. The motion passed unanimously.

818-021-0080
Renewal of License
Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every ~~person~~ **licensee** holding a current license. The licensee must ~~return the~~ complete~~d~~ **the online** renewal application **and pay the** ~~along with~~ current renewal fees prior to the expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085, "Reinstatement of Expired Licenses."
(1) Each dentist shall submit the renewal fee and completed ~~and signed~~ **online** renewal application ~~form~~ by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.
(2) Each **dental** hygienist must submit the renewal fee and completed ~~and signed~~ **online** renewal application ~~form~~ by September 30 every other year. **Dental** ~~H~~**h**ygienists licensed in odd numbered years shall apply for renewal in odd numbered years and **dental** hygienists licensed in even numbered years shall apply for renewal in even numbered years.
(3) The renewal application shall contain:
(a) Licensee's full name;
(b) Licensee's mailing address;

(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;
(e) Licensee's employer or person with whom the licensee is on contract;
(f) Licensee's assumed business name;
(g) Licensee's type of practice or employment;
(h) A statement that the licensee has met the **continuing** educational requirements for renewal set forth in OAR 818-021-0060 or 818-021-0070;
(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and
(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

OAR 818-021-0088 – Volunteer License
Ms. Martinez moved and Dr. Javier seconded that the Committee recommend the Board send OAR 818-021-0088 Volunteer License to a public rulemaking hearing as presented. The motion passed unanimously.

818-021-0088
Volunteer License
(1) An Oregon licensed dentist or dental hygienist who will be practicing for a supervised volunteer dental clinic, as defined in ORS 679.020(3)(f) and (g), may be granted a volunteer license provided licensee completes the following:
(a) Licensee must register with the Board as a health care professional and provide a statement as required by ORS 676.345.
(b) Licensee will be responsible to meet all the requirements set forth in ORS 676.345.
(c) Licensee must provide the health care service without compensation.
(d) Licensee shall not practice dentistry or dental hygiene for remuneration in any capacity under the volunteer license.
(e) Licensee must comply with all continuing education requirements for active licensed dentist or dental hygienist.
(f) Licensee must agree to volunteer for a minimum of 80 hours **in Oregon** per renewal cycle.
(2) Licensee may surrender the volunteer license designation at anytime and request a return to an active license. The Board will grant an active license as long as all active license requirements have been met.

OAR 818-026-0040 – Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit
Dr. Javier moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-026-0040 Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit to a public rulemaking hearing as presented. The motion passed unanimously.

818-026-0040
Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia
Permits: Nitrous Oxide Permit
Nitrous Oxide Sedation.
(1) The Board shall issue a Nitrous Oxide Permit to an applicant who:
(a) Is either a licensed dentist or licensed hygienist in the State of Oregon;

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

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

OAR 818-026-0050 – Minimal Sedation Permit
Ms. Martinez moved and Dr. Javier seconded that the Committee recommend the Board send OAR 818-026-0050 Minimal Sedation Permit to a public rulemaking hearing as presented. The motion passed unanimously.

818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in
an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient’s airway, quickly alter the patient’s position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can
reasonably be obtained.
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(~~10~~**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 818-026-0080 – Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
Ms. Martinez moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified
Provider Induces Anesthesia to a public rulemaking hearing as presented. The motion passed unanimously.

818-026-0080
Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon ~~Board of~~ Medical ~~Examiners~~ **Board**, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.
(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist, a dental hygienist or an Expanded Function Dental Assistant (EFDA) who performs procedures on a patient who is receiving anesthesia induced by a physician

anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document the patient's condition at discharge as required by the rules applicable to the level of anesthesia being induced. A copy of the anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.
(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.
(8) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of his/her intent. Such notification need only be submitted once every licensing period.

OAR 818-035-0020 – Authorization to Practice
Dr. Javier moved and Mr. Dunn seconded that the Committee recommend the Board send OAR 818-035-0020 Authorization to Practice to a public rulemaking hearing as amended and present the rule to the Board for further discussion regarding the fifteen day timeframe is subsection three. The motion passed unanimously.

818-035-0020
Authorization to Practice
(1) A supervising dentist, without first examining a new patient, may authorize a dental hygienist:
(a) To take a health history from a patient;
(b) To take dental radiographs;
(c) To perform periodontal probings and record findings;
(d) To gather data regarding the patient; and
(e) To diagnose, treatment plan and provide dental hygiene services.
(2) When **dental** hygiene services are provided pursuant to subsection **(1)**, the supervising dentist need not be on the premises when the services are provided.
(3) When **dental** hygiene services are provided pursuant to subsection **(1)**, the patient must be scheduled to be examined by the supervising dentist within fifteen business days following the day the **dental** hygiene services are provided.
(4) If a new patient has not been examined by the supervising dentist subsequent to receiving dental hygiene services pursuant to subsection **(1)**, no further dental hygiene services may be provided until an examination is done by the supervising dentist.
(5) A dental hygienist may practice dental hygiene in the places specified by ORS 680.150 under general supervision upon authorization of a supervising dentist. **When dental hygiene services are provided pursuant to this subsection, subsections (2), (3) and (4) also apply.**
(6) A dentist who authorizes a dental hygienist to practice dental hygiene on a limited access patient must review the **dental** hygienist's findings.

OAR 818-035-0025 – Prohibitions

Ms. Martinez moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-035-0025 Prohibitions to a public rulemaking hearing as presented. The motion passed unanimously.

818-035-0025
Prohibitions
A dental hygienist may not:
(1) Diagnose and treatment plan other than for dental hygiene services;
(2) Cut hard or soft tissue with the exception of root planing;
(3) Extract any tooth;
(4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);
(5) Prescribe, administer or dispense any drugs except as provided by OAR 818-035-0030, **OAR** 818- 035-0040, **OAR** 818-026-0060(~~11~~ **12**), **OAR 818-026-0065(12)** and 818-026-0070(~~11~~ **12**);
(6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;
(7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;
(8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway
Restriction (HOMAR) on any patient.
(9) Place or remove healing caps or healing abutments, except under direct supervision.
(10) Place implant impression copings, except under direct supervision.

OAR 818-042-0040 – Prohibited Acts
Dr. Javier moved and Ms. Martinez seconded that the Committee recommend the Board send OAR 818-042-0040 Prohibited Acts to a public rulemaking hearing as presented. The motion passed unanimously.

818-042-0040
Prohibited Acts
No licensee may authorize any dental assistant to perform the following acts:
(1) Diagnose or plan treatment.
(2) Cut hard or soft tissue.
(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty (OAR 818-042-0113 and OAR 818-042-0114) or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.
(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.
(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.
(6) Administer any drug except fluoride, topical anesthetic, desensitizing agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)(a), OAR 818-026-0060(~~11~~**12**), OAR 818-026-0065(~~11~~**12**), OAR 818-026-0070(~~11~~**12**) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.
(7) Prescribe any drug.
(8) Place periodontal packs.
(9) Start nitrous oxide.
(10) Remove stains or deposits except as provided in OAR 818-042-0070.

(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.
(13) Use lasers, except laser-curing lights.
(14) Use air abrasion or air polishing.
(15) Remove teeth or parts of tooth structure.
(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.
(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.
(19) Apply denture relines except as provided in OAR 818-042-0090(2).
(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(22) Perform periodontal probing.
(23) Place or remove healing caps or healing abutments, except under direct supervision.
(24) Place implant impression copings, except under direct supervision.
(25) Any act in violation of Board statute or rules.

HB 2627 – Interim Therapeutic Restorations

Dr. Javier moved and Ms. Martinez seconded for OBD staff to draft language incorporating Interim Therapeutic Restorations in the appropriate rules to be presented to a public rulemaking hearing. The motion passed unanimously.

The meeting was adjourned at 3:25 p.m.

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
August 20, 2021

Board Member & Staff Updates

Some exciting staff transitions to report. Both of these changes were effective July 1, 2021.

Ingrid Nye has filled the open Investigator Position. Ingrid joined the OBD in November 2015. Samantha VandeBerg will transition to Ingrid's previous positon as our new Examination and Licensing Manager. Samantha joined the OBD in March 2018.

These positions require unique skills and specialized in-depth knowledge of Board of Dentistry licensing laws, rules, regulations, and procedures. Both have developed the knowledge, skills and abilities to perform these functions. Their commitment and willingness to seek new challenges and support the OBD is noteworthy and on behalf of the Board I thank them both.

The Office Specialist position was open for recruitment from July 19 through August 1st. The next steps of the recruitment process will occur and I hope to introduce our newest staff member at a future board meeting.

OBD Budget Status Report

Attached is the latest budget report for the 2019 – 2021 Biennium, which ended on June 30, 2021. There will be final financial transactions reconciled before the biennium is closed. This report is from July 1, 2019 through June 30, 2021 shows revenue of $3,718,165.71 and expenditures of $3,242,270.59. **Attachment #1**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2020 – June 30, 2021. 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**

Dental Hygiene License Renewal

The renewal period started on July 20, 2021 and it is progressing within the new database environment. It has been a challenging deployment and I will have an update at tis meeting.

Agency Head Financial Transactions Report July 1, 2020 – June 30, 2021

Board Policy requires that at least annually the entire Board review agency head financial transactions and that acceptance of the report be recorded in the minutes. I request that the Board review and if there are no objections, approve this report, which follows the close of the recent fiscal year. I am happy to answer any questions regarding this report.
Attachment #3 ACTION REQUESTED

2021 Legislative Session Wrap Up

HB 2528- Creates a new Licensee for the Board of Dentistry to regulate- Dental Therapists (DT). The Board last added a new type of Licensee back in the 1940s with Dental Hygienists. It will involve creating a new division of rules, amend other divisions to add appropriate references to DTs, create a myriad of new application forms, update website, create a new Rules Committee of some type, implement new fee structure, etc…

HB 2627- Expands Dental Hygienists with an Expanded Practice Permit scope regarding the placement of Interim Therapeutic Restorations. Also requires the Board to adopt education standards and instructor requirements related to interim therapeutic restorations as well.

HB 2074- Increases the PDMP fee from $25 to $35 per year. The OBD will not raise fees on dentists and will absorb the additional cost, but monitor it to see if there will be a need to raise dental licensure fees in the future.

HB 2078- The pain management CE rules will need to be amended to update the timing requirement to complete a pain management continuing education class required for dentists.

HB 2970- Updates the statute on who may own or operate a dental clinic, but sunsets January 1, 2023.

HB 2993- Updates rulemaking requirements including the provision that agencies must include a statement identifying how adoption of rules will effect racial equity in the state.

SB 5511- The OBD Budget Bill presentation and process went smoothly. The budget was approved and there were no additional requests for information or any issues I noted during the legislative session.

A Bill Tracker Report shows all the bills I had flagged for the OBD. **Attachment #4**

HB 2359

This new legislation will require Licensees to use health care interpreters from an OHA Registry unless other criteria are met and other provisions. The Board should review this closer for discussion and consider if any action should be taken on it at his time.
Attachment #5 ACTION REQUESTED

TriMet Contract 2021 -2022

I am asking the Board to ratify my entering into a contract with TriMet for the Universal Pass Program, which will allow the OBD provide transportation passes for employees that are eligible to receive such passes for transportation to and from work.
Attachment #6 ACTION REQUESTED

HPSP - Year 11 Reports

The 11th Annual HPSP Reports are included for review. **Attachment #7**

2021 Third Party Audit Resuts for HPSP

I attached the executive summary for the 2021 Independent Third-Party Health Professionals' Services Program Audit Results per ORS 676.190 (8) The health profession licensing boards must arrange for an independent third party to conduct an audit every four years of the impaired health professional program for the licensees of the health profession licensing boards to ensure compliance with program guidelines. The health profession licensing boards must report the results of the audit to the Legislative Assembly in the manner provided by ORS 192.245 and to the Governor. The report does not contain individually identifiable information about licensees. **Attachment #8**

Board Best Practices Self-Assessment & Score Card
As a part of the legislatively approved Performance Measures, the Board needs to complete the attached Best Practices Self-Assessment Score Card so that it can be included as a part of the 2021 annual progress report. I will provide the report at the October Board meeting.
Attachment #9 ACTION REQUESTED

Oregon Buys Newsletter
New procurement system and processes have been implemented for state government.
Attachment #10

Strategic Planning Update
A reminder that the OBD will undertake strategic planning in person on October 22 & 23 later this year. The facilitators and the location have been selected and preparations are right on track. I will have an update at the meeting. Thank you for making arrangements to attend and participate in this important activity.

Newsletter
The OBD will plan on a fall/winter 2021 Newsletter. Board members are welcome to contribute articles or ideas to OBD Staff.

Appn Year 2021

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

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0505	FINES AND FORFEITS	417,212.52	0.00	417,212.52	200,000.00	-217,212.52
0205	OTHER BUSINESS LICENSES	3,142,635.00	54,420.00	3,197,055.00	3,270,001.00	72,946.00
0975	OTHER REVENUE	14,428.06	250.00	14,678.06	49,999.00	35,320.94
0605	INTEREST AND INVESTMENTS	48,397.65	816.98	49,214.63	20,000.00	-29,214.63
0210	OTHER NONBUSINESS LICENSES AND FEES	14,250.00	650.00	14,900.00	10,000.00	-4,900.00
0410	CHARGES FOR SERVICES	25,105.50	0.00	25,105.50	20,000.00	-5,105.50
		3,662,028.73	**56,136.98**	**3,718,165.71**	**3,570,000.00**	**-148,165.71**

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORIT'	197,060.00	6,615.00	203,675.00	226,800.00	23,125.00
		197,060.00	**6,615.00**	**203,675.00**	**226,800.00**	**23,125.00**

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3210	ERB ASSESSMENT	343.98	14.04	358.02	427.00	68.98
3260	MASS TRANSIT	7,297.62	302.26	7,599.88	8,250.00	650.12
3270	FLEXIBLE BENEFITS	194,571.29	8,993.54	203,564.83	281,472.00	77,907.17
3110	CLASS/UNCLASS SALARY & PER DIEM	1,246,118.73	56,335.48	1,302,454.21	1,312,557.00	10,102.79
3250	WORKERS' COMPENSATION ASSESSMENT	296.63	13.12	309.75	464.00	154.25
3240	UNEMPLOYMENT ASSESSMENT	16.24	2.03	18.27	0.00	-18.27
3230	SOCIAL SECURITY TAX	95,796.95	4,304.92	100,101.87	105,198.00	5,096.13
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	183,563.58	7,384.16	190,947.74	207,191.00	16,243.26
3221	PENSION BOND CONTRIBUTION	64,199.16	2,227.69	66,426.85	73,260.00	6,833.15
3190	ALL OTHER DIFFERENTIAL	15,637.48	157.50	15,794.98	38,194.00	22,399.02
3180	SHIFT DIFFERENTIAL	8.00	0.00	8.00	0.00	-8.00
3170	OVERTIME PAYMENTS	1,919.04	530.81	2,449.85	6,136.00	3,686.15
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	4,219.00	4,219.00
		1,809,768.70	**80,265.55**	**1,890,034.25**	**2,037,368.00**	**147,333.75**

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	0.00	5,836.00	5,836.00
4575	AGENCY PROGRAM RELATED SVCS & SUPP	34,955.23	1,567.50	36,522.73	134,566.00	98,043.27
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	583.00	583.00

Attachment #1

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4425	FACILITIES RENT & TAXES	169,361.41	7,496.16	176,857.57	179,097.00	2,239.43
4650	OTHER SERVICES AND SUPPLIES	93,529.85	923.79	94,453.64	97,999.00	3,545.36
4225	STATE GOVERNMENT SERVICE CHARGES	162,860.48	52.00	162,912.48	161,339.00	-1,573.48
4325	ATTORNEY GENERAL LEGAL FEES	217,755.01	18,353.21	236,108.22	271,973.00	35,864.78
4300	PROFESSIONAL SERVICES	303,229.52	13,363.59	316,593.11	255,911.00	-60,682.11
4315	IT PROFESSIONAL SERVICES	10,500.00	0.00	10,500.00	140,031.00	129,531.00
4200	TELECOMM/TECH SVC AND SUPPLIES	26,030.40	1,045.63	27,076.03	24,925.00	-2,151.03
4715	IT EXPENDABLE PROPERTY	35,164.96	7,393.92	42,558.88	23,482.00	-19,076.88
4150	EMPLOYEE TRAINING	19,934.79	0.00	19,934.79	54,223.00	34,288.21
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	705.00	705.00
4275	PUBLICITY & PUBLICATIONS	4,371.71	67.65	4,439.36	14,855.00	10,415.64
4250	DATA PROCESSING	81,295.25	8,265.33	89,560.58	68,458.00	-21,102.58
4400	DUES AND SUBSCRIPTIONS	10,101.52	199.90	10,301.42	7,126.00	-3,175.42
4175	OFFICE EXPENSES	42,469.21	556.43	43,025.64	91,230.00	48,204.36
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	7,563.00	7,563.00
4100	INSTATE TRAVEL	19,955.49	1,466.40	21,421.89	50,784.00	29,362.11
		1,231,514.83	**60,751.51**	**1,292,266.34**	**1,590,686.00**	**298,419.66**

CAPITAL OUTLAY

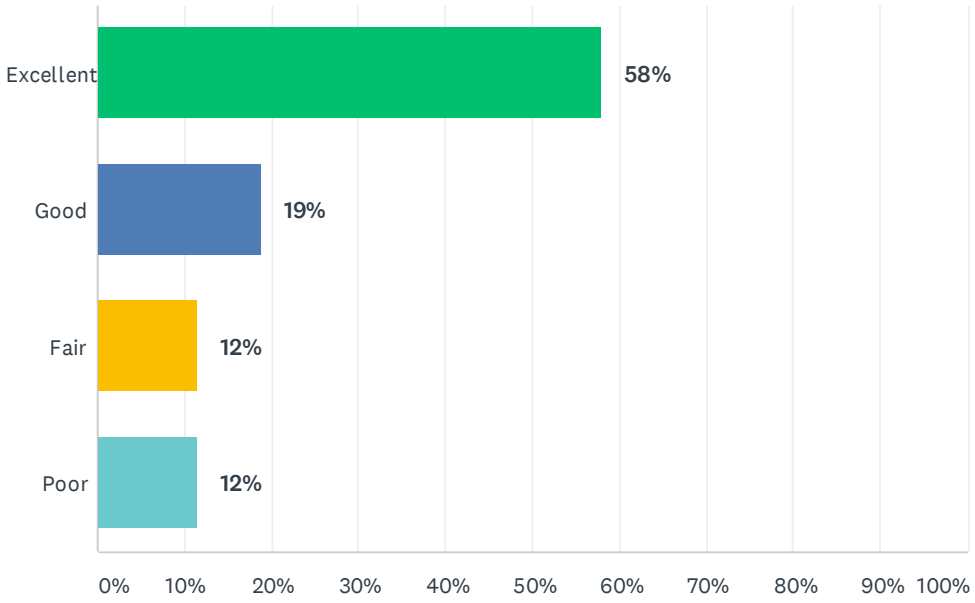
Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
5550	DATA PROCESSING SOFTWARE	59,970.00	0.00	59,970.00	0.00	-59,970.00
		59,970.00	**0.00**	**59,970.00**	**0.00**	**-59,970.00**

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	56,136.98	3,718,165.71	3,570,000.00
	Total	56,136.98	3,718,165.71	3,570,000.00
EXPENDITURES	PERSONAL SERVICES	80,265.55	1,890,034.25	2,037,368.00
	SERVICES AND SUPPLIES	60,751.51	1,292,266.34	1,590,686.00
	CAPITAL OUTLAY	0	59,970	0.00
	Total	141,017.06	3,242,270.59	3,628,054.00
TRANSFER OUT	TRANSFER OUT	6,615	203,675	226,800.00
	Total	6,615	203,675	226,800.00

Attachment #1

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

Answered: 69 Skipped: 2

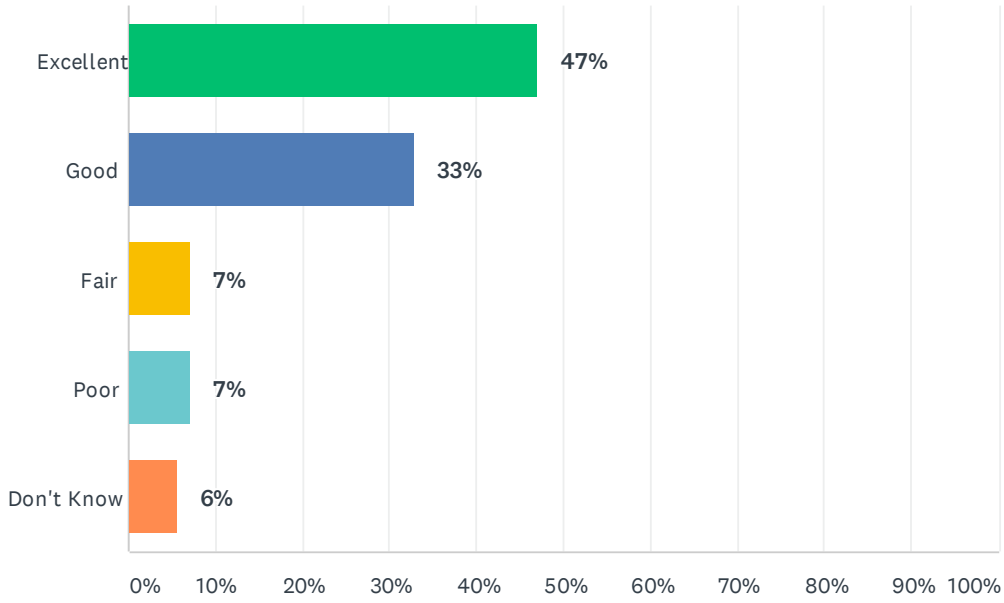


ANSWER CHOICES	RESPONSES	
Excellent	58%	40
Good	19%	13
Fair	12%	8
Poor	12%	8
TOTAL		69

Attachment #2

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

Answered: 70 Skipped: 1

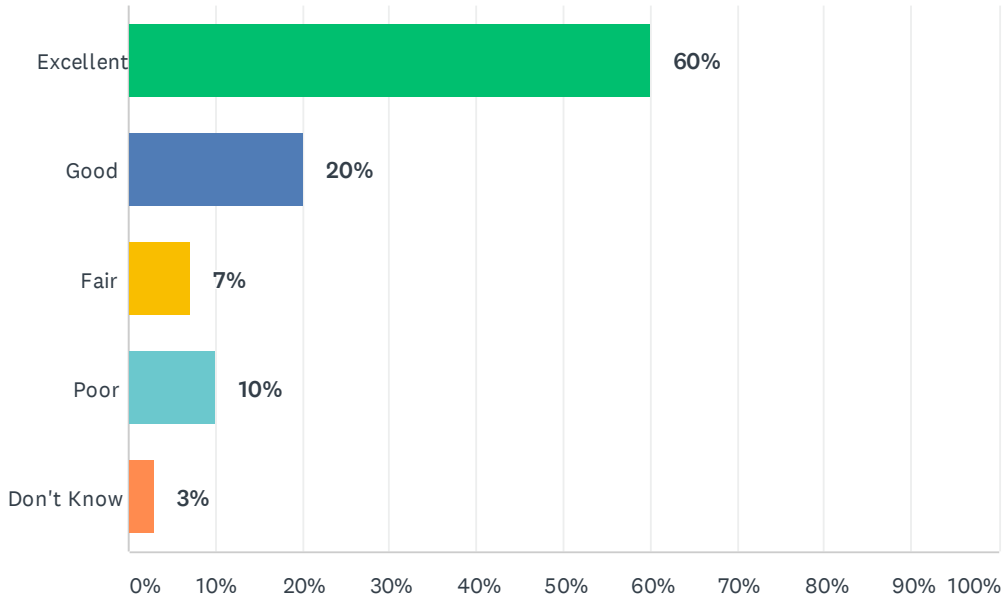


ANSWER CHOICES	RESPONSES	
Excellent	47%	33
Good	33%	23
Fair	7%	5
Poor	7%	5
Don't Know	6%	4
TOTAL		70

Attachment #2

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

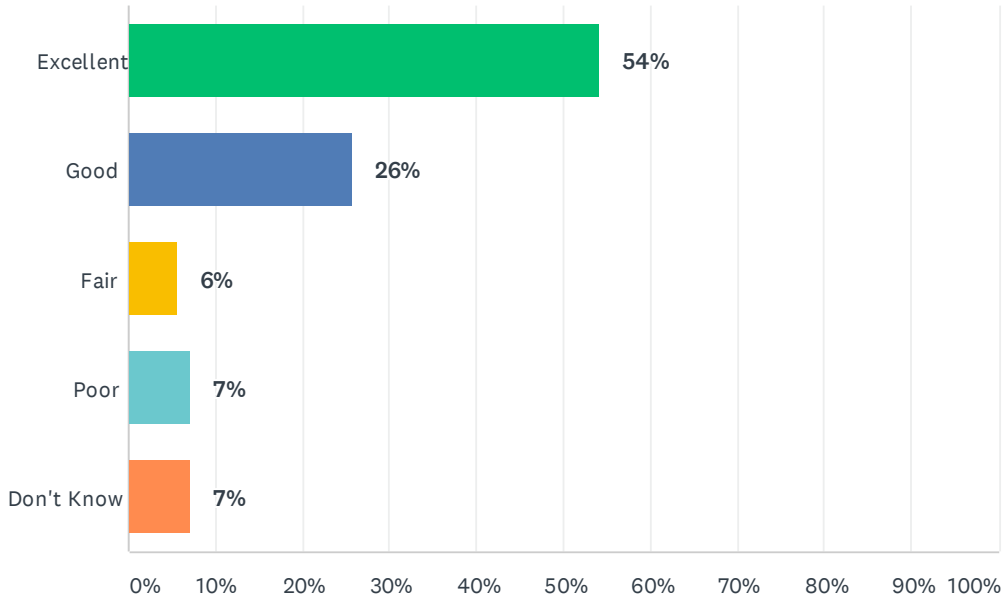
Answered: 70 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	60%	42
Good	20%	14
Fair	7%	5
Poor	10%	7
Don't Know	3%	2
TOTAL		70

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

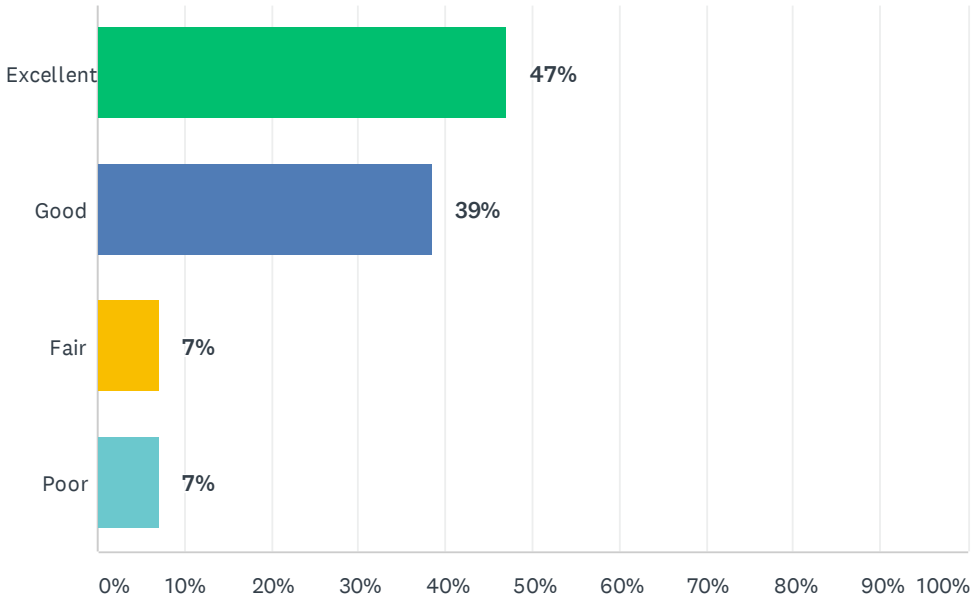
Answered: 70 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	54%	38
Good	26%	18
Fair	6%	4
Poor	7%	5
Don't Know	7%	5
TOTAL		70

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

Answered: 70 Skipped: 1

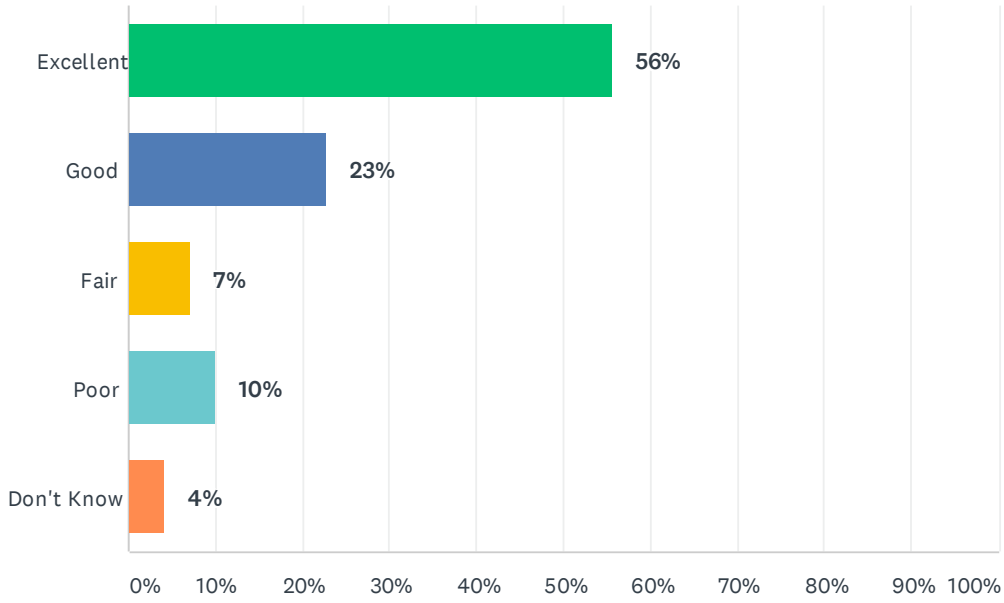


ANSWER CHOICES	RESPONSES	
Excellent	47%	33
Good	39%	27
Fair	7%	5
Poor	7%	5
TOTAL		70

Attachment #2

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

Answered: 70 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	56%	39
Good	23%	16
Fair	7%	5
Poor	10%	7
Don't Know	4%	3
TOTAL		70

Attachment #2

Fiscal Year 2021 Agency Head Financial Transactions

SUMMARY of Agency Head Financial Transactions July 1, 2020 – June 30, 2021

Spots Card Purchases (Agency credit card paid directly by state)

	Total
Registrations/Memberships	$ 6,385.00
Office Equipment/Supplies	$ 15,652.23
Publications/Subscriptions	$ 680.28
Board Meeting/Staff Training Food	$ 2,782.58
Transportation	$ 85.85
Misc. (Comcast, FEDEX, Background checks)	$ 1,868.26
	$ 27,454.20

Travel Expenses - Stephen Prisby

Instate Travel using Zipcar (paid with OBD CC)	$85.85
Total Instate Travel expenses:	$85.85

Instate Travel Reimbursed to Employee:

$0

Out of State Travel

None **$0**

Total - Agency Head Travel Expenses Reimbursed to Employee:

$0

Fiscal Year 2021 Agency Head Financial Transactions

Annual Leave Summary July 1, 2020 – June 30, 2021

Accrual or type of leave	7/1/2020 Balance	Accrual per month	Earned	Used	6/30/2021 Balance
Vacation	**292**	**11.34**	**136**	**60**	**268**
Vacation Payout	**100**	**-**	**-**	**100**	**0**
Sick Leave	**658**	**8**	**96**	**34**	**720**
Personal Business	**24**	**-**	**-**	**24**	**0**
Discretionary Governor's Leave	**8**	**-**	**-**	**8**	**0**

Agency Head Financial Transactions
Spots Card and Travel Reimbursement
Fiscal Year 2021 by Quarter

SPOTS Card Purchases: (Agency credit card paid directly by state)	**sub-total**	**Total**
July - September		**$6,362.54**
Best Buy	$40.99	
AT&T	$93.30	
Office Depot	$424.69	
Mailfinance	$1644.27	
ADOBE ID Creative	$125.94	
Zoom	$14.99	
Comcast	$265.20	
Fedex	$13.48	
FieldPrint	$12.50	
Board Meeting Food	$356.33	
AADB Membership	$3285.00	
Zipcar	$85.85	
October – December		**$8,141.82**
AT&T	$1,609.76	
Office Depot	$1,289.97	
Mailfinance	$1,644.27	
ADOBE ID Creative	$125.94	
Zoom	$17.49	
Comcast	$265.20	
Fedex	$152.42	
FieldPrint	$12.50	
Board Meeting Food	$711.01	
AADB Mid-Year Meeting Registration	$1425.00	
Heartsmart AED Battery	$169.00	

Fiscal Year 2021 Agency Head Financial Transactions

Neopost Mailer Ink	$194.91	
Survey Monkey Membership	$384.00	
ADA CDT Codes Manual	$140.35	
January – March		**$4913.67**
AT&T	$1,443.78	
Office Depot	$1,433.32	
Mailfinance	$1,644.27	
ADOBE ID Creative	$125.94	
Yubico IT Security Keys	$285.00	
Comcast	$39.94	
Fedex	$10.84	
FieldPrint	$25	
Board Meeting Food	$328.30	
Pearl Buck Nameplates	$41.10	
Professional Licensing Report Subscription	$228.00	
April – June		**$8036.17**
AT&T	$1,267.17	
Office Depot	$1433.32	
Mailfinance	$734.82	
ADOBE ID Creative	$41.98	
BOLI Poster	$17.00	
Heartsmart AED Sticky Pads	$80.54	
NIC	$1654.00	
Pearl Buck Nameplates	$20.40	
Board Meeting Food	$1,386.94	
DOJ Law Conference	$440.00	
Clear Investigator Training	$960.00	
SPOTS Card Purchases:		**Total**
(Agency credit card paid directly by state)		
		$27,454.20

BillTracker

Custom Report

Report Date: July 30, 2021

Bill Number	Last Action

HB 2074 07/19/21 - Governor signed.

Increases prescription monitoring program fees from $25 to $35.
Takes effect on 91st day following adjournment sine die.

Relating to prescription monitoring program fees; and prescribing an effective date.

Relating to prescription monitoring program fees; and prescribing an effective date.

HB 2075 07/19/21 - Governor signed.

Establishes vendor license and annual fee for persons engaging in certain conduct regarding radiation devices and equipment, including X-ray machines and tanning devices. Modifies registration fee for certain radiation devices and equipment from per machine basis to per tube basis. Increases registration fee for tanning devices.
Becomes operative January 1, 2022.
Declares emergency, effective on passage.

Relating to radiation; and declaring an emergency.

Relating to radiation; and declaring an emergency.

HB 2076 06/26/21 - In committee upon adjournment.

Establishes Emergency Health Care Systems Program and Emergency Health Care System Advisory Board within Oregon Health Authority. Directs authority to designate emergency health care centers for provision of cardiac and pediatric emergency health care. Modifies terminology related to emergency medical services. Authorizes Governor to make available for use emergency medical services personnel and equipment. Creates offense of unlawful operation of unlicensed emergency medical services agency. Punishes by maximum of 364 days' imprisonment, $6,250 fine, or both. Becomes operative January 1, 2022.
Directs authority to designate emergency health care regions within state. Becomes operative January 1, 2023.
Directs authority to designate emergency health care centers for provision of stroke and trauma emergency health care. Directs program to establish emergency health care data systems for collection of information related to emergency health care in this state. Requires licensure for nontransport EMS service. Defines "nontransport EMS service." Becomes operative January 1, 2025.
Takes effect on 91st day following adjournment sine die.

Relating to emergency medical services; prescribing an effective date.

Relating to emergency medical services; creating new provisions; amending ORS 146.015, 181A.375, 353.450, 431A.055, 431A.100, 441.020, 442.507, 442.870, 445.030, 478.260, 682.017, 682.025, 682.031, 682.035, 682.041, 682.045, 682.047, 682.051, 682.056, 682.059, 682.062, 682.063, 682.066, 682.068, 682.075, 682.079, 682.085, 682.089, 682.105, 682.107, 682.204, 682.208, 682.216, 682.218, 682.220, 682.224 and 682.245; repealing ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070, 431A.075, 431A.080, 431A.085, 431A.090, 431A.095, 431A.100, 431A.105, 431A.525, 431A.530, 682.027 and 682.039; and prescribing an effective date.

HB 2078 06/10/21 - Chapter 50, (2021 Laws): Effective date January 1, 2022.

Repeals electronic credentialing information program.
Removes requirement for Pain Management Commission to review pain management curricula of educational institutions. Modifies pain management education requirements for health professionals.
Removes requirement for Oregon Health Authority to annually report to Legislative Assembly on Oregon Health Information Technology program.
Aligns with federal law requirements about eligibility of temporary public employees to qualify for health benefit coverage.

Relating to health.

Relating to health.

BillTracker

Custom Report

Report Date: July 30, 2021

Bill Number	Last Action

HB 2079 06/26/21 - In committee upon adjournment.

Requires health care entities to obtain approval from Oregon Health Authority before any mergers, acquisitions or affiliations of entities that had $25 million or more in net patient revenue in prior fiscal year or before mergers, acquisitions or affiliations that will result in one entity having increase in net patient revenue of $10 million or more. Specifies procedures.

Requires Oregon Health Policy Board to establish criteria for approval of mergers, acquisitions and affiliations based on specified factors.

Relating to health care providers.

Relating to health care providers; creating new provisions; and amending ORS 413.032, 413.037, 413.101, 413.181, 415.013, 415.019 and 415.103.

HB 2080 06/26/21 - In committee upon adjournment.

Establishes Office of Pharmaceutical Purchasing in Oregon Health Authority and specifies duties. Requires office to administer multistate prescription drug purchasing consortium.

Authorizes Oregon Health Authority to require prior authorization for drugs under specified conditions.

Relating to pharmaceuticals.

Relating to pharmaceuticals; creating new provisions; and amending ORS 413.032, 414.312, 414.314, 414.318, 414.320, 414.325, 414.326, 414.334, 414.337 and 689.185.

HB 2081 06/10/21 - Chapter 51, (2021 Laws): Effective date January 1, 2022.

Modifies Health Care Cost Growth Target program and Health Care Cost Growth Target Implementation Committee.

Directs Oregon Health Authority to adopt schedule of civil penalties for providers or payers that fail to report cost growth data or to develop and implement performance improvement plan if required to do so.

Relating to health care costs.

Relating to health care costs.

HB 2084 06/26/21 - In committee upon adjournment.

Requires Oregon Health Authority to report to interim committees of Legislative Assembly related to health on impacts of federal changes arising from executive or legislative branches of federal government on access to health care in this state and to recommend legislation, if any, that is needed to ensure no diminution of access to quality, affordable health care by residents of this state.

Relating to health care.

Relating to health care.

HB 2087 06/26/21 - In committee upon adjournment.

Requires Oregon Health Authority to adopt rules to ensure that health care providers use health care interpreters, reimbursed by state, when interacting with medical assistance recipients who have limited English proficiency or who communicate in sign language.

Relating to health care interpreters.

Relating to health care interpreters; creating new provisions; and amending ORS 413.550 and 413.552.

BillTracker

Custom Report

Report Date: July 30, 2021

Bill Number	Last Action
HB 2164	06/26/21 - In committee upon adjournment. Directs office of the Governor to study laws related to health and provide results to interim committees of Legislative Assembly no later than September 15, 2022.] Sunsets January 2, 2023.] Renames "Health Care for All Oregon Children" program to "Cover All People" program. Expands eligibility for children from up to 19 years of age to age 26 or younger and includes parents of children enrolled in program who would qualify for medical assistance but for immigration status. Requires Oregon Health Authority in collaboration with Department of Consumer and Business Services to seek federal approval necessary to maximize federal financial participation in costs of program. Takes effect on 91st day following adjournment sine die. Relating to health; prescribing an effective date. Relating to health; creating new provisions; amending ORS 192.556, 413.201, 413.225, 414.231 and 414.578; and prescribing an effective date.
HB 2167	07/27/21 - Governor signed. Directs Office of Governor to study and make recommendations regarding certain proposals relating to state boards and commissions. Requires office to submit report on findings by January 1, 2023.] Creates Racial Justice Council within Office of Governor. Directs council to report at least once per year on strategies designed to institutionalize racial justice into conduct of state business. Directs council to provide advice and recommendations to Governor relating to racial justice. Directs council to advise and assist state agencies in creating racial impact statements for programs in agency request budgets. Directs council to communicate with Legislative Assembly to monitor investments in and track progress toward racial equity. Requires state agencies to include racial impact statements with agency request budgets. Requires Governor's budget to include narrative summarizing racial impact statements. Relating to state entities. Relating to state entities.
HB 2222	06/26/21 - In committee upon adjournment. Modifies definition of "meeting" for purposes of public meetings law to state that meeting may occur without regard to location or stated purpose for which members of governing body convene. Excludes one-on-one meetings of two members of governing body from definition of "meeting," even if serial one-on-one meetings take place between members of governing body. Establishes affirmative duty of chief administrative officer of public body or employee of public body who routinely and customarily advises governing body on public meetings law requirements to advise governing body on whether meeting content qualifies for executive session. Establishes joint and several liability for specified public body officers and employees who, with willful misconduct, fail or incorrectly advise governing body of meeting content's eligibility for executive session. Authorizes Oregon Government Ethics Commission to adopt rules establishing criteria for when official or employee of public body has affirmative duty to advise on meeting content qualification for executive session. Authorizes commission to impose civil penalties on members of governing body or specified officers or employees of public body for conducting executive sessions in which meeting content does not meet executive session requirements. Relating to public meetings. Relating to public meetings; amending ORS 192.610, 192.660, 192.680, 244.290 and 244.350.
HB 2315	06/10/21 - Chapter 114, (2021 Laws): effective on the 91st day following adjournment sine die. Directs Oregon Health Authority and specified professional regulatory boards to require licensees regulated by authority or board to complete six hours of] continuing education related to suicide risk assessment, treatment and management every six years] at specified intervals and to report completion of continuing education to authority or board. Allows authority and boards to establish minimum requirements that licensee must meet to be exempt from requirement to complete continuing education. Takes effect on 91st day following adjournment sine die. Relating to continuing education for professionals; and prescribing an effective date. Relating to continuing education for professionals; and prescribing an effective date.

Bill Number	Last Action
HB 2321	06/26/21 - In committee upon adjournment.

Requires Oregon Health Authority to convene advisory committee to study adequacy of personal protective equipment provided to health care workers to protect against SARS-CoV-2 and to report findings to interim committee of Legislative Assembly.

Sunsets January 2, 2023.

Declares emergency, effective on passage.

Relating to health care workers; declaring an emergency.

Relating to health care workers; and declaring an emergency.

HB 2335	06/26/21 - In committee upon adjournment.

Enacts interstate Nurse Licensure Compact. Permits Oregon State Board of Nursing to disclose specified information to Interstate Commission of Nurse Licensure Compact Administrators. Exempts individuals practicing nursing in this state under compact from restrictions on use of titles. Allows board to establish account to meet financial obligations imposed on State of Oregon as result of participation in compact. Continuously appropriates moneys from account to board for specified purpose.

Enacts Interstate Medical Licensure Compact. Permits Oregon Medical Board to disclose specified information to Interstate Medical Licensure Compact Commission. Exempts individuals practicing medicine in this state under compact from restrictions on use of titles. Allows board to establish account to meet financial obligations imposed on State of Oregon as result of participation in compact. Continuously appropriates moneys from account to board for specified purpose.

Declares emergency, effective on passage.

Relating to interstate health professional licensure compacts; declaring an emergency.

Relating to interstate health professional licensure compacts; creating new provisions; amending ORS 676.177, 677.080, 677.290, 678.021, 678.023 and 678.170; and declaring an emergency.

HB 2359	07/27/21 - Chapter 453, (2021 Laws): Effective date July 14, 2021.

Requires health care providers to work with health care interpreters from health care interpreter registry operated by Oregon Health Authority to provide interpretation services. Requires health professional regulatory boards, Department of Human Services and authority to adopt rules to enforce requirement. Provides exceptions.

Requires interpretation service companies to only employ or contract with health care interpreters listed on health care registry, subject to exceptions.

Requires Oregon Council on Health Care Interpreters to develop and approve standards for testing, qualification and certification of certain health care interpreters.

Requires authority to train and certify or qualify health care interpreters and maintain central registry of certified or qualified health care interpreters.

Requires coordinated care organizations to work with health care interpreters listed on health care interpreter registry.

Makes certain health care interpreters subject workers for purposes of workers' compensation benefits.

Declares emergency, effective on passage.

Relating to health care interpreters; and declaring an emergency.

Relating to health care interpreters; and declaring an emergency.

HB 2362	07/27/21 - Governor signed.

Requires approval from Department of Consumer and Business Services or Oregon Health Authority before any mergers, acquisitions, contracts or affiliations of health care entities and other entities if entities had $25 million or more] meet or exceed specified thresholds in average net patient revenue or in gross amount of premiums in preceding three fiscal years or net patient revenue of $10 million or more]. Specifies exceptions and procedures.

Requires Oregon Health Policy Board to establish criteria for approval by authority of mergers, acquisitions and affiliations based on specified factors.

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

Relating to health care providers.

Relating to health care providers.

BillTracker

Custom Report

Report Date: July 30, 2021

Bill Number	Last Action
HB 2376	06/26/21 - In committee upon adjournment.

Requires health care provider who prescribes opioid to offer prescription for naloxone, or similar drug, and educational material under specified circumstances. Defines "health care provider." Allows health professional regulatory board to impose discipline for violation.

Becomes operative on January 1, 2022.

Takes effect on 91st day following adjournment sine die.

Relating to naloxone; prescribing an effective date.

Relating to naloxone; creating new provisions; amending ORS 677.190, 678.111 and 679.140; and prescribing an effective date.

HB 2401	06/26/21 - In committee upon adjournment.

Makes certain actions taken by employer because of employee's service as member of board, commission, council or committee created by statute unlawful employment practice. Allows employee to bring civil action or file complaint with Commissioner of Bureau of Labor and Industries for violation.

Takes effect on 91st day following adjournment sine die.

Relating to employment protections; prescribing an effective date.

Relating to employment protections; creating new provisions; amending ORS 659A.885; and prescribing an effective date.

HB 2459	07/07/21 - Chapter 357, (2021 Laws): Effective date January 1, 2022.

Includes in definition of "conversation" communication occurring through video conferencing program for purposes of statutes regulating recording of communications. Prohibits recording of communication occurring through video conferencing program if participants are not informed of recording. Punishes by maximum of 364 days' imprisonment, $6,250 fine, or both. Specifies exceptions.

Relating to video conferencing.

Relating to video conferencing.

HB 2461	06/26/21 - In committee upon adjournment.

Directs Oregon Business Development Department] Oregon Homeland Security Council to establish program to create Oregon Critical Disaster Preparedness Stockpile to ensure robust stock of emergency supplies and equipment.

Directs Oregon Homeland Security Council] council, in consultation with Oregon Health Authority and relevant state agencies, to develop list of essential equipment, materials, supplies, distribution channels and manufacturing capabilities for stockpile, including personal protective equipment, communicable disease testing equipment and all-hazards emergency surge supplies. Requires council to report to Legislative Assembly.

Directs department] Oregon Business Development Department to establish and administer Oregon Resiliency Partnership in consultation with other entities]. Limits civil liability in certain circumstances.

Declares emergency, effective on passage.

Relating to critical disaster preparedness; declaring an emergency.

Relating to critical disaster preparedness; and declaring an emergency.

HB 2494	06/26/21 - In committee upon adjournment.

Establishes legislative Task Force on the Impacts of COVID-19 on Health Care Delivery Systems to evaluate impacts of COVID-19 on health care delivery systems in this state.

Sunsets December 31, 2022.

Takes effect on 91st day following adjournment sine die.

Relating to health care; prescribing an effective date.

Relating to health care; and prescribing an effective date.

Bill Number	Last Action
HB 2508	06/10/21 - Chapter 117, (2021 Laws): Effective date June 1, 2021.

Requires Oregon Health Authority to ensure] Prescribes requirements for reimbursement by Oregon Health Authority and coordinated care organizations of health services delivered using telemedicine.

Modifies requirements for health benefit plan coverage of telemedicine.

Requires Department of Consumer and Business Services to report to interim committees of Legislative Assembly, no later than March 1, 2023, on impact of required reimbursement of telemedicine health services by health benefit plans on cost of health insurance premiums in Oregon.

Declares emergency, effective on passage.

Relating to telemedicine; and declaring an emergency.

Relating to telemedicine; and declaring an emergency.

HB 2528	07/19/21 - Governor signed.

Directs Oregon Board of Dentistry to issue dental therapist license to qualified applicant. Prohibits unlicensed use of title "dental therapist" and practice of dental therapy. Provides exceptions to prohibition. Requires dental therapist to purchase and maintain liability insurance. Requires dental therapist to dedicate majority of practice to specified patient populations. Directs board to consult with dental therapists and dental therapist organizations in rulemaking.

Takes effect on 91st day following adjournment sine die.

Relating to dental therapy; and prescribing an effective date.

Relating to dental therapy; and prescribing an effective date.

HB 2557	06/26/21 - In committee upon adjournment.

Establishes COFA Dental Program in Oregon Health Authority to provide dental care to low-income citizens of Pacific Islands in Compact of Free Association who reside in Oregon and lack access to affordable dental coverage. Specifies eligibility requirements for program and duties of authority in administering program.

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association.

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association; creating new provisions; and amending ORS 413.032 and 735.608.

HB 2591	07/27/21 - Governor signed.

Allows mobile school-based health centers to qualify for safety net grants from Oregon Health Authority.]

Requires Oregon Health Authority to provide planning grants to 10 school districts or education service districts to evaluate need and develop plans for school-based health services. Requires authority to provide funding to operate school-based health center or school nurse model at conclusion of two-year planning process.

Requires authority to develop requirements for up to three school districts or education service districts to receive grants for planning for and operation of mobile school-linked health centers.

Requires authority to award grants to three school-based health centers to operate pilot projects to expand student access to mental and physical health care services through use of telehealth. Specifies requirements.

Extends sunset on current program for school planning grants and technical assistance from January 2, 2026, to January 2, 2028.

Declares emergency, effective July 1, 2021.

Relating to school-based health center grants; and declaring an emergency.

Relating to school-based health center grants; and declaring an emergency.

HB 2622	07/07/21 - Chapter 362, (2021 Laws): Effective date January 1, 2022.

Requires hospitals and ambulatory surgical centers to adopt policies that require use of smoke evacuation system during surgical procedures likely to generate surgical smoke.

Relating to surgical smoke.

Relating to surgical smoke.

Bill Number	Last Action
HB 2627	06/10/21 - Chapter 69, (2021 Laws): effective on the 91st day following adjournment sine die.

Allows expanded practice dental hygienist to perform interim therapeutic restoration. Requires agreement between dentist and expanded practice dental hygienist to include expanded practice dental hygienist's scope of practice regarding interim therapeutic restorations. Defines "interim therapeutic restoration."

Directs Oregon Board of Dentistry to adopt rules to establish educational and instructional requirements for interim therapeutic restoration and to approve applications from education providers for training courses that meet requirements. Requires certain expanded practice dental hygienists to complete approved training course.

Takes effect on 91st day following adjournment sine die.

Relating to interim therapeutic restorations; and prescribing an effective date.

Relating to interim therapeutic restorations; and prescribing an effective date.

HB 2638	06/26/21 - In committee upon adjournment.

Limits liability for certain claims for damages arising out of acts or omissions taken during COVID-19 emergency period in reasonable compliance with government guidance related to COVID-19.

Relating to limitations of liability during the COVID-19 emergency.

Relating to limitations of liability during the COVID-19 emergency.

HB 2752	06/26/21 - In committee upon adjournment.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.

Takes effect on 91st day following adjournment sine die.

Relating to information regarding vaccines; prescribing an effective date.

Relating to information regarding vaccines; and prescribing an effective date.

HB 2816	06/26/21 - In committee upon adjournment.

Establishes BIPOC health care provider loan forgiveness program within Oregon Health Authority to provide loan repayment subsidies to BIPOC health care providers. Defines "BIPOC."

Establishes BIPOC Health Care Provider Fund to carry out provisions of program.

Takes effect on 91st day following adjournment sine die.

Relating to health care provider incentives; prescribing an effective date.

Relating to health care provider incentives; and prescribing an effective date.

HB 2891	06/26/21 - In committee upon adjournment.

Requires health care facilities, health care providers, local public health authorities and public and private safety agencies to maintain capacity, including sufficient amounts of certain supplies, to continue in normal operation for 120 days at 25 percent mortality rate. Defines "25 percent mortality rate." Directs Oregon Health Authority and health professional regulatory boards to report to Office of Emergency Management. Directs office to report annually to interim committee of Legislative Assembly related to emergency preparedness.

Takes effect on 91st day following adjournment sine die.

Relating to emergency preparedness; prescribing an effective date.

Relating to emergency preparedness; and prescribing an effective date.

HB 2901	06/26/21 - In committee upon adjournment.

Requires coordinated care organization drug outlets to dispense seven-day supply of prescription drug to veteran with disability, at no cost to veteran, if veteran is unable to obtain prescription drug through United States Department of Veterans Affairs.

Relating to prescription drugs for veterans.

Relating to prescription drugs for veterans.

Bill Number	Last Action
HB 2927	07/19/21 - Governor signed.

Renames Office of Emergency Management as Oregon Department of Emergency Management. Establishes department as independent state agency. Directs department to carry out certain functions related to regional and statewide emergency response and preparedness.

Transfers Oregon Emergency Response System from Department of State Police to Oregon Department of Emergency Management, operative July 1, 2025.

Renames office of State Fire Marshal as Department of the State Fire Marshal and establishes department as independent state agency, operative July 1, 2023.

Transfers Oregon Homeland Security Council to Office of Governor. Adds members to and modifies duties of commission.

Establishes Emergency Preparedness Advisory Council to facilitate policy recommendations related to catastrophic disaster. Sunsets council on January 2, 2030.

Establishes Local Government Emergency Management Advisory Council to provide advice and recommendations to Oregon Department of Emergency Management regarding department's emergency preparedness and response functions. Sunsets council on January 2, 2030.

Establishes task force to make recommendations as to whether State Fire Marshal should be made independent state agency or housed within existing state agency, operative immediately. Directs task force to report recommendations by February 1, 2022.

Becomes operative on July 1, 2022, except as specified.

Appropriates moneys from General Fund and increases certain expenditure limitations for various state agencies to carry out provisions of Act.

Declares emergency, effective on passage.

Relating to emergency management; and declaring an emergency.

Relating to emergency management; and declaring an emergency.

HB 2970	07/07/21 - Chapter 366, (2021 Laws): Effective date June 23, 2021.

Defines "device" for purposes of practice of advanced nonablative esthetics. Prohibits use of device not registered with United States Food and Drug Administration. Defines "mechanical or electrical apparatus, appliance or device" for purposes of esthetics.

Provides that Board of Certified Advanced Estheticians is subject to oversight by Health Licensing Office.

Specifies evidence of education that applicant for residential care facility administrator license must provide to Health Licensing Office.

Allows nonprofit charitable corporation that provides dental services to individuals 65 years of age and older and individuals unable to stand or walk unassisted to own, operate, conduct or maintain dental practice, clinic or office. Sunsets January 1, 2023.

Declares emergency, effective on passage.

Relating to health care; and declaring an emergency.

Relating to health care; and declaring an emergency.

HB 2993	07/27/21 - Chapter 463, (2021 Laws): Effective date January 1, 2022.

Requires agency to appoint advisory committee to represent interests of persons likely to be affected by proposed rule.]

Provides that advisory committees appointed by agency as part of rulemaking must represent interests of persons and communities likely to be affected by rule.

Requires agency to include in notice of rulemaking statement identifying how adoption of rule will affect racial equity.

Relating to administrative rules.

Relating to administrative rules.

BillTracker

Custom Report

Report Date: July 30, 2021

Bill Number	Last Action
HB 3057	06/10/21 - Chapter 92, (2021 Laws): Effective date May 24, 2021.
	Authorizes Oregon Health Authority to disclose individually identifiable information related to COVID-19 to certain persons and under certain circumstances. Sunsets June 30, 2022. Declares emergency, effective on passage.
	Relating to the disclosure of information related to COVID-19; and declaring an emergency.
	Relating to the disclosure of information related to COVID-19; and declaring an emergency.
HB 3087	06/26/21 - In committee upon adjournment.
	Directs Oregon Health Authority to establish volunteer vaccine administration program to utilize specified volunteer health care providers to administer vaccines in emergency. Defines "emergency." Declares emergency, effective on passage.
	Relating to vaccine administration; declaring an emergency.
	Relating to vaccine administration; and declaring an emergency.
HB 3159	07/19/21 - Governor signed.
	Requires coordinated care organization, health care provider or health insurer to collect from patient, client or member data on race, ethnicity, preferred spoken and written languages, disability status, sexual orientation and gender identity. Establishes civil penalty for violation. Requires Oregon Health Authority to establish data system for receipt and storage of specified data. Requires authority to report every two years, beginning on June 1, 2022, on collection of data to appropriate interim committees of Legislative Assembly. Directs authority to administer grant program to provide funding to support safe data collection by specified organizations. Takes effect on 91st day following adjournment sine die.
	Relating to data collection; and prescribing an effective date.
	Relating to data collection; and prescribing an effective date.
SB 11	06/26/21 - In committee upon adjournment.
	Requires health benefit plan to reimburse cost of covered telemedicine health service provided by health professional licensed or certified in this state if same health service is covered when provided in person.
	Relating to telemedicine.
	Relating to telemedicine; creating new provisions; and amending ORS 743A.058 and 743A.185.
SB 61	06/30/21 - Effective date, January 1, 2022.
	Authorizes Oregon Government Ethics Commission to provide written commission advisory opinions, staff advisory opinions and oral or written staff advice on application of executive session provisions of Oregon public meetings law. Grants specified safe harbor provisions to persons who rely in good faith on commission opinions or advice.
	Relating to advice offered by Oregon Government Ethics Commission.
	Relating to advice offered by Oregon Government Ethics Commission.
SB 99	06/10/21 - Effective on the 91st day following adjournment sine die.
	Allows Board of Medical Imaging designee to perform inspections related to medical imaging and X-ray machines. Takes effect on 91st day following adjournment sine die.
	Relating to Board of Medical Imaging; and prescribing an effective date.
	Relating to Board of Medical Imaging; and prescribing an effective date.

Bill Number	Last Action
SB 254	06/26/21 - In committee upon adjournment.

Removes ability of parent to decline required immunizations against restrictable diseases on behalf of child for reason other than child's indicated medical diagnosis. Allows child who is not immunized or exempt for reason of indicated medical diagnosis to attend school that provides education program through online courses. Prohibits child from attending in person specified school-related events, meetings and opportunities. Allows Oregon Health Authority to recommend diseases in addition to restrictable diseases against which children may be immunized.

Directs boards that regulate certain licensed health care practitioners to review documents completed by licensed health care practitioners granting exemptions from immunization requirements because of indicated medical diagnosis. Defines "licensed health care practitioner." Requires boards to annually report to authority on results of review. Requires authority to report annually to Legislative Assembly on reports submitted to boards.

Directs authority to establish outreach and education plan regarding disease control in schools.

Allows child who is not immunized to continue attending school in person until August 1, 2022. Allows child who is not immunized and has schedule for immunizations approved by authority to continue attending school in person after August 1, 2022.

Declares emergency, effective on passage.

Relating to health care; declaring an emergency.

Relating to health care; creating new provisions; amending ORS 433.102, 433.235, 433.255, 433.260, 433.267, 433.269, 433.273 and 433.284; and declaring an emergency.

SB 423	06/26/21 - In committee upon adjournment.

Allows patient located in Oregon to receive health care services through telemedicine from specified out-of-state health care provider. Defines "telemedicine."

Takes effect on 91st day following adjournment sine die.

Relating to telemedicine; prescribing an effective date.

Relating to telemedicine; and prescribing an effective date.

SB 454	06/26/21 - In committee upon adjournment.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.

Takes effect on 91st day following adjournment sine die.

Relating to ingredients in vaccines; prescribing an effective date.

Relating to ingredients in vaccines; and prescribing an effective date.

SB 488	06/26/21 - In committee upon adjournment.

Adds exposure to or infection by SARS-CoV-2 to definition of occupational disease for purposes of workers' compensation. Specifies presumptions as to compensability for occupational disease or occupational injury that apply to subject worker's death, disability, impairment of health, loss of work time and expenses of medical treatment or services, including diagnostic or preventive medical treatment or services, as result of exposure to SARS-CoV-2 or COVID-19.

Sunsets provisions on 180th day following expiration or termination of Governor's declaration of emergency concerning COVID-19 pandemic, including any extension of declaration.

Declares emergency, effective on passage.

Relating to the compensability of COVID-19 for the purposes of workers' compensation; declaring an emergency.

Relating to the compensability of COVID-19 for the purposes of workers' compensation; creating new provisions; amending ORS 656.802; and declaring an emergency.

SB 505	06/26/21 - In committee upon adjournment.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.

Takes effect on 91st day following adjournment sine die.

Relating to ingredients in vaccines; prescribing an effective date.

Relating to ingredients in vaccines; and prescribing an effective date.

Bill Number	Last Action
SB 557	06/26/21 - In committee upon adjournment.
	Establishes COFA Dental Program in Oregon Health Authority to provide dental care to low-income citizens of Pacific Islands in Compact of Free Association who reside in Oregon, qualify for medical assistance through Oregon Supplemental Income Program and lack access to affordable dental coverage. Specifies eligibility requirements for program and duties of authority in administering program.
	Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association.
	Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association; creating new provisions; and amending ORS 413.032 and 735.608.
SB 640	06/26/21 - In committee upon adjournment.
	Establishes Indian Health Scholarship Program to provide free tuition and fees for qualifying Indian health profession students in exchange for student commitment to work at tribal service site after graduation. Appropriates moneys for 2021-2023 biennium to Oregon Health and Science University for purpose of administering Indian Health Scholarship Program. Declares emergency, effective July 1, 2021.
	Relating to tribal health; declaring an emergency.
	Relating to tribal health; creating new provisions; amending ORS 676.454 and 676.467; and declaring an emergency.
SB 655	06/26/21 - In committee upon adjournment.
	Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information. Takes effect on 91st day following adjournment sine die.
	Relating to ingredients in vaccines; prescribing an effective date.
	Relating to ingredients in vaccines; and prescribing an effective date.
SB 666	06/26/21 - In committee upon adjournment.
	Modifies public meeting notice requirements for meetings held in executive session. Removes labor negotiations exception for executive session.
	Relating to public meetings.
	Relating to public meetings; amending ORS 192.640 and 192.660.
SB 697	06/26/21 - In committee upon adjournment.
	Prescribes additional requirements for health benefit plan coverage of telemedical health services. Takes effect on 91st day following adjournment sine die.
	Relating to telemedical health services; prescribing an effective date.
	Relating to telemedical health services; amending ORS 743A.058 and 743A.185; and prescribing an effective date.

Bill Number	Last Action
SB 758	06/26/21 - In committee upon adjournment.

Changes "Oregon Medical Marijuana Act" to "Oregon Medical and Therapeutic Cannabis Act." Allows person designated to produce marijuana by registry identification cardholder to enter into agreement with registry identification cardholder to transfer marijuana to another registry identification cardholder or primary caregiver. Directs Oregon Health Authority to adopt policies and make public statement regarding equitable access to marijuana for medical use.] Allows medical marijuana dispensary and recreational marijuana retailer to transfer marijuana to individual who holds valid out-of-state medical marijuana patient card. Requires authority to ensure cybersecurity of personally identifiable information in authority databases and electronic systems.] Exempts out-of-state medical marijuana patient from taxation on retail sale of marijuana items. Specifies health care providers who may recommend medical use of marijuana to registry identification cardholder. Provides that Oregon Health Authority may not charge fee greater than $20 for registry identification card for certain individuals. Directs authority to issue permanent registry identification card to individual with lifetime debilitating medical condition. Requires organizations designated as primary caregivers to allow consumption of marijuana for medical use.] Removes criminal records check requirements for applicants for authority registration. Provides that certain marijuana grow sites are not subject to tracking requirements or marijuana plant limits].

Requires marijuana retailers and medical marijuana dispensaries to make available online terpene testing results.]

Directs Oregon Liquor Control Commission to establish care and accommodation program to ensure long-term access to marijuana products for registry identification cardholders. Allows certain recreational marijuana processors to receive marijuana from medical marijuana grow site for purposes of processing marijuana.]

Requires distribution of moneys from Oregon Marijuana Account for purposes of administering medical marijuana program.

Becomes operative January 1, 2022.

Directs authority to issue permanent registry identification card to individual with lifetime debilitating medical condition.

Requires marijuana retailers and medical marijuana dispensaries to make available online terpene testing results.

Becomes operative June 1, 2022.

Directs authority to adopt policies and make public statement regarding equitable access to marijuana for medical use. Requires authority to ensure cybersecurity of personally identifiable information in authority databases and electronic systems.

Becomes operative September 1, 2022.

Takes effect on 91st day following adjournment sine die.

Relating to medical marijuana; prescribing an effective date.

Relating to medical marijuana; creating new provisions; amending ORS 475B.020, 475B.220, 475B.431, 475B.570, 475B.630, 475B.707, 475B.759, 475B.788, 475B.791, 475B.797, 475B.801, 475B.810, 475B.822, 475B.831, 475B.834, 475B.837, 475B.840, 475B.858, 475B.879, 475B.885, 475B.895, 475B.898, 475B.901, 475B.904, 475B.913, 475B.916, 475B.952 and 475B.961 and section 5, chapter 2, Oregon Laws 2021 (Ballot Measure 110 (2020)); repealing ORS 475B.794, 475B.816, 475B.819, 475B.843 and 475B.861; and prescribing an effective date.

SB 5511	06/30/21 - Effective date, July 1, 2021.

Limits biennial expenditures from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by Oregon Board of Dentistry.

Declares emergency, effective July 1, 2021.

Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.

Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.

Enrolled
House Bill 2359

Sponsored by Representatives SALINAS, RUIZ, Senator FREDERICK; Representatives ALONSO LEON, BYNUM, CAMPOS, DEXTER, GRAYBER, LEIF, NOSSE, PHAM, REYNOLDS, SANCHEZ, SCHOUTEN, SOLLMAN, VALDERRAMA (Presession filed.)

CHAPTER .....

AN ACT

Relating to health care interpreters; creating new provisions; amending ORS 413.550, 413.552, 413.556, 413.558, 414.572, 656.027 and 657.046; repealing ORS 657.048; and declaring an emergency.

Whereas current law contains a loophole for health care providers and interpretation service companies to justify working with untrained health care interpreters despite the availability of health care interpreters who are qualified or certified by the Oregon Health Authority; and

Whereas current law does not hold accountable health care providers and interpretation service companies for failing to work with qualified or certified interpreters or for failing to work with best practices in providing health care interpretation services; and

Whereas there is currently no complaint process for health care interpreters who experience wage or other labor violations; and

Whereas there is a growing demand for health care interpreters in rural communities in this state, especially for interpreters capable of interpreting languages of limited diffusion in those areas; and

Whereas health care interpreters suffer from the inequitable business practices of interpretation service companies; and

Whereas due to the low payment rates and the rising cost of training and testing, current and potential health care interpreters are reluctant to invest in training, testing, qualification or certification because of the low return on their investment; and

Whereas there is a lack of uniformity statewide in the quality of health care interpretation services; and

Whereas there is a lack of a uniform training curriculum statewide; now, therefore,

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of ORS 413.550 to 413.558.

SECTION 2. (1) Except as provided in subsection (2) of this section, a health care provider shall work with a health care interpreter from the health care interpreter registry administered by the Oregon Health Authority under ORS 413.558 when communicating with a patient who prefers to communicate in a language other than English, unless the health care provider is a doctor or clinician who is proficient in the patient's preferred language.

(2) A health care provider who is otherwise required to work with a health care interpreter from the health care interpreter registry may work with a health care interpreter who is not listed on the health care interpreter registry only if the provider:

(a) Verifies, in the manner prescribed by rule by a board or agency described in section 3 of this 2021 Act, that the provider has taken appropriate steps needed to obtain a health care interpreter from the health care interpreter registry in accordance with rules adopted by the authority under ORS 413.558; or

(b) Has offered the patient the services of a health care interpreter from the health care interpreter registry and the patient declined the offer and chose a different interpreter.

(3) A health care provider shall give personal protective equipment, consistent with established national standards, to health care interpreters providing services on-site at no cost to the health care interpreter and may not suggest to the health care interpreter that the health care interpreter should procure the health care interpreter's own personal protective equipment as a condition of working with the health care provider.

(4) A health care provider shall maintain records of each patient encounter in which the provider worked with a health care interpreter from the health care interpreter registry. The records must include:

(a) The name of the health care interpreter;

(b) The health care interpreter's registry number; and

(c) The language interpreted.

(5) The boards and agencies described in section 3 of this 2021 Act shall adopt rules to carry out the provisions of this section, which may include additional exemptions under subsection (2) of this section.

SECTION 3. Section 2 of this 2021 Act may be enforced by any means permitted under law by:

(1) A health professional regulatory board with respect to a health care provider under the jurisdiction of the board.

(2) The Oregon Health Authority or the Department of Human Services with regard to health care providers or facilities regulated by the authority or the department and health care providers enrolled in the medical assistance program.

(3) The authority with regard to emergency medical services providers licensed under ORS 682.216 and clinical laboratories licensed under ORS 438.110.

SECTION 4. (1) An interpretation service company operating in this state:

(a) Except as provided in paragraph (b) of this subsection, may not arrange for a health care interpreter to provide interpretation services in health care settings if the health care interpreter is not listed on the health care interpreter registry described in ORS 413.558.

(b) May arrange for a health care interpreter who is not listed on the health care interpreter registry to provide interpretation services in health care settings only if:

(A) A health care provider represents to the interpretation service company that the health care provider:

(i) Has taken appropriate steps necessary to arrange for a health care interpreter from the health care interpreter registry in the manner prescribed by rule under section 2 of this 2021 Act; and

(ii) Was unable to arrange for a health care interpreter from the health care interpreter registry; and

(B) The interpretation service company does not employ a health care interpreter listed on the health care interpreter registry who is available to provide interpretation services to the health care provider.

(c) May not represent to a health care provider that a contracted or employed health care interpreter referred by the company is a certified health care interpreter unless the interpreter has met the requirements for certification under ORS 413.558 and has been issued a valid certification by the authority.

(d) May not require or suggest to a health care interpreter that the health care interpreter procure the health care interpreter's own personal protective equipment as a condition of receiving a referral.

(2) An interpretation service company shall maintain records of each encounter in which the company refers to a health care provider worked with a health care interpreter from the health care interpreter registry or a health care interpreter who is not on the registry. The records must include:

(a) The name of the health care interpreter; and

(b) The health care interpreter's registry number, if applicable.

SECTION 5. Section 6 of this 2021 Act is added to and made a part of ORS chapter 414.

SECTION 6. (1) As used in this section:

(a) "Certified health care interpreter" has the meaning given that term in ORS 413.550.

(b) "Qualified health care interpreter" has the meaning given that term in ORS 413.550.

(2) The Oregon Health Authority shall adopt rules to ensure that a coordinated care organization, in accordance with ORS 414.572 (2)(e), and any other health care provider that is reimbursed for the cost of health care by the state medical assistance program:

(a) Works with a certified health care interpreter or a qualified health care interpreter when interacting with a recipient of medical assistance, or a caregiver of a recipient of medical assistance, who has limited English proficiency or who communicates in signed language; and

(b) Is reimbursed for the cost of the certified health care interpreter or qualified health care interpreter.

SECTION 7. (1) As used in this section, "health care interpreter" has the meaning given that term in ORS 413.550.

(2) The Oregon Health Authority shall, in collaboration with the Oregon Council on Health Care Interpreters and health care interpreters, conduct a study:

(a) Of the best model for an online platform for patients and health care providers to contract with health care interpreters and on how to use state and federal funds to finance the platform, to be completed no later than July 1, 2022; and

(b) Regarding sight translation as it pertains to the definition of "health care interpreter" in ORS 413.550 and related best practices.

(3) No later than January 1, 2022, the authority shall report to the interim committees of the Legislative Assembly related to health the results of the studies described in subsection (2) of this section and recommendations for legislative changes, if necessary, to implement the findings of the studies.

SECTION 8. ORS 413.550 is amended to read:

413.550. As used in ORS 413.550 to 413.558:

(1) "Certified health care interpreter" means an individual who has been approved and certified by the Oregon Health Authority **under ORS 413.558.**

(2) "Coordinated care organization" has the meaning given that term in ORS 414.025.

[*(2)*] **(3)** "Health care" means medical, surgical**, oral** or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

[*(3)*] **(4)(a)** "Health care interpreter" means an individual who is readily able to:

[*(a)*] **(A) Communicate in English and** communicate with a person with limited English proficiency **or who communicates in signed language**;

[*(b)*] **(B)** Accurately interpret the oral statements of a person with limited English proficiency, or the statements of a person who communicates in [*sign*] **signed** language, into English;

(C) Accurately interpret oral statements in English to a person with limited English proficiency or who communicates in signed language;

[*(c)*] **(D)** Sight translate documents from a person with limited English proficiency; **and**

[*(d)*] **(E)** Interpret the oral statements of other persons into the language of the person with limited English proficiency or into [*sign*] **signed** language[*; and*]**.**

[*(e) Sight translate documents in English into the language of the person with limited English proficiency.*]

(b) "Health care interpreter" also includes an individual who can provide the services described in paragraph (a) of this subsection using relay or indirect interpretation.

(5) "Health care interpreter registry" means the registry described in ORS 413.558 that is administered by the authority.

(6) "Health care provider" means any of the following that are reimbursed with public funds, in whole or in part:

(a) An individual licensed or certified by the:

(A) State Board of Examiners for Speech-Language Pathology and Audiology;

(B) State Board of Chiropractic Examiners;

(C) State Board of Licensed Social Workers;

(D) Oregon Board of Licensed Professional Counselors and Therapists;

(E) Oregon Board of Dentistry;

(F) State Board of Massage Therapists;

(G) Oregon Board of Naturopathic Medicine;

(H) Oregon State Board of Nursing;

(I) Oregon Board of Optometry;

(J) State Board of Pharmacy;

(K) Oregon Medical Board;

(L) Occupational Therapy Licensing Board;

(M) Oregon Board of Physical Therapy;

(N) Oregon Board of Psychology;

(O) Board of Medical Imaging;

(P) State Board of Direct Entry Midwifery;

(Q) Respiratory Therapist and Polysomnographic Technologist Licensing Board;

(R) Board of Registered Polysomnographic Technologists;

(S) Board of Licensed Dietitians; and

(T) State Mortuary and Cemetery Board;

(b) An emergency medical services provider licensed by the Oregon Health Authority under ORS 682.216;

(c) A clinical laboratory licensed under ORS 438.110;

(d) A health care facility as defined in ORS 442.015;

(e) A home health agency licensed under ORS 443.015;

(f) A hospice program licensed under ORS 443.860; or

(g) Any other person that provides health care or that bills for or is compensated for health care provided, in the normal course of business.

(7) "Interpretation service company" means an entity, or a person acting on behalf of an entity, that is in the business of arranging for health care interpreters to work with health care providers in this state.

[*(4)*] **(8)** "Person with limited English proficiency" means a person who, by reason of place of birth or culture, [*speaks*] **communicates in** a language other than English and does not [*speak*] **communicate in** English with adequate ability to communicate effectively with a health care provider.

(9) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

[*(5)*] **(10)** "Qualified health care interpreter" means an individual who has [*received*] **been issued** a valid letter of qualification from the authority **under ORS 413.558**.

[*(6)*] **(11)** "Sight translate" means to translate a written document into spoken or [*sign*] **signed** language.

SECTION 9. ORS 413.552 is amended to read:

413.552. (1) The Legislative Assembly finds that persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often unable to interact effectively with health care providers. Because of language differences, persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information.

(2) The Legislative Assembly further finds that the lack of competent health care interpreters among health care providers impedes the free flow of communication between the health care provider and patient, **negatively impacting health outcomes and** preventing clear and accurate communication and the development of empathy, confidence and mutual trust that is essential for an effective relationship between health care provider and patient.

(3) It is the policy of the Legislative Assembly to require [*the use of*] **working with** certified health care interpreters or qualified health care interpreters [*whenever possible*] to ensure the accurate and adequate provision of health care to persons with limited English proficiency and to persons who communicate in [*sign*] **signed** language.

(4) It is the policy of the Legislative Assembly that health care for persons with limited English proficiency be provided according to the guidelines established under the policy statement issued August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights, entitled, "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," and the 1978 Patient's Bill of Rights.

SECTION 10. ORS 413.556 is amended to read:

413.556. The Oregon Council on Health Care Interpreters shall work in cooperation with the Oregon Health Authority to:

(1) Develop **and approve** testing, qualification and certification standards**, consistent with national standards,** for health care interpreters for persons with limited English proficiency and for persons who communicate in [*sign*] **signed** language.

[*(2) Coordinate with other states, the federal government or professional organizations to develop and implement educational and testing programs for health care interpreters.*]

[*(3) Examine operational and funding issues, including but not limited to the feasibility of developing a central registry and annual subscription mechanism for health care interpreters.*]

[*(4)*] **(2)** Do all other acts as shall be necessary or appropriate under the provisions of ORS 413.550 to 413.558.

SECTION 11. ORS 413.558 is amended to read:

413.558. (1) In consultation with the Oregon Council on Health Care Interpreters, the Oregon Health Authority shall by rule establish procedures for testing, qualification and certification of health care interpreters for persons with limited English proficiency or for persons who communicate in [*sign*] **signed** language, including but not limited to:

(a) Minimum standards for qualification and certification as a health care interpreter, **which may be modified as necessary,** including:

(A) Oral [*and written*] **or signed** language skills in English and in the language for which health care interpreter qualification or certification is granted; and

(B) Formal education or training in **interpretation,** medical **behavioral or oral health** terminology, anatomy and physiology[*, medical interpreting ethics and interpreting skills*];

(b) Categories of expertise of health care interpreters based on the English and non-English skills, or interpreting skills, and the medical terminology skills of the person seeking qualification or certification;

(c) Procedures for receiving applications and for examining applicants for qualification or certification;

(d) The content and administration of required examinations;

(e) The requirements and procedures for reciprocity of qualification and certification for health care interpreters qualified or certified in another state or territory of the United States or by another certifying body in the United States; and

(f) Fees for application, examination, initial issuance, renewal and reciprocal acceptance of qualification or certification as a health care interpreter if deemed necessary by the authority.

(2) Any person seeking qualification or certification as a health care interpreter must submit an application to the authority. If the applicant meets the requirements for qualification or certification established by the authority under this section, the authority shall issue a letter of qualification or a certification to the health care interpreter. **The authority shall notify a person of the authority's determination on the person's application no later than 60 days after the date the application is received by the authority.**

(3) The authority shall work with other states, the federal government or professional organizations to develop educational and testing programs and procedures for the qualification and certification of health care interpreters.

(4) In addition to the requirements for qualification established under subsection (1) of this section, a person may be qualified as a health care interpreter only if the person:

(a) Is able to fluently interpret [*the dialect,*] slang**, idioms and specialized vocabulary in English and the slang, idioms** or specialized vocabulary of the non-English language for which qualification is sought; and

(b) Has had at least 60 hours of health care interpreter training that includes anatomy and physiology and concepts of [*medical*] **health care** interpretation.

(5) A person may not use the title of "qualified health care interpreter" in this state**, or any other title, designation, words, letters, abbreviation, sign or device tending to indicate that the person is a qualified health care interpreter,** unless the person has met the requirements for qualification established under subsections (1) and (4) of this section and has been issued a valid letter of qualification by the authority.

(6) In addition to the requirements for certification established under subsection (1) of this section, a person may be certified as a health care interpreter only if:

(a) The person has met all the requirements established under subsection (4) of this section; and

(b) The person has passed written and oral examinations required by the authority in English, in a non-English language or [*sign*] **signed** language and in medical terminology.

(7) A person may not use the title of "certified health care interpreter" in this state**, or any other title, designation, words, letters, abbreviation, sign or device tending to indicate that the person is a certified health care interpreter,** unless the person has met the requirements for certification established under subsections (1) and (6) of this section and has been issued a valid certification by the authority.

(8) The authority shall:

(a) Provide health care interpreter training and continuing education in accordance with standards adopted by the Oregon Council on Health Care Interpreters under ORS 413.556 to professionalize the health care interpreter workforce in this state. The training may be provided at no cost or, if not, must be affordable.

(b) Maintain a record of all health care interpreters who have completed an approved training program.

(c) Establish and maintain a central registry for all health care interpreters who are qualified or certified by the authority and establish a process for health care interpreters to biennially update their contact information and confirm their participation in the registry.

(d) Adopt rules to carry out the provisions of this section.

(9) The authority shall provide the notice described in ORS 183.335 (1) to all certified and qualified health care interpreters listed on the registry prior to the adoption, amendment or repeal of any rule concerning qualified or certified health care interpreter services.

SECTION 12. The amendments to ORS 413.558 by section 11 of this 2021 Act do not require the Oregon Health Authority or the Oregon Council on Health Care Interpreters to

establish a new health care interpreter registry in addition to the health care interpreter registry in effect on the effective date of this 2021 Act.

SECTION 13. ORS 414.572 is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 14. ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364, Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon Laws 2019, is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be

local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 15. ORS 656.027 is amended to read:

656.027. All workers are subject to this chapter except those nonsubject workers described in the following subsections:

(1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection "domestic servant" means any worker engaged in household domestic service by private employment contract, including, but not limited to, home health workers.

(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker.

(3)(a) A worker whose employment is casual and either:

(A) The employment is not in the course of the trade, business or profession of the employer; or

(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

(b) For the purpose of this subsection, "casual" refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $500.

(4) A person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States.

(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state.

(6) Firefighter and police employees of any city having a population of more than 200,000 that provides a disability and retirement system by ordinance or charter.

(7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor **to be a nonsubject worker**.

(b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor must qualify as an independent contractor. Any sole proprietor licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(8) Except as provided in subsection (23) of this section, partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor **to be a nonsubject worker**.

(9) Except as provided in subsection (25) of this section, members, including members who are managers, of limited liability companies, regardless of the nature of the work performed. However, members, including members who are managers, of limited liability companies with more than one member, while engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, are subject workers. When labor or services are performed under contract, the limited liability company must qualify as an independent contractor **to be a nonsubject worker**.

(10) Except as provided in subsection (24) of this section, corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers, subject to the following limitations:

(a) If the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS chapter 308A, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption.

(b) If the activities of the corporation involve the commercial harvest of timber and all officers of the corporation are members of the same family and are parents, daughters or sons, daughters-in-law or sons-in-law or grandchildren, then all such officers may elect to be nonsubject workers. For all other corporations involving the commercial harvest of timber, the maximum number of exempt corporate officers for the corporation shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor **to be a nonsubject worker**.

(11) A person performing services primarily for board and lodging received from any religious, charitable or relief organization.

(12) A newspaper carrier utilized in compliance with the provisions of ORS 656.070 and 656.075.

(13) A person who has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for performance of services as an athlete other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance, or any amateur sports official who is certified by a recognized Oregon or national certifying authority, which requires or provides liability and accident insurance for such officials. A roster of recognized Oregon and national certifying authorities will be maintained by the Department of Consumer and Business Services, from lists of certifying organizations submitted by the Oregon School Activities Association and the Oregon Park and Recreation Society.

(14) Volunteer personnel participating in the ACTION programs, organized under the Domestic Volunteer Service Act of 1973, P.L. 93-113, known as the Foster Grandparent Program and the Senior Companion Program, whether or not the volunteers receive a stipend or nominal reimbursement for time and travel expenses.

(15) A person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment. As used in this subsection "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or piling.

(b) A motor vehicle used in the transportation of rocks, gravel, sand, dirt or asphalt concrete.

(c) A motor vehicle used in the transportation of property by a for-hire motor carrier that is required under ORS 825.100 or 825.104 to possess a certificate or permit or to be registered.

(16) A person engaged in the transportation of the public for recreational down-river boating activities on the waters of this state pursuant to a federal permit when the person furnishes the equipment necessary for the activity. As used in this subsection, "recreational down-river boating activities" means those boating activities for the purpose of recreational fishing, swimming or sightseeing utilizing a float craft with oars or paddles as the primary source of power.

(17) A person who receives no wage other than ski passes or other noncash remuneration for performing volunteer:

(a) Ski patrol activities; or

(b) Ski area program activities sponsored by a ski area operator, as defined in ORS 30.970, or by a nonprofit corporation or organization.

(18) A person 19 years of age or older who contracts with a newspaper publishing company or independent newspaper dealer or contractor to distribute newspapers to the general public and perform or undertake any necessary or attendant functions related thereto.

(19) A person performing foster parent or adult foster care duties pursuant to [*ORS 412.001 to 412.161 and 412.991 or*] ORS chapter [*411,*] 418, 430 or 443.

(20) A person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or nominal reimbursements or vouchers for meals, lodging or expenses.

(21) A person performing services under a property tax work-off program established under ORS 310.800.

(22) A person who performs service as a caddy at a golf course in an established program for the training and supervision of caddies under the direction of a person who is an employee of the golf course.

(23)(a) Partners who are actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in a partnership. If all partners are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such partners may elect to be nonsubject workers. For all other partnerships licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt partners shall be whichever is the greater of the following:

(A) Two partners; or

(B) One partner for each 10 partnership employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the partnership qualifies as an independent contractor. Any partnership licensed under

ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(24)(a) Corporate officers who are directors of a corporation actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed. If all officers of the corporation are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such officers may elect to be nonsubject workers. For all other corporations licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt corporate officers shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the corporation qualifies as an independent contractor. Any corporation licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(25)(a) Limited liability company members who are members of a company actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the company, regardless of the nature of the work performed. If all members of the company are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such members may elect to be nonsubject workers. For all other companies licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt company members shall be whichever is the greater of the following:

(A) Two company members; or

(B) One company member for each 10 company employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the company qualifies as an independent contractor. Any company licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(26) A person serving as a referee or assistant referee in a youth or adult recreational soccer match whose services are retained on a match-by-match basis.

[*(27) A person performing language translator or interpreter services that are provided for others through an agent or broker.*]

[*(28)*] **(27)** A person who operates, and who has an ownership or leasehold interest in, a passenger motor vehicle that is operated as a taxicab or for nonemergency medical transportation. As used in this subsection:

(a) "Lease" means a contract under which the lessor provides a vehicle to a lessee for consideration.

(b) "Leasehold" includes, but is not limited to, a lease for a shift or a longer period.

(c) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers or to provide errand services to locations selected by the third party.

(d) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district.

SECTION 16. ORS 657.046 is amended to read:

657.046. (1) As used in this chapter, "employment" does not include service performed in the operation of a passenger motor vehicle that is operated as a taxicab or a passenger motor vehicle that is operated for nonemergency medical transportation, by a person who has an ownership or leasehold interest in the passenger motor vehicle, for an entity that is operated by a board of owner-operators elected by the members of the entity.

(2) As used in this section:

(a) "Leasehold" has the meaning given that term in ORS 656.027 [*(28)*] **(27)**.

(b) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity of at least three persons and not more than seven persons;

(B) On a route that begins or ends in Oregon, is used primarily to transport persons;

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers to locations selected by the third party; and

(D) Is not used more than secondarily or incidentally for errand services or to transport property, instead of or in addition to transporting passengers.

(c) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity of at least three persons and not more than seven persons;

(B) On a route that begins or ends in Oregon, is used primarily to transport persons;

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district; and

(D) Is not used more than secondarily or incidentally for errand services or to transport property, instead of or in addition to transporting passengers.

(3) The provisions of this section do not apply to service performed for:

(a) A nonprofit employing unit;

(b) This state;

(c) A political subdivision of this state; or

(d) An Indian tribe.

SECTION 17. ORS 657.048 is repealed.

SECTION 18. (1) Section 4 of this 2021 Act and the amendments to ORS 413.550, 413.552 and 413.556 by sections 8 to 10 of this 2021 Act become operative on September 1, 2022.

(2) Sections 2, 3 and 6 of this 2021 Act and the amendments to ORS 414.572 by section 13 of this 2021 Act become operative on July 1, 2022.

SECTION 19. Notwithstanding any other provision of law, the General Fund appropriation made to the Oregon Health Authority by section 1 (3), chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), for the biennium beginning July 1, 2021, for central services, state assessments and enterprise-wide costs, is increased by $670,664 for carrying out the provisions of this 2021 Act.

SECTION 20. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 2 (3), chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), for the biennium beginning July 1, 2021, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, tobacco tax receipts, marijuana tax receipts, beer and wine tax receipts, provider taxes and Medicare receipts, but excluding lottery funds and federal funds not described in section 2, chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), collected or received by the Oregon Health Authority, for central services, state assessments and enterprise-wide costs, is increased by $66,812 for carrying out the provisions of this 2021 Act.

SECTION 21. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 5 (3), chapter _____, Oregon Laws 2021 (Enrolled House

Bill 5024), for the biennium beginning July 1, 2021, as the maximum limit for payment of expenses from federal funds, excluding federal funds described in section 2, chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), collected or received by the Oregon Health Authority, for central services, state assessments and enterprise-wide costs, is increased by $118,194 for the purpose of carrying out the provisions of this 2021 Act.

SECTION 22. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.

Passed by House June 17, 2021

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 22, 2021

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

.....
Shemia Fagan, Secretary of State

TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON

EMPLOYER CONTRACT FOR

TRIMET ALTERNATE UNIVERSAL ANNUAL PASS FARE PROGRAM

This Contract is entered into **September 1, 2021** by and between the Tri-County Metropolitan Transportation District of Oregon ("TriMet") and **OREGON BOARD OF DENTISTRY** ("Employer") located at **1500 SW 1st Avenue**, **Portland, OR 97201**.

1. Universal Annual Pass Program
   Employer shall implement the Universal Annual Pass Program at Employer's work site(s) in accordance with the attached and incorporated Exhibit A, Universal Annual Pass Administrative Program Requirements (Program Requirements) as may be amended by TriMet. By signature hereto, Employer certifies that it has read and agrees to be bound by all of the Program Requirements, including but not limited to the Requirements initialed by Employer and those applicable to the Institutional Web Portal ("Services").

2. Term
   This Contract shall be in effect from the date listed above through August 31, 2022, unless terminated sooner by TriMet as provided in the Program Requirements. TriMet also may terminate this Contract upon 30 days advance written notice to Employer, and in such event where Employer is in compliance with this Contract, TriMet will reimburse Employer for all returned Universal Annual Passes based on the number of days remaining in the Contract term.

3. Employer Payment
   Employer's total payment due under this Contract is **$3,048.23**. Refer to the Exhibit B Schedule for calculation of Universal Annual Pass price. Employer's Universal Annual Pass price per employee per year under this Contract is **$398.09**. Additional fare instruments purchased during the contract year will be prorated based on this price, as set forth in section D.2) of Exhibit A of this Contract.

4. Universal Annual Pass Qualified Employees
   The total number of Employer's qualified employees, as defined in Exhibit A, Paragraph B, is **6**.

5. Correspondence/Communications
   (a) TriMet's Representative and Employer's Transportation Coordinator shall be responsible for routine, day-to-day correspondence and communications regarding Employer's implementation of the Pass Program. Upon commencement of this Contract, TriMet and Employer shall provide written notice to each other of the name and address of their respective designated Representative and Transportation Coordinator, and shall provide prompt written notice of any change thereto.

(b) All notices required to be given by the terms of this Contract shall be provided in writing and signed by the person serving the notice, and shall be sufficient if given in person, mailed postage pre-paid certified return receipt or telefaxed (with confirmation record) to the persons at the signature addresses below, or to such other address as either Party may notify the other of in writing. Any notice given personally shall be deemed to have been given on the day that it is personally delivered or telefaxed (with confirmation record), and if mailed three days after the date of the postmark of such mailing.

6. Limitation of Liability

TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, TRIMET, ITS OFFICERS, DIRECTORS, EMPLOYEES, AGENTS, SERVICES PROVIDERS AND LICENSORS SHALL NOT BE LIABLE TO EMPLOYER OR ANYONE FOR ANY INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL OR EXEMPLARY DAMAGES, INCLUDING BUT NOT LIMITED TO DAMAGES FOR LOST PROFITS, GOODWILL, USE, DATA OR OTHER INTANGIBLE LOSSES (REGARDLESS OF WHETHER WE HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES), HOWEVER CAUSED, WHETHER BASED UPON CONTRACT, NEGLIGENCE, STRICT LIABILITY IN TORT, WARRANTY OR ANY OTHER LEGAL THEORY. IN NO EVENT SHALL TRIMET'S TOTAL LIABILITY TO EMPLOYER IN CONNECTION WITH THE PASS PROGRAM AND THE SERVICES FOR ALL DAMAGES, LOSSES AND CAUSES OF ACTION EXCEED AMOUNTS PAID TO TRIMET UNDER THIS AGREEMENT DURING THE PRIOR 12 MONTHS.

7. Indemnity

EMPLOYER AGREES TO DEFEND, INDEMNIFY AND HOLD HARMLESS TRIMET AND ITS OFFICERS, DIRECTORS, EMPLOYEES, CONTRACTORS, AGENTS, LICENSORS, SUPPLIERS, SUCCESSORS AND ASSIGNS FROM AND AGAINST ANY CLAIMS, LIABILITIES, DAMAGES, JUDGMENTS, AWARDS, LOSSES, COSTS, EXPENSES OR FEES (INCLUDING REASONABLE ATTORNEYS' FEES) ARISING OUT OF OR RELATING TO VIOLATION OF THIS CONTRACT, INCLUDING WITHOUT LIMITATION EMPLOYER'S USE OF THE SERVICES OTHER THAN AS EXPRESSLY AUTHORIZED IN THIS CONTRACT.

8. No Third Party Beneficiary

Employer and TriMet are the only Parties to this Contract and as such are the only Parties entitled to enforce its terms. Nothing in this Agreement gives or shall be construed to create or provide any legal right or benefit, direct, indirect or otherwise to any other Party unless that Party is individually identified by name herein with the express and stated designation as an intended beneficiary of the terms of this Contract.

9. Authority

Each Party represents that the individual signing below is duly authorized by that Party to enter into this Contract and bind that Party to its terms.

10. Entire Agreement

This Contract and any attached exhibits constitute the entire agreement between the Parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, regarding this Contract not specified herein. No waiver, consent, modification or change of terms of this Contract shall bind either Party unless in writing and signed by both Parties and all necessary approvals have been

obtained. Such waiver, consent, modification or change, if made shall be effective only in the specific instance and for the specific purpose given.

11. Execution of Contract

This Contract and any written modifications thereto, may be executed in two or more counterparts, each of which together shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a "pdf" format date file, such signature shall create a valid and binding obligation of the Party executing (or on whose behalf such signature is made) with the same force and effect as if such facsimile or "pdf" signature page were an original thereof.

OREGON BOARD OF DENTISTRY	**THE TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON**
By: _____ *signature*	By: _____ *signature*
Date: _____	Date: _____
Name: _____ *please print*	Name: JC Vannatta
Title: _____	Title: Executive Director of Public Affairs
Address: _____	Address: 1800 SW 1st Avenue, Suite 300 Portland, Oregon 97201
Telephone Number: _____	

TriMet Alternate Universal Annual Pass Fare Program
ADMINISTRATIVE PROGRAM REQUIREMENTS
Effective September 1, 2021

The TriMet Universal Annual Pass Program ("Program") is available to employers within TriMet's service district who purchase annual passes for their employees. Participating employers are required to implement the Program in accordance with the terms of these Administrative Program Requirements ("Requirements") and as otherwise determined by TriMet.

A. Definition Of A Worksite
   1) A "worksite" is a building or group of buildings located at one physical location within the TriMet service district and under the control of an employer.
   2) An employer with multiple worksites in the district may include out-of-district worksites, provided that the out-of-district worksite represents less than 25% of the employer's total number of enrolled employees within the TriMet district.

B. Definition Of A Qualified Employee
   1) Participating employers must purchase a Universal Annual Pass (Pass) for each qualified employee (100% participation) at each participating worksite regardless of whether the employee uses transit at the time of purchase.
   2) For the purposes of the Program, a "qualified" employee is defined as any person on, or expected to be on, the employer's payroll, full or part-time, for at least six consecutive months, including business owners, associates, partners, and partners classified as professional corporations. Part-time is defined as 80 or more hours per 28-day period.
   3) An employee who works at multiple worksites is considered a qualified employee at the worksite of his/her cost center. A cost center is the department through which the employee's salary is paid.
   4) Contract employees, per-diem employees, and/or temporary employees are considered qualified employees only if they are covered under the employer's benefits package.
   5) Exempted from the Program are:
      - Part-time volunteers (defined as less than 80 hours per 28-day period);
      - Full-time volunteers (defined as 80 or more hours per 28-day period);
      - Employees working less than part-time (less than 80 hours per 28-day period);
      - Field personnel required to use their personal vehicle as a condition of their job;
      - Employees whose regular work commute has either a start or an end time outside of TriMet's service hours (service hours are 5:00 A.M through 1:00 A.M.);
      - Residents of the State of Washington;
      - Independent contractors;
      - Temporary or seasonal employees hired for a term of less than six (6) months;
      - Employees exempted by the Department of Environmental Quality (DEQ) for Employee Commute Option (ECO) rule purposes;
      - Regularly sworn officers of local law enforcement agencies within the TriMet boundaries, including the Oregon State Police; and
      - Employees who have an annual transit pass from another source (i.e., employee is a TriMet dependent or works for two employers and has received a pass through the other employer).

      The total number of employee exemptions shall not exceed 50% of the employer's total employee population. If an employer wishes to include categories of exempted employees and/or volunteers in the Program, as defined in B.5) above, the exempted personnel to be included must have a TriMet approved fare instrument. The employer must purchase a Pass for 100% of the category(s) of exempted personnel.
   6) The employer's authorized representative must execute an Employer Declaration, a form of which is attached as Exhibit C, attesting to the number of employer's qualified employees.

C. Definition of Transit Mode Split

1) The transit mode split is defined as follows:
(Total number of transit trips to the worksite by qualified employees) divided by (Total number of trips to the worksite by qualified employees).
2) If more than one commute mode is used to travel to a worksite, the commute mode for the longest portion of the trip constitutes the commute mode for the purposes of the Program.

D. Program Requirements; General

1) The Program shall be based on an annual contract term of September 1 through August 31 in accordance with Paragraph F below. For employers joining the Program mid-year, the Program cost shall be prorated based on the number of months remaining in the contract term (September 1 through August 31).
2) TriMet will issue Universal Annual Pass fare instruments (contactless fare cards containing a Universal Annual Pass, as determined by TriMet) for all qualified employees at the employer's contract price. If the employer hires additional qualified employees during the contract term, the employer shall purchase additional fare instruments, at a prorated cost based on the number of months remaining in the contract term (September 1 through August 31) for these additional new hires.
3) TriMet does not prohibit employers from re-selling the Passes to their employees; however, the selling price shall not exceed the per employee Pass price paid by Employer under this contract.
4) TriMet will not provide refunds for terminated employees. Replacement fare instruments will be provided for replacement employees only in accordance with paragraph F.2) below.
5) Employer shall designate and authorize a Program Administrator(s) to assist in implementation of these Requirements, including authorizations necessary for the Program Administrator to access and utilize TriMet's Institutional Website on behalf of Employer. Employer assumes sole responsibility for ensuring that Program Administrator(s) are duly authorized to administer the Program on behalf of Employer.

E. Program Contract Pricing

Employer's per Pass pricing calculation formula is shown on the Exhibit B Schedule, attached hereto.

F. Program Fare Instrument; Use of Fare Instrument; Remedies

1) Employer shall be responsible for distributing to each participating employee, a TriMet approved fare instrument, which shall be a contactless fare card (Hop Fastpass®). The Employer shall verify participating employee eligibility before a fare instrument is provided to an employee. Only the Employer's Program Administrator(s) may provide participating employees with a fare instrument, including distributing contactless fare cards. Only one fare instrument may be distributed per employee.
2) Employers using contactless Hop Fastpass® cards (fare cards) as the fare instrument:
   a. TriMet approved contactless fare cards containing a Universal Annual Pass fare may also be used as the valid fare instrument. Fare cards shall include the Employer's name and employee's name, and may also include a photo.
   b. If the approved fare card does not include a photo, the employee may be asked to display other valid photo identification as proof of their identity.
   c. TriMet may produce fare cards for participating Employers, and may charge a reasonable administrative fee for this service. Fare cards produced by TriMet remain the property of TriMet, the use of which is subject to the terms of the contract between Employer and TriMet.
   d. Employers may produce their own personalized fare cards, if approved by TriMet, which must include the Employer's name, employee's name, and may include a photo of the employee. In this case, blank white plastic card stock developed to interact with a contactless card reader will be provided by TriMet to the Employer, to be used solely for the purpose of creating a fare card for use on TriMet service.
   e. Fare cards are intended to be reused by the employee, and may be used for the subsequent contract year when containing a Universal Annual Pass fare valid for that period.
   f. Prior to providing the employee with a fare card containing an Annual Pass, Employer shall obtain the employee's written agreement to the Program guidelines and participant responsibilities as set forth in the Employee Agreement Form provided by TriMet, which will include the employee's acceptance and agreement to the Privacy Policy located at https://myhopcard.com/home/privacy and the Terms of

Service located at https://myhopcard.com/home/terms. TriMet may update the Privacy Policy and Terms of Service from time to time as provided in the Privacy Policy and Terms of Service.

g. Employers shall be required to maintain a record associating card ID number with a unique employee identifier. Employers shall be required to upload a list including employee's first name, last name, and email address via CSV file to the Institutional Web Portal, as further described in Section 3.
h. Employees are required to tap their contactless card prior to each vehicle boarding and upon occupying any TriMet district areas requiring proof of fare payment. Employees must sign a written statement accepting these proof of fare payment provisions.
i. A valid fare instrument shall allow travel on TriMet vehicles within the TriMet service district during the contract term, including LIFT paratransit vehicles, as well as Portland Streetcar.
j. TriMet may replace lost, stolen, or damaged Hop Fastpass® fare instruments for Employer's participating employees, and may charge the Employer a reasonable administrative fee for this service. To be eligible for replacement, the employee's fare instrument must first be disabled by Employer's Program Administrator. Employer may also request that TriMet disable the fare instrument, and in this case, TriMet reserves the right to require Employer to provide additional information about the lost, stolen or damaged fare instrument, such as card ID number. If the fare instrument cannot be disabled, the Employer may purchase additional fare instruments based on the number of months remaining in the contract year (September 1 through August 31).
k. TriMet may provide replacement fare instruments for replacement employees. To be eligible, the Employer must have disabled the fare instrument issued to the separated employee. Employer may also request that TriMet disable the fare instrument, and in this case, TriMet reserves the right to require Employer to provide additional information about the replaced fare instrument, such as card ID number. Replacement fare instruments shall be provided only in accordance with the requirements set forth in this paragraph F.2).

3) The fare instrument is non-transferable and is a valid fare instrument only for the participating employee to whom it is issued. The fare instrument may not be provided to, sold to, or used by anyone other than the participating employee to whom it is issued. Use of the fare instrument is subject to all provisions in the TriMet Code, violation of which may result in fines and/or exclusion.
4) Any alteration of the fare instrument, shall render the fare instrument invalid.
5) In the event that TriMet reasonably believes that any of an Employer's employees has duplicated, altered, or otherwise used the fare instrument in a manner not authorized by this Contract, upon notice from TriMet, Employer shall conduct a reasonable investigation of the matter, including notice to the employee and an opportunity for the employee to respond. Employer shall submit written findings of its investigation to TriMet. TriMet reserves the right to make its own independent investigation and determinations as to whether the misuse occurred. If, based on the results of an investigation, TriMet determines that the misuse occurred, TriMet reserves the right to require the Employer to return the employee's fare instrument or provide written assurance to TriMet that Employer has disabled the effectiveness of the employee's fare instrument. Employer shall not forward any Employer-generated photo ID cards to TriMet. In addition, TriMet reserves all rights and remedies available under law.
6) If TriMet reasonably believes that Employer has provided falsified information, intentionally provided fare instruments to non-participating employees or other ineligible persons, or that Employer is otherwise in breach of the contract including but not limited to failure to make a contract payment when due, TriMet reserves the right in its sole discretion to demand within the timelines specified by TriMet, that Employer return any or all fare instruments or that Employer provide other assurance that Employer has disabled the effectiveness of any fare instruments, and may also immediately terminate the Contract. In addition, TriMet reserves all rights and remedies available under law. In the event of contract termination by TriMet, Employer's sole remedy shall be reimbursement for the remainder of the contract term, so long as fare instruments are disabled, employer's failure to distribute the fare instruments does not constitute a breach of the contract, and employer is otherwise not in default of the contract terms. Any reimbursement to employer may be prorated by TriMet based on the number of days remaining in the contract term.
7) In the event a lawsuit is filed to obtain performance of any kind under this Contract, each Party shall be responsible for its own attorney fees, costs and disbursements, at trial and on appeal.
8) In no event shall either Party be liable for any consequential, special, incidental or punitive damages, whether under theory of tort, contract, statute or otherwise.

G. Use of Institutional Web Portal; Website Terms of Service

1) The Employer's Program Administrator shall use an Institutional Web Portal ("Services") as a tool to administer and manage the Employer's Program.
2) Program Administrators, pending approval by TriMet, shall be given secure login credentials to access their Employer's Program account using the Services. Program Administrators shall use the Services for the sole purpose of managing their Employer's Program, and only as provided in these Requirements. Program Administrators are responsible for any activity that occurs under their account. Program Administrators shall keep usernames and passwords secure and shall not allow anyone else to use them to access the Services. TriMet is not responsible for any loss that results from the unauthorized use of Program Administrator's username and password, with or without Program Administrator's knowledge.
3) Using the Services, Program Administrators shall be able to perform certain tasks including, but not limited to:
    a. Order fare instruments.
    b. Order fare products.
    c. Manage and edit their Employer's account profile, such as maintaining contact information and shipping information.
    d. Manage their employee participant's fare cards, including blocking cards (deactivate) in case of loss or theft, and unblocking cards (reactivate).
4) Employer's use of the Services is subject to TriMet's Privacy Policy, located at: https://myhopcard.com/home/privacy.
5) All content included in or through the Services, such as text (including blog posts, schedules, arrival information, fare information), graphics (including maps), designs, logos, presentations, videos, data, instructions, photos, and software (the "Materials"), is the property of TriMet or its licensors. The Materials are protected by copyright, trademark and other intellectual property laws. TRIMET®, WES®, TRANSITTRACKER™, Hop Fastpass® and other trademarks, service marks and logos that we use, are trademarks of TriMet. Third-Party trademarks that appear in connection with the Services are the property of their respective owners. The trademarks displayed in connection with the Services may not be used without express written permission.
6) TriMet grants Employer a personal, United States, royalty-free, non-assignable and non-exclusive license to use the Materials available as part of the Services. This license is for the sole purpose of using the Services for TriMet's intended purposes and is subject to the license restrictions below.
7) Unless laws prohibit these restrictions or you have our written permission, Employer may not:
    a. Copy, modify, distribute, sell, or lease any part of our Services or included software;
    b. Reverse engineer or attempt to extract the source code of our software or copy the scripts of the website;
    c. Download, print, copy, distribute or otherwise use Materials for commercial purposes, including commercial publication, sale or personal gain;
    d. Use any manual process or robot, spider, scraper, or other automated means to collect information or Materials from the Services or from users of the Services;
    e. Circumvent any of the technical limitations of the Services or interfere with the Services, including by preventing access to or use of the Services by our other users;
    f. Change or remove any copyright, trademark, or other proprietary notices, including without limitation attribution information, credits, and copyright notices that have been placed on or near the Materials;
    g. Impersonate any person or entity or misrepresent yourself or your entity in connection with the Services, or attempt to use another user's account without the user's permission; or
    h. Post or transmit through the Services any material that reasonably could be considered obscene, lewd, lascivious, excessively violent, harassing, or otherwise objectionable to some or all users.

8) With respect to any content submitted or made available to TriMet (including through our "Contact Us" pages), Employer grants to TriMet a non-exclusive, perpetual, worldwide, fully paid and royalty-free, transferable license to use, copy, distribute, publicly display, modify, and create derivative works from such content, for the limited purpose of operating, promoting, and improving the Services, and to develop new Services. In the event that Employer submits or posts any creative suggestions, proposals, or ideas about TriMet products and services, Employer agrees that such submissions will be automatically treated as non-confidential and non-proprietary. TriMet may use Employer's feedback without any obligation or credit to Employer.
9) THE SERVICES AND MATERIALS ARE PROVIDED "AS IS," "AS AVAILABLE," AND WITHOUT WARRANTIES OF ANY KIND. ALL USE OF THE SERVICES AND MATERIALS IS AT EMPLOYER'S SOLE RISK. TO THE FULLEST EXTENT PERMITTED BY LAW, TRIMET DISCLAIMS ALL WARRANTIES OF ANY KIND, WHETHER EXPRESS, IMPLIED OR STATUTORY, INCLUDING WITHOUT LIMITATION IMPLIED WARRANTIES OF TITLE, QUALITY, PERFORMANCE, MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, ACCURACY, AND NON-INFRINGEMENT, AS WELL AS WARRANTIES IMPLIED FROM A COURSE OF DEALING OR COURSE OF PERFORMANCE. TRIMET DOES NOT WARRANT THAT THE SERVICES WILL BE CONTINUOUS, PROMPT, SECURE, OR ERROR-FREE. TRIMET ASSUMES NO LIABILITY FOR ANY ERRORS OR OMISSIONS, INCLUDING THE INACCURACY OF CONTENT, OR FOR ANY DAMAGES OR LOSSES THAT EMPLOYER OR ANY THIRD PARTY MAY INCUR AS A RESULT OF THE UNAVAILABILITY OF THE SERVICES. TRIMET ASSUMES NO RESPONSIBILITY, AND SHALL NOT BE LIABLE FOR, ANY DAMAGES TO EMPLOYER'S EQUIPMENT, DEVICES OR OTHER PROPERTY CAUSED FROM USE OF THE SERVICES.

H. Payment Options; Issuance of Fare Instruments; and Contract Remedies
1) The employer shall be required to enter into a written contract based on the annual term of September 1 through August 31, in a minimum annual amount of the Annual Adult pass price. The contract amount may be prorated for less than one year, as provided for in these program requirements. An Employer signed contract must be received by TriMet before the contract start date.
2) Subject to (a) and (b) below, Employers with a total contract amount of $6,050 or greater may elect to submit the total payment amount in full, or shall pay the total payment in equal quarterly installments. Employers with a total contract amount of less than $6,050 must submit payment in full.
   a. Payment in Full: All Employers new to the Program must submit full payment prior to receiving fare instruments. Employers renewing their participation in the Program by executing a new contract, with prior credit approval from TriMet will be invoiced with payment due net 30 days from the invoice date or the contract start date, whichever is later.
   b. Quarterly Payments: Employers new to the Program that are eligible to elect to make quarterly payments are required to submit payment for the first quarter prior to receiving fare instruments, with subsequent quarterly payments due net 30 days from the invoice date. Employers renewing their participation in the Program by executing a new contract, with prior credit approval from TriMet will be invoiced for the first quarter with payment due net 30 days from the invoice date or the contract start date, whichever is later.
3) Payment for additional fare instruments purchased throughout the contract year must be paid in one lump sum, and will not be calculated into remaining quarterly payments. Payment for additional fare instruments is due net 30 days from the date of the invoice. If employer is an entity for which applicable law specifies a maximum time period for payment, that maximum time period shall apply.
4) If approved by TriMet, Employer may also purchase limited use disposable tickets, including 1-Day Passes and 2½-Hour Tickets. Employers new to the Program must submit payment in full before fare products will be shipped. Employers with prior credit approval from TriMet will be invoiced for fare products with payment due net 30 days from the invoice date.
5) Payments not received by the due date will accrue interest at an annual rate of 18%. If employer is an entity for which applicable law specifies a maximum interest rate that the entity may pay, that maximum interest rate shall apply.
6) In the event an employer fails to make a payment as scheduled in the contract, TriMet reserves all its rights and remedies under law, including but not limited to the right to suspend future issuance of fare instruments

and as otherwise provided in Paragraph F above.

7) Invoices past due over 90 days will be forwarded to TriMet's Legal Department for further action.
8) Payment(s) shall be made by either ACH or submitted to TriMet's Finance Department, Attn: TriMet #43002 P.O. Box 35146 Seattle, WA 98124-9828.
9) Fare instruments will be provided to the employer, normally within ten (10) business days of TriMet's receipt of an employer's total payment or first quarterly installment due as described above. For employers renewing their participation in the Program by executing a new contract, and with prior credit approval from TriMet, fare instruments will be provided normally within ten (10) business days of receipt of an employer's signed contract. TriMet is not responsible for late deliveries. A designated representative of the employer must sign for receipt of the fare instruments. TriMet reserves the right to limit the number of fare instruments provided at any one time, or to determine the distribution schedule thereof.

I. Employer Designated Agents

1) Employer may elect to participate in the Program through their designated agent ("Employer Designated Agent"). Employer Designated Agent will enter into a contract with TriMet for implementation of the Program in accordance with these Program requirements, including the purchase of and payment for fare instruments.
2) Employer Designated Agent must be an incorporated entity, established for the purpose of providing administrative services to facilitate employer transportation options or other employer related services, including commercial or industrial property management and/or other transportation related services.
3) Upon TriMet's request, Employer Designated Agent shall provide TriMet with written authorization from employer on employer's official letterhead evidencing employer's designation of Employer Designated Agent.

J. Information Required of Employers

1) Prior to contract approval, TriMet must receive the executed Employer Declaration attesting to the accuracy of the following information:
   a. the total number of employees, in all work groups;
   b. the total number of qualified employees, according to these Program Requirements;
   c. the total number of employees in other employee work groups to also include in the Program.
   d. A participating employer must update the information in the Employer Declaration on a quarterly basis, or in the event of a significant (10% or more) increase in the number of participating employees.
   e. TriMet shall not be bound and assumes no obligation in any respect with regard to the Program until TriMet's authorized signator executes the contract.
2) TriMet, at its sole discretion, may require an employer to verify the number of qualified employees and to confirm employee status at any time during the term of the contract. TriMet may also require an employer to demonstrate that fare instruments are kept in secure locked storage, accessible only to the employer's designated program administrator(s).
3) Employees must sign a statement (Employee Agreement Form) verifying receipt of a fare instrument. The statement includes a signed acknowledgement by the employee that the fare instrument is non-transferable and may only be used by the employee to whom it was issued, and that the fare instrument must be returned to the employer upon separation from employment. Employees determined to knowingly violate these terms may face criminal prosecution for theft of services.
4) Each fare instrument includes a unique serial number for the purposes of tracking and control. For each employee that receives a fare instrument, the employer's designated program administrator, or the program administrator's designee, shall record the fare instrument's ID serial number on the Employee Agreement Form, along with the employees' signed statement agreeing to the terms and conditions of receiving the fare instrument.
5) All fields of the Employee Agreement Form must be completed in full. The employer must return a copy of the Employee Agreement Form to TriMet by October 1st, and make the form available for TriMet's review upon request by TriMet. The employer shall retain a copy of the Employee Agreement Form through the end of the contract period.

6) Employer shall provide TriMet an IRS (EIN) Employer Identification Number, or if Employer does not have an IRS EIN Employer shall supply a Social Security Number for purposes of compliance with IRS Section 6109. Employer shall submit a completed Federal IRS Form W-9 to TriMet, Attn: Revenue Accountant, 1800 SW 1st Avenue, Suite 300, Portland, Oregon, 97201, or by email to AccountsReceivable@trimet.org.

IBH Solutions
Health Professionals' Services Program (HPSP)
Satisfaction Report

Year 11 Annual Report: January and July 2021 Surveys

IBH Health Professionals' Services Program
1220 SW Morrison Street, Suite 600
Portland, Oregon 97205
1.888.802.2843
Fax: 503.961.7142

Attachment #7

Executive Summary

Health Professionals' Services Program Satisfaction Survey: Year 11 Annual Report

Overview: This Health Professionals' Services Program report reviews the satisfaction survey results for the eleventh year of the program. Surveys were sent at the beginning of both January and July 2021 to the following groups of stakeholders: Licensees, Workplace Monitors, Providers (GMC/PMCs and third-party evaluators), and Health Associations.

An overview of the number of surveys sent, number of responses received, and the response rate by stakeholder group is displayed below:

Table 1: Response Rate – Year 11	Licensees	Workplace Monitors	Providers (GMC/PMC/3rd Party Evaluators)	Health Associations
# Sent	354	327	48	16
# of Responses	55	20	12	3
Response Rate	15.5%	6.1%	25.0%	18.8%

Response rates were low for licensees and workplace monitors. Although there are many ways to interpret this, it could be an indicator of the ongoing level of stress that health professionals (both the licensees and workplace monitors) are experiencing in the workplace. IBH will continue to be sensitive to this issue and will try to provide increased support and resources for licensees. In addition, HPSP Agreement Monitors will re-double their efforts to develop rapport with and be supportive of workplace monitors.

Highlights

- Licensee responses were received from all four boards:
  - Just over 98% "agree" or "strongly agree" that they understand the program's statutory monitoring requirements.
  - A strong majority feel that they are treated with dignity (76.4%) and respect (80%).
  - 78.6% feel that the program requirements are clearly explained.
  - 87.3% feel that HPSP provides a "significant amount" or between a "significant amount" and "some" structure. 89.1% of respondents feel this way about the program's accountability.
  - A minimum of 83% of respondents "agree" or "strongly agree" that:
    - questions/concerns are responded to within one business day;
    - questions/concerns are addressed fully;
    - information is communicated clearly and professionally; and
    - the Agreement Monitor is knowledgeable about his/her case.
  - The portal was used by 80% of respondents and, of those, 73% find it "useful" or "extremely useful."
  - 83.6% rated HPSP as "excellent," "above average," or "average." In fact, 34.5% rated it "excellent."
- All GMC/PMC providers and evaluator respondents rated the program positively.
  - 100% of respondents felt that questions and concerns were responded to promptly and that information was communicated clearly and professionally.
  - 93% indicated that they had all necessary information was on hand when they met with the licensee.
  - All but one respondent provided an "excellent" or "above average" rating of their overall experience working with HPSP staff. The other respondent provided an "average" rating. Notably, 50% provided an excellent rating.
- Responses were received from Workplace Monitors for licensees from each board:
  - All but one workplace monitor respondent indicated that they are satisfied with IBH's support in his/her role as a workplace monitor.
  - IBH's ability to monitor licensees to ensure safety in the workplace is endorsed by 95% of monitors who provided a rating.
  - "Excellent" was the most frequent response to the items rating IBH's services, including response timeframe; knowledge of licensee when there is a concern in the workplace; ability to respond to questions regarding program administration; frequency of feedback; and overall services.
  - 95% rated their overall experience working with IBH as "excellent," "above average," or "average."

- Representatives of three professional associations, representing licensees of the Medical Board, Nursing Board and Pharmacy Board, provided survey responses.
    - HPSP's services were rated as "extremely valuable" (1) or valuable (2) for membership.
    - "Excellent" and "above average" were the ratings of HPSP's timeliness of response, knowledge level of staff and HPSP's services overall.
    - Feedback from members was rated "above average" by those who provided a rating.
    - IBH worked diligently in the spring to hold conversations with the various professional associations. These efforts will continue.

All responses will be reviewed by the PAC and an action plan will be put into place to provide for continued improvement.

IBH Solutions
Health Professionals' Services Program (HPSP)
Satisfaction of LICENSEES

Purpose

The purpose of assessing participants (licensees) in the Health Professionals' Services Program (HPSP) is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of HPSP. In order to provide continuous quality services, IBH evaluates licensees' satisfaction with HPSP twice yearly.

Feedback is obtained from licensees via a satisfaction survey that is mailed or emailed to each licensee. When mailed, licensees are given the option of completing the enclosed survey and mailing it back to IBH in the postage-paid envelope or completing the survey online through the included link. The survey is short and can be completed in 2-3 minutes. Feedback includes information about program administration, IBH customer service, communication, Agreement Monitors, the portal, and overall services.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the IBH Policy Advisory Committee (PAC) is quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 11	Year 10	Year 9	Year 8	Year 7
# Sent	172	354	387	383	403	435
# of Responses	19	55	65	80	99	149
Response Rate	11.0%	15.5%	16.8%	20.1%	24.6%	34.3%

The HPSP Licensee Satisfaction Survey was issued to all the licensees who had been enrolled for more than 4 months. This delay allows licensees to become established in the program before providing program feedback.

The survey was emailed to 159 licensees and mailed to 13 this period, for a total of 172 surveys distributed. A total of 19 responses were received, representing a response rate of 11.0%. This is the lowest rate we have seen to-date and should be monitored carefully moving forward.

For the year, a total of 354 surveys were distributed with 55 responses received, bringing the response rate to 15.5%, just over 1 percentage point lower than last year's rate. Results, then, should be considered with caution as it cannot be assumed that the results represent all participants.

Respondents

Question 1: Respondents are first asked the board by which they are licensed. Data is displayed in Table 2. For both the period and the year, roughly half the respondents were licensed by the Medical Board, one-quarter by the Board of Nursing, and 10% each by the Board of Dentistry and Board of Pharmacy. One individual chose not to list his/her licensing board. It is encouraging to see representation from all four boards.

Data Table 2:

Table 2: Respondents by Board	This Period (n=19)		Year 11 (n=55)		Year 10 (n=65)	
	#	%	#	%	#	%
Medical Board	9	47.4%	30	54.5%	39	60.0%
Board of Nursing	5	26.3%	13	23.6%	21	32.3%
Board of Dentistry	2	10.5%	6	10.9%	3	4.6%
Board of Pharmacy	2	10.5%	5	9.1%	2	3.1%
No Response	1	5.3%	1	1.8%		

Table 3 displays a response rate for each Board for the period (responses by board divided by number surveyed per board). These rates can be compared to the overall response rate for the period of 11.0% so that any skew in the data can be identified. In this case, responses are skewed slightly toward the Board of Dentistry and away from the Board of Nursing. This skew is minimal, however, representing a difference of 1 licensee.

Data Table 3:

Table 3: Response Rate by Board This Period	Number Surveyed	Number of Respondents	Response Rate
Medical Board	83	9	10.8%
Board of Nursing	58	5	8.6%
Board of Dentistry	12	2	16.7%
Board of Pharmacy	19	2	10.5%

Question 2: Continuing to learn about the response pool, the survey then asks if the respondent is currently participating in the toxicology program. Results for the period and the year show that 89% of respondents were testing. Licensees with mental health only diagnoses with no indication of a substance use disorder are not required to test unless required by their board or recommended by their independent third-party evaluator. (See Data Table 4).

Data Table 4:

Table 4: Participating in Toxicology Program?	This Period (n=19)		Year 11 (n=55)		Year 10 (n=65)	
	#	%	#	%	#	%
Yes	17	89.5%	49	89.1%	61	93.8%
No	1	5.3%	4	7.3%	4	6.2%
No Response	1	5.3%	2	3.6%		

Overall Program

Question #3: This question asks licensees to respond to four statements regarding the overall program. These statements include understanding the program's statutory requirements, the ability of the program to treat the licensee with dignity and with respect, and the program requirements being clearly explained. Although original response data is displayed in Tables 5a-c, the chart below combines the data for the year to provide additional insight into the response patterns:

	Strongly Agree or Agree	Disagree or Strongly Disagree
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	98.2%	1.8%
The program treats me with dignity.	76.4%	23.7%
The program treats me with respect.	80.0%	20.0%
The program requirements are clearly explained.	78.2%	21.8%

Importantly, just over 98% of respondents "agree" or "strongly agree" that they understand the program's statutory monitoring requirements. The majority of respondents also feel that they are treated with dignity (76.4%) and respect (80%). Finally, over three-quarters of respondents (78.6%) feel that the program requirements are clearly explained. When compared with last year's data (Table 5c), the total percentage of "strongly agree" or "agree" responses is within a few percentage points on each item.

Mode responses this year were "strongly agree" for the dignity item, split between "strongly agree" and "agree" for the respect item and "agree" for the other two.

Data Table 5a, b and c: The mode (most frequent) response is highlighted in red.

Table 5a: This Period (n=19)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	8	42.1%	**11**	**57.9%**						
The program treats me with dignity.	**9**	**47.4%**	5	26.3%	3	15.8%	2	10.5%		
The program treats me with respect.	**9**	**47.4%**	6	31.6%	2	10.5%	2	10.5%		
The program requirements are clearly explained.	8	42.1%	8	42.1%	2	10.5%	1	5.3%		

Table 5b: Year 11 (n=55)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	21	38.2%	**33**	**60.0%**	1	1.8%				
The program treats me with dignity.	**23**	**41.8%**	19	34.6%	9	16.4%	4	7.3%		
The program treats me with respect.	22	40.0%	22	40.0%	7	12.7%	4	7.3%		
The program requirements are clearly explained.	20	36.4%	**23**	**41.8%**	10	18.2%	2	3.6%		

Table 5c: Year 10 (n=65)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	30	46.2%	**32**	**49.2%**	2	3.1%	1	1.5%		
The program treats me with dignity.	**26**	**40.0%**	17	26.2%	11	16.9%	11	16.9%		
The program treats me with respect.	**26**	**40.0%**	17	26.2%	14	21.5%	8	12.3%		
The program requirements are clearly explained.	18	27.7%	**32**	**49.2%**	11	16.9%	4	6.2%		

Question #4: Continuing to evaluate the overall program, the next question asks respondents to rate the amount of structure and the amount of accountability the program provides. The scale is "0" (none) to "4" (a significant amount) with "2" representing "some." The mode response was a "significant amount" (4) for both items for the period and the year. This is consistent with responses the last few years. Looking at this year's data, the percentage of "3" and "4" responses was 87.3% for structure and 89.1% for accountability, both of which are an increase from last year.

Data Table 6a, b and c: The mode (most frequent) response is highlighted in red.

Table 6a: This Period (n=19)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**13**	**68.4%**	4	21.1%	1	5.3%	1	5.3%				
The amount of accountability the program provides	**14**	**73.7%**	3	15.8%	1	5.3%	1	5.3%				

Table 6b: Year 11 (n=55)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**33**	**60.0%**	15	27.3%	5	9.1%	1	1.8%	1	1.8%		
The amount of accountability the program provides	**42**	**76.4%**	7	12.7%	4	7.3%	1	1.8%	1	1.8%		

Table 6c: Year 10 (n=65)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**30**	**46.2%**	13	20.0%	18	27.7%	1	1.5%	3	4.6%		
The amount of accountability the program provides	**41**	**63.1%**	12	18.5%	7	10.8%	2	3.1%	3	4.6%		

Customer Service

Question #5: This question queries response time frame, quality of response, communication style, and Agreement Monitor knowledge. Data tables 7a-c show the specific responses to each item and the mode responses. The chart below combines the "strongly agree" and "agree" responses as well as the "strongly disagree" or "disagree" responses for the year:

	Strongly Agree or Agree	Strongly Disagree or Disagree
My questions and/or concerns are responded to within one business day	89.1%	10.9%
My questions and/or concerns are addressed fully within the structure of the program	85.4%	14.6%
Information is communicated clearly and professionally	83.6%	16.4%
My Agreement Monitor is knowledgeable about my case.	87.3%	10.9%

The clear majority of respondents positively endorsed each item. That said, the percentage of "strongly agree" and "agree" responses is a few points lower than last year on all items.

The mode for "my Agreement Monitor is knowledgeable about my case" was "strongly agree," while it was "agree" for all other items this year. For the period, the mode response was "strongly agree" for all four items.

Data Table 7a, b and c: The mode (most frequent) response is highlighted in red.

Table 7a: This Period (n=19)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	**9**	**47.4%**	7	36.8%	2	10.5%	1	5.3%		
My questions and/or concerns are addressed fully within the structure of the program	**8**	**42.1%**	7	36.8%	3	15.8%	1	5.3%		
Information is communicated clearly and professionally	**8**	**42.1%**	7	36.8%	3	15.8%	1	5.3%		
My Agreement Monitor is knowledgeable about my case	**13**	**68.4%**	3	15.8%	3	15.8%				

Table 7b: Year 11 (n=55)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	21	38.2%	**28**	**50.9%**	4	7.3%	2	3.6%		
My questions and/or concerns are addressed fully within the structure of the program	23	41.8%	**24**	**43.6%**	5	9.1%	3	5.5%		
Information is communicated clearly and professionally	23	41.8%	23	41.8%	4	7.3%	5	9.1%		
My Agreement Monitor is knowledgeable about my case	**33**	**60.0%**	15	27.3%	6	10.9%			1	1.8%

Table 7c: Year 10 (n=65)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	24	36.9%	**30**	**46.2%**	7	10.8%	3	4.6%	1	1.5%
My questions and/or concerns are addressed fully within the structure of the program	25	38.5%	**26**	**40.0%**	2	3.1%	10	15.4%	2	3.1%
Information is communicated clearly and professionally	**30**	**46.2%**	22	33.8%	3	4.6%	9	13.8%	1	1.5%
My Agreement Monitor is knowledgeable about my case	**34**	**52.3%**	21	32.3%	4	6.2%	5	7.7%	1	1.5%

HPSP Portal

Question #6: This question asks respondents to rate the usefulness of the portal ***if*** they have used it. This year, 80% of respondents (44) indicated that they had used the portal, which is an increase from 75% who did so last year. Further, of those who use portal, approximately 73% find it "useful" or "extremely useful." The mode is "useful" for both the period and the year, just like last year.

Data Table 8: The mode (most frequent) response is highlighted in red.

Table 8: If you used the HPSP Portal (hpspmonitoring.com) in the last six months, please rate its usefulness.	This Period (n=15)		Year 11 (n=44)		Year 10 (n=53)	
	#	%	#	%	#	%
Extremely Useful	1	6.7%	10	22.7%	10	18.9%
Useful	**9**	**60.0%**	**22**	**50.0%**	**25**	**47.2%**
Somewhat Useful	4	26.7%	11	25.0%	13	24.5%
Not Useful	1	6.7%	1	2.3%	5	9.4%

Respondents are asked to provide comments specific to the portal and told that they will have room for general comments at the end of the survey.

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. It would not work at all once (see below).
2. Information about testing sites, especially weekend hours, is often incorrect and never seems to be updated.
3. The portal needs to continue to show after 5 pm if there is a test that day

Overall Rating of Services

Question #7: Respondents are asked to rate the overall services. The mode response was "excellent" for both the period and the year. In total, 34.5% rated the program "excellent" while another 18.2% rated it "above average." A total of 83.6% rated the program as "average" or better this year. That is an increase from last year's 78.4%.

Data Table 9: The mode (most frequent) response is highlighted in red.

Table 9: Overall Rating	This Period (n=19)		Year 11 (n=55)		Year 10 (n=65)		Year 9 (n=80)		Year 8 (n=99)		Year 7 (n=149)		Year 6 (n=161)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Excellent	**6**	**31.6%**	**19**	**34.5%**	18	27.7%	**27**	**33.8%**	34	34.3%	35	23.5%	40	24.8%
Above Average	4	21.1%	10	18.2%	**19**	**29.2%**	24	30.0%	**37**	**37.4%**	**57**	**38.3%**	**51**	**31.7%**
Average	6	31.6%	17	30.9%	14	21.5%	21	26.3%	18	18.2%	35	23.5%	44	27.3%
Below Average	1	5.3%	5	9.1%	7	10.8%	5	6.3%	6	6.1%	10	6.7%	13	8.1%
Poor	2	10.5%	3	5.5%	7	10.8%	3	3.8%	4	4.0%	7	4.7%	12	7.5%
No Response			1	1.8%							5	3.4%	1	0.6%

Additional Comments

At the conclusion of the survey, respondents are asked for any additional comments. In addition to the three comments received earlier in the survey, six concluding comments were received this period. All nine of these substantive comments will be reviewed and addressed individually by the PAC over the next month.

Actual Comments Received – This Period

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected. Names and locations have been removed for confidentiality purposes.*

1. Great experience thus far. Thank you!
2. I feel the 5 year commitment is excessive
3. "Average" compared to what?
   I've had issues a few times with the app not working. Once, the app, portal, and automated phone would not let me check in and I was eventually sent to a person who seemed to not really understand that I was just trying to check in.
   Otherwise, I appreciate my agreement monitor's help with me starting a new job and making arrangements around it. My monitor ([Name]) is always helpful and is an asset to your program!!!!!
4. The Program and Agreement Monitors are attempting to monitor professionals that are under tremendous pressure in their careers and personal lives. They are oblivious to the demands of the professional and do not realize that it's impossible to abide by the Programs guidelines, nor do their employment monitors care about the guidelines. Working only 40 hrs a weeks is not sustainable in this professional nor is being able to leave to test. Attempting to even take a much deserved vacation proves to be more stressful in this program than it's worth. I'm jumping through the Programs hoops that are expensive but not even close to helpful. I expected support from the Program but instead it is just policing me and trying to catch me making a mistake. I've been a nurse for 13 years and in the program for 2 years, however I'm pursuing another career now. It's not worth the stress, pain and suffering - nursing shortages, the pandemic horrors, the abuse from patients and families, and all the demands of this Program. OSBN and HPSP do not care about nurses or other health care professionals, they just assume the worst in them.
5. My agreement monitor, [Name], is FANTASTIC!!! She is very knowledgable and helpful.

6. IBH continues to be the biggest obstacle to my Recovery. IBH actively interferes with my ability to re-establish healthy habits both at work and at home. The understanding of my professional role and responsibilities is absolutely non-existent and no accommodations are made for supporting my career. Unless I am willing to discuss my history with whomever I am working with that day, I am forced to lie when I have to leave to test; aren't we supposed to be working on being honest? The attitude of IBH towards me is punitive despite almost 5 years of exemplary work. My Therapist, Physician and Workplace monitor are hassled and disrespected through no fault of their own; reports are lost or misplaced on a regular basis and documentation requests are not made in a timely manner and I am held responsible for IBH incompetence. Test sites when I travel are poorly prepared for me and require unreasonable amounts of time and effort (2.5 hours last time I tested on the road and the requirement that I twirl around naked in front of the observer since they didn't understand the procedure despite my giving them a copy in advance). The requirement to submit time and date stamped photos for a single Exemption Day to go hiking with my son was yet another example of IBH disrespect. IBH absolutely does NOT treat me with respect or dignity. Unfortunately for me, I have been monitored in other States and I have experienced Programs that care, support and are respectful. IBH is none of those things.

Summary Analysis

The response rate for this survey this year is 15.5%, the lowest to-date. The ongoing impact of the pandemic may be an issue, but this will need to be watched. Results should be considered with caution as it cannot be assumed that the results represent all program participants. Responses were received from all four boards, with roughly half the respondents licensed by the Medical Board, one-quarter by the Board of Nursing, and 10% each by the Board of Dentistry and Board of Pharmacy. This is fairly representative of the population that was surveyed with only a very slight skew toward the Board of Dentistry and away from the Board of Nursing.

Importantly, just over 98% of respondents “agree” or “strongly agree” that they understand the program’s statutory monitoring requirements. The majority of respondents feel that they are treated with dignity (76.4%) and respect (80%). Finally, over three-quarters of respondents (78.6%) feel that the program requirements are clearly explained. The largest group of respondents endorsed that the program provides a “significant amount” of structure and accountability. Between 83% and 90% of all respondents “agree” or “strongly agree” that their questions/concerns are responded to within one day; that their questions/concerns are addressed fully within the structure of the program; that information is communicated clearly and professionally and that their Agreement Monitor is knowledgeable about their case. Just over 80% (44) of respondents indicated that they had used the portal, which is an increase from 75% who did so last year. The largest group of respondents for both the period and the year rated portal as “useful.” Overall, 83.6% of respondents rated the program as “excellent,” “above average” or “average” this year. In fact, a rating of “excellent” was endorsed by 34.5% of respondents.

All responses, including comments, will be reviewed closely by the PAC and addressed accordingly.

IBH Solutions
Health Professionals' Services Program (HPSP)
Satisfaction of WORKPLACE MONITORS

Purpose

The purpose of assessing the Workplace Monitors is to obtain constructive feedback that can be used to improve the services provided by HPSP. IBH strives to maintain the quality, effectiveness, and efficiency of the program, and thus evaluates Workplace Monitors' satisfaction with HPSP twice yearly.

Feedback is obtained from Workplace Monitor via a satisfaction survey that is emailed or mailed to Workplace Monitors who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes. Feedback includes information about timeliness of response, knowledge level of staff, the monthly safe practice form and an overall rating of IBH's support of the supervision of licensees. The survey also asks for any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One role of the IBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 11	Year 10	Year 9	Year 8	Year 7
# Sent	159	327	331	340	322	331
# Responses	5	20	60	42	46	62
Response Rate	3.1%	6.1%	18.1%	12.4%	14.3%	18.7%

This period the Workplace Monitors' satisfaction survey had a response rate of only 3.1%, with 5 responses out of 159 surveys sent. This brings the response rate for the year down to 6.1% with 20 responses out of 327 sent. In prior years the rate has fluctuated from period to period, but this is more significant. Given the low response rate, results should not be considered representative of the population of workplace monitors.

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Professional Licensing Board

Question 1: Respondents are first asked which professional board licenses the employee they monitor. This period, three were licensed by the Medical Board, one by the Board of Nursing and one was not identified. For the year, the pattern more closely matches enrollment with 40% licensed by the Board of Nursing (8), 35% by the Medical Board (7), and 5% (1) each by the Boards of Pharmacy and Dentistry. There were also three not identified for the year.

As a point of comparison, the percentage of participating licensees from each board is: Medical - 48%, Nursing – 34%, Dental – 7%, and Pharmacy – 11%.

Data Table 2: The mode (most frequent) response is highlighted in red.

Table 2: Type of Services Provided	This Period (n=5)		Year 11 (n=20)		Year 10 (n=60)	
	#	%	#	%	#	%
Medical Board	**3**	**60%**	7	35%	**34**	**56.7%**
Board of Nursing	1	20%	**8**	**40%**	22	36.7%
Board of Pharmacy			1	5%	1	1.7%
Board of Dentistry			1	5%	2	3.3%
Other / Not Identified	1	20%	3	15%	1	1.7%
No Response						

Supervision Support

Question 2: The next item reads: "IBH supports you in your role as workplace monitor. How satisfied are you with our support?" This year, all respondents except one were satisfied with IBH's support. In fact, 45% (9) were "very satisfied," while the mode response was "satisfied" with 50%. The mode for the period, however, was "very satisfied" at 60% (3).

Data Table 3: The mode (most frequent) response is in red:

Table 3: Supervision Support	This Period (n=5)		Year 11 (n=20)		Year 10 (n=60)	
	#	%	#	%	#	%
Very Satisfied	**3**	**60%**	9	45%	**37**	**61.7%**
Satisfied	2	40%	**10**	**50%**	22	36.7%
Unsatisfied			1	5%		
Very Unsatisfied					1	1.7%
No Response						

Workplace Safety

Question 3: IBH's ability to monitor the licensee to ensure safety in the workplace is queried in the next item. This is one of HPSP's most vital functions so it is important to note that responses are primarily positive. In fact, for the period, 100% of respondents rated this "excellent." For the year, the largest group of respondents (45% or 9) rated it "excellent." This is followed by "above average" (30% or 6) and then "average" (15% or 3).

If we remove the one individual who chose not to respond to this item, then we find that 18 out of 19, or 95%, of respondents rated IBH's as able to ensure safety in the workplace.

Data Table 4: The mode (most frequent) response is highlighted in red:

Table 4: Workplace Safety	This Period (n=5)		Year 11 (n=20)		Year 10 (n=60)	
	#	%	#	%	#	%
Excellent	5	100%	9	45%	35	58.3%
Above Average			6	30%	16	26.7%
Average			3	15%	9	15.0%
Below Average			1	5%		
Poor						
No Response			1	5%		

A follow-up question requests any suggested changes or recommendations. None were provided this period.

Services

Question 4: Respondents are asked to think about their recent contacts with IBH and rate the following: response timeframe, knowledge of licensee when there is a concern in the workplace; ability to respond to questions regarding program administration; and frequency of feedback from IBH. Finally, an overall rating is requested. The mode response to each item was "excellent" this year, just like last year. Responses were positive overall with no "poor" ratings. In fact, there was only one "below average" rating which was to the overall rating item; this rating was provided by the same respondent who indicated s/he was "unsatisfied" with IBH's support. Despite that, 80% of respondents rated the program "above average" or "excellent" this year.

Data for this period, this year and the prior year follows on the next page.

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Data Tables 5a and b: The mode (most frequent) response is highlighted in red.

Table 5a This Period (n=5)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	2	40%	**3**	**60%**								
Staff knowledge of a licensee when there is concern in the workplace	1	20%	1	20%							3	60%
Our ability to respond to questions regarding program administration	2	40%	2	40%							1	20%
Frequency of feedback from IBH regarding licensee's compliance	**3**	**60%**	1	20%							1	20%
Overall rating of our services	2	40%	**3**	**60%**								

Table 5b Year 11 (n=20)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**11**	**55%**	6	30%	3	15%						
Staff knowledge of a licensee when there is concern in the workplace	**7**	**35%**	2	10%	2	10%					9	45%
Our ability to respond to questions regarding program administration	**10**	**50%**	4	20%	4	20%					2	10%
Frequency of feedback from IBH regarding licensee's compliance	**9**	**45%**	4	20%	4	20%					3	15%
Overall rating of our services	**9**	**45%**	7	35%	3	15%	1	5%				

Table 5c Year 10 (n=60)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**36**	**60.0%**	12	20.0%	3	5.0%	1	1.7%			8	13.3%
Staff knowledge of a licensee when there is concern in the workplace	**29**	**48.3%**	9	15.0%	4	6.7%					18	30.0%
Our ability to respond to questions regarding program administration	**33**	**55.0%**	17	28.3%	3	5.0%			1	1.7%	6	10.0%
Frequency of feedback from IBH regarding licensee's compliance	**33**	**55.0%**	15	25.0%	6	10.0%			1	1.7%	5	8.3%
Overall rating of our services	**37**	**61.7%**	17	28.3%	5	8.3%	1	1.7%				

Overall Experience

Question 5: Respondents are asked to rate their overall experience working with IBH. The mode response was "excellent" at 80% of respondents for the period and 60% for the year. Looking at the year data, an additional 15% (3) rated the program "above average." In total this year, 95% rated the program "average" or better. The "poor" response was from the same respondent who gave the other noted negative responses on prior questions.

Data Table 6: The mode (most frequent) response is highlighted in red:

Table 6: Overall Experience	This Period (n=5)		Year 11 (n=20)		Year 10 (n=60)	
	#	%	#	%	#	%
Excellent	**4**	**80%**	**12**	**60%**	**37**	**61.7%**
Above Average			3	15%	19	31.7%
Average	1	20%	4	20%	3	5.0%
Below Average					1	1.7%
Poor			1	5%		
N/A or No Response						

Additional Comments

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. I think the weekly email requirement is silly but its probably a statutory requirement. No complaints overall
2. RBH should notify monitee when medical director decides to increase testing frequency of monitee.

   RBH could improve upon their efforts at locating out of town test sites (so that monitee does not have to make phone calls on their own to locate test sites that are within a reasonable traveling distance).

Summary Analysis

The response rate for this survey was extremely low, both for the period (3.1%) and the year (6.1%.) As such, results should be interpreted carefully as they may not be representative of the entire population. That said, the breakdown by board of those who responded (40% Board of Nursing, 35% Medical Board, 5% Board of Pharmacy and 5% Board of Dentistry) is similar to the licensee make-up of the program. Further, results are similar to those received in past years.

Notably, 95% of respondents this year indicated that they are satisfied with IBH's support of their role as workplace monitor. Equally important, 95% of respondents who provided a rating indicated that IBH is able to ensure safety in the workplace. The largest group of respondents rated IBH's response timeframe, knowledge of licensees, ability to respond to questions regarding program administration and frequency of feedback as "excellent." HPSP's overall services were rated as "excellent" or "above average" by 80% of respondents this year. In total, 95% of respondents rated their overall experience working with IBH positively, with 60% rating it "excellent."

The PAC committee will review the survey data and the comments carefully.

IBH Solutions
Health Professionals' Services Program (HPSP)
Satisfaction of PROFESSIONAL ASSOCIATIONS

Purpose

The purpose of assessing representatives from the related professional associations is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of HPSP. In order to provide continuous quality services, IBH evaluates this stakeholder group's satisfaction with HPSP twice yearly.

Feedback is obtained from Association representatives via a satisfaction survey that is emailed to representatives who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes.

Feedback includes information about the timeliness of response, knowledge level of staff, ability to enroll licensees and an overall rating of IBH services. Also, the survey asks about the value of HPSP to their membership and asks for any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the IBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 11	Year 10	Year 9	Year 8	Year 7
# Sent	11	16	10	10	8	8
# Responses	3	3	0	2	1	1
Response Rate	27.3%	18.8%	0%	20.0%	12.5%	12.5%

Eleven surveys were sent out this period to various contacts at related professional associations and three were returned, for a response rate of 27.3%. This brings the response rate for the year to 18.8%, representing three responses out of 16 surveys sent. IBH worked diligently in the spring to hold conversations with the various professional associations. These efforts will continue.

A breakdown of the associations surveys this period and last period follows:

		This Period (July)	Last Period (January)
Oregon Dental Association	ODA	2	1
Oregon Medical Association	OMA	1	1
Oregon Pharmacy Association	OPA	1	1
Oregon Nurses Association	ONA	2	1
Oregon Pharmacists Recovery Network	P.R.N.	1	
Oregon Association of Nurse Anesthetists	ORANA	1	
Oregon Center for Nursing	OCN	1	
Oregon Association of Hospitals and Health Systems	OAHHS	2	
Oregon Psychiatric Physician's Association	OPPA		1

Associated Board

Question 1: The first question asks the respondents which board the associations' members are licensed by. The three respondents indicated the following boards: Medical Board, Nursing Board and Pharmacy Board.

Customer Service

Question 2: Respondents are then asked to "Please think about your recent contact with IBH and rate" the 1) timeliness of HPSP's response, 2) the knowledge level of HPSP's staff and 3) HPSP's services overall. A scale of "excellent" to "poor" is provided. One respondent rated all three items as "excellent" and the second rated them all "above average." The third respondent indicated that these items were "not applicable" meaning that s/he had not initiated a request to HPSP.

Value to Members

Question 3: Next, the question "How valuable is the Health Professionals' Services Program to your membership?" is asked. A four-point scale ranging from "extremely valuable" to "extremely unvaluable" is provided. Two respondents indicated that HPSP is "valuable" for members and one indicated it is "extremely valuable."

Question 4: The last survey question asks the respondent to rate the feedback received from membership regarding IBH on a five-point scale ranging from "excellent" to "poor." Two respondents endorsed that feedback has been "above average" and the third selected "not applicable" meaning that s/he had not received any feedback.

Respondents are then asked for any additional comments. One (1) was provided:

1. *We are glad to keep in contact about ongoing development HPSP services in order to provide an accessible and safe space for licensees in need of such services.*

Summary Analysis

Three responses from contacts at the various professional associations were received, one each from an association related to the Nursing, Medical and Pharmacy Board. Responses were positive, indicating that services were "excellent" (1) or "above average" (1). Further, responses indicated that HPSP is "valuable" (2) or "extremely valuable" (1) for members. Feedback from membership has been "very good" (2.)

IBH's efforts this spring to communicate with the various professional associations is already proving fruitful. Additional conversations are planned for the upcoming months.

IBH Solutions
Health Professionals' Services Program (HPSP)
Satisfaction of PROVIDERS

Purpose

The purpose of assessing GMC/PMC providers and third-party evaluators is to solicit feedback that can be used to improve the services provided through HPSP. IBH strives to maintain the quality, effectiveness, and efficiency of the program, and evaluates these providers' satisfaction with HPSP twice yearly.

Feedback is obtained from these providers via a satisfaction survey that is emailed. The survey is short and can be completed in 2-3 minutes. Feedback includes information about IBH's communication, responsiveness of staff, overall rating of experience, and any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the IBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 11	Year 10	Year 9	Year 8
# Sent	22	48	51	52	52
# Responses	7	12	10	11	14
Response Rate	31.8%	25.0%	19.6%	21.2%	26.9%

Surveys were sent to 9 GMC/PMC providers and 13 third-party evaluators by email this period, for a total of 22 surveys distributed. Seven responses were received for a rate of 31.8%. For the year, the response rate is 25%, representing 12 responses to the 48 surveys that were sent. These rates represent an increase from the prior two years.

Role of Respondent

The first question asks the respondents the capacity in which they provide services to HPSP licensees. This period, three respondents indicated they serve as an "evaluator" and three as a "monitor" (GMC/PMC). The final respondent indicated they serve as both.

For the year, five identified as an "evaluator," six as a "monitor" and one as both. Two also identified as a treatment provider/therapist.

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Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to communication between HPSP and the provider. Specifically, they were asked if questions and concerns were responded to promptly, information was communicated clearly and professionally, and if they had all the necessary information when they met with the licensee. For the period, the mode was "agree" for the first two statements and "strongly agree" for the third. Two respondents did not feel they had all the information needed when they met with the licensee, but otherwise each of the statements was universally positively endorsed. This was also true for the year: Responses were split evenly between "strongly agree" and "agree" for questions being answered promptly and information being communicated clearly and professionally. The mode for having all information needed when seeing the licensee was "strongly agree" for the year, although there were those two "disagree" responses mentioned earlier. Overall, responses were more positive this year than last year with a greater percentage of "strongly agree" responses to each of the three items.

Data Tables 2a and b: The mode (most frequent) response is highlighted in red.

Table 2a: This Period (n=7)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	3	42.9%	**4**	**57.1%**								
Information was communicated clearly and professionally	3	42.9%	**4**	**57.1%**								
I had all the information I needed when I saw the licensee	**3**	**42.9%**	2	28.6%	2	28.6%						

Table 2b: This Year (n=12)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	6	50%	6	50%								
Information was communicated clearly and professionally	6	50%	6	50%								
I had all the information I needed when I saw the licensee	**6**	**50%**	4	33.3%	2	16.7%						

Table 2c: Year 10 (n=10)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	3	30%	**5**	**50%**					1	10%	1	10%
Information was communicated clearly and professionally	4	40%	**5**	**50%**					1	10%		
I had all the information I needed when I saw the licensee	3	30%	**6**	**60%**							1	10%

Overall Experience

Question 3: Respondents are next asked "Overall, how would you rate your experience working with IBH staff of HPSP?" For the period, three respondents (42.9%) rated their experience "excellent" and four rated it "above average." For the year, the mode response was "excellent" with half (50% or 6) of the responses. There was one "average" response for the year, but the remainder were "above average." Results are more positive than last year.

Data Table 3: The mode (most frequent) response is highlighted in red where applicable.

Table 3: Overall Rating	This Period (n=7)		Year 11 (n=12)		Year 10 (n=10)	
	#	%	#	%	#	%
Excellent	3	42.9%	**6**	**50%**	2	20%
Above Average	**4**	**57.1%**	5	41.7%	**5**	**50%**
Average			1	8.3%	2	20%
Below Average						
Poor						
N/A or No Response					1	10%

Additional Comments

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. I now have an RBH staff person who sends information when a direct deposit is made to my account so the correct participant's account can be credited. Thank you.
2. HPSP Staff are both fair minded and knowledgeable.
3. If the IBH were to offer an opportunity for evaluators to do an on-site visit to get to know staff, resources and policies/procedures, I'd be very interested in participating.
4. Reports e-mailed SECURE or faxed occasionally get misdirected
5. My complaint is always the same. There should be an initial planning session with all parties and the client involved.
6. Great program & staff!

Summary Analysis

The response rate was 31.8% for the period and 25% for the year. These rates represent an increase from the prior two years. There was a balanced set of responses each from evaluators and monitors both this period and year.

Overall, responses were positive throughout the year and improved from last year. Responses were split evenly between "strongly agree" and "agree" for questions being answered promptly and information being communicated clearly and professionally. The mode for having all information needed when seeing the licensee was "strongly agree." When rating their experience working with the IBH staff of HPSP, the mode response for the year was "excellent" with half (50% or six) of the responses. There was one "average" response for the year, but the remainder were "above average."

Six comments were received: Three were positive, one expressed a concern and two provided recommendations. The PAC will review all survey data and comments.

Health Professionals' Services Program Summary Annual Report
Highlights of Year Eleven 7/1/20-6/30/21

The purpose of this report is to provide a summary of the highlights of the eleventh year of the Health Professionals' Services Program (HPSP) to the representatives of the participating health licensing boards. HPSP began provision of monitoring services to the Oregon Board of Dentistry, Oregon Board of Nursing, Oregon Medical Board, and the Oregon Board of Pharmacy on July 1, 2010. The Oregon Health Authority previously oversaw HPSP's provision of services to the boards.

The following data tables were developed to give an overview of the HPSP program during the period from July 1, 2020 through June 30, 2021.

Table 1: Enrollment Overview: Year 11

Enrollment Overview: Year 11 (7/1/20 - 6/30/21)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 10 (6/30/20)	12	74	20	100	**206**
Enrolled: Board Referral*	3	16	2	7	**28**
Enrolled: Self-Referral*	0	2	0	6	**8**
Successfully Completed	2	18	1	20	**41**
Terminations	1	12	2	6	**21**
Total Enrolled End of Year 11 (6/30/20)	**12**	**62**	**19**	**87**	**180**
Referred but Not Enrolled/Inquiry Only	*0*	*1*	*0*	*3*	*4*

**Referral Type at the time of enrollment*

Table 1 provides a summary of year eleven enrollment, beginning with the number of licensees enrolled at the end of year ten and reviewing the changes in enrollment during the year. In particular, it displays: the number of licensees referred by the licensing board to the program, the number of self-referrals to the program, the number of licensees who successfully completed the program, and the number of licensees who were terminated from the program by the licensing boards. The total enrollees at the end of year eleven follows from this data. Table 1 also displays the number of licensees who did not yet enroll but were referred or self-initiated contact with the program prior to the end of the year. Table 2 provides the same information but for year ten enrollment (see next page).

At the end of year eleven, the program had 180 participants, a 12.6% decrease from the 206 participants at the beginning of the year. Total enrollment decreased because the number of completions (41) and terminations (21) when combined (62), was greater than the 36 new enrollees (28 board referrals plus 8 self-referrals). The total completions and terminations this year (62) is comparable to those last year (36+25 = 61), however the new referrals were far greater last year (47) than this year (36).

The impact of COVID should be considered when reflecting on this decrease. Although not solely responsible, the change in business practices for the year certainly was felt. Meanwhile, we know that mental health across our nation suffered throughout the pandemic and substance use (and abuse) increased. To reflect this, we should expect a higher referral rate in the year ahead.

It is important to note that the number of completions is nearly double that of the number of terminations, underlining the success of the program. All four boards had licensees both successfully complete and end the program as terminations. There were also new board referrals by all four boards, with self-referrals by the Board of Nursing (2) and Medical Board (6.) This volume of self-referrals is up 2 cases from the 6 self-referrals last year.

Table 2: Enrollment Overview: Year 10

Enrollment Overview: Year 10 (7/1/19 - 6/30/20)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 9 (6/30/19)	13	89	23	95	**220**
Enrolled: Board Referral*	3	18	3	17	**41**
Enrolled: Self-Referral*	0	1	0	5	**6**
Successfully Completed	1	19	4	12	**36**
Terminations	3	15	2	5	**25**
Total Enrolled End of Year 10 (6/30/20)	**12**	**74**	**20**	**100**	**206**
Referred but Not Enrolled/Inquiry Only*	*0*	*9*	*0*	*1*	*10*

**Referral Type at the time of enrollment*

***Data in this row was updated to reflect cases that enrolled subsequent to last year's report. They are captured in year eleven's enrollments.*

Table 3: Case Disposition (7/1/10 – 6/30/21)

Case Disposition as of 6/30/21	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled	**49**	**598**	**65**	**332**	**1044**
Number Successfully Completed	25	293	30	183	531
Number Active	12	62	19	87	180
Total Successful (Active + Completions)	37	355	49	270	711
Percentage Successful	**75.5%**	**59.4%**	**75.4%**	**81.3%**	**68.1%**
Number Termed	12	243	16	62	333
Percentage Unsuccessful	**24.5%**	**40.6%**	**24.6%**	**18.7%**	**31.9%**

Table 3 displays the cumulative data on the disposition of cases since the program's inception. To date, 1,044 licensees have enrolled, and 531 of these have completed; an additional 180 are on track to complete for a total of 68%. The percentage successful ranges across the Boards from 59.4% (Board of Nursing), to 75% (Board of Dentistry and Board of Pharmacy) to 81% (Medical Board.)

Unfortunately, 333 licensees have been terminated. These cases include situations where HPSP and the Boards acted to protect public safety. IBH would like to discuss adding peer support as an element for the Board of Nursing specifically. This is something that the Medical Board participants engage in and it has been empirically proven to increase success in monitoring programs.

Table 4: Video/In-Person Contacts

Video/In-Person Contacts: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Video/In-Person Contacts (including Intakes)	0	6	0	7	**13**
Number of Video/In-Person Intakes	0	3	0	2	**5**
Total Enrolled During Year 11	3	18	2	13	**36**
Percent with Video/In-Person Intakes	0.0%	16.7%	0.0%	15.4%	**13.9%**

During year eleven, HPSP met via video conference with a total of 13 licensees, five for intakes and the other eight for annual reviews. The Medical Board had seven licensees meet with their agreement monitor via video conference and the Board of Nursing had six. The video conference intakes account for ~14% of the intakes completed during year eleven; up from 4% last year.

IBH was pleased to begin offering the video conference option this year and will continue to do so even after COVID restrictions lift for those who cannot make it to our office. In fact, licensees are offered an in-person or video option for annual reviews and intakes at this time. Please note that in some cases it is not appropriate or helpful, so it may not be universally offered.

Table 5: Program Termination Reasons

Termination Reasons: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Deceased	1				**1**
Inappropriate Referral (Determined after Enrollment)					**0**
License Inactivated		1			**1**
License Retired					**0**
License Revoked		2			**2**
License Surrendered		4	2	6	**12**
License Suspended					**0**
Probation		5			**5**
TOTAL	**1**	**12**	**2**	**6**	**21**

Table 5 reviews the reasons for terminations from HPSP this year. Please note that a licensee must be enrolled in order to be considered terminated from the program, thus cases closed as a “failure to enroll” are not captured in table four. A total of 21 licensees were terminated from the program in year eleven, compared to 25 last year. A total of six Medical Board licensees were terminated, all due to surrendered licenses. The Board of Nursing had 12 terminations: four due to surrendered licenses, five due to probation, two due to a revoked license and one due to an inactivated license. Two Board of Pharmacy licensees were terminated this year, both due to a surrendered license. One licensee from the Board of Dentistry is now deceased and is thus no longer able to participate in the program. Surrendering one’s license was the most common reason for termination from the program in year eleven, as it was for most of the prior years of the program.

Table 6: Licensees Formally Not Participating During the Program Year

Licensees Formally Not Participating (At Any Time During Year 11)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Formally Not Participating (But Not Suspended)		4			**4**
Suspended: Board Request					**0**
Suspended: Expired License					**0**
Suspended: Health - Severe Issues		1			**1**
Suspended: Incarcerated				1	**1**
Suspended: Non-Compliance - Financial				1	**1**
Suspended: Per Board, Open HPSP But Not Participating					**0**
TOTAL	**0**	**5**	**0**	**2**	**7**

Table 6 details the number of licensees who were "formally not participating" at any time during year eleven. This includes those who were suspended as well as those who were not actually suspended but are formally ***not*** participating. Reasons for suspension were varied: For the Board of Nursing, one was suspended due to severe health issues and four were formally not participating (but not suspended). The Medical Board had one licensee suspended due to financial non-compliance and one due to incarceration. Neither the Board of Pharmacy nor the Board of Dentistry had any licensees suspended or formally not participating this year.

By the close of the eleventh program year, there was only one licensee formally not participating (see Table 6 below.) This licensee from the Medical Board is suspended due to incarceration.

Table 7: Licensees Formally Not Participating at the End of the Year

Licensees Formally Not Participating (At End of Year 11)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Formally Not Participating (But Not Suspended)					**0**
Suspended: Board Request					**0**
Suspended: Expired License					**0**
Suspended: Health - Severe Issues					**0**
Suspended: Incarcerated				1	**1**
Suspended: Non-Compliance - Financial					**0**
Suspended: Per Board, Open HPSP But Not Participating					**0**
TOTAL	**0**	**0**	**0**	**1**	**1**

Table 8: Non-Compliance Reports by Licensee

Non-Compliance Reports by Licensee: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Non-Compliance Reports	5	105	16	41	167
Total Non-Compliance Reports as a Percentage of Average # of Licensees Enrolled in Year 11	41.7%	154.4%	82.1%	43.9%	86.5%
# of Licensees with NC Reports	4	28	4	19	55
# of Licensees with NC Reports as a Percentage of Average # of Licensees Enrolled in Year 11	33.3%	41.2%	20.5%	20.3%	28.5%
# of Licensees with >1 NC report	1	15	2	8	26
# of Licensees with >3 NC report	0	8	2	3	13

Table 8 gives the total number of non-compliance reports by board and then reports this number as a percentage of the average number of licensees enrolled during the year. A break-down of these reports is then listed, showing the number of licensees who received reports, the number with more than one report throughout the year, and the number with more than three reports throughout the year. Further, the number of licensees with a non-compliance report is reflected as a percentage of the average number of licensees enrolled in the program. This figure was 28.5% for year eleven, meaning that just more than a quarter of licensees had a non-compliance report at some point during the year. This figure is down from 34.3% the prior year. This figure ranged from 41.2% (Board of Nursing) to 20.3% (Medical Board).

A total of 55 licensees had one or more non-compliance reports this year, a decrease from 73 last year. A total of 167 non-compliance reports were submitted this year, also a decrease from the 227 last year. The Board of Nursing licensees had 105 reports this year; 51 of these, though, were for four licensees. The Medical Board had 41 non-compliant reports this year, the Board of Pharmacy had 16 and the Board of Dentistry had five (5). Thirteen licensees across all four boards had more than three non-compliant reports submitted, ranging from no (0) Board of Dentistry licensees to eight (8) Board of Nursing licensees.

The total number of non-compliance reports submitted as a percentage of the average number of enrolled licensees was 86.5%, a strong decrease from last year's 106.6%. It is important to remember that this decrease in non-compliance occurred during a year characterized by the stress of managing the pandemic. While individual's daily lives were characterized by increased stress, loss of structure and significant change, enrolled licensees were able to continue in their sobriety due in part to the structure and accountability of HPSP.

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Table 9: Self-Referrals Known to Board After Report of Non-Compliance

Self-Referrals Known to Board After Report of Non-Compliance	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Year 1 (7/1/10 - 6/30/11)	0	0	0	11	**11**
Year 2 (7/1/11 - 6/30/12)	0	1	0	8	**9**
Year 3 (7/1/12 - 6/30/13)	1	0	0	5	**6**
Year 4 (7/1/13 - 6/30/14)	0	0	0	4	**4**
Year 5 (7/1/14 - 6/30/15)	0	4	0	7	**11**
Year 6 (7/1/15 - 6/30/16)	0	0	0	3	**3**
Year 7 (7/1/16 - 6/30/17)	0	0	0	4	**4**
Year 8 (7/1/17 - 6/30/18)	0	0	0	3	**3**
Year 9 (7/1/18 - 6/30/19)	0	2	0	4	**6**
Year 10 (7/1/19 - 6/30/20)	0	2	0	4	**6**
Year 11 (7/1/20 - 6/30/21)	0	2	0	2	**4**
TOTAL	**1**	**11**	**0**	**55**	**67**

The self-referral option is a great way to encourage early intervention. Table 9 shows the number of self-referred licensees who were reported non-compliant and are thus now known to the board. This year, both the Medical Board and Board of Nursing had two self-referrals who switched to being board known. The Board of Dentistry and Board of Pharmacy did not have any; this is expected given that they did not have any self-referrals participating at any point during year eleven.

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Table 10: Non-Compliance Reasons

Non-Compliance Reasons*: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Failure to Enroll	0	2	0	0	**2**
Failure to Participate: Missed AM Check-in	1	19	1	2	**23**
Failure to Participate: Missed IVR Call	1	41	14	10	**66**
Failure to Participate: Missed Test (includes failure to provide specimen)	1	62	14	15	**92**
Failure to Participate: Non-Payment	0	0	0	0	**0**
Failure to Participate: Other	1	12	0	8	**21**
Hospitalization	0	0	0	0	**0**
Violated Restriction on Practice	0	3	0	1	**4**
Positive Non-RBH Test	0	1	0	0	**1**
Positive Toxicology Test	2	18	0	13	**33**
Impaired in a Health Care Setting in the Course of Employment (including admitted substance use & diversion of medications)	0	2	0	0	**2**
Impaired Outside of Employment (including admitted substance use & diversion of medications)	0	8	1	5	**14**
Public Endangerment	0	0	0	0	**0**
Criminal Behavior (including DUI)	0	1	0	2	**3**
Unapproved Use of Prescription Medication	0	1	0	0	**1**
TOTAL	**6**	**170**	**30**	**56**	**262**
Unique Licensees with 1 or More Non-Compliance Reports	***4***	***28***	***4***	***19***	***55***

** There may be more than 1 reason per report*

Table 10 shows the reasons why a non-compliance report was submitted to the appropriate board. It is not uncommon for a single non-compliance report to have multiple reasons for the non-compliance; all of these reasons are captured in the table. The most common reason for non-compliance was the licensee failing to test as scheduled. This was the case on 92 reports, down from 128 last year. Failure to test has been the most frequent reason for a non-compliance report for the past eight years. Missed IVR calls, positive toxicology tests, missed agreement monitor check-ins and "failure to participate: other" were the next most common reasons. For the last three years these reasons have continued to be the most frequent in various orders. Note that "missed IVR calls" (or any missed check-in to the testing notification system) is only reported in conjunction with another non-compliance instance, like a missed test. There are not any particularly notable differences between the boards. With the greater total number of reports, the Board of Nursing does have more reasons for non-compliance than the other boards.

Table 11: Non-Negative Toxicology Tests

Non-Negative Toxicology Tests: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Invalid Tests	0	17	5	16	**38**
Positive Tests (non-negative results)	3	32	2	17	**54**
Total Non-Negative Tests (Positive + Invalid)	**3**	**49**	**7**	**33**	**92**
Positive Tests as a Percentage of Average # of Licensees Enrolled in Year 11	25.0%	47.1%	10.3%	18.2%	**28.0%**
Number of Licensees with a Positive Test	2	13	2	4	**21**
Number of Licensees with a Positive Test as a Percentage of Average # of Licensees Enrolled in Year 11	16.7%	19.1%	10.3%	4.3%	**10.9%**

Table 11 shows the number of invalid and positive toxicology tests per board. These include urinalysis (UA), hair, and blood tests. The non-negative results include re-test results, but if the specimens were also either positive or invalid on the original toxicology screen, they were only counted once each.

This year a total of 38 tests were invalid. IBH has continued to work closely with the forensic scientists and other experts at Medtox/Labcorp regarding the volume of invalid results across our customers. We are pleased to report that Medtox/Labcorp implemented a change to address this issue earlier this month and we are already seeing a decrease in the number of invalids. With this change in place, examples of problems moving forward that may cause an invalid test result include large amounts of particulates like blood in the sample, substituting another liquid for the urine sample, or adulterating the sample with some type of additive that interferes with the processing of the result.

There were a total of 54 positive toxicology tests during year eleven, similar to 52 last year. Thirty-two of these were from the Board of Nursing, 17 from the Medical Board, two from the Board of Pharmacy and three from the Board of Dentistry. Table 11 also reflects the number of positive tests as a percentage of the average number of licensees enrolled in the program during year eleven. Overall the positive tests are 28% of the average number of enrolled licensees, a slight increase from last year's 24%. The boards ranged from a low of 10.3% (Board of Pharmacy) to a high of 47.1% (Board of Nursing). This percentage (positive tests relative to average number of enrolled licensees) is impacted by the number of licensees with more than one positive test. Thus, Table 9 also includes the number of licensees with a positive test. This number is then reflected as a percentage of the average number of licensees enrolled in the program. Across the program, the percentage of licensees with a positive test is 10.9%, down from 13.6% last year and 15.6% two years ago. The Board of Nursing's percentage is 19.1% based on 13 licensees with positive tests. This is followed by the Board of Dentistry with 16.7% (2 licensees), then the Board of Pharmacy with 10.3% (2 licensees) and finally the Medical Board with 4.3% (4 licensees).

Table 12: Drugs Resulting in Positive Tests

Drugs Resulting in Positive Tests: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
amphetamines / methamphetamines	1	1		5	**7**
cocaine metabolite		1	1		**2**
ethyl glucuronide (ETG)		15	1	2	**18**
ethyl glucuronide (ETG) – PETH		9			**9**
marijuana metabolite (THC)	2	3		10	**15**
opioids (narcotics/opiates)		3			**3**
TOTAL	**3**	**32**	**2**	**17**	**54**
Number of Licensees with a Positive Test	***2***	***13***	***2***	***4***	***21***

Table 12 shows the various drugs that resulted in a positive test result. This table ***only*** includes the drugs resulting in the positive test, excluding any substances excused by the MRO. As we have seen historically, the largest number of positive tests was for alcohol (ethyl glucuronide (ETG)). This year positive ETG tests accounted for 33.3% of the positive tests (18 positives). Alcohol metabolites identified through a PEth (blood) test rather than a urine toxicology screen also accounted for an additional 16.7% of the positive tests (9). Thus, half (50% or 27) of the positive tests were due to alcohol consumption. The next most frequently found substance this year was marijuana metabolite with 27.8% of the positives (15 tests). This category only accounted for 2.8% of the positive tests last year. That said, two licensees were responsible for 9 of the 15 positives for marijuana metabolite.

Table 13: Missed Test Details – Breakdown by Reason

Missed Test Breakdown by Reason: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
No Call	1	68	14	11	**94**
No Show	0	26	1	4	**31**
Refused	0	1	0	1	**2**
TOTAL	**1**	**95**	**15**	**16**	**127**

Table 13 gives details on licensees who failed to take a scheduled toxicology test. No call refers to licensees who failed to check in to the daily testing notification system (IVR/portal/app) and did not test as scheduled. No Show refers to situations when the licensee did not go to the collection site to give a specimen but did check to see if a test was required through the daily testing notification system (IVR/portal/app). Refused refers to licensees who went to the collection site but did not provide an adequate specimen. This is considered a refusal to test which is treated like a positive test unless the licensee can provide a medical explanation from a physician, verifying that the licensee has a medical condition which prevents the licensee from providing an adequate sample. There were two “refusals” this year, one from the Board of Nursing and one from the Medical Board.

There was a total of 127 missed tests this year compared to 139 last year. The majority (94) of misses were due to No Call while 31 were due to No Show. This means that more licensees missed a test after failing to check-in than did not test despite apparent knowledge of the requirement to do so.

In total, ninety-five of the missed tests were missed by Board of Nursing licensees, 16 by Medical Board licensees, 16 by Board of Pharmacy licensees and 1 by the Board of Dentistry licensees. Although there were 127 missed tests, note that

there are only 92 non-compliance reports related to missed tests. In some cases, reports were not required because the license had already been terminated or suspended before the issue was confirmed and in other cases because the licensee was on “periodic non-compliance reports” and thus multiple missed tests were reported on one non-compliance report.

Table 14: Missed Test Details – By Licensees

Missed Test Details: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Number of Missed Tests	1	95	15	16	**127**
Number of Licensees with a Missed Test	1	18	4	12	**35**
Licensees with a Missed Test as a Percentage of Average # of Licensees Enrolled in Year 11	8.3%	26.5%	20.5%	12.8%	**18.1%**

Table 14 shows the total number of missed tests (also reported in Table 13) as compared to the number of unique licensees who missed a scheduled toxicology test. If these numbers were identical, it would mean that each licensee was only responsible for one missed test. The larger the difference in these numbers, the more times a single licensee is responsible for multiple missed tests. This year, 35 licensees were responsible for the 127 missed tests, an average of approximately 3.5 missed tests per licensee. In fact, though four (4) licensees were responsible for just over half of the missed tests.

Table 14 also shows the number of missed tests as a percentage of the average number of licensees enrolled in year eleven. Across the boards, this percentage was 18.1%. The Board of Nursing was highest with 26.5%, meaning that about a quarter of licensees missed at least one test. The Board of Pharmacy had 20.5% of licensees miss a test (1 in 5 licensees missed a test), the Board of Dentistry had 8.3% (1 in 15 licensees) and the Medical Board had 12.8% (1 in 8 licensees).

Report continued next page

Table 15: Workplace Safe Practice Reports

Workplace Safe Practice Reports: Year 11	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Licensees who had Reports Submitted	13	68	17	85	**183**
Number of Reports Received / Reviewed	116	590	150	878	**1734**
Percentage of Required Reports Received	87.2%	94.7%	81.5%	93.2%	**92.1%**
Number of Reports Received with Concerns Noted	0	4	0	4	**8**
Percentage of Reports with Concerns Noted	0.0%	0.7%	0.0%	0.5%	**0.5%**
Percentage of Reports in which Noted Concerns were Addressed	100.0%	100.0%	100.0%	100.0%	**100.0%**
Number of Licensees with a Report with Concerns Noted	0	3	0	3	**6**
Number of Licensees with Concerns Reported who also had a NC report	0	2	0	2	**4**
Above as a Percentage of the Total Licensees with NC Reports	N/A	7.1%	N/A	10.5%	**7.3%**

Table 15 displays details on the workplace safe practice reports received from workplace monitors during the year, including the number of licensees who had reports submitted, the total number of reports received and reviewed and the percentage of the required reports that were actually received. This year, an average of 92.1% of the required reports were received with a total of 1,734 reports received and carefully reviewed for 183 licensees. HPSP will continue to employ the tools that are in place to carefully track and follow-up on these reports each month.

Table 15 additionally displays the number and percentage of reports in which the workplace monitor noted concerns about the licensee in the workplace. There were only eight (8) such reports this year, with four each from licensees of the Board of Nursing and the Medical Board. The Boards of Dentistry and Pharmacy did not have any such reports this year. It is important to note that 100% of the reports with a concern noted had an appropriate plan developed and put into place to address the concerns.

Further displayed in Table 15 is the number of licensees with a report indicating concerns who also had a non-compliance report. In fact, two-thirds (4) of the (6) licensees with a workplace concern noted *did* have a non-compliance report on record. Finally, Table 15 displays the number of licensees with a workplace safe practice report noting concerns *and* a non-compliance report as a percentage of the total number of licensees with a non-compliance report. This figure was 10.5% for the Medical Board and 7.1% for the Board of Nursing. Again, these licensees with a non-compliance report displayed concerning behavior in the workplace. This emphasizes the importance, and effectiveness, of monitoring.

What's Next? Year Twelve

It is important to note that the COVID-19 pandemic was in effect during the entirety of this reporting year, which presented unique challenges to the monitoring program and certainly healthcare in general. We were pleased to see that the structure, support, and accountability of monitoring allowed licensees to be as successful as in past years. However, we do anticipate that this coming year will be more difficult for licensees to navigate as the trauma response reaction will likely lead to increased need for support and resources. We also anticipate an increase in referrals across all boards as healthcare providers who have been struggling with substance use and mental health symptoms during the pandemic will be identified.

Looking ahead to next year, the HPSP team will focus on:

- Continued relationship building with professional associations, including Oregon Nurses Association (ONA), Oregon Medical Association (OMA), Oregon Association of Nurse Anesthetists (ORANA), Oregon Podiatric Medicine Association (OPMA), Oregon Dental Association (ODA), Oregon Pharmacy Association (OPA) and Oregon Association of Hospitals and Health Systems (OAHHS).
- Continue to offer and encourage in-person (when appropriate) and video contacts between Agreement Monitors and licensees.
- Continue to educate licensees, associations, and treatment providers about the licensee opportunities and advantages of self-referral.
- Meet with staff from each board to discuss board-specific issues and initiatives, and how to work collaboratively to increase licensees' successful completion from HPSP.

Kate Manelis, LMSW, HPSP Program Manager
July 22, 2021

IBH Monitoring

Health Professionals' Services Program (HPSP)

Enrollment Survey Report

July 2020

Purpose

In February of 2018, IBH Monitoring introduced a new survey that reviews the enrollment process. Enrollment Surveys are distributed in the fourth month after a licensee successfully enrolled in the Health Professionals' Services Program (HPSP). HPSP recognizes the significant importance of the enrollment process. Licensees need to receive an extensive amount of information and to develop a clear understanding of the expectations placed on them while they are participating in HPSP. The better their understanding of the expectations and the systems available to support them, the more successful they will be. The purpose of the Enrollment Survey is to gather information about each licensee's experiences during enrollment in order to help IBH evaluate the effectiveness of, and the clarity of communications during, the enrollment process.

Surveys are distributed via email. Licensees are asked to follow the included link to access and complete the survey. Requested feedback covers methods of communication used during enrollment, the quality (clarity, consistency and timeliness) of that communication, and staff's helpfulness. The quality of the relationship with their agreement monitor is also queried. If the licensee met with their agreement monitor in person for an intake, feedback is requested on the helpfulness of that encounter. At the conclusion of the survey, licensees are asked to provide any other feedback on the process.

Response Rate

Between July 2020 and June 2021 ("Program Year Eleven"), the Enrollment Survey was distributed to 32 licensees who enrolled in the program between March 1, 2020 and February 28, 2021. Note that responses are recorded based on when they are received rather than when the survey was sent. Eight (8) responses were received during the year, resulting in a 25.0% response rate. This is within the range of the previous response rates.

Table 1: Response Rate	**Program Year 11**	**Program Year 10**	**Program Year 9**
# Sent	32	57	29
# Returned	8	18	8
Response Rate	25.0%	31.6%	27.6%

Data Results

*Mode responses (the most frequent response in each dataset) are in **red**, excluding N/A responses. Not all items have a mode response.* Note that comments are shown as the respondent typed or wrote them: Spelling, punctuation, and grammar have not been corrected.

Communication

The first three questions query the methods, quality, quantity, and timeliness of communication during the enrollment process.

Question 1 – Methods of Communication

Licensees are first asked to indicate which ways they received information about the program during the enrollment process. The number of methods a licensee can list is not limited. This year, the eight licensees listed a total of 12 methods. Phone calls (7 or 87.5%) and email (5 or 62.5%) were the communication methods listed. Although not listed in their responses, licensees are all referred to our website to access guidelines and other information.

When asked, licensees did not recommend any other methods of communicating information about the program during the enrollment process

Table 2: Methods of Communication	Program Year 11 (n=12)		Program Year 10 (n=18)	
	#	%	#	%
In person			3	16.7%
Website			6	33.3%
Email	5	62.5%	14	77.8%
Phone Call	**7**	**87.5%**	**16**	**88.9%**
Mail			5	27.8%

Report continues on the next page

Question 2 – Quantity and Quality of Communication

Licensees are next asked if they received all the necessary information to understand the program requirements and if it was clear, concise and consistent. A scale of "strongly agree" to "strongly disagree" is used. This year, 87.5% of responses were either "strongly agree" or "agree" to all four items. The mode response to the first item, having received all the information needed, was "agree." The mode response to the other three items, that the information was clear, concise and consistent, was "strongly agree."

Licensees are given the option to "provide any recommendations related to providing information to new enrollees." Two comments were provided:

1. *I was asking about specific situations relating to my very rural location and somewhat unique situation. I received some conflicting information but it was resolved soon after. I also like to ask a lot of questions so I do not break any of the rules.*
2. *I am a participant and concurrent enrollee in HPSP and 3 other start equivalents. HPSP was by far the most user friendly and humanistic.*

Data from this year is provided below, followed by data from last year on the next page. Response trends were more positive this year than last, reflecting the efforts made by the IBH team to improve the enrollment experience.

Table 3a: Quantity and Quality of Communication - Year 11 (n=8)	**Strongly Agree**		**Agree**		**Neither Agree Nor Disagree**		**Disagree**		**Strongly Disagree**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I received all the information I need/needed about the program to understand the requirements.	3	37.5%	**4**	**50.0%**			1	12.5%				
The information I received was clear.	**4**	**50.0%**	3	37.5%	1	12.5%						
The information I received was concise.	**4**	**50.0%**	3	37.5%			1	12.5%				
The information I received was consistent.	**4**	**50.0%**	3	37.5%	1	12.5%						

Table 3b: Quantity and Quality of Communication - Year 10 (n=18)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I received all the information I need/needed about the program to understand the requirements.	2	11.1%	**10**	**55.6%**			4	22.2%	2	11.1%		
The information I received was clear.	4	22.2%	**8**	**44.4%**			4	22.2%	2	11.1%		
The information I received was concise.	3	16.7%	**6**	**33.3%**	3	16.7%	3	16.7%	3	16.7%		
The information I received was consistent.	3	16.7%	**7**	**38.9%**	3	16.7%	2	11.1%	3	16.7%		

Question 3 – Timeliness of Information

As a final question regarding communication, licensees are asked to rate the timeliness of the provision of the information during the enrollment process. All but one respondent (7 or 87.5%) felt that information was provided at just the right pace, while one (12.5%) felt that they needed more information sooner.

No responses were provided to the question “Please provide any recommendations related to providing information to new enrollees.”

Table 4: Timeliness of Information	Year 11 (n=8)		Year 10 (n=18)	
	#	%	#	%
Too Fast to Process			1	5.6%
Just Right	**7**	**87.5%**	**12**	**66.7%**
Too Slow – I needed more information sooner	1	12.5%	5	27.8%

Report continues on the next page

IBH Staff Members

The next three questions relate to the licensees' interactions with IBH staff members.

Question 4 – Helpfulness of Staff

Licensees are asked how helpful staff members are and responses were all positive. All respondents rated their agreement monitor "very good" in terms of helpfulness. Over half (5 or 62.5%) also rated the administrative team "very good" while the others (3 or 37.5%) rated the team "good."

No additional comments were provided.

Table 5a: Helpfulness of Staff Program Year 11 (n=8)	Very Good		Good		Acceptable		Poor		Very Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
IBH administrative team	**5**	**62.5%**	3	37.5%								
Agreement Monitor	**8**	**100%**										

Table 5b: Helpfulness of Staff Program Year 10 (n=18)	Very Good		Good		Acceptable		Poor		Very Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
IBH administrative team	4	22.2%	3	16.7%	5	27.8%	**6**	**33.3%**				
Agreement Monitor	**10**	**55.6%**	4	22.2%	2	11.1%			1	5.6%	1	5.6%

Report continues on the next page

Question 5 – In-Person/Video Conference Meeting with Agreement Monitor

The impact of an in-person or video conference intake meeting on the licensees' understanding of the program is queried in question five. Due to the COVID pandemic, no in-person intakes have been provided in the last 18 months. IBH began a pilot study offering a video conference intake meeting for licensees with their Agreement Monitor during the fall of 2020. This became common practice by spring of 2021. Thus, many of the licensees surveyed in this report did not have an option for a video-conference meeting or an in-person intake due to COVID. One licensee indicated that they did have a video-conference meeting this year. This individual did not feel it changed their enrollment experience.

Table 6: In-Person / Video Conference Meeting with Agreement Monitor	Program Year 11 (n=1)		Program Year 10 (n=3)	
	#	%	#	%
It significantly improved my enrollment experience.			**2**	**66.7%**
It partially improved my enrollment experience.			1	33.3%
It did not change my enrollment experience.	1	100%		
It degraded my enrollment experience.				
It significantly degraded my enrollment experience.				

Question 6 – Relationship with Agreement Monitor

The next item asks respondents to rate their agreement with the following statement "I have developed a strong working relationship with my Agreement Monitor." Notably, 87.5% (7) of the respondents indicated that they "strongly agree" or "agree" with this statement. The other respondent (1 or 12.5%) selected the response "neither agree nor disagree."

Table 7: Strong Working Relationship with Agreement Monitor	Program Year 11 (n=8)		Program Year 10 (n=18)	
	#	%	#	%
Strongly Agree	3	37.5%	6	33.3%
Agree	**4**	**50.0%**	**8**	**44.4%**
Neither Agree Nor Disagree	1	12.5%	4	22.2%
Disagree				
Strongly Disagree				

One comment was provided:

1. *She is a very caring and compassionate person, which has been very helpful in my recovery.*

Characteristics of Respondent Pool

Question 7: Board Licensing Respondents

Of the 32 enrollees who were sent surveys this year:

- 14 (43.8%) were licensed by the Board of Nursing;
- 14 (43.8%) by the Oregon Medical Board;
- 2 (6.3%) by the Board of Pharmacy; and
- 2 (6.3%) by the Board of Dentistry.

Of these 32 enrollees, the 8 respondents indicated that they were licensed by the Medical Board (4 or 50%), the Board of Nursing (3 or 37.%) and the Board of Dentistry (1 or 12.5%).

We can calculate a response rate by board and compare it to the 25% response rate overall:

- The Board of Dentistry had a **50%** response rate (1 responder out of 2 survey recipient).
- The Medical Board's response rate was **28.6%** (4 responders out of 14 survey recipients).
- The Board of Nursing's rate was **21.4%** (3 responders out of 28 survey recipients).
- The Board of Pharmacy's rate was **0%** (0 responders out of 2 survey recipients).

Question 8: Comments

The final question asks respondents to "provide any comments on the enrollment process (e.g. What was most helpful? What do you wish was done differently?)" Two responses were received:

1. *The kindness and compassion of everyone at HPSP has helped reduce my anxiety during an emotionally difficult time. Thank you all.*
2. *Having the scheduled phone interview with the agreement monitor was much preferred over a prolonged email exchange.*

Summary

Surveys were sent to the thirty-two licensees who enrolled between March 1, 2020 and February 28, 2021. Eight responses were received for a response rate of 25%. Respondents were licensed by the Board of Nursing, the Oregon Medical Board, and the Board of Dentistry.

Licensees indicated learning about the program through both phone calls and email messages. All but one licensee (87.5%), "agreed" or "strongly agreed" that they received all needed information and that it was clear, concise and consistent. Further, 87.5% felt that they received information at the right pace (neither too fast nor too slow.)

All respondents rated their agreement monitor "very good" in terms of helpfulness. Over half (5 or 62.5%) also rated the administrative team "very good" while the others (3 or 37.5%) rated the team "good." In addition, 87.5% (7) of the respondents indicated that they "strongly agree" or "agree" that they have developed a strong working relationship with their agreement monitor.

One of the respondents reported a video conference intake meeting with their Agreement Monitor but did not feel it changed the enrollment experience.

A total of five comments were provided throughout the survey. Four were positive and 1 was neutral.

The IBH PAC will review all of the survey data carefully, including each of the comments. After review, the IBH PAC will identify opportunities for improvement.

IBH Monitoring

Health Professionals' Services Program (HPSP)

Exit Interview Report

Year 11: July 1, 2020 – June 30, 2021

Purpose

Exit Interviews are conducted when a licensee successfully completes the Health Professionals' Services Program (HPSP). The purpose of the Exit Interview is to gather information about the licensee's experience as a participant and to help IBH Monitoring evaluate the importance and effectiveness of each aspect of the monitoring program.

Exit Interviews are mailed to licensees giving them the option of completing the questions online or completing the enclosed Exit Interview and mailing it back to IBH Monitoring in the postage paid envelope.

Requested feedback includes length of time in the program, their rating of the support systems that aided them in successful completion, their rating of their Agreement Monitor, Customer Service, and the Toxicology Program, and the value of the newsletter and website. The Exit Interview also includes a series of outcome related items focusing on the workplace, personal life, and interpersonal relationships. An overall evaluation of the impact of participation in the program is requested at the conclusion of the survey along with any comments.

Response Rate

The Exit Interview was distributed to 41 licensees who successfully completed the program between July 1, 2020 and June 30, 2021. Note that responses are recorded based on when they are received rather than when the licensee completed.

Thirteen (13) responses were received during the year, resulting in a 31.7% response rate. This is very similar to last year's rate (31.4%).

Table 1: Response Rate	**Year 11**	**Year 10**	**Year 9**	**Year 8**	**Year 7**
# Sent	41	35	41	46	42
# Returned	13	11	17	14	8
Response Rate	31.7%	31.4%	41.5%	30.4%	19.0%

Data Results

*Mode responses (the most frequent response in each dataset) are in **red**, excluding N/A responses. Not all items have a mode response. Note that comments are shown as the respondent typed or wrote them: Spelling, punctuation, and grammar have not been corrected.*

Characteristics of Responder Pool

The first two questions give us a picture of the characteristics of the licensees who responded to the exit interview.

Question 1 - Length of Time in Program

Licensees are first asked to indicate how long they were enrolled in the program. Historically, responses have predominately been between three and five years. There was more variability this year with one-third (4 or 30.8%) of the answers being "approximately 2 years" and another 15.4% (2) being more than 5 years.

Table 2: Length of Time in Program	Year 11 (n=13)		Year 10 (n=11)	
	#	%	#	%
Approximately 2 years	4	30.8%	1	9.1%
Approximately 3 years				
Approximately 4 years	**5**	38.5%	**6**	**54.6%**
Approximately 5 years	2	15.4%	4	36.4%
More than 5 years (but not career length)	2	15.4%		
Career Length				

Report continues on the next page

Question 2: Board Licensing Respondent

Of the 41 successful completers this year who received surveys: 18 (43.9%) were licensed by the Board of Nursing, 20 (48.8%) by the Oregon Medical Board, two (4.9%) by the Board of Dentistry and one (2.4%) by the Board of Pharmacy.

Of the thirteen submitted survey responses: Seven of the respondents were licensed by the Board of Nursing (53.9%), four by the Oregon Medical Board (30.8%), and two by the Board of Dentistry (2 or 15.4%). There were not any respondents from the Board of Pharmacy but since there was only one completer from this board, it is not surprising. This data is reflected in Table 3.

Table 3: Board Licensing Respondent	**Year 11 (n=13)**		**Year 10 (n=11)**	
	#	**%**	**#**	**%**
Oregon Medical Board	4	30.8%	3	27.3%
Board of Nursing	**7**	**53.9%**	**6**	**54.6%**
Board of Dentistry	2	15.4%		
Board of Pharmacy			2	18.2%

From this, we can calculate a response rate for each board and compare it to the 31.7% overall response rate. Note that the extreme response rates for the Board of Dentistry and Board of Pharmacy simply reflect the small size of the surveyed population.

- Medical Board - 20.0% (4 responders out of 20 completers.)
- Board of Nursing - 38.9% (7 responders out of 18 completers.)
- Board of Dentistry - 100% (2 responders out of 2 completers.)
- Board of Pharmacy - 0% (0 responders out of 1 completer.)

Program Ratings

The remainder of the survey questions ask responders to rate various aspects of the program and their impact on their personal and work life.

Report continues on the next page

Question 3 - Support Systems

Question three asks respondents to rate the support systems that aided in their successful completion of the program. As data is examined, it will be helpful to know that one respondent to this survey responded with the most negative response option provided to these items and those throughout the rest of the survey and also expressed his/her dissatisfaction in negative comments throughout the survey as well.

Table 4a: Support Systems - Year 11 (n=13); OMB only questions (n=4)	**Extremely Useful**		**Useful**		**Neutral** (Neither Useful Nor Unuseful)		**Unuseful**		**Extremely Unuseful**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Individual Meeting with Monitoring Consultant (PMC) ***(OMB licensee only)***			1	25%	1	25%	1	25%			1	25%
Group Monitoring Meeting (GMC) ***(OMB licensee only)***			1	25%					1	25%	2	50%
Regular contacts with Agreement Monitor	3	23.1%	3	23.1%	2	15.4%	2	15.4%	2	15.4%	1	7.7%
Participating in random toxicology testing	4	30.8%	4	30.8%	2	15.4%	1	7.7%	2	15.4%		
Having a monitoring agreement and addendums	3	23.1%	**5**	**38.5%**	3	23.1%	1	7.7%	1	7.7%		
Submitting documentation for requirements	1	7.7%	**7**	**53.9%**	2	15.4%	1	7.7%	1	7.7%	1	7.7%
Attending evaluations by third party assessors	2	15.4%	**4**	**30.8%**	3	23.1%			1	7.7%	3	23.1%

As we saw last year (data on next page), there was a broad spectrum of ratings to each of the listed statements. Combining the responses is helpful in further analysis (see chart below). Doing so we find that this year responses were more strongly weighted on the "Extremely Useful" and "Useful" side for all components except the GMC/PMC components which were split evenly (1 on each side).

	Useful/Extremely Useful	**Unuseful/Extremely Unuseful**
PMC	25.0%	25.0%
GMC	25.0%	25.0%
Agreement Monitor Contact	**46.2%**	30.8%
Random Testing	**61.6%**	23.1%
Monitoring Agreement	**61.6%**	15.4%
Submitting Documentation	**61.6%**	15.4%
3rd Party Evaluations	**46.2%**	7.7%

Additional comments about the support systems that aided in your successful completion:

1. *I don't know the answer to this but I would have not been able to complete the program without the emotional support of family and friends. With that being said, if I hadn't been able to take a loan out, I couldn't have afforded the program. I don't know what nurses do that have no financial backing or emotional. I would not have been able to complete program. I personal know people who turned in their*

license as they couldn't afford it. Like I said, I don't know the answer, I know nurses need help to get healthy and give their best to their patients, and I thank you for that.

2. *Absolutely no support was received.*

Last year's data is shown below for comparison.

Table 4b: Support Systems - Year 10 (n=11); OMB only questions (n=3)	**Extremely Useful**		**Useful**		**Neutral (Neither Useful Nor Unuseful)**		**Unuseful**		**Extremely Unuseful**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Individual Meeting with Monitoring Consultant (PMC) ***(OMB licensee only)***			1	33.3%	1	33.3%	1	33.3%				
Group Monitoring Meeting (GMC) ***(OMB licensee only)***					1	33.3%	1	33.3%			1	33.3%
Regular contacts with Agreement Monitor	2	18.2%	**5**	**45.5%**	3	27.3%	1	9.1%				
Participating in random toxicology testing			**5**	**45.5%**	4	36.4%	1	9.1%	1	9.1%		
Having a monitoring agreement and addendums	1	9.1%	**5**	**45.5%**	2	18.2%	1	9.1%	2	18.2%		
Submitting documentation for requirements			**4**	**36.4%**	3	27.3%	3	27.3%	1	9.1%		
Attending evaluations by third party assessors			2	18.2%	**4**	**36.4%**	1	9.1%	1	9.1%	3	27.3%

Question 4: Agreement Monitors, Customer Service, Toxicology Program

The next question asks for a rating of agreement monitors, customer service and the toxicology program using a scale of "below average" to "excellent."

Table 5a: Program Components - Year 11 (n=13)	**Excellent**		**Above Average**		**Average**		**Below Average**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Your Agreement Monitor	**8**	**61.5%**	3	23.1%	2	15.4%				
IBH MONITORING Customer Service	4	30.8%	**7**	**53.9%**	1	7.7%	1	7.7%		
HPSP Toxicology Program	3	23.1%	**5**	**38.5%**	3	23.1%	2	15.4%		

- Agreement monitors received very positive ratings with eight (8 or 61.5%) "excellent" ratings and three (3) additional ratings of "above average" (23.1%.) In all then, 84.6% of ratings for agreement monitors were **better** than "average." The remaining ratings were "average" (2 or 15.4%). The mode response was "excellent" just like last year.

- Customer service received a similar number of positive responses with 84.7% of responses either "excellent" or "above average." However, the mode response was "above average" (7 or 53.9%), like last year. There was one additional response of "average" (7.7%) and one of "below average (7.7%).
- Toxicology was rated positively by 61.6% (8) of respondents. The mode response was "above average" with five responses; this is an improvement from last year. This year, there were also three "average" responses (23.1%) but there were two "below average" responses.

Last year's data is displayed below.

Table 5b: Program Components - Year 10 (n=11)	Excellent		Above Average		Average		Below Average		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
Your Agreement Monitor	**7**	**63.6%**	1	9.1%	3	27.3%				
IBH MONITORING Customer Service	4	36.4%	**5**	**45.5%**	2	18.2%				
HPSP Toxicology Program	2	18.2%	3	27.3%	**4**	**36.4%**	1	9.1%	1	9.1%

Question 5: Value of the Newsletter and the Website

Licensees are asked to rate the value of the newsletter and the website ("portal"). Like last year, ratings continue to be spread broadly. The mode response for both this year, however, was "valuable." Efforts to enrich the newsletter were begun in the last 6 months and plans are in place to begin enhancing the website in the next year.

Table 6a: Communication Tools - Year 11 (n=13)	Extremely Valuable		Valuable		Little Value		No Value		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
HPSP Newsletter (HealthProCHOICES)	1	7.7%	**5**	**38.5%**	3	23.1%	4	30.8%		
HPSP Website (hpspmonitoring.com)	2	15.4%	**4**	**30.8%**	2	15.4%	3	23.1%	2	15.4%

Table 6b: Communication Tools - Year 10 (n=11)	Extremely Valuable		Valuable		Little Value		No Value		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
HPSP Newsletter (HealthProCHOICES)	1	9.1%	4	36.4%	2	18.2%	4	36.4%		
HPSP Website (hpspmonitoring.com)			**6**	**54.6%**	3	27.3%	2	18.2%		

Question 6: Program's Impact on Professional Life

This question asks licensees to reflect on the impact of the program on their professional life. Specifically, the item states: "Now that you have completed monitoring, please indicate the extent to which you agree or disagree with the following statements about your professional life." Notably, 87% of respondents are "more satisfied with work," with a mode response of "agree." The item, "I feel less stressed or burned out at work" has a mode of "strongly agree" (5 or 38.5%) and a total 61.6% of respondents who "agree" or "strongly agree." Another 61.6% believe their "work feels more meaningful." All of the "strongly disagree" responses were made by one individual who was negative in tone throughout the survey.

Data is more positive this year than it was last year. (Table 7b.)

Table 7a: Professional Life Year 11 (n=13)	**Strongly Agree**		**Agree**		**Neither Agree Nor Disagree**		**Disagree**		**Strongly Disagree**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I am more satisfied with work.	3	23.1%	**7**	**53.9%**	2	15.4%			1	7.7%		
I feel less stressed or burned out at work.	**5**	**38.5%**	3	23.1%	4	30.8%			1	7.7%		
I am better able to understand or empathize with my patients.	3	23.1%	3	23.1%	**6**	**46.2%**			1	7.7%		
The medical care I provide to my patients has improved.	1	7.7%	**5**	**38.5%**	4	30.8%	1	7.7%	1	7.7%	1	7.7%
My professional relationships have improved.	2	15.4%	4	30.8%	**5**	**38.5%**	1	7.7%	1	7.7%		
My work feels more meaningful.	2	15.4%	**6**	**46.2%**	4	30.8%			1	7.7%		

Table 7b: Professional Life Year 10 (n=11)	**Strongly Agree**		**Agree**		**Neither Agree Nor Disagree**		**Disagree**		**Strongly Disagree**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I am more satisfied with work.	3	27.3%	3	27.3%	3	27.3%	1	9.1%	1	9.1%		
I feel less stressed or burned out at work.	2	18.2%	**4**	**36.4%**	3	27.3%	1	9.1%	1	9.1%		
I am better able to understand or empathize with my patients.	2	18.2%	3	27.3%	**5**	**45.5%**			1	9.1%		
The medical care I provide to my patients has improved.	2	18.2%	2	18.2%	**6**	**54.6%**			1	9.1%		
My professional relationships have improved.			3	27.3%	**6**	**54.6%**			2	18.2%		
My work feels more meaningful.	1	9.1%	2	18.2%	**7**	**63.6%**			1	9.1%		

Question 7: Program's Impact on Personal and Interpersonal Life

This question asks licensees to reflect on the impact of the program on their personal and interpersonal life. Specifically, the item states: "Now that you have completed monitoring, please indicate the extent to which you agree or disagree with the following statements about your personal and interpersonal life." The majority of items had a mode response of "agree." Again, the same individual "strongly disagreed" with all items except for one where they responded with "N/A." Combining the "strongly agree" and "agree" responses, the following categories are especially worth noting that 77% felt that they were "better able to cope with life changes" and "better equipped to manage [their] own health." Also, 69.3% felt they have a "better work-life balance," are "more engaged in [their] community," are "more satisfied with [their] personal relationships, are "better equipped to manage problems at home," and have an improved self-esteem.

Data for this year and last year follows:

Table 8a: Personal and Interpersonal Life - Year 11 (n=13)	**Strongly Agree**		**Agree**		**Neither Agree Nor Disagree**		**Disagree**		**Strongly Disagree**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I feel better able to cope with life changes.	3	23.1%	**7**	**53.9%**	2	15.4%			1	7.7%		
I feel better equipped to manage my own health.	4	30.8%	**6**	**46.2%**	2	15.4%			1	7.7%		
My self-esteem improved.	2	15.4%	**7**	**53.9%**	3	23.1%			1	7.7%		
My mood improved.	3	23.1%	**5**	**38.5%**	4	30.8%			1	7.7%		
I have a better work-life balance.	3	23.1%	**6**	**46.2%**	2	15.4%			1	7.7%	1	7.7%
I am more engaged in my community.	1	7.7%	**8**	**61.5%**	3	23.1%			1	7.7%		
My personal life is less stressful.	3	23.1%	4	30.8%	4	30.8%			2	15.4%		
My spouse/partner and I communicate better.	3	23.1%	3	23.1%	5	38.5%					2	15.4%
I am more satisfied with my personal relationships.	3	23.1%	**6**	**46.2%**	2	15.4%	1	7.7%	1	7.7%		
I am better equipped to manage problems at home.	3	23.1%	**6**	**46.2%**	2	15.4%			1	7.7%	1	7.7%
I spend more meaningful time with family or friends.	3	23.1%	**5**	**38.5%**	3	23.1%			1	7.7%	1	7.7%

Report continues on the next page

Table 8b: Personal and Interpersonal Life - Year 10 (n=11)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I feel better able to cope with life changes.	2	18.2%	**6**	**54.6%**	2	18.2%			1	9.1%		
I feel better equipped to manage my own health.	2	18.2%	**5**	**45.5%**	3	27.3%			1	9.1%		
My self-esteem improved.	1	9.1%	4	36.4%	4	36.4%			2	18.2%		
My mood improved.	1	9.1%	**5**	**45.5%**	4	36.4%			1	9.1%		
I have a better work-life balance.	1	9.1%	4	36.4%	**5**	**45.5%**			1	9.1%		
I am more engaged in my community.	1	9.1%	3	27.3%	**5**	**45.5%**	1	9.1%	1	9.1%		
My personal life is less stressful.			**5**	**45.5%**	4	36.4%	1	9.1%	1	9.1%		
My spouse/partner and I communicate better.			2	18.2%	**4**	**36.4%**			2	18.2%	3	27.3%
I am more satisfied with my personal relationships.			**5**	**45.5%**	4	36.4%	1	9.1%	1	9.1%		
I am better equipped to manage problems at home.	1	9.1%	4	36.4%	4	36.4%	1	9.1%	1	9.1%		
I spend more meaningful time with family or friends.			4	36.4%	**5**	**45.5%**			2	18.2%		

Question 8: Overall Impact of HPSP

The final question asks, “All things considered, how would you describe the impact of your participation in HPSP?” Respondents are given space to expand on their response. Like last year, the mode response was “I feel I am much better off than prior to my participation in HPSP.” In total, 84.7% of participants feel better off than prior to participation. The one individual who “strongly disagreed” in questions 6 and 7 also here indicated feeling “worse off” and provided the 4th comment as listed on the next page.

Table 9: Overall Impact of HPSP	Year 11 (n=13)		Year 10 (n=11)	
	#	%	#	%
I feel I am much better off than prior to my participation in HPSP.	**7**	**53.9%**	**7**	**63.6%**
I feel I am slightly better off than prior to my participation in HPSP.	4	30.8%	1	9.1%
I feel I am neither better nor worse off after participating in HPSP.	1	7.7%	3	27.3%
I feel I am slightly worse than prior to my participation in HPSP.				
I feel I am much worse than prior to my participation in HPSP.	1	7.7%		

Please expand on your response:

1. *Rehab was very beneficial and the weekly group call ins. The toxicology program because of the randomness caused significant strain to my work duties. Regular testing at a more frequent interval would have been much more therapeutic. The toxicology program actually lead me to cancel operations for patients on the day of operation or leave them npo, leave patients waiting in the clinic for an extra hour or be canceled. I was always a low risk for use. Some other way to incorporate sobriety compliance would have been vastly beneficial and the program as organized caused significant work stress.*
2. *The coping skills that I have developed has helped me to cope in my everyday life.*
3. *I am definitely healthier and due to counseling outside of hpsp, I have dealt with a trauma that likely started that downhill slide. And I couldn't have got back to my feet without hpsp.*
4. *I am out literally thousands of dollars. The last 4 years made me feel like a [xxxx] convict on parole (minus the GPS locater on a he ankle). The added stress level every single day this "program" added to my life probably aged me by a decade or more. My livelihood was threatened by your organization on multiple occasions and I feared for my ability to earn a living on a daily basis.*
5. *It was rather long. I feel like I could've been through at the 3 year mark.*
6. *Given the success of HPSP in relation to maintaining sobriety, monitoring is a must for health care providers.*

Additional Comments

At the conclusion of the survey, respondents are asked to share any additional comments. The following were shared this year:

1. *This entire process has made me a better person. The balance I have in my life has provided me with the ability to move forward on the goals I have for my life and my family.*
2. *In no way does this program serve the public. The handful of people that participate at any given time is basically meaningless compared to the thousands of health care workers licensed in the state of Oregon. If anyone really gave a [xxxxx] about keeping the public safe there would be a random testing requirement for all healthcare workers as part of licensing requirement. The military does it and guess what it works. The right thing will never be done because of the financial burden that would be involved. Typical!*

Summary

The response rate for this year was 31.7%, representing 13 respondents out of 41 licensees who completed the program this year. Licensees were enrolled for anywhere from two to more than five years, although most common response was four years. Response rates based on number of surveys sent to licensees of each board were: 20% Medical Board (4 responses), 38.9% Board of Nursing (7 responses) and 100% Board of Dentistry (2 responses.) The Board of Pharmacy did not have any licensees respond to this survey this year, but only one Pharmacist completed and thus received a survey this program year.

Licensees are asked to rate the usefulness of a variety of support systems that they experienced while participating in HPSP. Program components were all rated primarily positive, with the exception of GMC and PMC participation for which the small sample of respondents were split in opinion. The mode for "Regular contacts with agreement monitor" and "participating in random toxicology" were tied between "extremely

useful" and "useful." "Useful" was the mode for "having a monitoring agreement and addendums," "submitting documentation for requirements," and "attending evaluations by third party assessors."

Overall, 85% of respondents rated their agreement monitor and customer service "excellent' or "above average." The mode response for agreement monitors was "excellent" and for customer service was "above average." Toxicology was rated average or better by 85% of respondents and had a mode response of "above average." Both the newsletter and the website were rated "valuable" by the largest group of respondents. That said, efforts to enrich the newsletter were begun in the last 6 months and plans are in place to begin enhancing the website in the next year.

Respondents overall felt that the program had a positive impact on their professional, personal and interpersonal lives. In fact, there were not any more than two "negative" responses to any item and most only had one such response all made by the same person. Notably, 87% of respondents are "more satisfied with work," and 62% are "less stressed or burned out at work" and believe their "work feels more meaningful." Further, 77% felt that they were "better able to cope with life changes" and "better equipped to manage [their] own health." And finally, 69% felt they have a "better work-life balance," are "more engaged in [their] community," are "more satisfied with [their] personal relationships, are "better equipped to manage problems at home" and have improved self-esteem.

The final question asks, "All things considered, how would you describe the impact of your participation in HPSP?" Like last year, the mode response was "I feel I am **much** better off than prior to my participation in HPSP." In total, 85% of licensees thought they were better off after participating in HPSP.

Ten (10) substantive responses were received throughout the survey. The IBH Monitoring PAC will review the survey data along with each of the comments carefully. The IBH Monitoring PAC will then identify opportunities for improvement and develop interventions if necessary.

HPSP Finanical Report - Year 11 (07/20 - 06/21)

Item #	Budget Categories	Original Budget / Year	07/01/20 - 06/30/21	Difference
1	Reliant Payroll	$595,001	$589,662	-1%
2	Supplies, materials, equipment	$10,500	$6,208	-41%
3	Space & utilities	$34,338	$10,729	-69%
4	Insurance E/O and D/O (please ensure this reflects requested insurance under new MSA, not previously requested insurance)	$5,169	$5,548	7%
5	Travel and per diem (not reimbursed under contract, but is built into pricing)	$5,000	$0	-100%
6	Oversight Council honoraria, travel, per diem (not reimbursed under contract, should be built into pricing)	NA	NA	
7	Admin fees (indirect) - 14.8%	$162,265	$161,363	-1%
8	Data Processing	$34,338	$46,121	34%
9	Communications and Software Licenses	$17,500	$12,093	-31%
10	Interactive Wellness Websites, CareFlash, HealthVault	NA	NA	
11	1-800 Interactive voice response randomization system	$11,904	$19,200	61%
12	Professional services (Medical Director and Consulting Psychiatrist)	$60,816	$81,723	34%
13	Printing/Copying (please provide an overview of what is being printed)	$500	$558	12%
14	Legal Fees for Court Orders	$10,000	$10,000	0%
15	Postage for test material and agreements/releases	$7,500	$7,980	6%
	TOTAL	$954,831	$951,184	0%
	Profit Margin	15.0%	13.6%	-10%
	Annual Charge	$1,098,056	$1,080,184	
	Annual Charge with 6 months of Revised Rates	$1,080,184		

Oregon
Kate Brown, Governor

DATE: March 29, 2021

TO: Governor Kate Brown and the 2021 Legislative Assembly

FROM: Health Profession Licensing Boards (Oregon Board of Dentistry, the Oregon Medical Board, the Oregon State Board of Nursing and the State Board of Pharmacy Board)

Executive Summary: ORS 676.190 (8) Independent Third-Party Health Professionals' Services Program (HPSP) Audit Results

Background and Purpose

In 2010, the Oregon State Legislature established the Health Professionals' Service Program (HPSP) to assist health providers with substance abuse and/or mental health disorders and to protect the public from licensees unable to practice safely due to one or both disorders.

In 2017, the Oregon Medical Board, Dental Board, Board of Nursing, and Board of Pharmacy ("the Boards") collectively executed a master service contract (MSA) with Integrated Behavioral Health Solutions, LLC (IBH), to provide the following services:

- Licensee monitoring, including licensee enrollment and case monitoring, workplace monitoring and reporting, and random toxicology testing.
- Outreach and training to licensees, third-party evaluators, consultants, treatment providers, and licensee supervisors.
- Quality assessment and performance improvement, including establishing formal policies and procedures, required minimum staffing levels, obtaining and reporting licensee and stakeholder input, and performance measurement.
- Periodic reporting on licensee enrollment, compliance, and other factors.

The Boards compensate IBH for these services; each Board pays a proportional share based on a formula accounting for total licensees and those licensees enrolled in the program.

The Boards contracted with Sjoberg Evashenk Consulting to conduct an audit as required by ORS 676.190 (8). The audit scope required a Performance Audit over the course of 6 months and concluded on January 15, 2021. The following is a summary of the audit's findings, recommendations, and results.

Key Audit Findings

- Amounts invoiced by IBH adhered to contract payment provisions. Monthly program fees were correctly calculated based on the number of licensees and enrollees of each Board, and each Board was billed their proportional share of the monthly program fee.
- IBH employed sound controls over licensee monitoring, including administering the appropriate number of toxicology tests, establishing a monitoring agreement with the licensee, ensuring routine communication between the monitor and licensee, and establishing protocols for agreement and workplace monitors.

- IBH could not demonstrate that it provided all required educational materials and outreach presentations to licensees, third-party evaluators, consultants, treatment providers, and licensee supervisors (workplace monitors), and stakeholders.
- IBH met most Quality Assessment and Performance Improvement Program requirements, but opportunities for improvement remain. This includes ensuring it adheres to contract provisions regarding the frequency of licensee surveys—which conflicted with informal agreements—and Agreement Monitoring staffing levels. Between July 2017 and June 2020, IBH did not meet staffing requirements 17 percent of the time.
- IBH met many, but not all, MSA reporting requirements. Monthly reports did not always include adequate information regarding licensees in compliance with monitoring agreements and geographical information. IBH did not regularly submit quarterly reports on outreach activities; bi-annual reports on licensee or stakeholder input were not always submitted timely; and IBH did not submit required annual financial reports. In some cases, this resulted from conflicts between existing contract requirements and informal agreements between IBH and the Boards.
- Opportunities exist to better clarify contract language and expectations, including ensuring the frequency of licensee survey reporting (along with exit interviews and stakeholder surveys) and reporting requirements to reflect actual practice and meet the needs of the Boards.

Key Recommendations

- Evaluate contract provisions, where IBH non-compliance was noted in this report, to ensure the provisions reflects the Boards' expectations and desired practice, and monitor compliance accordingly.
- Ensure IBH provides all required educational materials and outreach efforts, including creation of a formal training manual for potential workplace monitors.
- Ensure IBH provides adequate FTE levels for each year's pricing tier; consideration should be given to the inclusion of FTE levels in the required benchmark reporting and penalty structure.
- Ensure accuracy in reporting performance statistics; while only one reporting inaccuracy was identified, consistent methodologies for calculating success rates against performance benchmarks is essential for program monitoring.

Results

IBH met most contractual requirements, generally met required minimal success rate standards, and submitted to the Boards invoices and reports that were accurate and supported by substantiating documentation. However, this audit also revealed instances of minor miscalculations in reporting one (1) performance metric and several instances in which IBH did not meet certain contract provisions related to outreach and training, quality assurance program requirements, and reporting requirements.

The Boards have met to discuss the audit recommendations and findings. They are in the process of issuing an amendment to the contract with language to better align with the expectations of the program. All parties have agreed to restructure quarterly meetings to ensure requirements are being met.

Complete Audit

To obtain a complete copy of the 33-page Performance Audit of the Health Professionals' Services Program, please contact Gretchen Kingham, Oregon Medical Board Executive Assistant, at Gretchen.Kingham@omb.oregon.gov.

Best Practices Self-Assessment Guide:
Information in Support of Best Practices

Best Practices Criteria
1. Executive Director's performance expectations are current. • Goals and expectations for the Executive Director are reviewed annually.
2. Executive Director receives annual performance feedback. • The Administrative Workgroup reviews the Executive Director's performance annually and makes recommendations to the Board.
3. The agency's mission and high-level goals are current and applicable. • The OBD's next Strategic Plan will be worked on in 2021 for implementation in 2022. • Agency performance measures, as well as short and long term goals, are reviewed annually.
4. The Board reviews the Annual Performance Progress Report. • Performance measures are reviewed as a part of the budget.
5. The Board is appropriately involved in review of agency's key communications. • Board members are informed of relevant news and information. • Board members prepared to submit articles for inclusion in the newsletter.
6. The Board is appropriately involved in policy-making activities. • The Board's committees review policy making issues. • The Board reviews all legislative proposals that could impact the Board.
7. The agency's policy option budget packages are aligned with their mission and goals. • The Board reviews agency's proposed policy option packages. • The Board reviews the Agency Request Budget.
8. The Board reviews all proposed budgets. • The Board reviews the Agency Request Budget.
9. The Board periodically reviews key financial information and audit findings. • The Board reviews agency head financial and payroll transactions annually at a Board Meeting. • The Board reviews agency performance audits.
10. The Board is appropriately accounting for resources. • All Board revenue and expenditures are reviewed by the Board. • All Board expenditures are reviewed and approved by the Executive Director and Office Manager. • Physical inventory of all agency property is conducted annually.
11. The agency adheres to accounting rules and other relevant financial controls. • Board staff prepares all transaction entries in accordance with Oregon Statute, Oregon Administrative Rules, Oregon Accounting Manual and Generally Accepted Accounting principles. • The Board has annually received the Department of Administrative Services Comprehensive Annual Financial Report Gold Star Award for timely and complete financial data.
12. Board members act in accordance with their roles as public representatives. • Board members appropriately recuse themselves from cases which create an actual or potential conflict of interest. • The Board follows public meetings and records laws. • The Board uses good judgment in upholding the Board's Mission Statement of Protecting the Citizens of Oregon.

13. The Board coordinates with others where responsibilities and interest overlap.
    - Board members and staff participate in appropriate professional associations.
    - The OBD works with the OHSU School of Dentistry on certain issues.
    - The OBD works with the ODA, ODHA, ODAA, TDIC and others that request it- to present important practice related issues to members and licensees.
    - The OBD is actively involved in the American Association of Dental Boards (AADB), American Association of Dental Administrators (AADA) and regional testing agencies.

14. The Board members attend/complete relevant training sessions.
    - New Board members attend new Board member orientation presented by OBD Staff and assigned attorney.
    - Board members utilize the Governor's Board Training.

15. The Board reviews its management practices to ensure best practices are utilized.
    - On an annual basis, in regular board meetings and as needed.

Best Practices Self-Assessment

Annually, Board members are to self-evaluate their adherence to a set of best practices and report the percent total best practices met by the Board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.		
2. Executive Director receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The Board reviews the Annual Performance Progress Report.		
5. The Board is appropriately involved in review of agency's key communications.		
6. The Board is appropriately involved in policy-making activities.		
7. The agency's policy option budget packages are aligned with their mission and goals.		
8. The Board reviews all proposed budgets.		
9. The Board periodically reviews key financial information and audit findings.		
10. The Board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The Board coordinates with others where responsibilities and interest overlap.		
14. The Board members identify and attend appropriate training sessions.		
15. The Board reviews its management practices to ensure best practices are utilized.		
Total Number		
Percentage of total:		

Project eNewsletter | June 2021

The countdown begins!

We are full of anticipation as July 1 is almost upon us! After months of planning and preparation, the Oregon Procurement Information Network (ORPIN) will be replaced with OregonBuys on July 1. This will mark the completion of the first phase in this two-phased project.

ORPIN is now in archive mode and remains available for historical purposes. Starting July 1, all state procurement activity will be processed through OregonBuys and staff will use the OregonBuys Marketplace to browse statewide price agreements.

We want to thank the army of agency staff and Oregon Cooperative Procurement Program (OrCPP) members who partnered with us to get to this point. You've helped with testing, participated in core teams, stepped up as organization administrators, sent in templates, and attended training. We wouldn't be replacing ORPIN without your collaboration - thank you for helping make OregonBuys a success!

OregonBuys: One unified system — modernizing state procurement

Visit project website

Need a training refresher?

Transitioning to a new system isn't always easy. We've created a couple of new web pages to help with the switch to OregonBuys.

Visit the new web pages below to access self-paced training modules along with instruction guides and a terminology crosswalk. These resources are free and available to you anytime (Workday Learning account required):

- State agency training and resources
- Local government training and resources

What's next? July state agency forum

We're planning now for Phase 2's release of added OregonBuys procure-to-pay functionality across state agencies in a series of three waves.

State agencies are invited to join us for a virtual forum to learn more about what to expect and who should be involved:

July 28 from 9 to 10:30 a.m.

Virtual Zoom session

Click the button below to register - you'll get an email with Zoom login information:

Register to attend

Suppliers – it's not too late to register

Suppliers, it's never too late to register for a supplier account in OregonBuys. Over 11,000 suppliers are already registered, and starting on July 1, bids (opportunities, notices, etc.) will post on OregonBuys.

If it's been a while since you visited the OregonBuys site, the homepage has a new look and feel. Click the button below and go to the blue register button in the top right corner of the site to get started:

Get a supplier account

UNFINISHED BUSINESS & RULES

818-001-0000
Notice of Proposed Rule Making
Prior to the adoption, amendment, or repeal of any permanent rule, the Oregon Board of Dentistry shall give notice of the proposed adoption, amendment, or repeal:
(1) By publishing a notice in the Secretary of State's Bulletin referred to in ORS 183.370 at least 21 days prior to the effective date.
(2) By mailing, **emailing or electronic mailing** a copy of the notice to persons on the mailing list established pursuant to ORS 183.335(8) at least 28 days before the effective date of the adoption, amendment, or repeal.
(3) By mailing, **emailing or electronic mailing** a copy of the notice to the following persons and publications:
(a) Oregon Dental Hygienists' Association;
(b) Oregon Dental Assistants Association;
(c) Oregon Association of Dental Laboratories;
(d) Oregon Dental Association;
(e) The Oregonian;
(f) Oregon Health & Science University, School of Dentistry;
(g) The United Press International;
(h) The Associated Press;
(i) The Capitol Building Press Room.

818-001-0002
Definitions
As used in OAR chapter 818:
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(5) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(6) "Hygienist" means a person licensed pursuant to ORS 680.010 to 680.170 to practice dental hygiene.
(7) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(8) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(9) "Licensee" means a dentist or hygienist.
(10) "Volunteer Licensee" is a dentist or dental hygienist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.

(11) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(12) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) “Dental Anesthesiology” is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Orthodontics and Dentofacial Orthopedics" is the area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(h) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(i) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(j) "Prosthodontics" is the branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

(13) “Full-time” as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry or dental hygiene.
(14) For purposes of ORS 679.020(4)(h) the term “dentist of record” means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
(15) “Dental Study Group” as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(16) “Physical Harm” as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(17) “Teledentistry” is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
(18) “BLS for Healthcare Providers or its Equivalent” the **BLS/**CPR certification standard is the American Heart Association’s BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial **BLS/**CPR course must be a hands-on course; online **BLS/**CPR courses will not be approved by the Board for initial **BLS/**CPR certification: After the initial **BLS/**CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A **BLS/**CPR certification card with an expiration date must be received from the **BLS/**CPR provider as documentation of **BLS/**CPR certification. The Board considers the **BLS/**CPR expiration date to be the last day of the month that the **BLS/**CPR instructor indicates that the certification expires.

818-001-0082
Access to Public Records
(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased upon receipt of a written request. The Board may withhold copies of public records until the requestor pays for the copies.
(3) The Board follows the Department of Administrative Service’s statewide policy (107-001-030) for fees in regards to public records request; in addition, the Board establishes the following fees:
(a) $0.10 per name and address for computer-generated lists on paper ~~or labels~~; $0.20 per name and address for computer-generated lists on paper ~~or labels~~ sorted by specific zip code;
(b) Data files ~~on diskette~~ **submitted electronically** or **on a device** ~~CD~~:
(A) All Licensed Dentists — $50;
(B) All Licensed Dental Hygienists — $50;
(C) All Licensees — $100.
(c) Written verification of licensure — $2.50 per name; and
(d) Certificate of Standing — $20.

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

(#) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical 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 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).

(#) A dentist placing endosseous 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, 2022.)

818-012-0070
Patient Records
(1) Each licensee shall have prepared and maintained an accurate and legible record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:
(a) Name and address and, if a minor, name of guardian;
(b) Date description of examination and diagnosis;
(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure,

Alternatives, Risks and Questions) or ~~"SOAP" (Subjective Objective Assessment Plan) or their~~ **its** equivalent.
(d) Date and description of treatment or services rendered;
(e) Date, description and documentation of informing the patient of any recognized treatment complications;
(f) Date and description of all radiographs, study models, and periodontal charting;
(g) **Current** ~~H~~**h**ealth history; and
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(2) Each licensee shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.
(3) Each licensee shall maintain patient records and radiographs for at least seven years from the date of last entry unless:
(a) The patient requests the records, radiographs, and models be transferred to another licensee who shall maintain the records and radiographs;
(b) The licensee gives the records, radiographs, or models to the patient; or
(c) The licensee transfers the licensee's practice to another licensee who shall maintain the records and radiographs.
(4) When a dental implant is placed the following information must be given to the patient in writing and maintained in the patient record:
(a) Manufacture brand;
(b) Design name of implant;
(c) Diameter and length;
(d) Lot number;
(e) Reference number;
(f) Expiration date;
(g) Product labeling containing the above information may be used in satisfying this requirement.
(5) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.
(6) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

818-012-XXXX - Compliance with Governor's Executive Orders

(1) During a declared emergency, unprofessional conduct includes failing to comply with any applicable provision of a Governor's Executive Order or any provision of this rule.
(2) Failing to comply as described in subsection (1) includes, but is not limited to:
(a) Operating a business required by an Executive Order to be closed under any current Executive Order.
(b) Providing services at a business required by an Executive Order to be closed

under any current Executive Order.
(c) Failing to comply with Oregon Health Authority (OHA) guidance implementing an Executive Order, including but not limited to:
(A) Failing to satisfy required criteria in OHA guidance prior to resuming elective and non-emergent procedures;
(B) Failing to implement a measured approach when resuming elective and nonemergent procedures in accordance with OHA guidance;
(d) Failing to comply with any Board of Dentistry guidance implementing an Executive Order;
(3) No disciplinary action or penalty action shall be taken under this rule if the Executive Order alleged to have been violated is not in effect at the time of the alleged violation.
(4) Penalties for violating this rule include: up to $5,000 per violation pursuant to ORS 679.140(10). Any such penalties shall be imposed in accordance with ORS 679.140.

818-015-0007
Specialty Advertising
(1) A dentist may only advertise as a specialist in an area of dentistry which is recognized by the Board and in which the dentist is licensed or certified by the Board.
(2) The Board recognizes the following specialties:
(a) Endodontics;
(b) Oral and Maxillofacial Surgery;
(c) Oral and Maxillofacial Radiology;
(d) Oral and Maxillofacial Pathology;
(e) Orthodontics and Dentofacial Orthopedics;
(f) Pediatric Dentistry;
(g) Periodontics;
(h) Prosthodontics;
(i) Dental Public Health;
(j) Dental Anesthesiology**;**
(k) Oral Medicine;
(l) Orofacial Pain.
(3) A dentist whose license is not limited to the practice of a specialty under OAR 818-021-0017 may advertise that the dentist performs or limits practice to specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists except those licensed pursuant to 818-021-0017: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."

818-021-0012
Specialties Recognized
(1) A dentist may advertise that the dentist is a dentist anesthesiologist, endodontist, oral and maxillofacial pathologist, oral and maxillofacial surgeon, oral and maxillofacial radiologist, **oral medicine dentist, orofacial pain dentist,** orthodontist and dentofacial orthopedist, pediatric dentist, periodontist, prosthodontist or dental public health dentist, only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.
(2) A dentist may advertise that the dentist specializes in or is a specialist in dental

anesthesiology, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, oral and maxillofacial radiology, **oral medicine, orofacial pain,** orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics or dental public health only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.

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 includes an examination and the dentist passes the examination.
(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) 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. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.
(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 implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period.

818-021-0080
Renewal of License
Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every ~~person~~ **licensee** holding a current license. The licensee must ~~return the~~ complete~~d~~ **the online** renewal

application **and pay the** ~~along with~~ current renewal fees prior to the expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085, "Reinstatement of Expired Licenses."

(1) Each dentist shall submit the renewal fee and completed ~~and signed~~ **online** renewal application ~~form~~ by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.

(2) Each **dental** hygienist must submit the renewal fee and completed ~~and signed~~ **online** renewal application ~~form~~ by September 30 every other year. **Dental** ~~H~~**h**ygienists licensed in odd numbered years shall apply for renewal in odd numbered years and **dental** hygienists licensed in even numbered years shall apply for renewal in even numbered years.

(3) The renewal application shall contain:

(a) Licensee's full name;

(b) Licensee's mailing address;

(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;

(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;

(e) Licensee's employer or person with whom the licensee is on contract;

(f) Licensee's assumed business name;

(g) Licensee's type of practice or employment;

(h) A statement that the licensee has met the **continuing** educational requirements for renewal set forth in OAR 818-021-0060 or 818-021-0070;

(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and

(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

818-021-0088

Volunteer License

(1) An Oregon licensed dentist or dental hygienist who will be practicing for a supervised volunteer dental clinic, as defined in ORS 679.020(3)(f) and (g), may be granted a volunteer license provided licensee completes the following:

(a) Licensee must register with the Board as a health care professional and provide a statement as required by ORS 676.345.

(b) Licensee will be responsible to meet all the requirements set forth in ORS 676.345.

(c) Licensee must provide the health care service without compensation.

(d) Licensee shall not practice dentistry or dental hygiene for remuneration in any capacity under the volunteer license.

(e) Licensee must comply with all continuing education requirements for active licensed dentist or dental hygienist.

(f) Licensee must agree to volunteer for a minimum of 80 hours **in Oregon** per renewal cycle.

(2) Licensee may surrender the volunteer license designation at anytime and request a return to an active license. The Board will grant an active license as long as all active license requirements have been met.

818-026-0040

Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia

Permits: Nitrous Oxide Permit

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

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

818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient’s airway, quickly alter the patient’s position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient’s skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can
reasonably be obtained.
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(~~10~~**11**) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

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

818-035-0010
Definitions
All terms used in this Division shall have the meanings assigned under ORS 679.010 except that:
(1) "Limited Access Patient" means a patient who is unable to receive regular dental hygiene treatment in a dental office.
(2) "Long-Term Care Facility" shall have the same definition as that established under ORS 442.015(14)(b).
(3) When performed by an Expanded Practice Dental Hygienist with a Collaborative Agreement in accordance with OAR 818-035-0065 (5):
(a) "Temporary Restoration" means a restoration placed for a shorter time interval for use while definitive restoration is being fabricated or placed in the future.
(b) "Atraumatic/Alternative Restorative Techniques" means restoring and preventing caries in limited access patients and as a community measure to control caries in large numbers of the population.
(c) "Interim Therapeutic Restoration" means a direct provisional restoration placed to temporarily stabilize a tooth until a dentist subsequently diagnoses the need for further definitive treatment, and that:
(A) Consists of the removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material; and
(B) Does not require the administration of local anesthesia.

818-035-0020
Authorization to Practice
(1) A supervising dentist, without first examining a new patient, may authorize a dental hygienist:
(a) To take a health history from a patient;
(b) To take dental radiographs;
(c) To perform periodontal probings and record findings;
(d) To gather data regarding the patient; and
(e) To diagnose, treatment plan and provide dental hygiene services.
(2) When **dental** hygiene services are provided pursuant to subsection **(1)**, the supervising dentist need not be on the premises when the services are provided.
(3) When **dental** hygiene services are provided pursuant to subsection **(1)**, the patient must be scheduled to be examined by the supervising dentist within fifteen business days following the day the **dental** hygiene services are provided.
(4) If a new patient has not been examined by the supervising dentist subsequent to receiving dental hygiene services pursuant to subsection **(1)**, no further dental hygiene services may be provided until an examination is done by the supervising dentist.
(5) A dental hygienist may practice dental hygiene in the places specified by ORS 680.150 under general supervision upon authorization of a supervising dentist. **When dental hygiene services are provided pursuant to this subsection, subsections (2), (3) and (4) also apply.**

(6) A dentist who authorizes a dental hygienist to practice dental hygiene on a limited access patient must review the **dental** hygienist's findings.

818-035-0025 (*Combined changes from ITR & Rules Oversight)
Prohibit~~ions~~ed Acts
A dental hygienist may not:
(1) Diagnose and treatment plan other than for dental hygiene services;
(2) Cut hard or soft tissue with the exception of root planing**, except as provided in OAR 818-035-0065**;
(3) Extract any tooth;
(4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);
(5) Prescribe, administer or dispense any drugs except as provided by OAR 818-035-0030, **OAR** 818- 035-0040, **OAR** 818-026-0060(~~11~~ **12**)**, OAR 818-026-0065(12)** and 818-026-0070(~~11~~ **12**);
(6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;
(7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;
(8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway
Restriction (HOMAR) on any patient.
(9) Place or remove healing caps or healing abutments, except under direct supervision.
(10) Place implant impression copings, except under direct supervision.

818-035-0065
Expanded Practice Dental Hygiene Permit
The Board shall issue an Expanded Practice Permit to a Dental Hygienist who holds an unrestricted Oregon license, and completes an application approved by the Board, pays the permit fee, and
(1) Certifies on the application that the dental hygienist has completed at least 2,500 hours of supervised dental hygiene clinical practice, or clinical teaching hours, and also completes 40 hours of courses chosen by the applicant in clinical dental hygiene or public health sponsored by continuing education providers approved by the Board; or
(2) Certifies on the application that the dental hygienist has completed a course of study, before or after graduation from a dental hygiene program, that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205; and
(3) Provides the Board with a copy of the applicant's current professional liability policy or declaration page which will include, the policy number and expiration date of the policy.
(4) Notwithstanding OAR 818-035-0025(1), prior to performing any dental hygiene services an Expanded Practice Dental Hygienist shall examine the patient, gather data, interpret the data to determine the patient's dental hygiene treatment needs and formulate a patient care plan.
(5) An Expanded Practice Dental Hygienist may render the services described in paragraphs **(6),** (~~6~~**7**)(a) to ~~(d)~~ **(e)** of this rule to the patients described in ORS 680.205(1) if the Expanded Practice Dental Hygienist has entered into a written collaborative agreement in a format approved by the Board with a dentist licensed under ORS Chapter 679.
(6) Upon completion of a Board-approved curriculum, an Expanded Practice Permit Dental Hygienist may perform interim therapeutic restorations as allowed by ORS 680.205..
~~(6)~~ **(7)** The collaborative agreement must set forth the agreed upon scope of the dental hygienist's practice with regard to:

(a) Administering local anesthesia;
(b) Administering temporary restorations **with or** without excavation;
(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs; and
(d) Performing interim therapeutic restorations after diagnosis by a dentist; and
(e) Referral parameters.
~~(7)~~ **(8)**The collaborative agreement must comply with ORS 679.010 to 680.990.
~~(8) From the date this rule is effective, the Board has the authority to grant a Limited Access Permit through December 31, 2011, pursuant to ORS 680.200.~~

818-035-0100
Record Keeping
(1) An Expanded Practice Dental Hygienist shall refer a patient annually to a dentist who is available to treat the patient, and note in the patient's official chart held by the facility that the patient has been referred.
(2) When a licensed dentist has authorized an Expanded Practice Dental Hygienist to administer local anesthesia, place temporary restorations without excavation, **perform interim therapeutic restorations with or without excavation after diagnosis by a dentist,** or prescribe prophylactic antibiotics and nonsteroidal anti-inflammatory drugs, the Expanded Practice Dental Hygienist shall document in the patient's official chart the name of the collaborating dentist and date the collaborative agreement was entered into.

818-042-0040
Prohibited Acts
No licensee may authorize any dental assistant to perform the following acts:
(1) Diagnose or plan treatment.
(2) Cut hard or soft tissue.
(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty **(**OAR 818-042-0113 and OAR 818-042-0114**)** or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.
(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.
(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient’s mouth.
(6) Administer any drug except fluoride, topical anesthetic, desensitizing agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)(a), OAR 818-026-0060(~~11~~**12**), OAR 818-026-0065(~~11~~**12**), OAR 818-026-0070(~~11~~**12**) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.
(7) Prescribe any drug.
(8) Place periodontal packs.
(9) Start nitrous oxide.
(10) Remove stains or deposits except as provided in OAR 818-042-0070.
(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.
(13) Use lasers, except laser-curing lights.
(14) Use air abrasion or air polishing.
(15) Remove teeth or parts of tooth structure.

(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.
(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.
(19) Apply denture relines except as provided in OAR 818-042-0090(2).
(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(22) Perform periodontal probing.
(23) Place or remove healing caps or healing abutments, except under direct supervision.
(24) Place implant impression copings, except under direct supervision.
(25) Any act in violation of Board statute or rules.

Enrolled
House Bill 2627

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

CHAPTER .....

AN ACT

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

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

SECTION 1. ORS 680.205 is amended to read:

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

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

(A) Nursing homes as defined in ORS 678.710;

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

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

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

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

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

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

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

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

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

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(e) Patients whose income is less than the federal poverty level.

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(2) Unless different criteria for referral of a patient or resident to a dentist are included in an agreement described in subsection (3) of this section, at least once each calendar year, an expanded practice dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) An expanded practice dental hygienist may render the services described in paragraphs (a) to [*(d)*] **(e)** of this subsection to the patients described in subsection (1) of this section if the expanded practice dental hygienist has entered into an agreement in a format approved by the board with a dentist licensed under ORS chapter 679. The agreement must set forth the agreed-upon scope of the dental hygienist's practice with regard to:

(a) Administering local anesthesia;

(b) Administering temporary restorations **with or** without excavation;

(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; [*and*]

(d) Performing interim therapeutic restoration after diagnosis by a dentist; and

[*(d)*] **(e)** Referral parameters.

(4) This section does not authorize an expanded practice dental hygienist to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(5) An expanded practice dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients.

(6) An expanded practice dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

(7) As used in this section and section 4 of this 2021 Act, "interim therapeutic restoration" means a direct provisional restoration placed to temporarily stabilize a tooth until a dentist subsequently diagnoses the need for further definitive treatment, and that:

(a) Consists of the removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material; and

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SECTION 2. The amendments to ORS 680.205 by section 1 of this 2021 Act apply to agreements described in ORS 680.205 that are entered into or renewed on or after the operative date specified in section 6 of this 2021 Act.

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(2) Expanded practice dental hygienists performing interim therapeutic restorations under the dental pilot project program of the Oregon Health Authority as of the effective date of this 2021 Act may continue performing interim therapeutic restorations until the rules established by the board take effect.

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(2) An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).

(3) Notwithstanding subsection (2) of this section, an expanded practice dental hygienist who is operating within the Dental Health Workforce Pilot Project No. 200 through the dental pilot project program of the Oregon Health Authority as of the effective date of this

2021 Act, and who has completed training to perform interim therapeutic restorations, is exempt from completing training under subsection (2) of this section.

SECTION 5. Section 4 of this 2021 Act is added to and made a part of ORS chapter 680.

SECTION 6. (1) Section 4 of this 2021 Act and the amendments to ORS 680.205 by section 1 of this 2021 Act become operative on January 1, 2022.

(2) The Oregon Board of Dentistry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the 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 board by section 4 of this 2021 Act and the amendments to ORS 680.205 by section 1 of this 2021 Act.

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Shemia Fagan, Secretary of State

School of Dentistry

Interim Therapeutic Restoration (ITR) Training Manual

Oregon Dental Pilot Project #200

Table of Contents

Didactic

Both the expanded practice dental hygienist (EPDH) and dentist must complete all didactic work prior to the in-person training. The online course includes 6 modules will take approximately 1-1.5 hours to complete. The coursework is sequential and builds directly on previous coursework, prior to beginning the independent lab work described below.

Modules

1. Oregon Governing Legislation and Policy
    - Senate Bills 738 and 786
    - Oregon Administrative Rules
2. The Science of Partial Caries Removal
3. ITR Placement Criteria
4. ITR Placement Techniques
    - Glass Ionomer Overview
    - Glass Ionomer Characteristics and Materials
    - ITR placement and technique
5. Preparation for pre-in-person session laboratory work
6. ITR Tracking and Follow-Up
    - Evaluation and Tracking
    - Follow-up
    - Adverse Outcomes Protocols

After completing didactic modules 2-6, EPDHs should complete the accompanied quizzes with a score of 75% or higher.

Independent Lab Work

Following the instructions on *ITR Placement Techniques*, the EPDH should practice placing ITRs on 5 -10 prepared teeth prior to attending the in-person training.

The purpose of the independent pre-in-person session lab work is to familiarize the EPDH with characteristics and techniques for using glass-ionomer restorative materials.

Placement Practice
Each dyad (EPDH and dentist) will be responsible for obtaining equipment for and completing assigned lab work prior to attending the in-person program section (see Appendix B: Equipment List).

Using instructions in the didactic portion of this program, the dentist will prepare or purchase 5-10 teeth on a typodont that meet qualifications for placing an ITR. ITR tooth acceptability can be found in *Module 3: ITR Placement Criteria*. Make sure to prep a mixture of Class I lesions on various surfaces as well as Class V lesions. This will allow the EPDH to practice placing ITRs on a variety of teeth.

With guided assistance from the collaborating Dentist, the EPDH should place a minimum of five ITRs on the typodont. It is suggested that the EPDH place additional ITRs if they are able, in order to become familiar and comfortable with manipulating the material prior to performing this procedure on patients.

ITR Evaluation
Using the form in Appendix A, the Dentist should evaluate each ITR based on the following three criteria. Each criterion is rated as acceptable or unacceptable:

1. Margins are sealed
2. Occlusion is in light contact or not in contact
3. Minimal excess material

An ITR is considered acceptable if the material is not in hyper---occlusion, if there are no marginal voids, and there is minimal excess material.

The dentist will review the ITRs according to the checklist and protocols outlined in the didactic portion of the program, and evaluate the ITR placement based on the provided criteria.
The dentist should document the evaluation of each ITR on the Evaluation Form in Appendix A.

The EPDH will bring the typodont with completed restorations and scoring sheet completed by the collaborating dentist to the in-person session for review.

In-person Training Day

Purpose
The in-person clinical portion of the program will allow both the EPDH and dentist to receive additional instruction and practice what they learned with experienced ITR placement faculty and mentors.

Agenda

Time	Agenda
9:00 – 9:30	Review of typodont placements
9:30 – 10:00	Prep for patients
10:00 – 1:30	Clinical Training
1:30 – 2:00	Technique Critique and Self-Evaluation
2:00 – 2:15	Conclusion and Next steps

Clinical Training Requirements
- Each EPDH will place 5 ITRs on patients under guided supervision
- Each placement will be reviewed by a dentist (See Appendix A. ITR Evaluation Form).
- Any placements evaluated as not acceptable will be redone

Materials to Bring
- Typodonts with completed ITRs
- Fuji GC Capsule applicator

Additional Practice
Following the in-person training, the EPDH may be required to place additional ITRs independently.

For each placement, EPDHs must submit the following documents:
- A completed consent form
- A completed ITR Evaluation Form (see Appendix A)
- X-rays
- Three photographic images:
  1) pre-op (prior to any treatment)
  2) the tooth after the cavity has been cleaned and prepared for restoration)
  3) post-op (after completion. The post-op photograph should show occlusal contacts using articulating paper.

Appendices
A. ITR Evaluation Form
B. Equipment list

Interim Therapeutic Restorations Evaluation of Scoring Sheet
Training Type: _____ Laboratory _____ Clinical

Location: _____ Date: _____

EPDH Name: _____

Supervising Dentist Name/Signature: _____

Faculty Name/Signature:

Restoration #1: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #2: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #3: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #4: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #5: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				

Equipment List

The following equipment list itemizes tools and equipment necessary to complete the ITR training.

Item

Typodont – with full set of teeth (pre-drilled or drilled by dentist)
Curing Light
Amalgamator
Articulating Paper
Fuji II LC Capsules – any color
GC Cavity Conditioner
Fuji GC Capsule applicator
Set of instruments

- ½ Hollenbeck
- Small excavator
- Small cleoid discoid carver
- Articulating Paper Forceps

Disposable materials:

- Cotton pellet
- Cotton tipped applicator
- Gloves
- Vaseline
- Fendermate or Wizard Wedge
- Oral Birchwood Assorted

Enrolled
House Bill 2627

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

CHAPTER .....

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

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

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

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

(A) Nursing homes as defined in ORS 678.710;

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

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

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

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

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(a) Administering local anesthesia;

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(4) This section does not authorize an expanded practice dental hygienist to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

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(2) An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).

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

PLACE: **VIRTUAL VIA ZOOM**
DATE: **June 30, 2021**
TIME: **1:00 p.m. – 2:00 p.m.**

Attendees:

OBD - Board President Alicia Riedman, RDH, EPP, Stephen Prisby, Haley Robinson, Ingrid Nye, Samantha VandeBerg & Sr. AAG Lori Lindley

OHA - Sarah Kowalski, Amy Umphlett, Cate Wilcox & Kelly Hansen

Zoom Meeting:
https://us02web.zoom.us/j/81772583801?pwd=V0pBR1NRWTBHakp4U2wwMjIzZnVhUT09
#1-253-215-8782, Meeting ID: 817 7258 3801, Passcode: 489529

Due to the passage of HB 2627 (2021), OBD Staff have reached out to the OHA to discuss interim therapeutic restorations. The OBD will need to amend rules for dental hygiene, to incorporate reference to interim therapeutic restorations and education requirements as well.

The OHA has experience with Dental Pilot Project #200, and the OBD would like to enlist their experience to help inform the OBD on rules and education requirements regarding interim therapeutic restorations.

Besides updating the relevant DH EPP Rules the Board as directed by HB 2627 must:

- Approve applications from oral health care education providers for training courses that meet the requirements established in rules adopted by the board establishing educational and instructional requirements for interim therapeutic restoration to be performed by an expanded practice dental hygienist.
- An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).

The OBD's Rules Oversight Committee met on June 18, 2021. The Committee directed OBD Staff to bring proposed amended rules to the August 20, 2021 Board meeting for consideration to go forward to public rulemaking hearing(s).

HB 2627 (2021) – Attached

Dental Pilot Project #200 Abstract - Attached

Draft OAR 818-035-0010 – Attached

Draft OAR 818-035-0065 – Attached

Draft OAR 818-035-0100 - Attached

General Comments - Attached

Policy on (ITR) – American Academy of Pediatric Dentistry - Attached

HB 2528 (2021) – Attached

CO & CA DPP #200 ITR Course Requirements – Attached

CO & CA DPA Rules Information - Attached

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

Oregon Health Authority

800 NE Oregon St, Ste 370
Portland, Oregon 97232-2186
Office: 971-673-1563
Fax: 971-673-0231
healthoregon.org/dpp

Oregon Health Authority
Dental Pilot Project Program

Dental Pilot Project: Application #200

Abstract
Training Dental Hygienists to Place Interim Therapeutic Restorations
March 18, 2016

Applicant/Sponsor:	Oregon Health & Science University, School of Dentistry, 3181 SW Sam Jackson Park Road, Portland, OR 97239
Project Director:	Eli Schwarz, DDS, MPH, PhD Department of Community Dentistry, Oregon Health & Science University 3030 SW Moody Ave, Suite 135B Portland, OR 97201
Training Supervisor(s):	Eli Schwarz, DDS, MPH, PhD & Richie Kohli, BDS, MS

Sponsor Type:	Non-Profit Educational Institution

Oregon Health & Science University is a nationally prominent research university and Oregon's only public academic health center. It educates health professionals and scientists and provides leading-edge patient care, community service and biomedical research.

The OHSU School of Dentistry shares the mission of the Oregon Health & Science University to provide educational programs, basic and clinical research, and high quality care and community programs. We strive to foster an environment of mutual respect where the free exchange of ideas can flourish. The dental school prepares graduates in general dentistry and the dental specialties to deliver compassionate and ethical oro-facial health care.

The mission of the Department of Community Dentistry is to promote critical analysis of social, behavioral, and policy-influenced factors that affect oral health outcomes in both individual patients and the entire population. These goals are achieved through a comprehensive didactic and experiential learning curriculum that begins in year one of the pre-doctoral program and culminates with the DS4 clinical rotations in community based dental clinics. We strive to develop curricula that lay the foundation for the student's life-time professional

development, commitment to service and community collaboration, and ensure awareness and cultural competency of the comprehensive and complex nature of health care for vulnerable populations.

Purpose:	• Teaches new skills to existing categories of dental health care personnel.
	• To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place "Interim Therapeutic Restorations" (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Proposed Project Period:	11/1/2015 – 9/1/2020

Proposed Number of Sites:	Polk County**:** Central School District School: 5 School Sites

Site Locations:	
Training/Didactic Phase:	• Didactic training will be held via online management system called Sakai, webinars, and in-person meetings in the conference rooms at Capitol Dental Care. • Didactic resources are available through University of the Pacific (UoP). • Laboratory and clinical training will take place at Capitol Dental Care which has fully equipped dental clinics.
Utilization Phase:	• **Ash Creek Elementary**, Independence OR. 492 total student enrollment, 243 K-2nd grade students. 64% free and reduced lunch population • **Independence Elementary**, Independence, OR. 421 total student enrollment, 200 K-2nd grade students. 77.7% free and reduced lunch population • **Monmouth Elementary**, Monmouth OR. 547 total student enrollment. 266 K-2nd grade students. 55.9% free and reduced lunch population. • **Falls City Elementary**, Falls City, OR. 97 total school enrollment. 31 K-2nd grade students. 70.1% free and reduced lunch population.

	• **Community Action Head Start**-Independence Site. 40 children, age 3-5. OCDC Head Start-Independence Site. • In addition, we have also been meeting regularly with a Steering Group of those likely to participate in the pilot project, now and at a future time. These include representatives from: • Capitol Dental Care • Virginia Garcia Memorial Health Center • Advantage Dental • Kemple Memorial Children's Dental Clinic

Proposed Number of Trainees:	**10-12**
Proposed Number of Supervisors:	**4**
Number of Collaborating Dentists:	**4**
Proposed Number of Sites:	**5**

Application Chronology:

Application Submitted:	November 2, 2015
Application Approved for Completeness:	November 30, 2015
Application Received by Technical Review Board:	December 11, 2015
TRB Application Review Comments Due:	January 28, 2016
MOA Received by Program:	February 5, 2016
Applicants Notified of Intent to Approve:	February 19, 2016
Application Under 10 Day Period of Public Comment:	February 22, 2016 – March 4, 2016
Project Approved by Director:	March 8, 2016
Oregon Board of Dentistry Notified of Approval Status:	March 10, 2016

Estimated Cost and Funding Source(s):

Estimated Cost:	$111,797.01
Funding Source(s) Committed:	Three sources of funding have been identified: 1) Oregon Health Plan (OHP) covers dental care for Medicaid members through capitated payments to the Dental Care Organization (DCO) to which the CCO has assigned the members; 2) The training, technical assistance, and evaluation will be funded in the initial year through a telehealth grant from the Oregon Health Authority through September 2016; 3) A group of funders of Oregon Oral Health Funders Collaborative that has supported the planning grant to

	develop the present application has expressed an interest to fund ongoing support of the evaluation and testing of the pilot project.
Total Committed:	$111,797.01 for first 18 months

Background and History of the Project:
Selected Passages from the DPP #200 Application

Need for the Project:

Numerous reports within the last ten years have addressed workforce shortages in the dental field, lack of access to oral health care among low-income, rural, and other disadvantaged population groups, and the resulting profound oral health disparities experienced by these groups. Recent reports document that very slow progress is being made in improving the access to oral health care for these population groups. The health transformation process underway in Oregon has recently expanded access to the Oregon Health Plan for around 250,000 additional members. However, since the workforce situation has not been addressed, the existing dental workforce is under additional pressure and overall, access to dental care may further deteriorate. According to an Oregon Healthcare Workforce Institute analysis, the number of dentists practicing in Oregon decreased by 8% from 2010 to 2012 which may indicate a continuous trend. The traditional dental care delivery model of stationary dental offices or community health centers with dental practitioners and auxiliaries needs to be expanded to test alternative and sustainable models.

Studies in other states have shown that a remotely located dentist, working with an Expanded Practice Dentist Hygienist (EPDH), who is seeing a patient at a different location, can collaboratively deliver quality dental care. Led by an EPDH, Capitol Dental Care will implement telehealth-connected oral health teams to reach children who have not been receiving dental care on a regular basis and to provide community-based dental diagnostic, prevention and early intervention services, including ITR placement when indicated by the dentist.

Description of patients:

Demographic Data about Availability of Health Care Services
Polk County continues to show an increase in diversity, especially within the Hispanic population. 11.2% of the population considers themselves Hispanic compared to 10% in 2007. The Caucasian population has grown from 86% to 87.9% while the American Indian/Alaskan Native population has remained consistent at 1.9%. There were slight increases in the African American population from .4% to .5% and in the Asian/Pacific Islander population from 1.6% to 1.9% in 2009. According to the 2005-2009 US Census Bureau data, 11.4% of Polk County residents speak a language other than English in their home compared to 14% of Oregon residents and 19.6% of US residents.

Oral Health needs assessment suggested that 34.3% of the Polk County residents had no dental visit in the last 12 months. Currently, only about 20% of Oregon dentists accept Oregon Health Plan (OHP) members. In Marion and Polk Counties, there are 122 OHP enrolled dentists. This is approximately 1 dentist for every 550 members of the Willamette Valley Community Health (WVCH) Coordinated Care Organization. Although this may be considered an acceptable ratio issues remain of provider timely availability, appointment timing, and

insurance coverage; thus, there are still barriers for OHP members' access.

Oregon 2012 Smile Survey: This statewide survey gauges the health of the Oregon dental system by looking at the oral health, access, and overall quality of dental care for school children, aged 6 to 9. The survey examines the percentage of children who need urgent dental care, have any tooth decay, have rampant tooth decay (7 or more cavities), and have received dental sealants. The survey showed those with lower incomes, non-English speaking, and Hispanic background generally have worse dental health outcomes than those who have higher incomes, speak only English, and are white.

Purpose of the Project:

To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place "Interim Therapeutic Restorations" (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Oregon is in the midst of a dental health care crisis with more than 91 areas in the state designated as dental care health professional shortage areas (Kaiser Family Foundation study, April 28, 2014). This level of "deficiency" translates to more than 61% of Oregon residents not having their dental care needs met. One county where the need is particularly great is Polk County, and it is within this county - and the Polk County School District that a collaborative consisting of OHSU School of Dentistry, University of the Pacific Center for Special Care, and Capitol Dental Care (CDC) will implement its pilot project to train Expanded Dental Hygienists to place interim therapeutic restorations (ITR) within the context of a telehealth connected dental team.

This OHSU project has been planned and developed in collaboration with the University of the Pacific, Arthur A. Dugoni School of Dentistry (UoP) and Capitol Dental Care (CDC).

Project Description:

Under the dental pilot project program [Capitol Dental Care] CDC will build upon existing community outreach programs in Polk County by adding the telehealth model to existing preventive services, which include assessment, radiographs, intra-oral photographs, cleanings, sealants, fluorides, oral health instruction, and ITR if indicated. CDC's telehealth connected dental team of Expanded Practice Dental Hygienists, dental assistants, and supervising dentist, will visit three schools within the District, serving approximately 10 children per day~75 per month with a total expected population of 1200-1500 measurable encounters over the life of the 15-month project.

Those children with advanced disease in need of additional care will be referred for care either through CDC's mobile van operatory, or directed to a dental clinic for restorative care, as needed.

This Dental Workforce Pilot Project (DWPP) will add one new duty to those currently permitted for Expanded Practice Dental Hygienists (EPDHs) that are part of a community-based telehealth connected team system of care already under way.

The Oregon Health and Science University will train Expanded Practice Dental Hygienists (EPDH) to perform a new duty in community settings to improve the oral health of underserved populations and demonstrate their ability to carry out this duty.

Project Objectives:

Short-Term Objectives:	• Train EPDHs and evaluate their competence to place ITRs.
Long-Term Objectives:	• Through the performance of these duties to allow EPDHs working in community settings with underserved populations to facilitate collaboration with a dentist and to develop an appropriate plan of care for the patient. The placement of ITRs when directed to do so by a collaborating dentist will allow EPDHs to stabilize patients' oral health from further deterioration until they can be seen by a dentist in an appropriate setting. • To facilitate the development of new models of care designed to improve the oral health status of underserved populations.

Laws and Regulations Pertinent to the Proposed Project:	The Dental Practice Act governs the scope of practice for both dentists and dental hygienists operating in the state of Oregon. The key provisions can be found at Oregon Revised Statutes, Chapter 680 (680.010 – 680.210 and 680.990 (Dental Hygienists). Currently, an Expanded Practice Dental Hygienist (EPDH) may only perform the placement and finishing of direct alloy and direct composite restorations after the supervising dentist has prepared the tooth (teeth) for restorations (ORS 818-035-0072).

818-035-0010
Definitions

All terms used in this Division shall have the meanings assigned under ORS 679.010 except that:

(1) "Limited Access Patient" means a patient who is unable to receive regular dental hygiene treatment in a dental office.

(2) "Long-Term Care Facility" shall have the same definition as that established under ORS 442.015(14)(b).

(3) "Interim Therapeutic Restoration" when performed by an Expanded Practice Dental Hygienist with a Collaborative Agreement means a direct provisional restoration placed to temporarily stabilize a tooth until a dentist subsequently diagnoses the need for further definitive treatment, and that:

(a) Consists of the removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material; and

(b) Does not require the administration of local anesthesia.

818-035-0010
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Commented [S1]:
Temporary restorations and language under HB2528-B are going to highlight an issue with temporary restorations.

I do not see that they are they defined under the Oregon DPA? Highlighting a concern here that will likely be problematic once rule making begins for HB2528-B.

Under (3) (b) Page 2 of HB2627 states
(b) Administering temporary restorations **with or** without excavation;

It appears that they are equating the ITR with a temporary restoration with excavation.

This will present issues as HB2528-B allows a dental therapist to place an ITR under general supervision but requires indirect supervision for a temporary restoration.

See HB2528-B, Page 6, Line 11-12, Section 9 (1)**SECTION 9. (1) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the general supervision of the dentist.**

See HB2528-B, Page 6, Line 39, Section 9. (1) **(u) Atraumatic restorative therapy and interim restorative therapy;**

See HB2528-B, Page 7, Line 3-4, Section 9 (2)**SECTION 9. (2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist.**

See HB2528-B, Page 7, Line 5, Section 9 (2)**SECTION 9. (2) (a) Placement of temporary restorations;**

818-035-0025

Prohibitions

A dental hygienist may not:

(1) Diagnose and treatment plan other than for dental hygiene services;

(2) Cut hard or soft tissue with the exception of root planing;

(3) Extract any tooth;

(4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);

(5) Prescribe, administer or dispense any drugs except as provided by OAR 818-035-0030, 818-035-0040, 818-026-0060(11) and 818-026-0070(11);

(6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;

(7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;

(8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.

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

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

Commented [HT*O1]: Since they are removing "soft material" We should have Bernie/Angela look at this to see if we need to add after "root planning" **except as provided in OAR 818-035-0065**.

818-035-0065
Expanded Practice Dental Hygiene Permit
The Board shall issue an Expanded Practice Permit to a Dental Hygienist who holds an unrestricted Oregon license, and completes an application approved by the Board, pays the permit fee, and
(1) Certifies on the application that the dental hygienist has completed at least 2,500 hours of supervised dental hygiene clinical practice, or clinical teaching hours, and also completes 40 hours of courses chosen by the applicant in clinical dental hygiene or public health sponsored by continuing education providers approved by the Board; or
(2) Certifies on the application that the dental hygienist has completed a course of study, before or after graduation from a dental hygiene program, that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205; and
(3) Provides the Board with a copy of the applicant's current professional liability policy or declaration page which will include, the policy number and expiration date of the policy.
(4) Notwithstanding OAR 818-035-0025(1), prior to performing any dental hygiene services an Expanded Practice Dental Hygienist shall examine the patient, gather data, interpret the data to determine the patient's dental hygiene treatment needs and formulate a patient care plan.
(5) An Expanded Practice Dental Hygienist may render the services described in paragraphs(6)(a) to ~~(d)~~ **(e)** of this rule to the patients described in ORS 680.205(1) if the Expanded Practice Dental Hygienist has entered into a written collaborative agreement in a format approved by the Board with a dentist licensed under ORS Chapter 679.
(6) If an Expanded Practice Dental Hygienist enters into a collaborative agreement to perform interim therapeutic restorations, the Expanded Practice Dental Hygienist must complete a Board approve training course through an oral health care education provider approved by the Board.
~~(6)~~ **(7)** The collaborative agreement must set forth the agreed upon scope of the dental hygienist's practice with regard to:
(a) Administering local anesthesia;
(b) Administering temporary restorations **with or** without excavation;
(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs; and
(d) Performing interim therapeutic restorations after diagnosis by a dentist; and
(e) Referral parameters.
~~(7)~~ **(8)**The collaborative agreement must comply with ORS 679.010 to 680.990.
~~(8) From the date this rule is effective, the Board has the authority to grant a Limited Access Permit through December 31, 2011, pursuant to ORS 680.200.~~

Commented [HT*O2]: I would insert a new (6) This would be my suggestion based on HB 2627 (4): **SECTION 4. (1) The Oregon Board of Dentistry shall approve applications from oral health care education providers for training courses that meet the requirements established in rules adopted by the board establishing educational and instructional requirements for interim therapeutic restoration to be performed by an expanded practice dental hygienist. (2) An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).**

Commented [HT*O3]: Since we are making changes to OAR 818-035-0065 I would remove #8 because it is no longer needed, this was put in place while they changed the title from Limited Access Permit to Expanded Practice Permit.

818-035-0100
Record Keeping

(1) An Expanded Practice Dental Hygienist shall refer a patient annually to a dentist who is available to treat the patient, and note in the patient's official chart held by the facility that the patient has been referred.

(2) When a licensed dentist has authorized an Expanded Practice Dental Hygienist to administer local anesthesia, **perform interim therapeutic restorations after diagnosis by a dentist,** place temporary restorations **with or** without excavation or prescribe prophylactic antibiotics and nonsteroidal anti-inflammatory drugs, the Expanded Practice Dental Hygienist shall document in the patient's official chart the name of the collaborating dentist and date the collaborative agreement was entered into.

Temporary restorations and language under **HB2528-B (The Dental Therapy Bill)** are going to highlight an issue with temporary restorations.

Are they defined under the Oregon DPA? Highlighting a concern here that will likely be problematic once rule making begins for HB2528-B.

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See HB2528-B, Page 7, Line 5, Section 9 (2)**SECTION 9. (2) (a) Placement of temporary restorations;**

Under (3) (b) Page 2 of HB2627 states

(b) Administering temporary restorations **with or** without excavation;

Under (3) (b) Page 2 of HB2627 states

(b) Administering temporary restorations **with or** without excavation;

Policy on Interim Therapeutic Restorations (ITR)

Latest Revision

2017

How to Cite: American Academy of Pediatric Dentistry. Policy on interim therapeutic restorations (ITR). The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:72-3.

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that unique clinical circumstances can result in challenges in restorative care for infants, children, adolescents, and persons with special health care needs. When circumstances do not permit traditional cavity preparation and/or placement of traditional dental restorations or when caries control is necessary prior to placement of definitive restorations, interim therapeutic restorations (**ITR**)[1] may be beneficial and are best utilized as part of comprehensive care in the dental home.[2,3] This policy will differentiate ITR from atraumatic/alternative restorative techniques (**ART**)[4] and describe the circumstances for its use.

Methods

This policy was developed by the Council on Clinical Affairs and adopted in 2001. This document is a revision of the previous version, revised in 2013. This updated policy is based upon electronic database and hand searches of medical and dental literature using the terms: dental caries, cavity, primary teeth, deciduous teeth, atraumatic restorative treatment, interim therapeutic restoration, AND glass ionomer; fields: all; limits: within the last 10 years, humans, English, birth through age 18. Additionally, websites for the AAPD and the American Dental Association were reviewed. Expert and/or consensus opinion by experienced researchers and clinicians was also considered.

Background

ART has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care.[4-6] In many countries, practitioners provide treatment in non-traditional settings that restrict restorative care to placement of provisional restorations. Because circumstances do not allow for follow-up care, ART mistakenly has been interpreted as a definitive restoration. ITR utilizes similar techniques but has different therapeutic goals. Interim therapeutic restoration more accurately describes the procedure used in contemporary dental practice in the United States.

ITR may be used to restore, arrest or prevent the progression of carious lesions in young patients, uncooperative patients, or patients with special health care needs or when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed.[7,8] Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth, in erupting molars when isolation conditions are not optimal for a definitive restoration, or for caries control in patients with active lesions prior to treatment performed under general anesthesia.[9,10] The use of ITR has been shown to reduce the levels of cariogenic oral bacteria (e.g., Mutans streptococci, lactobacilli) in the oral cavity immediately following its placement.[11-13] However, this level may return to pretreatment counts over a period of six months after ITR placement if no other treatment is provided.[12]

The ITR procedure involves removal of caries using hand or rotary instruments with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as glass ionomer or resin-modified glass ionomer cement.[14] ITR has the greatest success when applied to single surface or small two surface restorations.[15,16] Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure.[16,17] Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations, especially when glass ionomers (which have fluoride releasing and recharging properties) are used.[18-20]

Policy statement

The AAPD recognizes ITR as a beneficial provisional technique in contemporary pediatric restorative dentistry. ITR may be used to restore and prevent the progression of dental caries in young patients, uncooperative patients, patients with special health care needs, and situations in which traditional cavity preparation and/or placement of traditional dental restorations are not feasible. ITR may be used for caries control in children with multiple carious lesions prior to definitive restoration of the teeth.

ABBREVIATIONS

AAPD: American Academy Pediatric Dentistry. **ART:** Atraumatic/alternative restorative techniques. **ITR:** Interim therapeutic restorations.

References

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16. da Franca C, Colares V, Van Amerongen E. Two-year evaluation of the atraumatic restorative treatment approach in primary molars class I and II restorations. Int J Paediatr Dent 2011;21(4):249-53.
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B-Engrossed
House Bill 2528

Ordered by the Senate June 18
Including House Amendments dated April 19 and Senate Amendments
dated June 18

Sponsored by Representatives SANCHEZ, BYNUM; Representatives ALONSO LEON, CAMPOS, DEXTER, MEEK, PRUSAK, SOLLMAN, WILLIAMS, WITT (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.

Directs Oregon Board of Dentistry to issue dental therapist license to qualified applicant. Prohibits unlicensed use of title "dental therapist" and practice of dental therapy. Provides exceptions to prohibition. Requires dental therapist to purchase and maintain liability insurance. Requires dental therapist to dedicate majority of practice to specified patient populations. Directs board to consult with dental therapists and dental therapist organizations in rulemaking.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

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

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

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

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

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

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

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

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

(a) Is at least 18 years of age;

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

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

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

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

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

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

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.

section.

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

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

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

(a) Is at least 18 years of age;

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

(c) Demonstrates**:**

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

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

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

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

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

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

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

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

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

(c) The examinations must:

(A) Be elementary and practical in character, and sufficiently thorough to test the fitness of the applicant to practice dental therapy;

(B) Be written in English; and

(C) Include questions on subjects pertaining to dental therapy.

(2) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:

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

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

(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a period of at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure.

(4) The board shall establish rules related to reexamination for an applicant who fails an examination.

SECTION 5. The Oregon Board of Dentistry may refuse to issue or renew a license to practice dental therapy if the applicant or licensee:

(1) Subject to ORS 670.280, has been convicted of a violation of the law. A certified copy of the record of conviction is conclusive evidence of conviction.

(2) Has been disciplined by a state licensing or regulatory agency of this state or another state regarding a health care profession if, in the judgment of the board, the acts or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the applicant or licensee to practice dental therapy in accordance with sections 2 to 12 of this 2021 Act. A certified copy of the disciplinary action is conclusive evidence of the disciplinary action.

(3) Has falsified an application for issuance or renewal of licensure.

(4) Has violated any provision of sections 2 to 12 of this 2021 Act or a rule adopted under sections 2 to 12 of this 2021 Act.

SECTION 6. (1) A person may not practice dental therapy or assume or use any title, words or abbreviations, including the title or designation "dental therapist," that indicate that the person is authorized to practice dental therapy unless the person is licensed under section 3 of this 2021 Act.

(2) Subsection (1) of this section does not prohibit:

(a) The practice of dental therapy by a health care provider performing services within the health care provider's authorized scope of practice.

(b) The practice of dental therapy in the discharge of official duties on behalf of the United States government, including but not limited to the Armed Forces of the United States, the United States Coast Guard, the United States Public Health Service, the United States Bureau of Indian Affairs or the United States Department of Veterans Affairs.

(c) The practice of dental therapy pursuant to an educational program described in section 3 of this 2021 Act.

(d) A dental therapist authorized to practice in another state or jurisdiction from making a clinical presentation sponsored by a bona fide dental or dental therapy association or society or an accredited dental or dental therapy education program approved by the Oregon Board of Dentistry.

(e) Bona fide students of dental therapy from engaging in clinical studies during the period of their enrollment and as a part of the course of study in a dental therapy education program described in section 3 (1) of this 2021 Act. The clinical studies may be conducted on

the premises of the program or in a clinical setting located off the premises. The facility, instructional staff and course of study at an off-premises location must meet minimum requirements established by the board by rule. The clinical studies at the off-premises location must be performed under the indirect supervision of a member of the program faculty.

(f) Bona fide full-time students of dental therapy, during the period of their enrollment and as a part of the course of study in a dental therapy education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, from engaging in community-based or clinical studies as an elective or required rotation in a clinical setting located in Oregon, if the community-based or clinical studies meet minimum requirements established by the board by rule and are performed under the indirect supervision of a member of the faculty of the Oregon Health and Science University School of Dentistry.

(g) The performance of duties by a federally certified dental health aide therapist or tribally authorized dental therapist in a clinic operated by the Indian Health Service, including, as described in 25 U.S.C. 1603, an Indian Health Service Direct Service Tribe clinic, a clinic operated under an Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) contract or a clinic operated under an urban Indian organization.

SECTION 7. (1) The Oregon Board of Dentistry may impose nonrefundable fees for the following:

(a) Application for licensure;

(b) Examinations;

(c) Biennial dental therapy licenses, both active and inactive;

(d) Licensure renewal fees;

(e) Permits; and

(f) Delinquency.

(2) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting fees and charges, the fees and charges established under sections 2 to 12 of this 2021 Act may not exceed the cost of administering sections 2 to 12 of this 2021 Act as authorized by the Legislative Assembly within the Oregon Board of Dentistry budget and as modified by the Emergency Board.

(3)(a) The Oregon Board of Dentistry may waive a license fee for a licensee who provides to the board satisfactory evidence that the licensee has discontinued the practice of dental therapy because of retirement.

(b) A licensee described in this subsection may apply to the board for reinstatement of the license pursuant to rules adopted by the board. An application under this paragraph must include a fee. If the licensee has been retired or inactive for more than one year from the date of application, the licensee shall include with the application satisfactory evidence of clinical competence, as determined by the board.

(4)(a) A license to practice dental therapy is valid for two years and may be renewed. A licensee shall submit to the board an application for renewal and payment of the fee.

(b) A dental therapist issued a license in an even-numbered year must apply for renewal by September 30 of each even-numbered year thereafter. A dental therapist issued a license in an odd-numbered year must apply for renewal by September 30 of each odd-numbered year thereafter.

(c) The board may charge a reasonable fee if the application for renewal or the fee is

submitted more than 10 days delinquent.

(5) A dental therapist shall inform the board of a change of the dental therapist's address within 30 days of the change.

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

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

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

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

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

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

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

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

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

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

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

(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.

(2) In addition to the information described in subsection (1) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease.

(3) A dentist who enters into a collaborative agreement with a dental therapist shall:

(a) Directly provide care to a patient that is outside the scope of practice of the dental therapist or arrange for the provision of care by another dentist; and

(b) Ensure that the dentist, or another dentist, is available to the dental therapist for timely communication during the dental therapist's provision of care to a patient.

(4) A dental therapist may perform and provide only those procedures and services authorized by the dentist and set out in the collaborative agreement, and shall maintain with the dentist an appropriate level of contact, as determined by the dentist.

(5) A dental therapist and a dentist who enter into a collaborative agreement together shall each maintain a physical copy of the collaborative agreement.

(6)(a) A dental therapist may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

(b) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.

(7)(a) A collaborative agreement must be signed by the dentist and dental therapist.

(b) A dental therapist shall annually submit a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If the collaborative agreement is revised in between annual submissions, a signed copy of the revised collaborative agreement must be submitted to the board as soon as practicable after the revision is made.

SECTION 9. (1) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the general supervision of the dentist:

(a) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider;

(b) Comprehensive charting of the oral cavity;

(c) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;

(d) Exposing and evaluation of radiographic images;

(e) Dental prophylaxis, including subgingival scaling and polishing procedures;

(f) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(g) Administering local anesthetic;

(h) Pulp vitality testing;

(i) Application of desensitizing medication or resin;

(j) Fabrication of athletic mouth guards;

(k) Changing of periodontal dressings;

(L) Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth;

(m) Emergency palliative treatment of dental pain;

(n) Preparation and placement of direct restoration in primary and permanent teeth;

(o) Fabrication and placement of single-tooth temporary crowns;

(p) Preparation and placement of preformed crowns on primary teeth;

(q) Indirect pulp capping on permanent teeth;

(r) Indirect pulp capping on primary teeth;

(s) Suture removal;

(t) Minor adjustments and repairs of removable prosthetic devices;

(u) Atraumatic restorative therapy and interim restorative therapy;

(v) Oral examination, evaluation and diagnosis of conditions within the supervising dentist's authorization;

(w) Removal of space maintainers;

(x) The dispensation and oral or topical administration of:

(A) Nonnarcotic analgesics;

(B) Anti-inflammatories; and

(C) Antibiotics; and

(y) Other services as specified by the Oregon Board of Dentistry by rule.

(2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist:

(a) Placement of temporary restorations;

(b) Fabrication of soft occlusal guards;

(c) Tissue reconditioning and soft reline;

(d) Tooth reimplantation and stabilization;

(e) Recementing of permanent crowns;

(f) Pulpotomies on primary teeth;

(g) Simple extractions of:

(A) Erupted posterior primary teeth; and

(B) Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss;

(h) Brush biopsies; and

(i) Direct pulp capping on permanent teeth.

(3) The dentist described in subsection (2) of this section shall review a procedure described in subsection (2) of this section that is performed by the dental therapist and the patient chart that contains information regarding the procedure.

(4)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to perform the services provided by the dental assistant or expanded function dental assistant.

(b) A dental therapist may supervise up to two individuals under this subsection.

SECTION 10. (1) A dental therapist may perform the procedures listed in section 9 of this 2021 Act so long as the procedures are included in an education program described in section 3 (1) of this 2021 Act or the dental therapist has received additional training in the procedure approved by the Oregon Board of Dentistry.

(2) A dental therapist shall purchase and maintain liability insurance as determined sufficient by the board.

(3) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

SECTION 11. A person licensed under section 3 of this 2021 Act is subject to the provisions of ORS 679.140.

SECTION 12. The Oregon Board of Dentistry shall adopt rules necessary to administer sections 2 to 12 of this 2021 Act. In adopting rules under this section, the board shall consult with dental therapists and organizations that represent dental therapists in this state.

SECTION 13. ORS 679.010 is amended to read:

679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(1) "Dental assistant" means a person who, under the supervision of a dentist **or dental therapist**, renders assistance to a dentist, **dental therapist,** dental hygienist, dental technician or another dental assistant or who, under the supervision of a dental hygienist, renders assistance to a dental hygienist providing dental hygiene.

(2) "Dental hygiene" is that portion of dentistry that includes, but is not limited to:

(a) The rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services;

(b) Prediagnostic risk assessment, scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services; and

(c) Prescribing, dispensing and administering prescription drugs for the services described in paragraphs (a) and (b) of this subsection.

(3) "Dental hygienist" means a person who, under the supervision of a dentist, practices dental hygiene.

(4) "Dental technician" means a person who, at the authorization of a dentist, makes, provides, repairs or alters oral prosthetic appliances and other artificial materials and devices that are returned to a dentist and inserted into the human oral cavity or that come in contact with its adjacent structures and tissues.

(5) "Dental therapist" means a person licensed to practice dental therapy under section 3 of this 2021 Act.

(6) "Dental therapy" means the provision of preventive dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under section 9 of this 2021 Act.

[*(5)*] **(7)** "Dentist" means a person who may perform any intraoral or extraoral procedure required in the practice of dentistry.

[*(6)*] **(8)** "Dentist of record" means a dentist that either authorizes treatment for, supervises treatment of or provides treatment for a patient in a dental office or clinic owned or operated by an institution as described in ORS 679.020 (3).

[*(7)(a)*] **(9)(a)** "Dentistry" means the healing art concerned with:

(A) The examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region, and of conditions of adjacent or related tissues and structures; and

(B) The prescribing, dispensing and administering of prescription drugs for purposes related to the activities described in subparagraph (A) of this paragraph.

(b) "Dentistry" includes, but is not limited to:

(A) The cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of:

(i) Dental schools accredited by the Commission on Dental Accreditation of the American Dental Association;

(ii) Post-graduate training programs; or

(iii) Continuing education courses.

(B) The prescription and administration of vaccines.

[*(8)*] **(10)** "Direct supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

[*(9)*] **(11)** "Expanded practice dental hygienist" means a dental hygienist who performs dental hygiene services in accordance with ORS 680.205 as authorized by an expanded practice dental hygienist permit issued by the board under ORS 680.200.

[*(10)*] **(12)** "General supervision" means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

[*(11)*] **(13)** "Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

SECTION 14. ORS 679.140 is amended to read:

679.140. (1) The Oregon Board of Dentistry may discipline as provided in this section any person licensed to practice dentistry in this state for any of the following causes:

(a) Conviction of any violation of the law for which the court could impose a punishment if the board makes the finding required by ORS 670.280. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is entered, is conclusive evidence of the conviction.

(b) Renting or lending a license or diploma of the dentist to be used as the license or diploma of another person.

(c) Unprofessional conduct.

(d) Any violation of this chapter or ORS 680.010 to 680.205, of rules adopted pursuant to this chapter or ORS 680.010 to 680.205 or of an order issued by the board.

(e) Engaging in or permitting the performance of unacceptable patient care by the dentist or by any person working under the supervision of the dentist due to a deliberate or negligent act or failure to act by the dentist, regardless of whether actual injury to the patient is established.

(f) Incapacity to practice safely.

(2) "Unprofessional conduct" as used in this chapter includes but is not limited to the following:

(a) Obtaining any fee by fraud or misrepresentation.

(b) Willfully betraying confidences involved in the patient-dentist relationship.

(c) Employing, aiding, abetting or permitting any unlicensed personnel to practice dentistry [*or*]**,** dental hygiene **or dental therapy**.

(d) Making use of any advertising statements of a character tending to deceive or mislead the public or that are untruthful.

(e) Impairment as defined in ORS 676.303.

(f) Obtaining or attempting to obtain a controlled substance in any manner proscribed by the rules of the board.

(g) Prescribing or dispensing drugs outside the scope of the practice of dentistry or in a manner that impairs the health and safety of an individual.

(h) Disciplinary action by a state licensing or regulatory agency of this or another state regarding a license to practice dentistry, dental hygiene**, dental therapy** or any other health care profession when, in the judgment of the board, the act or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the licensee or applicant to practice dentistry [*or*]**,** dental hygiene **or dental therapy** in accordance with the provisions of this chapter. A certified copy of the record of the disciplinary action is conclusive evidence of the disciplinary action.

(3) The proceedings under this section may be taken by the board from the matters within its knowledge or may be taken upon the information of another, but if the informant is a member of the board, the other members of the board shall constitute the board for the purpose of finding judgment of the accused.

(4) In determining what constitutes unacceptable patient care, the board may take into account

all relevant factors and practices, including but not limited to the practices generally and currently followed and accepted by persons licensed to practice dentistry in this state, the current teachings at accredited dental schools, relevant technical reports published in recognized dental journals and the desirability of reasonable experimentation in the furtherance of the dental arts.

(5) In disciplining a person as authorized by subsection (1) of this section, the board may use any or all of the following methods:

(a) Suspend judgment.

(b) Place a licensee on probation.

(c) Suspend a license to practice dentistry in this state.

(d) Revoke a license to practice dentistry in this state.

(e) Place limitations on a license to practice dentistry in this state.

(f) Refuse to renew a license to practice dentistry in this state.

(g) Accept the resignation of a licensee to practice dentistry in this state.

(h) Assess a civil penalty.

(i) Reprimand a licensee.

(j) Impose any other disciplinary action the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty.

(6) If the board places any person upon probation as set forth in subsection (5)(b) of this section, the board may determine and may at any time modify the conditions of the probation and may include among them any reasonable condition for the purpose of protection of the public and for the purpose of the rehabilitation of the probationer or both. Upon expiration of the term of probation, further proceedings shall be abated by the board if the person holding the license furnishes the board with evidence that the person is competent to practice dentistry and has complied with the terms of probation. If the evidence fails to establish competence to the satisfaction of the board or if the evidence shows failure to comply with the terms of the probation, the board may revoke or suspend the license.

(7) If a license to practice dentistry in this state is suspended, the person holding the license may not practice during the term of suspension. Upon the expiration of the term of suspension, the license shall be reinstated by the board if the board finds, based upon evidence furnished by the person, that the person is competent to practice dentistry and has not practiced dentistry in this state during the term of suspension. If the evidence fails to establish to the satisfaction of the board that the person is competent or if any evidence shows the person has practiced dentistry in this state during the term of suspension, the board may revoke the license after notice and hearing.

(8) Upon receipt of a complaint under this chapter or ORS 680.010 to 680.205, the board shall conduct an investigation as described under ORS 676.165.

(9) Information that the board obtains as part of an investigation into licensee or applicant conduct or as part of a contested case proceeding, consent order or stipulated agreement involving licensee or applicant conduct is confidential as provided under ORS 676.175. Notwithstanding ORS 676.165 to 676.180, the board may disclose confidential information regarding a licensee or an applicant to persons who may evaluate or treat the licensee or applicant for drug abuse, alcohol abuse or any other health related conditions.

(10) The board may impose against any person who violates the provisions of this chapter or ORS 680.010 to 680.205 or rules of the board a civil penalty of up to $5,000 for each violation. Any civil penalty imposed under this section shall be imposed in the manner provided in ORS 183.745.

(11) Notwithstanding the expiration, suspension, revocation or surrender of the license, or the

resignation or retirement of the licensee, the board may:

(a) Proceed with any investigation of, or any action or disciplinary proceedings against, the dentist [*or*]**,** dental hygienist **or dental therapist**; or

(b) Revise or render void an order suspending or revoking the license.

(12)(a) The board may continue with any proceeding or investigation for a period not to exceed four years from the date of the expiration, suspension, revocation or surrender of the license, or the resignation or retirement of the licensee; or

(b) If the board receives a complaint or initiates an investigation within that four-year period, the board's jurisdiction continues until the matter is concluded by a final order of the board following any appeal.

(13) Withdrawing the application for license does not close any investigation, action or proceeding against an applicant.

SECTION 15. ORS 679.170 is amended to read:

679.170. [*No person shall*] **A person may not**:

(1) Sell or barter, or offer to sell or barter, any diploma or document conferring or purporting to confer any dental degree, or any certificate or transcript made or purporting to be made, pursuant to the laws regulating the license and registration of dentists.

(2) Purchase or procure by barter, any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**, with intent that it be used as evidence of the holder's qualification to practice dentistry, or in fraud of the laws regulating [*such*] **the** practice **of dentistry**.

(3) With fraudulent intent, alter in a material regard any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**.

(4) Use or attempt to use any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**, which has been purchased, fraudulently issued, counterfeited or materially altered, either as a license or color of license to practice dentistry, or in order to procure registration as a dentist.

(5) Willfully make a false written or recorded oral statement to the Oregon Board of Dentistry in a material regard.

(6) Within 10 days after demand made by the board, fail to respond to the board's written request for information or fail to furnish to the board the name and address of all persons practicing or assisting in the practice of dentistry in the office of such person at any time within 60 days prior to the notice, together with a sworn statement showing under and by what license or authority such person and employee are and have been practicing dentistry.

(7) Employ or use the services of any unlicensed person, to practice dentistry [*or*]**,** dental hygiene **or dental therapy**, except as permitted by ORS 679.025, 679.176 and 680.010 to 680.205.

SECTION 16. ORS 679.250 is amended to read:

679.250. The powers and duties of the Oregon Board of Dentistry are as follows:

(1) To, during the month of April of each year, organize and elect from its membership a president who shall hold office for one year, or until the election and qualification of a successor.

(2) To authorize all necessary disbursements to carry out the provisions of this chapter, including but not limited to, payment for necessary supplies, office equipment, books and expenses for the conduct of examinations, payment for legal and investigative services rendered to the board, and such other expenditures as are provided for in this chapter.

(3) To employ such inspectors, examiners, special agents, investigators, clerical assistants, assistants and accountants as are necessary for the investigation and prosecution of alleged violations

and the enforcement of this chapter and for such other purposes as the board may require. Nothing in this chapter shall be construed to prevent assistance being rendered by an employee of the board in any hearing called by it. However, all obligations for salaries and expenses incurred under this chapter shall be paid from the fees accruing to the board under this chapter and not otherwise.

(4)(a) To conduct examinations of applicants for license to practice dentistry [*and*]**,** dental hygiene **and dental therapy** at least twice in each year.

(b) In conducting examinations for licensure, the board may enter into a compact with other states for conducting regional examinations with other board of dental examiners concerned, or by a testing service recognized by such boards.

(5) To meet for the transaction of other business at the call of the president. A majority of board members shall constitute a quorum. A majority vote of those present shall be a decision of the entire board. The board's proceedings shall be open to public inspection in all matters affecting public interest.

(6) To keep an accurate record of all proceedings of the board and of all its meetings, of all receipts and disbursements, of all prosecutions for violation of this chapter, of all examinations for license to practice dentistry, with the names and qualifications for examination of any person examined, together with the addresses of those licensed and the results of such examinations, a record of the names of all persons licensed to practice dentistry in Oregon together with the addresses of all such persons having paid the license fee prescribed in ORS 679.120 and the names of all persons whose license to practice has been revoked or suspended.

(7) To make and enforce rules necessary for the procedure of the board, for the conduct of examinations, for regulating the practice of dentistry, and for regulating the services of dental hygienists and dental auxiliary personnel not inconsistent with the provisions of this chapter. As part of such rules, the board may require the procurement of a permit or other certificate. Any permit issued may be subject to periodic renewal. In adopting rules, the board shall take into account all relevant factors germane to an orderly and fair administration of this chapter and of ORS 680.010 to 680.205, the practices and materials generally and currently used and accepted by persons licensed to practice dentistry in this state, dental techniques commonly in use, relevant technical reports published in recognized dental journals, the curriculum at accredited dental schools, the desirability of reasonable experimentation in the furtherance of the dental arts, and the desirability of providing the highest standard of dental care to the public consistent with the lowest economic cost.

(8) Upon its own motion or upon any complaint, to initiate and conduct investigations of and hearings on all matters relating to the practice of dentistry, the discipline of licensees, or pertaining to the enforcement of any provision of this chapter. In the conduct of investigations or upon the hearing of any matter of which the board may have jurisdiction, the board may take evidence, administer oaths, take the depositions of witnesses, including the person charged, in the manner provided by law in civil cases, and compel their appearance before it in person the same as in civil cases, by subpoena issued over the signature of an employee of the board and in the name of the people of the State of Oregon, require answers to interrogatories, and compel the production of books, papers, accounts, documents and testimony pertaining to the matter under investigation or to the hearing. In all investigations and hearings, the board and any person affected thereby may have the benefit of counsel, and all hearings shall be held in compliance with ORS chapter 183. Notwithstanding ORS 676.165, 676.175 and 679.320, if a licensee who is the subject of an investigation or complaint is to appear before members of the board investigating the complaint, the board

shall provide the licensee with a current summary of the complaint or the matter being investigated not less than five days prior to the date that the licensee is to appear. At the time the summary of the complaint or the matter being investigated is provided, the board shall provide to the licensee a current summary of documents or alleged facts that the board has acquired as a result of the investigation. The name of the complainant or other information that reasonably may be used to identify the complainant may be withheld from the licensee.

(9) To require evidence as determined by rule of continuing education or to require satisfactory evidence of operative competency before reissuing or renewing licenses for the practice of dentistry [*or*]**,** dental hygiene **or dental therapy**.

(10) To adopt and enforce rules regulating administration of general anesthesia and conscious sedation by a dentist or under the supervision of a dentist in the office of the dentist. As part of such rules, the board may require the procurement of a permit which must be periodically renewed.

(11) To order an applicant or licensee to submit to a physical examination, mental examination or a competency examination when the board has evidence indicating the incapacity of the applicant or licensee to practice safely.

SECTION 17. Section 1, chapter 716, Oregon Laws 2011, is amended to read:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

(4)(a) Notwithstanding ORS 679.020 and 680.020, a person may practice dentistry [*or*]**,** dental hygiene **or dental therapy** without a license as part of a pilot project approved under this section under the general supervision of a dentist licensed under ORS chapter 679 and in accordance with rules adopted by the authority.

(b) A person practicing dentistry [*or*]**,** dental hygiene **or dental therapy** without a license under this section is subject to the same standard of care and is entitled to the same immunities as a person performing the services with a license.

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 [*of this 2011 Act*]**, chapter 716, Oregon Laws 2011**.

SECTION 18. (1) Sections 2, 3 and 4 to 12 of this 2021 Act and the amendments to ORS 679.010, 679.140, 679.170 and 679.250 and section 1, chapter 716, Oregon Laws 2011, by sections 13 to 17 of this 2021 Act become operative on January 1, 2022.

(2) The amendments to section 3 of this 2021 Act by section 3a of this 2021 Act become operative on January 1, 2025.

(3) The Oregon Board of Dentistry may take any action before the operative dates specified in subsections (1) and (2) of this section that is necessary to enable the board to exercise, on and after the operative dates specified in subsections (1) and (2) of this section, all of the duties, functions and powers conferred on the board by sections 2, 3 and 4 to 12 of this 2021 Act and the amendments to ORS 679.010, 679.140, 679.170 and 679.250 and section 1, chapter 716, Oregon Laws 2011, and section 3 of this 2021 Act by sections 3a and 13 to 17 of this 2021 Act.

SECTION 19. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.

1.25 Placement of Interim Therapeutic Restorations by Dental Hygienists

(Adopted April 28, 2016, Effective June 30, 2016)

Pursuant to sections 12-220-504(1)(d) and 12-220-505, C.R.S., once issued a permit by the Board, a dental hygienist may place interim therapeutic restorations in a dental office setting under the "direct supervision" (defined by section 12-220-104(7), C.R.S.) or "indirect supervision" (defined by section 12-220-104(9), C.R.S.) of a dentist, or through "telehealth supervision" (defined by section 12-220-104(15), C.R.S.) for purposes of communication with the supervising dentist. A dentist shall not supervise more than 5 dental hygienists who place interim therapeutic restorations under telehealth supervision. A dentist who supervises a dental hygienist that provides interim therapeutic restorations under telehealth supervision must have a physical practice location in Colorado for purposes of patient referral for follow-up care.

A. Pursuant to section 12-220-104(10), C.R.S., an "interim therapeutic restoration" or "ITR" means a direct provisional restoration placed to stabilize a tooth on a pediatric or non-pediatric patient until a licensed dentist can assess the need for further definitive treatment and involves the:

   1. Removal of soft material using hand instrumentation, without the use of rotary instrumentation; and the

   2. Subsequent placement of the following restorative materials:

      a. Glass ionomer.

B. In order to be eligible for a permit to place an ITR, a dental hygienist must:

   1. Hold a license in good standing to practice dental hygiene in Colorado;

   2. Complete a course developed at the post-secondary education level offered under the direct supervision of a member of the faculty of a Colorado dental or dental hygiene school accredited by the Commission on Dental Accreditation (CODA) or its successor agency that complies with the following uniform training standards:

      a. Four hours of didactic instruction, including but not limited to:

         (1) Pulpal anatomy;

         (2) Principles of adhesive restorative materials;

         (3) Preparation of the tooth and placement techniques;

         (4) Diagnostic criteria for interim therapeutic restorations;

         (5) Evaluation of proper placement and technique; and

         (6) Protocols for handling sensitivity, complications, or unsuccessful completion and follow-up;

      b. Four hours of laboratory instruction that includes placement of interim therapeutic restorations on typodont teeth;

      c. Criteria for evaluating competency through placement of interim therapeutic restorations on a minimum of four teeth under direct supervision of faculty; and

d. Clinical evaluations of students must be performed by a dentist with a faculty appointment at an accredited Colorado dental or dental hygiene school.

3. Carry current professional liability insurance, on his/her own or through the supervising dentist, in the amount specified in section 12-220-307(2), C.R.S.; and

4. Submit documented proof of completing one of the following experience pathways in dental hygiene practice:

a. 2,000 hours of supervised dental hygiene practice after initial dental hygiene licensure;

b. 4,000 hours of unsupervised dental hygiene practice after initial dental hygiene licensure; or

c. A combination of the hours specified in paragraphs (4)(a) and (4)(b) of this Rule considered on a case-by-case basis by the Board.

d. The requirement for submitting documented proof of practice hours is waived for a dental hygienist applying to perform interim therapeutic restorations exclusively under the direct supervision of a dentist.

C. A dental hygienist shall not use local anesthesia for the purpose of placing interim therapeutic restorations.

D. A dental hygienist may place an ITR only after a supervising dentist provides a diagnosis, treatment plan, and instruction to perform the procedure.

E. If an ITR is authorized by a supervising dentist at a location other than the dentist's practice location, the dental hygienist shall provide the patient or the patient's representative with written notification that the care was provided at the direction of the supervising dentist. The dental hygienist shall include in the written notification the dentist's name, practice location address, and telephone number.

F. A dental hygienist who obtains a supervising dentist's diagnosis, treatment plan, and instruction to perform an ITR utilizing "telehealth by store-and-forward transfer" (defined by section 12-220-104(14), C.R.S.) shall notify the patient of the patient's right to receive interactive communication with the distant dentist upon request. Communication with the distant dentist may occur either at the time of the consultation or within thirty days after the dental hygienist notifies the patient of the results of the consultation.

G. A dental hygienist shall inform the patient or the patient's legal guardian, in writing, and require the patient or the patient's legal guardian to acknowledge by signature, that the ITR is a temporary repair to the tooth and that appropriate follow-up care with a dentist is necessary.

H. Pursuant to 12-220-201(1)(nn), C.R.S., the Board may take disciplinary action against an applicant or licensee for failing to comply with the requirements regarding the placement of interim therapeutic restorations.

TITLE 16. DENTAL HYGIENE BOARD OF CALIFORNIA - DEPARTMENT OF CONSUMER AFFAIRS PROPOSED LANGUAGE

Adopt Section 1109 of Title 16 of the California Code of Regulations (CCR) to read as follows:

§ 1109. Approval of Curriculum Requirements for Radiographic Decision-Making and Interim Therapeutic Restoration Courses for the Registered Dental Hygienist (RDH), Registered Dental Hygienist in Alternative Practice (RDHAP), and Registered Dental Hygienist in Extended Functions (RDHEF).

(a) The Dental Hygiene Board of California (Board) shall approve only those educational courses in Radiographic Decision-Making (RDM) and Interim Therapeutic Restorations (ITR) for the Registered Dental Hygienist (RDH), Registered Dental Hygienist in Alternative Practice (RDHAP), and Registered Dental Hygienist in Extended Functions (RDHEF) pursuant to sections 1910.5, 1921, and 1926.05 of the Business and Professions Code that continuously meet all course requirements. Continuation of approval will be contingent upon compliance with these requirements, in addition to the requirements set forth by sections 1104 through 1108 of Article 3 regarding Educational Programs. Each approved course shall be subject to Board review at any time for compliance with curriculum requirements. Course providers shall be responsible for notifying the Board in writing of any changes to the course content, physical facilities, and faculty within ten (10) days of such changes.

(b) Approval of RDM or ITR Educational Courses for the Student Enrolled in a Dental Hygiene Educational Program (DHEP). To be approved, an educational program shall comply with the following requirements:

(1) DHEP RDM Course Requirements.

(A) A California DHEP shall submit to the Board an “Application for Approval of a Course for Radiographic Decision-Making in a Dental Hygiene Educational Program” DHBC RDM-01 (New 01/19), hereby incorporated by reference;

(B) Submit a $300 application fee to the Board; and

(C) The course shall be sufficient in length for the students to develop competency in making decisions regarding which radiographs to expose

to facilitate diagnosis and treatment planning by a dentist but shall be, at a minimum, four (4) hours in length and include didactic, laboratory, and simulated clinical experiences.

(D) New or already approved DHEPs seeking to incorporate or offer a stand-alone permit course in RDM shall submit to the Board an "Application for Approval of a Course for Radiographic Decision-Making in a Dental Hygiene Educational Program," DHBC RDM-01 (New 01/19) and a $300 application fee prior to instruction.

(2) DHEP ITR Course Requirements.

(A) A California DHEP shall submit to the Board an "Application for Approval of a Course for Interim Therapeutic Restorations in a Dental Hygiene Educational Program" DHBC ITR-03 (New 01/19), hereby incorporated by reference; and

(B) Submit a $300 application fee to the Board; and

(C) The course shall be sufficient in length for the students to develop competency in placement of protective restorations but shall be, at a minimum, sixteen (16) hours in length, including four (4) hours of didactic training, four (4) hours of laboratory training, and eight (8) hours of clinical training.

(D) New or already approved DHEPs seeking to incorporate or offer a stand-alone permit course in ITR shall submit to the Board an "Application for Approval of a Course for Interim Therapeutic Restorations in a Dental Hygiene Educational Program," DHBC ITR-03 (New 01/19) and a $300 application fee prior to instruction.

(3) In addition to the instructional components described in this subdivision, an RDM or ITR DHEP educational course shall be established at the postsecondary educational level.

(c) Approval of RDM or ITR Continuing Educational (CE) Courses for the RDH, RDHAP, and RDHEF. All courses must be approved by the Board before offered by the provider. To be approved, an educational program shall comply with the following requirements:

(1) RDM CE Course Requirements.

(A) An applicant course provider shall submit to the Board an "Application for Approval of a Continuing Educational Course in Radiographic Decision-Making for the RDH, RDHAP, and RDHEF" DHBC RDM-02 (New 01/19), hereby incorporated by reference; and

(B) Submit a $300 application fee to the Board; and

(C) The course shall be sufficient in length for the participants to develop competency in making decisions regarding which radiographs to expose to facilitate diagnosis and treatment planning by a dentist but shall be, at a minimum, four (4) hours in length and include didactic, laboratory, and simulated clinical experiences.

(2) ITR CE Course Requirements.

(A) An applicant course provider shall submit to the Board an "Application for Approval of a Continuing Educational Course in Placement of Interim Therapeutic Restorations for the RDH, RDHAP, and RDHEF" DHBC ITR-04 (New 01/19), hereby incorporated by reference; and

(B) Submit a $300 application fee to the Board; and

(C) The course shall be sufficient in length for the participants to develop competency in placement of protective restorations but shall be, at a minimum, sixteen (16) hours in length, including four (4) hours of didactic training, four (4) hours of laboratory training, and eight (8) hours of clinical training.

(3) In addition to the instructional components described in subdivisions (c)(1) and (c)(2), a program or course shall be established at a post-graduate educational level.

(d) Requirements for Approval of DHEP and CE RDM and ITR Courses.

(1) Administration.

To be approved, each course shall provide the resources necessary including, but not limited to, equipment and facilities, to satisfy the educational requirements as specified in this section. Course providers shall be

responsible for informing the Board of any changes in writing to the course content, physical facilities, and faculty within ten (10) days of such changes.

(2) Admission.

(A) To be eligible for admission to an RDM or ITR Course for the Student in a DHEP, students shall:

(i) Be a student in good standing in a DHEP; and

(ii) Possess current certification in Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) from the American Heart Association (AHA) or the American Red Cross (ARC).

(B) To be eligible for admission to a CE Course in RDM or ITR for the RDH, RDHAP, and RDHEF, participants shall:

(i) Possess a valid, active license as an RDH, RDHAP, or RDHEF issued by the Board, and

(ii) Possess current certification in Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) from the American Heart Association (AHA) or the American Red Cross (ARC).

(3) Faculty.

Didactic, laboratory, preclinical, and clinical faculty, including the program or course director and supervising dentist(s) shall:

(A) Possess a valid, active California RDH, RDHAP, RDHEF license, or Doctor of Dental Surgery (DDS) license, or Doctor of Dental Medicine (DMD) license with no disciplinary actions in any jurisdiction to practice dental hygiene or dentistry;

(B) Possess current certification in Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) from the American Heart Association (AHA) or American Red Cross (ARC);

(C) RDH, RDHAP, and RDHEF faculty shall possess current licensure in RDM and ITR placement; and

(D) Be calibrated in instruction and grading of RDM and ITR.

(4) Facilities and Equipment.

(A) RDM and ITR Courses for the Student in a DHEP.

Didactic instruction may take place in an in-person or an online environment. Each course shall have access to adequate equipment and facilities for lectures and testing.

Laboratory and clinical instruction shall be held at a physical facility. Physical facilities and equipment shall be maintained and replaced in a manner designed to provide students with a course that will meet the educational objectives set forth in this section. A physical facility shall have all the following:

(i) A patient clinic area, laboratory, and a radiology area;

(ii) Access to equipment necessary to develop dental hygiene skills in RDM and ITR duties; and

(iii) Infection control equipment shall be provided as described in 16 CCR section 1005.

(B) RDM CE Courses for the RDH, RDHAP, and RDHEF.

Didactic instruction may take place in an in-person or an online environment. Each course shall have access to adequate equipment and facilities for lectures and testing and shall be maintained and replaced in a manner designed to provide participants with a course that will meet the educational objectives set forth in this section.

(C) ITR CE Courses for the RDH, RDHAP, and RDHEF.

Didactic instruction may take place in an in-person or an online environment. Each course shall have access to adequate equipment and facilities for lectures and testing.

Laboratory and clinical instruction shall be held at a physical facility. Physical facilities and equipment shall be maintained and replaced in a manner designed to provide participants with a course designed to meet the educational objectives set forth in this section. A physical facility shall have all the following:

(i) A patient clinic area, laboratory, and a radiology area;

(ii) Access to equipment necessary to develop dental hygiene skills in ITR duties; and

(iii) Infection control equipment shall be provided as described in 16 CCR section 1005.

(5) Health and Safety.

DHEP and CE course providers shall comply with all local, state, and federal health and safety laws and regulations.

(A) All students or participants shall have access to the course's hazardous waste management plan for the disposal of needles, cartridges, medical waste, and storage of oxygen and nitrous oxide tanks.

(B) All students or participants shall have access to the course's clinic and radiation hazardous communication plan.

(C) All students or participants shall receive a copy of the course's bloodborne and infectious diseases exposure control plan, which shall include emergency needlestick information.

(D) Faculty shall review with each student or participant all requirements pursuant to this section.

(6) Curriculum and Learning Resources.

(A) RDM didactic instruction shall include:

(i) Caries Management by Risk Assessment (CAMBRA) concept;

(ii) Guidelines for RDM to include, but not limited to, the following concepts of:

(a) The American Dental Association's *Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation* and

(b) The American Academy of Pediatric Dentistry's *Guidelines on Prescribing Dental Radiographs.*

(iii) The guidelines developed by Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry

(Pacific) for use in training for Health Workforce Pilot Project (HWPP) #172 including:

(a) Instruction on specific decision-making guidelines that incorporate information about the patient's health, radiographic history, time span since previous radiographs were taken, and availability of previous radiographs; and

(b) Instruction pertaining to the general condition of the mouth including extent of dental restorations present, visible signs of abnormalities, including broken teeth, dark stain within the tooth, and visible holes in teeth.

(B) RDM laboratory instruction shall include a review of clinical cases with instructor-led discussion about radiographic decision-making in clinical situations.

(C) RDM simulated-clinical instruction shall include case-based examination with various clinical situations where trainees make decisions about which radiographs to expose and demonstrate competency to faculty based on these case studies.

(D) ITR placement. Didactic, laboratory, and clinical instruction shall include:

(i) Review of pulpal anatomy.

(ii) Theory of adhesive restorative materials used in the placement of adhesive protective restorations including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques.

(iii) Criteria used in clinical dentistry pertaining to the use and placement of adhesive protective restorations; Criteria shall include, but not limited to:

(a) Patient factors:

(1) According to the American Society of Anesthesiologists Physical Status Classification, the patient is Class III or less;

(2) The patient is cooperative enough to have the interim restoration placed without the need for special protocols, including sedation or physical support;

(3) The patient, or responsible party, has provided consent for the ITR procedure; and

(4) The patient reports that the tooth is asymptomatic, or if there is mild sensitivity which stops within a few seconds of the removal of the offending stimulus.

(b) Tooth Factors:

(1) The lesion is accessible without the need for creating access using a dental handpiece;

(2) The margins of the lesion are accessible so that clean, non-involved margins can be obtained around the entire periphery of the lesion with the use of hand instrumentation;

(3) The depth of the lesion is more than two millimeters from the pulp on radiographic examination or is judged by the DDS or DMD to be a shallow lesion such that the treatment does not endanger the pulp or require the use of local anesthetic; and

(4) The tooth is restorable and does not have other significant pathology.

(iv) Theory of protocols to deal with adverse outcomes used in the placement of adhesive protective restorations including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques;

(v) Criteria for evaluating successful completion of adhesive protective restorations including, but not limited to, restorative material not in hyper occlusion, no marginal voids, and minimal excess material;

(vi) Protocols for adverse outcomes after ITR placement including, but not limited to; exposed pulp, tooth fracture, gingival tissue

injury, high occlusion, open margins, tooth sensitivity, rough surface, complications, or unsuccessful completion of adhesive protective restorations including situations requiring immediate referral to a dentist; and

(vii) Protocols for follow-up of adhesive protective restorations, including, but not limited to, at least two (2) follow-up examinations of the ITR within a twelve (12) month period.

(E) Minimum ITR Requirements.

(i) Laboratory instruction shall include placement of ten (10) adhesive protective restorations where students or participants demonstrate competency in this technique on typodont teeth.

(ii) Clinical instruction shall include experiences where students or participants demonstrate, at a minimum, the placement of five (5) adhesive therapeutic restorations that shall be evaluated by the program faculty to criteria-referenced standards.

(F) Curriculum shall require adherence to infection control standards as provided in 16 CCR section 1005.

(G) Curriculum shall prepare the student or participant to assess, plan, implement and evaluate procedures as provided in subdivision (c)(6) of this section to perform with competence and judgment.

(H) Students or participants shall be provided a course syllabus that contains:

(i) Course learning outcomes;

(ii) Titles of references used for course materials;

(iii) Content objectives; and

(iv) Grading criteria which includes competency evaluations and laboratory, preclinical, and clinical rubrics to include problem solving and critical thinking skills that reflect course learning outcomes.

(I) Successful completion shall require students or participants to achieve competency at a minimum of 75% in each of the competencies.

(7) Recordkeeping.

DHEP and CE course providers shall possess and maintain the following for a period of not less than five (5) years:

(A) Individual student or participant records, including those necessary to establish satisfactory completion of the course;

(B) Copies of lab and clinical competency documents;

(C) Copies of faculty calibration plans, faculty credentials, licenses, and certifications including documented background in educational methodology within the previous two years;

(D) Copies of student or participant course evaluations and a summation thereof; and

(E) Copies of curriculum, including course syllabi, exams, sample test questions and clinic rubrics.

(e) Satisfactory completion of courses in RDM and ITR placement shall be determined using criteria-referenced completion standards, where the instructor determines when the student or participant has achieved RDM and ITR placement competency based on these standards, including the duration of time needed to achieve competency. Any student or participant who does not achieve competency in these duties in the specified period of instruction may receive additional education and evaluation, or, in the judgment of the faculty, may be discontinued from the RDM or ITR courses.

(f) Certificates of Completion. Pursuant to the regulatory requirements set forth by 16 CCR section 1016, subdivision (h)(1), only after a student or participant has successfully completed the requirements of a course in RDM, ITR, or RDM and ITR, may a DHEP or course provider provide the student or participant with an original "Certification of Completion of a Course in Interim Therapeutic Restoration for the RDH, RDHAP, and RDHEF", "Certification of Completion of a Course in Radiographic Decision-Making for the RDH, RDHAP, and RDHEF", or "Certification of Completion of a Course in Radiographic Decision-Making and Interim Therapeutic Restorations for the RDH, RDHAP, and RDHEF", as applicable.

(g) Appeals.

(1) The Board may deny or withdraw its approval of a course for noncompliance with this section. If the Board denies or withdraws approval of a course, the reasons for withdrawal or denial will be provided in writing within sixty (60) business days.

(2) Any course provider or applicant whose approval is denied or withdrawn shall be granted an informal conference before the Executive Officer or his or her designee prior to the effective date of such action. The applicant or course provider shall be given at least ninety (90) business days' notice of the time and place of such informal conference and the specific grounds for the proposed action.

(3) The applicant or course provider may contest the denial or withdrawal of approval by either:

(A) Appearing at the informal conference. The Executive Officer shall notify the course provider of the final decision of the Executive Officer within thirty (30) business days of the informal conference. Based on the outcome of the informal conference, the course provider may then request a hearing to contest the Executive Officer's final decision. A course provider shall request a hearing by written notice to the Board within thirty (30) business days of the postmark date of the letter of the Executive Officer's final decision after informal conference. Hearings shall be held pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code; or

(B) Notifying the Board in writing the course provider's election to forego the informal conference and to proceed with a hearing pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Such notification shall be made to the Board before the date of the informal conference.

NOTE: Authority cited: Sections 1905, 1906, and 1910.5, Business and Professions Code. Reference: Section 1910.5, Business and Professions Code.

8. Curriculum

A. Trainee Minimum Level of Competence

All trainees will hold current Oregon licenses as EPDHs. All trainees will have completed training during their educational programs or have a certificate of completion of a course in Radiation Safety and in placement of Pit and Fissure Sealants. All trainees will have at least one year experience working in community sites or programs. Training will take place at Capitol Dental Care and include lecture laboratory, and clinical instruction. Completion of the initial training will be based on a "Mastery-Level" summative evaluation meaning that trainees will be certified by the instructors as having mastered the instructional materials. **See "Description of Trainee Evaluation Process" in sections B, C, and D below.**

B. Description of Course Content

a. Curriculum Description

The curriculum described here is intended to enable allied dental personnel in the performance of one new duty:

- Place "Interim Therapeutic Restorations" (ITR) when directed to do so by a collaborating dentist.

It should be noted that the American Academy of Pediatric Dentistry Policy on Interim Therapeutic Restorations (ITR) describes the technique as follows: "The ITR procedure involves removal of caries using hand or slow speed rotary instruments with caution not to expose the pulp." In this DWPP project we will instruct trainees to perform this procedure using hand instruments without the use of slow speed rotary instruments.

All these licensed professionals already have training and experience and are allowed to take radiographs and photographs, chart intraoral conditions, perform intraoral procedures, and place dental sealants. Instruction for these duties will involve lecture, laboratory and clinical instruction at Capitol Dental care. The training will incorporate the rationale and techniques necessary for the new duty. This will be followed by the utilization and monitoring phase for the duration of the project.

C. A description of the methodology utilized in the didactic and clinical phases.

Training in the new duties listed above will take place in a three-day training program. The schedule and topics to be covered are:

- Day One AM
    a. Overview of the DWPP
    b. Program schedule and requirements
    c. Review of legal and regulatory framework for the DWPP
    d. Description of training and utilization phases of the program
    e. Trainee responsibilities
- Day One PM
    a. Interim Therapeutic Restorations (ITR)
    b. Review of American Association of Pediatric Dentistry's Policy on Interim Therapeutic Restorations

Extract Pages
Training Dental Hygienists to place Interim Therapeutic Restorations
Application for Dental Pilot Projects Program SB 738

c. Lecture instruction on the rationale, indications, and techniques for placement of an ITR.
d. Laboratory demonstration and guided practice on placement of ITRs on typodonts.
e. Independent placement of ITRs on typodonts with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.

- Day Two
    a. Review of rationale, indications, and techniques for placement of an ITR and preparation for clinical procedures.
    b. Clinic instruction and examination
    c. Trainee placement of ITRs with instructor coaching and supervision
    d. Trainee independent placement of ITRs with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.
- Day Three
    a. Continue clinic instruction and examination

This curriculum has been successfully applied and evaluated in comparable dental pilot project demonstrations conducted by UoP in California.

D. Description of Trainee Evaluation

The course structure and trainee evaluation are based on the fact that all these licensed professionals already have training and experience and are allowed to take radiographs and photographs, chart intraoral conditions, perform intraoral procedures, and place dental sealants. Therefore the new duties are relatively minor extensions of the current scope of practice of these EPDHs.

ITR placement:

During the ITR training, trainees will practice placing 10 ITRs (a mixture of Class I, II, III and V restorations) on typodonts. The three instructors will provide feedback and coaching to the trainees during the practical training experience. Trainees will then complete another 10 ITRs independently. The instructors will evaluate all 10 of the trainee's ITRs using an ITR Evaluation Score Sheet. The score sheet evaluates whether the margins were sealed, if the restoration is too high, and if the material was confined to the cavity. Each of these characteristics will be assessed as either acceptable or unacceptable. A trainee is certified as completing the training when he or she has independently completed at least 5 satisfactory ITRs in a row.

Following the didactic and laboratory training program, trainees will place ITRs on patients in the clinic. Trainees will place 5 ITRs with instructor coaching and feedback. Trainees will then complete up to another 10 ITRs independently. The instructors will evaluate all of the trainee's ITRs using an ITR Evaluation Score Sheet. The score sheet evaluates whether the margins were sealed, if the restoration is too high, and if the material was confined to the cavity. Each of these characteristics will be assessed as either acceptable or unacceptable. A trainee is certified as completing the training when he or she has independently completed at least 5 satisfactory ITRs in a row.

Once trainees complete the clinical phase, they will enter the utilization/monitoring phase of the project where they will continue to have ITRs they place monitored by instructors via periodic in-person evaluation and a review of photographs and radiographs for all ITRs placed.

Course Completion:
Any trainee who has not achieved competency in the new procedure during the three-day instruction period described above will receive additional training and evaluation until they do.

E. Identification of Time Required to Complete Course

Time required to complete the didactic and clinical phases of training is a minimum of three days.

Colorado Course Requirements – Interim Therapeutic Restorations

Colorado Dental Practice Act: See https://dpo.colorado.gov/Dental/Laws
Interim Therapeutic Restoration, Colorado Revised Statues 12-220-104

- Colorado passed legislation in 2016 authorizing dental hygienists to place interim therapeutic restorations. Revised 2021. Previously under a sunset statute, now permanent.

Code of Colorado Regulations
Secretary of State
State of Colorado

DEPARTMENT OF REGULATORY AGENCIES

Colorado Dental Board

DENTISTS & DENTAL HYGIENISTS RULES AND REGULATIONS

https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=9529

1.25 Placement of Interim Therapeutic Restorations by Dental Hygienists

B. In order to be eligible for a permit to place an ITR, a dental hygienist must:

1. Hold a license in good standing to practice dental hygiene in Colorado;

2. Complete a course developed at the post-secondary education level offered under the direct supervision of a member of the faculty of a Colorado dental or dental hygiene school accredited by the Commission on Dental Accreditation (CODA) or its successor agency that complies with the following uniform training standards:

a. Four hours of didactic instruction, including but not limited to:

(1) Pulpal anatomy;

(2) Principles of adhesive restorative materials;

(3) Preparation of the tooth and placement techniques;

(4) Diagnostic criteria for interim therapeutic restorations;

(5) Evaluation of proper placement and technique; and

(6) Protocols for handling sensitivity, complications, or unsuccessful completion and follow-up;

b. Four hours of laboratory instruction that includes placement of interim therapeutic restorations on typodont teeth;

c. Criteria for evaluating competency through placement of interim therapeutic restorations on a minimum of four teeth under direct supervision of faculty; and

d. Clinical evaluations of students must be performed by a dentist with a faculty appointment at an accredited Colorado dental or dental hygiene school.

California Course Requirements – Interim Therapeutic Restorations

DENTAL HYGIENE BOARD OF CALIFORNIA
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TITLE 16. DENTAL HYGIENE BOARD OF CALIFORNIA - DEPARTMENT OF CONSUMER AFFAIRS PROPOSED LANGUAGE

Adopt Section 1109 of Title 16 of the California Code of Regulations (CCR) to read as follows:

Proposed Language for 16 CCR 1109 (ca.gov)

(2) DHEP ITR Course Requirements.

(A) A California DHEP shall submit to the Board an "Application for Approval of a Course for Interim Therapeutic Restorations in a Dental Hygiene Educational Program" DHBC ITR-03 (New 01/19), hereby incorporated by reference; and

(B) Submit a $300 application fee to the Board; and

(C)The course shall be sufficient in length for the students to develop competency in placement of protective restorations but shall be, at a minimum, sixteen (16) hours in length, including four (4) hours of didactic training, four (4) hours of laboratory training, and eight (8) hours of clinical training.

(D)New or already approved DHEPs seeking to incorporate or offer a standalone permit course in ITR shall submit to the Board an "Application for Approval of a Course for Interim Therapeutic Restorations in a Dental Hygiene Educational Program," DHBC ITR-03 (New 01/19) and a $300 application fee prior to instruction

Dental Pilot Project #200
Education/Training Requirements – Interim Therapeutic Restorations

Extracted from Application for Dental Pilot Projects Program, "Training Dental Hygienists to place Interim Therapeutic Restorations"

C. A description of the methodology utilized in the didactic and clinical phases.
Training in the new duties listed above will take place in a three-day training program. The schedule and topics to be covered are:

- Day One AM
    a. Overview of the DWPP
    b. Program schedule and requirements
    c. Review of legal and regulatory framework for the DWPP
    d. Description of training and utilization phases of the program
    e. Trainee responsibilities
- Day One PM
    a. Interim Therapeutic Restorations (ITR)
    b. Review of American Association of Pediatric Dentistry's Policy on Interim Therapeutic Restorations

    c. Lecture instruction on the rationale, indications, and techniques for placement of an ITR.
    d. Laboratory demonstration and guided practice on placement of ITRs on typodonts.
    e. Independent placement of ITRs on typodonts with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.
- Day Two
    a. Review of rationale, indications, and techniques for placement of an ITR and preparation for clinical procedures.
    b. Clinic instruction and examination
    c. Trainee placement of ITRs with instructor coaching and supervision
    d. Trainee independent placement of ITRs with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.
- Day Three
    a. Continue clinic instruction and examination

E. Identification of Time Required to Complete Course
Time required to complete the didactic and clinical phases of training is a minimum of three days.

Oregon
Kate Brown, Governor

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

PLACE: **VIRTUAL VIA ZOOM**
DATE: **July 28, 2021**
TIME: **10:00 a.m. – 11:00 a.m.**

Attendees:
OBD - Board President Alicia Riedman, RDH, EPP, Stephen Prisby, Haley Robinson, Ingrid Nye, Samantha VandeBerg & Sr. AAG Lori Lindley

OHA/OHSU – Jo Bell, Linda Mann, Eli Schwarz, Richie Kohli, Leah Brandis, Sarah Kowalski, & Amy Umphlett

Zoom Meeting:
https://us02web.zoom.us/j/81873677116?pwd=bjI1SlM0a1dLaFU3bG5xSCtvQ2ZCZz09
#1-253-215-8782, Meeting ID: 818 7367 7116, Passcode: 976310

Due to the passage of HB 2627 (2021), OBD Staff have reached out to the OHA to discuss interim therapeutic restorations. The OBD will need to amend rules for dental hygiene, to incorporate reference to interim therapeutic restorations and education requirements as well.

The OHA has experience with Dental Pilot Project #200, and the OBD would like to enlist their experience to help inform the OBD on rules and education requirements regarding interim therapeutic restorations.

Besides updating the relevant DH EPP Rules the Board as directed by HB 2627 must:

- Approve applications from oral health care education providers for training courses that meet the requirements established in rules adopted by the board establishing educational and instructional requirements for interim therapeutic restoration to be performed by an expanded practice dental hygienist.
- An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).

The OBD's Rules Oversight Committee met on June 18, 2021. The Committee directed OBD Staff to bring proposed amended rules to the August 20, 2021 Board meeting for consideration to go forward to public rulemaking hearing(s).

Draft OAR 818-035-0010 – Attached

Draft OAR 818-035-0065 – Attached

Draft OAR 818-035-0100 - Attached

ITR Curriculum – Attached

OHSU ITR Training Manual - Attached

HB 2627 (2021) – Attached

818-035-0010
Definitions

All terms used in this Division shall have the meanings assigned under ORS 679.010 except that:

(1) "Limited Access Patient" means a patient who is unable to receive regular dental hygiene treatment in a dental office.

(2) "Long-Term Care Facility" shall have the same definition as that established under ORS 442.015(14)(b).

(3) When performed by an Expanded Practice Dental Hygienist with a Collaborative Agreement in accordance with OAR 818-035-0065 (5):

(a) “Temporary Restoration” means a restoration placed for a shorter time interval for use while definitive restoration is being fabricated or placed in the future.

(b) “Atraumatic/Alternative Restorative Techniques” means restoring and preventing caries in limited access patients and as a community measure to control caries in large numbers of the population.

(c) “Interim Therapeutic Restoration” means a direct provisional restoration placed to temporarily stabilize a tooth until a dentist subsequently diagnoses the need for further definitive treatment, and that:

(A) Consists of the removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material; and

(B) Does not require the administration of local anesthesia.

818-035-0025

Prohibitions

A dental hygienist may not:

(1) Diagnose and treatment plan other than for dental hygiene services;

(2) Cut hard or soft tissue with the exception of root planing, **except as provided in OAR 818-035-0065**;

(3) Extract any tooth;

(4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);

(5) Prescribe, administer or dispense any drugs except as provided by OAR 818-035-0030, 818-035-0040, 818-026-0060(11) and 818-026-0070(11);

(6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;

(7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;

(8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.

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

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

818-035-0065
Expanded Practice Dental Hygiene Permit
The Board shall issue an Expanded Practice Permit to a Dental Hygienist who holds an unrestricted Oregon license, and completes an application approved by the Board, pays the permit fee, and
(1) Certifies on the application that the dental hygienist has completed at least 2,500 hours of supervised dental hygiene clinical practice, or clinical teaching hours, and also completes 40 hours of courses chosen by the applicant in clinical dental hygiene or public health sponsored by continuing education providers approved by the Board; or
(2) Certifies on the application that the dental hygienist has completed a course of study, before or after graduation from a dental hygiene program, that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205; and
(3) Provides the Board with a copy of the applicant's current professional liability policy or declaration page which will include, the policy number and expiration date of the policy.
(4) Notwithstanding OAR 818-035-0025(1), prior to performing any dental hygiene services an Expanded Practice Dental Hygienist shall examine the patient, gather data, interpret the data to determine the patient's dental hygiene treatment needs and formulate a patient care plan.
(5) An Expanded Practice Dental Hygienist may render the services described in paragraphs **(6),** (~~6~~**7**)(a) to ~~(d)~~ **(e)** of this rule to the patients described in ORS 680.205(1) if the Expanded Practice Dental Hygienist has entered into a written collaborative agreement in a format approved by the Board with a dentist licensed under ORS Chapter 679.
(6) Upon completion of a Board-approved curriculum, an Expanded Practice Permit Dental Hygienist may perform interim therapeutic restorations as allowed by ORS 680.205..
~~(6)~~ **(7)** The collaborative agreement must set forth the agreed upon scope of the dental hygienist's practice with regard to:
(a) Administering local anesthesia;
(b) Administering temporary restorations **with or** without excavation;
(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs; and
(d) Performing interim therapeutic restorations after diagnosis by a dentist; and
(e) Referral parameters.
~~(7)~~ **(8)**The collaborative agreement must comply with ORS 679.010 to 680.990.
~~(8) From the date this rule is effective, the Board has the authority to grant a Limited Access Permit through December 31, 2011, pursuant to ORS 680.200.~~

818-035-0100
Record Keeping

(1) An Expanded Practice Dental Hygienist shall refer a patient annually to a dentist who is available to treat the patient, and note in the patient's official chart held by the facility that the patient has been referred.

(2) When a licensed dentist has authorized an Expanded Practice Dental Hygienist to administer local anesthesia, place temporary restorations without excavation, **perform interim therapeutic restorations with or without excavation after diagnosis by a dentist,** or prescribe prophylactic antibiotics and nonsteroidal anti-inflammatory drugs, the Expanded Practice Dental Hygienist shall document in the patient's official chart the name of the collaborating dentist and date the collaborative agreement was entered into.

School of Dentistry

Interim Therapeutic Restoration (ITR) Training Manual

Oregon Dental Pilot Project #200

Table of Contents

Didactic

Both the expanded practice dental hygienist (EPDH) and dentist must complete all didactic work prior to the in-person training. The online course includes 6 modules will take approximately 1-1.5 hours to complete. The coursework is sequential and builds directly on previous coursework, prior to beginning the independent lab work described below.

Modules

1. Oregon Governing Legislation and Policy
    - Senate Bills 738 and 786
    - Oregon Administrative Rules
2. The Science of Partial Caries Removal
3. ITR Placement Criteria
4. ITR Placement Techniques
    - Glass Ionomer Overview
    - Glass Ionomer Characteristics and Materials
    - ITR placement and technique
5. Preparation for pre-in-person session laboratory work
6. ITR Tracking and Follow-Up
    - Evaluation and Tracking
    - Follow-up
    - Adverse Outcomes Protocols

After completing didactic modules 2-6, EPDHs should complete the accompanied quizzes with a score of 75% or higher.

Independent Lab Work

Following the instructions on *ITR Placement Techniques*, the EPDH should practice placing ITRs on 5 -10 prepared teeth prior to attending the in-person training.

The purpose of the independent pre-in-person session lab work is to familiarize the EPDH with characteristics and techniques for using glass-ionomer restorative materials.

Placement Practice
Each dyad (EPDH and dentist) will be responsible for obtaining equipment for and completing assigned lab work prior to attending the in-person program section (see Appendix B: Equipment List).

Using instructions in the didactic portion of this program, the dentist will prepare or purchase 5-10 teeth on a typodont that meet qualifications for placing an ITR. ITR tooth acceptability can be found in *Module 3: ITR Placement Criteria*. Make sure to prep a mixture of Class I lesions on various surfaces as well as Class V lesions. This will allow the EPDH to practice placing ITRs on a variety of teeth.

With guided assistance from the collaborating Dentist, the EPDH should place a minimum of five ITRs on the typodont. It is suggested that the EPDH place additional ITRs if they are able, in order to become familiar and comfortable with manipulating the material prior to performing this procedure on patients.

ITR Evaluation
Using the form in Appendix A, the Dentist should evaluate each ITR based on the following three criteria. Each criterion is rated as acceptable or unacceptable:

1. Margins are sealed
2. Occlusion is in light contact or not in contact
3. Minimal excess material

An ITR is considered acceptable if the material is not in hyper---occlusion, if there are no marginal voids, and there is minimal excess material.

The dentist will review the ITRs according to the checklist and protocols outlined in the didactic portion of the program, and evaluate the ITR placement based on the provided criteria.
The dentist should document the evaluation of each ITR on the Evaluation Form in Appendix A.

The EPDH will bring the typodont with completed restorations and scoring sheet completed by the collaborating dentist to the in-person session for review.

In-person Training Day

Purpose
The in-person clinical portion of the program will allow both the EPDH and dentist to receive additional instruction and practice what they learned with experienced ITR placement faculty and mentors.

Agenda

Time	Agenda
9:00 – 9:30	Review of typodont placements
9:30 – 10:00	Prep for patients
10:00 – 1:30	Clinical Training
1:30 – 2:00	Technique Critique and Self-Evaluation
2:00 – 2:15	Conclusion and Next steps

Clinical Training Requirements
- Each EPDH will place 5 ITRs on patients under guided supervision
- Each placement will be reviewed by a dentist (See Appendix A. ITR Evaluation Form).
- Any placements evaluated as not acceptable will be redone

Materials to Bring
- Typodonts with completed ITRs
- Fuji GC Capsule applicator

Additional Practice
Following the in-person training, the EPDH may be required to place additional ITRs independently.

For each placement, EPDHs must submit the following documents:
- A completed consent form
- A completed ITR Evaluation Form (see Appendix A)
- X-rays
- Three photographic images:
  1) pre-op (prior to any treatment)
  2) the tooth after the cavity has been cleaned and prepared for restoration)
  3) post-op (after completion. The post-op photograph should show occlusal contacts using articulating paper.

Appendices
A. ITR Evaluation Form
B. Equipment list

Interim Therapeutic Restorations Evaluation of Scoring Sheet
Training Type: _____ Laboratory _____ Clinical

Location: _____ Date: _____

EPDH Name: _____

Supervising Dentist Name/Signature: _____

Faculty Name/Signature:

Restoration #1: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #2: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #3: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #4: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				
Restoration #5: Patient Name #: _____Tooth #: ____Surface : ____				
Criteria	Not Acceptable	Acceptable	Clinic DDS Initials	DDS Initials
Occlusion (in light contact or not in contact)				
Margins (sealed)				
Material (minimal excess material)				

Equipment List

The following equipment list itemizes tools and equipment necessary to complete the ITR training.

Item

Typodont – with full set of teeth (pre-drilled or drilled by dentist)
Curing Light
Amalgamator
Articulating Paper
Fuji II LC Capsules – any color
GC Cavity Conditioner
Fuji GC Capsule applicator
Set of instruments

- ½ Hollenbeck
- Small excavator
- Small cleoid discoid carver
- Articulating Paper Forceps

Disposable materials:

- Cotton pellet
- Cotton tipped applicator
- Gloves
- Vaseline
- Fendermate or Wizard Wedge
- Oral Birchwood Assorted

8. Curriculum

A. Trainee Minimum Level of Competence

All trainees will hold current Oregon licenses as EPDHs. All trainees will have completed training during their educational programs or have a certificate of completion of a course in Radiation Safety and in placement of Pit and Fissure Sealants. All trainees will have at least one year experience working in community sites or programs. Training will take place at Capitol Dental Care and include lecture laboratory, and clinical instruction. Completion of the initial training will be based on a "Mastery-Level" summative evaluation meaning that trainees will be certified by the instructors as having mastered the instructional materials. **See "Description of Trainee Evaluation Process" in sections B, C, and D below.**

B. Description of Course Content

a. Curriculum Description

The curriculum described here is intended to enable allied dental personnel in the performance of one new duty:

- Place "Interim Therapeutic Restorations" (ITR) when directed to do so by a collaborating dentist.

It should be noted that the American Academy of Pediatric Dentistry Policy on Interim Therapeutic Restorations (ITR) describes the technique as follows: "The ITR procedure involves removal of caries using hand or slow speed rotary instruments with caution not to expose the pulp." In this DWPP project we will instruct trainees to perform this procedure using hand instruments without the use of slow speed rotary instruments.

All these licensed professionals already have training and experience and are allowed to take radiographs and photographs, chart intraoral conditions, perform intraoral procedures, and place dental sealants. Instruction for these duties will involve lecture, laboratory and clinical instruction at Capitol Dental care. The training will incorporate the rationale and techniques necessary for the new duty. This will be followed by the utilization and monitoring phase for the duration of the project.

C. A description of the methodology utilized in the didactic and clinical phases.

Training in the new duties listed above will take place in a three-day training program. The schedule and topics to be covered are:

- Day One AM
    a. Overview of the DWPP
    b. Program schedule and requirements
    c. Review of legal and regulatory framework for the DWPP
    d. Description of training and utilization phases of the program
    e. Trainee responsibilities
- Day One PM
    a. Interim Therapeutic Restorations (ITR)
    b. Review of American Association of Pediatric Dentistry's Policy on Interim Therapeutic Restorations

c. Lecture instruction on the rationale, indications, and techniques for placement of an ITR.
d. Laboratory demonstration and guided practice on placement of ITRs on typodonts.
e. Independent placement of ITRs on typodonts with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.

- Day Two
    a. Review of rationale, indications, and techniques for placement of an ITR and preparation for clinical procedures.
    b. Clinic instruction and examination
    c. Trainee placement of ITRs with instructor coaching and supervision
    d. Trainee independent placement of ITRs with instructor evaluation of performance until student's master placement based on criteria for acceptable performance.
- Day Three
    a. Continue clinic instruction and examination

This curriculum has been successfully applied and evaluated in comparable dental pilot project demonstrations conducted by UoP in California.

D. Description of Trainee Evaluation

The course structure and trainee evaluation are based on the fact that all these licensed professionals already have training and experience and are allowed to take radiographs and photographs, chart intraoral conditions, perform intraoral procedures, and place dental sealants. Therefore the new duties are relatively minor extensions of the current scope of practice of these EPDHs.

ITR placement:

During the ITR training, trainees will practice placing 10 ITRs (a mixture of Class I, II, III and V restorations) on typodonts. The three instructors will provide feedback and coaching to the trainees during the practical training experience. Trainees will then complete another 10 ITRs independently. The instructors will evaluate all 10 of the trainee's ITRs using an ITR Evaluation Score Sheet. The score sheet evaluates whether the margins were sealed, if the restoration is too high, and if the material was confined to the cavity. Each of these characteristics will be assessed as either acceptable or unacceptable. A trainee is certified as completing the training when he or she has independently completed at least 5 satisfactory ITRs in a row.

Following the didactic and laboratory training program, trainees will place ITRs on patients in the clinic. Trainees will place 5 ITRs with instructor coaching and feedback. Trainees will then complete up to another 10 ITRs independently. The instructors will evaluate all of the trainee's ITRs using an ITR Evaluation Score Sheet. The score sheet evaluates whether the margins were sealed, if the restoration is too high, and if the material was confined to the cavity. Each of these characteristics will be assessed as either acceptable or unacceptable. A trainee is certified as completing the training when he or she has independently completed at least 5 satisfactory ITRs in a row.

Once trainees complete the clinical phase, they will enter the utilization/monitoring phase of the project where they will continue to have ITRs they place monitored by instructors via periodic in-person evaluation and a review of photographs and radiographs for all ITRs placed.

Course Completion:
Any trainee who has not achieved competency in the new procedure during the three-day instruction period described above will receive additional training and evaluation until they do.

E. Identification of Time Required to Complete Course

Time required to complete the didactic and clinical phases of training is a minimum of three days.

Enrolled
House Bill 2627

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

CHAPTER .....

AN ACT

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

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

SECTION 1. ORS 680.205 is amended to read:

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

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

(A) Nursing homes as defined in ORS 678.710;

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

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

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

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

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

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

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

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

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

(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by naturopathic physicians, nurse practitioners, physician assistants or midwives.

(e) Patients whose income is less than the federal poverty level.

(f) Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

(2) Unless different criteria for referral of a patient or resident to a dentist are included in an agreement described in subsection (3) of this section, at least once each calendar year, an expanded practice dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) An expanded practice dental hygienist may render the services described in paragraphs (a) to [*(d)*] **(e)** of this subsection to the patients described in subsection (1) of this section if the expanded practice dental hygienist has entered into an agreement in a format approved by the board with a dentist licensed under ORS chapter 679. The agreement must set forth the agreed-upon scope of the dental hygienist's practice with regard to:

(a) Administering local anesthesia;

(b) Administering temporary restorations **with or** without excavation;

(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; [*and*]

(d) Performing interim therapeutic restoration after diagnosis by a dentist; and

[*(d)*] **(e)** Referral parameters.

(4) This section does not authorize an expanded practice dental hygienist to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(5) An expanded practice dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients.

(6) An expanded practice dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

(7) As used in this section and section 4 of this 2021 Act, "interim therapeutic restoration" means a direct provisional restoration placed to temporarily stabilize a tooth until a dentist subsequently diagnoses the need for further definitive treatment, and that:

(a) Consists of the removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material; and

(b) Does not require the administration of local anesthesia.

SECTION 2. The amendments to ORS 680.205 by section 1 of this 2021 Act apply to agreements described in ORS 680.205 that are entered into or renewed on or after the operative date specified in section 6 of this 2021 Act.

SECTION 3. (1) Not later than January 1, 2022, the Oregon Board of Dentistry shall adopt rules to establish educational and instructional requirements for interim therapeutic restoration to be performed by an expanded practice dental hygienist under ORS 680.205. In establishing these requirements, the board shall use the curriculum, competency-based training protocols and learning outcomes established by the Dental Health Workforce Pilot Project No. 200 through the dental pilot project program of the Oregon Health Authority.

(2) Expanded practice dental hygienists performing interim therapeutic restorations under the dental pilot project program of the Oregon Health Authority as of the effective date of this 2021 Act may continue performing interim therapeutic restorations until the rules established by the board take effect.

SECTION 4. (1) The Oregon Board of Dentistry shall approve applications from oral health care education providers for training courses that meet the requirements established in rules adopted by the board establishing educational and instructional requirements for interim therapeutic restoration to be performed by an expanded practice dental hygienist.

(2) An expanded practice dental hygienist must successfully complete a training course approved by the board under this section before performing interim therapeutic restorations under ORS 680.205 (3)(d).

(3) Notwithstanding subsection (2) of this section, an expanded practice dental hygienist who is operating within the Dental Health Workforce Pilot Project No. 200 through the dental pilot project program of the Oregon Health Authority as of the effective date of this

2021 Act, and who has completed training to perform interim therapeutic restorations, is exempt from completing training under subsection (2) of this section.

SECTION 5. Section 4 of this 2021 Act is added to and made a part of ORS chapter 680.

SECTION 6. (1) Section 4 of this 2021 Act and the amendments to ORS 680.205 by section 1 of this 2021 Act become operative on January 1, 2022.

(2) The Oregon Board of Dentistry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the 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 board by section 4 of this 2021 Act and the amendments to ORS 680.205 by section 1 of this 2021 Act.

SECTION 7. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.

Passed by House April 10, 2021

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 12, 2021

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

.....
Shemia Fagan, Secretary of State

Enrolled
House Bill 2078

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown)

CHAPTER .....

AN ACT

Relating to health; creating new provisions; amending ORS 243.105, 413.310, 413.572, 413.590, 441.223, 459A.200, 675.110, 677.228, 677.510, 678.101, 684.092, 685.102, 685.106 and 689.285; and repealing ORS 441.224, 441.226, 441.228, 441.229, 441.232 and 441.233.

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

ELECTRONIC CREDENTIALING INFORMATION PROGRAM REPEALED

SECTION 1. ORS 441.224, 441.226, 441.228, 441.229, 441.232 and 441.233 are repealed.

PAIN MANAGEMENT EDUCATION

SECTION 2. ORS 413.572 is amended to read:

413.572. (1) The Pain Management Commission shall:

(a) Develop a pain management education program curriculum **for a one-hour training** and update it biennially.

(b) Provide health professional regulatory boards and other health boards, committees or task forces with the curriculum.

(c) Work with health professional regulatory boards and other health boards, committees or task forces to develop approved pain management education programs as required.

[*(d) Review the pain management curricula of educational institutions in this state that provide post-secondary education or training for persons required by ORS 413.590 to complete a pain management education program. The commission shall make recommendations about legislation needed to ensure that adequate information about pain management is included in the curricula reviewed and shall report its findings to the Legislative Assembly in the manner required by ORS 192.245 by January 1 of each odd-numbered year.*]

[*(2) As used in this section, "educational institution" has the meaning given that term in ORS 348.105.*]

(2) The curriculum must take into account the needs of Oregon Tribal communities, communities of color and other groups who have been disproportionately affected by adverse social determinants of health, such as racism, trauma, adverse childhood experiences and other factors that influence how an individual experiences chronic pain.

SECTION 3. ORS 413.590 is amended to read:

413.590. (1) [*An approved*] **The following practitioners must complete a** pain management education program described in ORS 413.572 (1)(c) or an equivalent pain management education program as described in ORS 675.110, 677.228, 677.510, 678.101, 684.092, 685.102 or 689.285 [*must be completed by*] **at initial licensure and every 36 months thereafter**:

(a) A physician assistant licensed under ORS chapter 677;

(b) A nurse licensed under ORS chapter 678;

(c) A psychologist licensed under ORS 675.010 to 675.150;

(d) A chiropractic physician licensed under ORS chapter 684;

(e) A naturopath licensed under ORS chapter 685;

(f) An acupuncturist licensed under ORS 677.759;

(g) A pharmacist licensed under ORS chapter 689;

(h) A dentist licensed under ORS chapter 679;

(i) An occupational therapist licensed under ORS 675.210 to 675.340;

(j) A physical therapist licensed under ORS 688.010 to 688.201; and

(k) An optometrist licensed under ORS chapter 683.

(2) The Oregon Medical Board, in consultation with the Pain Management Commission, shall identify by rule physicians licensed under ORS chapter 677 who, on an ongoing basis, treat patients in chronic or terminal pain and who must complete [*one*] **a** pain management education program [*established under*] **described in** ORS 413.572. The board may identify by rule circumstances under which a requirement under this section may be waived.

SECTION 4. ORS 675.110 is amended to read:

675.110. In addition to the powers otherwise granted under ORS 675.010 to 675.150, the Oregon Board of Psychology has all powers necessary or proper to:

(1) Determine qualifications of applicants to practice psychology in this state, prepare, conduct and grade examinations and license qualified applicants who comply with the provisions of ORS 675.010 to 675.150 and the rules of the board.

(2) Grant or deny renewal of licenses and renew licenses that have lapsed for nonpayment of the renewal fee, subject to the provisions of ORS 675.010 to 675.150.

(3) Suspend or revoke licenses, subject to ORS 675.010 to 675.150.

(4) Issue letters of reprimand and impose probationary periods with the authority to restrict the scope of practice of a licensed psychologist or to require practice under supervision.

(5) Impose civil penalties as provided in ORS 675.070.

(6) Restore licenses that have been suspended or revoked or voided by nonpayment of the renewal fee.

(7) Collect fees for application, examination and licensing of applicants, for renewal of licenses and for issuance of limited permits and use the fees to defray the expenses of the board as provided in ORS 675.140.

(8) Collect a delinquent renewal fee for licenses renewed after the deadline for renewal but before the grace period for renewal has expired.

(9) Investigate alleged violations of ORS 675.010 to 675.150.

(10) Issue subpoenas for the attendance of witnesses, take testimony, administer oaths or affirmations to witnesses, conduct hearings and require the production of relevant documents in all proceedings pertaining to the duties and powers of the board.

(11) Enforce ORS 675.010 to 675.150 and exercise general supervision over the practice of psychology in this state.

(12) Adopt a common seal.

(13) Formulate a code of professional conduct for the practice of psychology giving particular consideration to the Ethical Standards of Psychologists promulgated by the American Psychological Association.

(14) Establish standards of service and training and educational qualifications for rendering ethical psychological services in this state, including the formulation of standards for the issuance of licenses for areas of special competence.

(15) Formulate and enforce continuing education requirements for duly licensed psychologists to ensure the highest quality of professional services to the public.

(16) Deny renewal of a license, or renewal of a license that has lapsed for nonpayment of the renewal fee, unless the applicant completes, or provides documentation of [*previous*] completion **within the previous 36 months** of:

(a) A **one-hour** pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(b) An equivalent pain management education program, as determined by the board.

(17) For the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, require the fingerprints of a person who is:

(a) Applying for a license that is issued by the board;

(b) Applying for renewal of a license that is issued by the board; or

(c) Under investigation by the board.

(18) Prescribe, in consultation with the Oregon Board of Licensed Professional Counselors and Therapists, the duties of the Director of the Mental Health Regulatory Agency.

(19) Subject to the applicable provisions of ORS chapter 183, adopt reasonable rules to carry out the provisions of ORS 675.010 to 675.150.

SECTION 5. ORS 677.228 is amended to read:

677.228. (1) A person's license to practice under this chapter automatically lapses if the licensee fails to:

(a) Pay the registration fee as required by rule of the Oregon Medical Board.

(b) Notify the board of a change of location not later than the 30th day after such change.

(c) Complete prior to payment of the registration fee described in paragraph (a) of this subsection, or provide documentation of previous completion of, if required by rule of the board:

(A) A **one-hour** pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(B) An equivalent pain management education program, as determined by the board.

(2) If a license issued automatically lapses under this section, the holder of the license shall not practice until the conditions for which the license automatically lapsed no longer exist.

(3) A person whose license has automatically lapsed under subsection (1)(a) of this section is reinstated automatically when the licensee pays the registration fee plus all late fees then due.

(4) A person whose license has automatically lapsed under subsection (1)(b) of this section is reinstated automatically if the board receives notification of the current and correct address of the licensee not later than the 10th day after such automatic lapse takes effect. Otherwise the lapse continues until terminated by the board.

(5) A person whose license has automatically lapsed under subsection (1)(c) of this section is reinstated automatically when the board receives documentation of the person's completion of a pain management education program if required by subsection (1)(c) of this section.

SECTION 6. ORS 677.510 is amended to read:

677.510. (1) A person licensed to practice medicine under this chapter may not use the services of a physician assistant without the prior approval of the Oregon Medical Board.

(2) A supervising physician or a supervising physician organization may apply to the board to use the services of a physician assistant. The application must:

(a) If the applicant is not a supervising physician organization, state the name and contact information of the supervising physician;

(b) If the applicant is a supervising physician organization:

(A) State the names and contact information of all supervising physicians; and

(B) State the name of the primary supervising physician required by subsection (5) of this section;

(c) Generally describe the medical services provided by each supervising physician;

(d) Contain a statement acknowledging that each supervising physician has reviewed statutes and rules relating to the practice of physician assistants and the role of a supervising physician; and

(e) Provide such other information in such a form as the board may require.

(3) The board shall approve or reject an application within seven working days after the board receives the application, unless the board is conducting an investigation of the supervising physician or of any of the supervising physicians in a supervising physician organization applying to use the services of a physician assistant.

(4) A supervising physician organization shall provide the board with a list of the supervising physicians in the supervising physician organization. The supervising physician organization shall continually update the list and notify the board of any changes.

(5) A supervising physician organization shall designate a primary supervising physician and notify the board in the manner prescribed by the board.

(6)(a) A physician assistant may not practice medicine until the physician assistant enters into a practice agreement with a supervising physician or supervising physician organization whose application has been approved under subsection (3) of this section. The practice agreement must:

(A) Include the name, contact information and license number of the physician assistant and each supervising physician.

(B) Describe the degree and methods of supervision that the supervising physician or supervising physician organization will use. The degree of supervision, whether general, direct or personal, must be based on the level of competency of the physician assistant as judged by the supervising physician.

(C) Generally describe the medical duties delegated to the physician assistant.

(D) Describe the services or procedures common to the practice or specialty that the physician assistant is not permitted to perform.

(E) Describe the prescriptive and medication administration privileges that the physician assistant will exercise.

(F) Provide the list of settings and licensed facilities in which the physician assistant will provide services.

(G) State that the physician assistant and each supervising physician is in full compliance with the laws and regulations governing the practice of medicine by physician assistants, supervising physicians and supervising physician organizations and acknowledge that violation of laws or regulations governing the practice of medicine may subject the physician assistant and supervising physician or supervising physician organization to discipline.

(H) Be signed by the supervising physician or the primary supervising physician of the supervising physician organization and by the physician assistant.

(I) Be updated at least every two years.

(b) The supervising physician or supervising physician organization shall provide the board with a copy of the practice agreement within 10 days after the physician assistant begins practice with the supervising physician or supervising physician organization. The supervising physician or supervising physician organization shall keep a copy of the practice agreement at the practice location and make a copy of the practice agreement available to the board on request. The practice agreement is not subject to board approval, but the board may request a meeting with a supervising physician or supervising physician organization and a physician assistant to discuss a practice agreement.

(7) A physician assistant's supervising physician shall ensure that the physician assistant is competent to perform all duties delegated to the physician assistant. The supervising physician or supervising physician organization and the physician assistant are responsible for ensuring the competent practice of the physician assistant.

(8) A supervising physician or the agent of a supervising physician must be competent to perform the duties delegated to the physician assistant by the supervising physician or by a supervising physician organization.

(9) The board may not require that a supervising physician be physically present at all times when the physician assistant is providing services, but may require that:

(a) The physician assistant have access to personal or telephone communication with a supervising physician when the physician assistant is providing services; and

(b) The proximity of a supervising physician and the methods and means of supervision be appropriate to the practice setting and the patient conditions treated in the practice setting.

(10)(a) A supervising physician organization may supervise any number of physician assistants. The board may not adopt rules limiting the number of physician assistants that a supervising physician organization may supervise.

(b) A physician assistant who is supervised by a supervising physician organization may be supervised by any of the supervising physicians in the supervising physician organization.

(11) If a physician assistant is not supervised by a supervising physician organization, the physician assistant may be supervised by no more than four supervising physicians, unless the board approves a request from the physician assistant, or from a supervising physician, for the physician assistant to be supervised by more than four supervising physicians.

(12) A supervising physician who is not acting as part of a supervising physician organization may supervise four physician assistants, unless the board approves a request from the supervising physician or from a physician assistant for the supervising physician to supervise more than four physician assistants.

(13) A supervising physician who is not acting as part of a supervising physician organization may designate a physician to serve as the agent of the supervising physician for a predetermined period of time.

(14) A physician assistant may render services in any setting included in the practice agreement.

(15) A physician assistant for whom an application under this section has been approved by the board on or after January 2, 2006, shall submit to the board, within 24 months after the approval **and every 36 months thereafter**, documentation of completion of:

(a) A **one-hour** pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(b) An equivalent pain management education program, as determined by the board.

SECTION 7. ORS 678.101 is amended to read:

678.101. (1) Every person licensed to practice nursing shall apply for renewal of the license other than a limited license in every second year before 12:01 a.m. on the anniversary of the birthdate of the person in the odd-numbered year for persons whose birth occurred in an odd-numbered year and in the even-numbered year for persons whose birth occurred in an even-numbered year. Persons whose birthdate anniversary falls on February 29 shall be treated as if the anniversary were March 1.

(2) Each application must be accompanied by a nonrefundable renewal fee payable to the Oregon State Board of Nursing.

(3) The board may not renew the license of a person licensed to practice nursing unless:

(a) The requirements of subsections (1) and (2) of this section are met; and

(b) Prior to payment of the renewal fee described in subsection (2) of this section the person completes, or provides documentation of [*previous*] completion **within the previous 36 months,** of:

(A) A **one-hour** pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(B) An equivalent pain management education program, as determined by the board.

(4) The license of any person not renewed for failure to comply with subsections (1) to (3) of this section is expired and the person shall be considered delinquent and is subject to any delinquent fee established under ORS 678.410.

(5) A registered nurse who has been issued a license as a nurse practitioner, clinical nurse specialist or certified registered nurse anesthetist shall apply as specified by the board by rule for

renewal of the license and for renewal of the prescriptive [*privileges*] **authority** in every second year before 12:01 a.m. on the anniversary of the birthdate, as determined for the person's license to practice nursing.

SECTION 8. ORS 684.092 is amended to read:

684.092. (1) Except as provided in subsection (3) of this section, a chiropractic physician submitting a fee under ORS 684.090 shall, at the same time, verify with satisfactory evidence the successful completion of approved continuing chiropractic education during the preceding 12-month period as provided in subsection (2) of this section and completion, or documentation of [*previous*] completion **within the previous 36 months**, of:

(a) A **one-hour** pain management education program approved by the State Board of Chiropractic Examiners and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(b) An equivalent pain management education program, as determined by the board.

(2) A chiropractic physician submitting a fee under ORS 684.090 shall verify completion during the previous 12-month period of:

(a) At least 20 hours of approved continuing chiropractic education, for a person actively practicing chiropractic.

(b) At least six hours of approved continuing chiropractic education, for an active senior.

(3) The State Board of Chiropractic Examiners may exempt a chiropractic physician from the requirements of subsection (1) of this section upon an application by the chiropractic physician showing by evidence satisfactory to the board that the chiropractic physician is unable to comply with the requirements because of unusual or extenuating circumstances or because no program has been approved by the board.

SECTION 9. ORS 685.102 is amended to read:

685.102. (1) Except as provided in subsections (2) and (5) of this section, each person holding a license under this chapter shall submit annually by December 31, evidence satisfactory to the Oregon Board of Naturopathic Medicine of successful completion of an approved program of continuing education of at least 25 hours in naturopathic medicine, completed in the calendar year preceding the date on which the evidence is submitted, and completion during the renewal period, or documentation of [*previous*] completion **within the previous 36 months**, of:

(a) A pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(b) An equivalent pain management education program, as determined by the board.

(2) The board may exempt any person holding a license under this chapter from the requirements of subsection (1) of this section upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, a person may not be exempted from the requirements of subsection (1) of this section more than once in any five-year period.

(3) Notwithstanding subsection (2) of this section, a person holding a license under this chapter may be exempted from the requirements of subsection (1) of this section upon application showing evidence satisfactory to the board that the applicant is or will be in the next calendar year at least 70 years of age and is retired or will retire in the next calendar year from the practice of naturopathic medicine.

(4) The board shall require licensees to obtain continuing education for the use of pharmacological substances for diagnostic, preventive and therapeutic purposes in order to maintain current licensure.

(5) A person whose license is in inactive status must submit by December 31 of each year evidence satisfactory to the board of completion of 10 hours of approved continuing education in the calendar year preceding the date on which the evidence is submitted.

(6) Notwithstanding subsections (1), (2) and (5) of this section, in the case of an applicant under ORS 685.100 (6)(b) for reactivation of an inactive license, the continuing education requirement for reactivation shall be set by rule of the board.

SECTION 10. ORS 685.106 is amended to read:

685.106. (1) The Oregon Board of Naturopathic Medicine may offer a program of continuing education in naturopathic medicine to meet the requirements of ORS 685.102. The board may also approve a program to be presented by persons reasonably qualified to do so.

(2) Any person seeking approval of a program of continuing education in naturopathic medicine, to be offered to assist persons holding licenses under this chapter to comply with the requirements of ORS 685.102 (1), shall submit to the board, at such time as the board may require, [*copies of courses of study*] **a copy of the program** to be offered and proof of such other qualifications as the board may require. Approval granted to any program of continuing education shall be reviewed periodically and approval may be withdrawn from any program that fails to meet the requirements of the board.

(3) Any program of continuing education in naturopathic medicine offered or approved under this section shall consist of study covering new, review, experimental, research and specialty subjects in the field of naturopathic medicine.

SECTION 11. ORS 689.285 is amended to read:

689.285. (1) The Legislative Assembly finds and declares that:

(a) The continuous introduction of new medical agents and the changing concepts of the delivery of health care services in the practice of pharmacy make it essential that a pharmacist undertake a continuing education program in order to maintain professional competency and improve professional skills;

(b) The state has a basic obligation to regulate and control the profession of pharmacy in order to protect the public health and welfare of its citizens; and

(c) It is the purpose of this chapter to protect the health and welfare of Oregon citizens and to ensure uniform qualifications and continued competency of licensed pharmacists by requiring participation in a continuing pharmacy education program as a condition for renewal of licenses to practice pharmacy.

(2) All pharmacists licensed in the State of Oregon on and after October 3, 1979, shall satisfactorily complete courses of study and satisfactorily continue their education by other means as determined by the State Board of Pharmacy in subjects relating to the practice of the profession of pharmacy in order to be eligible for renewal of licenses.

(3) In accordance with applicable provisions of ORS chapter 183, the board shall adopt reasonable rules:

(a) Prescribing the procedure and criteria for approval of continuing pharmacy education programs, including the number of hours of courses of study necessary to constitute a continuing pharmacy education unit and the number of continuing pharmacy education units required annually for renewal of a pharmacist license.

(b) Prescribing the scope of the examinations given by the board including grading procedures.

(c) Prescribing the content of the form to be submitted to the board certifying completion of an approved continuing pharmacy education program.

(d) Necessary to carry out the provisions of this chapter.

(e) Prescribing the completion**, at initial licensure and every 36 months thereafter,** of:

(A) A **one-hour** pain management education program approved by the board and developed [*in conjunction with*] **based on recommendations of** the Pain Management Commission [*established under ORS 413.570*]; or

(B) An equivalent pain management education program, as determined by the board.

(4) In adopting rules pursuant to subsection (3) of this section, the board shall consider:

(a) The need for formal regularly scheduled pharmacy education programs.

(b) Alternate methods of study including home-study courses, seminars or other such programs for those persons who, upon written application to the board and for good cause shown, demonstrate their inability to attend regularly scheduled formal classroom programs.

(c) The necessity for examinations or other evaluation methods used to ensure satisfactory completion of the continuing pharmacy education program.

(5) The board may contract for the providing of educational programs to fulfill the requirements of this chapter. The board is further authorized to treat funds set aside for the purpose of continuing education as state funds for the purpose of accepting any funds made available under federal law on a matching basis for the promulgation and maintenance of programs of continuing education. In no instance shall the board require a greater number of hours of study than it provides or approves in the State of Oregon and which are available on the same basis to all licensed pharmacists.

(6) The board may levy an additional fee, established by the board by rule, for each license renewal to carry out the provisions of this chapter.

OREGON HEALTH INFORMATION TECHNOLOGY PROGRAM

SECTION 12. ORS 413.310 is amended to read:

413.310. (1) The Oregon Health Authority shall establish and maintain the Oregon Health Information Technology program to:

(a) Support the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570;

(b) Facilitate the exchange and sharing of electronic health-related information;

(c) Support improved health outcomes in this state;

(d) Promote accountability and transparency; and

(e) Support new payment models for coordinated care organizations and health systems.

(2) The authority may engage in activities necessary to become accredited or certified as a provider of health information technology and take actions associated with providing health information technology.

(3) Subject to ORS 279A.050 (7), the authority may enter into agreements with other entities that provide health information technology to carry out the objectives of the Oregon Health Information Technology program.

(4) The authority may establish and enforce standards for connecting to and using the Oregon Health Information Technology program, including standards for interoperability, privacy and security.

(5) The authority may conduct or participate in activities to enable and promote the secure transmission of electronic health information between users of different health information technology systems, including activities in other states. The activities may include, but are not limited to, participating in organizations or associations that manage and enforce agreements to abide by a common set of standards, policies and practices applicable to health information technology systems.

(6) The authority may, by rule, impose fees on entities or individuals that use the program's services in order to pay the cost of administering the Oregon Health Information Technology program.

(7) The authority may initiate one or more partnerships or participate in new or existing collaboratives to establish and carry out the Oregon Health Information Technology program's objectives. The authority's participation may include, but is not limited to:

(a) Participating as a voting member in the governing body of a partnership or collaborative that provides health information technology services;

(b) Paying dues or providing funding to partnerships or collaboratives;

(c) Entering into agreements, subject to ORS 279A.050 (7), with partnerships or collaboratives with respect to participation and funding in order to establish the role of the authority and protect

the interests of this state when the partnerships or collaboratives provide health information technology services; or

(d) Transferring the implementation or management of one or more services offered by the Oregon Health Information Technology program to a partnership or collaborative.

[*(8) At least once each calendar year the authority shall report to the Legislative Assembly, in the manner provided in ORS 192.245, on the status of the Oregon Health Information Technology program.*]

PUBLIC EMPLOYEE HEALTH BENEFIT PLAN ELIGIBILITY

SECTION 13. ORS 243.105 is amended to read:

243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

(1) "Benefit plan" includes, but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Comparable benefits for employees who rely on spiritual means of healing; and

(c) Self-insurance programs managed by the Public Employees' Benefit Board.

(2) "Board" means the Public Employees' Benefit Board.

(3) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

(4)(a) "Eligible employee" means an officer or employee of a state agency or local government who elects to participate in one of the group benefit plans described in ORS 243.135. The term includes, but is not limited to, state officers and employees in the exempt, unclassified and classified service, and state officers and employees, whether or not retired, who:

(A) Are receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or are receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

(C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached earliest retirement age as described in ORS 238A.165; or

(D) Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(b) "Eligible employee" does not include individuals:

(A) Engaged as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, unless the individuals are defined as eligible under rules of the board;

(D) Appointed under ORS 240.309**, except as required by 26 U.S.C. 4980H**;

(E) Provided sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals;

(F) Provided student health care services in conjunction with their enrollment as students at a public university listed in ORS 352.002; or

(G) Who are members of a collective bargaining unit that represents police officers or firefighters.

(5) "Family member" means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) "Local government" means any city, county or special district in this state or any intergovernmental entity created under ORS chapter 190.

(7) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of employees of a state agency or local government.

(8) "Premium" means the monthly or other periodic charge for a benefit plan.

(9) "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(10) "State agency" means every state officer, board, commission, department or other activity of state government.

(11) "Total medical expenditures" means payments to reimburse the cost of physical and mental health care provided to eligible employees or their family members, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

CONFORMING AMENDMENTS

SECTION 14. ORS 441.223 is amended to read:

441.223. (1) Upon receiving the recommendations of the Advisory Committee on Physician Credentialing Information, the Oregon Health Authority shall:

(a) Adopt administrative rules in a timely manner, as required by the Administrative Procedures Act, for the purpose of effectuating the provisions of ORS 441.221 to 441.223; **and**

[*(b) Consult with the advisory group convened under ORS 441.232 to review the recommendations and obtain advice on the rules; and*]

[*(c)*] **(b)** Ensure that the rules adopted by the Oregon Health Authority are identical and are consistent with the recommendations developed pursuant to ORS 441.222 for affected credentialing organizations.

(2) The uniform credentialing information required pursuant to the administrative rules of the Oregon Health Authority represents the minimum uniform credentialing information required by the affected credentialing organizations. Except as provided in subsection (3) of this section, a credentialing organization may request additional credentialing information from a health care practitioner for the purpose of completing credentialing procedures used by the credentialing organization to credential health care practitioners.

(3) In credentialing a telemedicine provider, a hospital is subject to the requirements prescribed by rule by the authority under ORS 441.056.

SECTION 15. ORS 459A.200 is amended to read:

459A.200. As used in ORS 459A.200 to 459A.266:

(1) "Analogous product" means:

(a) With regard to a virus, a product prepared from or with a virus or agent that is actually or potentially infectious, regardless of the degree of virulence or toxigenicity of the specific virus strain used.

(b) With regard to a therapeutic serum, a product composed of whole blood or plasma, or that contains some organic constituent or product that is not a hormone or amino acid derived from whole blood, plasma or serum.

(c) With regard to an antitoxin or toxin, a product, regardless of its origin source, that is intended to be applicable to the prevention, treatment or cure of a disease or human injury through a specific immune process.

(2) "Antitoxin" means a product containing the soluble substance in serum or other bodily fluid of an immunized animal that specifically neutralizes the toxin to which the animal is immune.

(3) “Authorized collector” means a person that enters into an agreement with a program operator for the purpose of collecting covered drugs under a drug take-back program.

(4) “Biologics” means a virus, therapeutic serum, toxin, antitoxin or analogous product applicable to the prevention, treatment or cure of human diseases or injuries.

(5)(a) “Covered drug” means a drug that a covered entity has discarded or abandoned or that a covered entity intends to discard or abandon.

(b) “Covered drug” includes:

(A) Prescription drugs, as defined in ORS 689.005;

(B) Nonprescription drugs, as defined in ORS 689.005;

(C) Drugs marketed under a brand name, as defined in ORS 689.515;

(D) Drugs marketed under a generic name, as defined in ORS 689.515; and

(E) Combination products.

(c) “Covered drug” does not include:

(A) Vitamins or supplements;

(B) Herbal-based remedies or homeopathic drugs, products or remedies;

(C) Products that are regulated as both cosmetics and nonprescription drugs by the federal Food and Drug Administration;

(D) Drugs and biological products for which a covered manufacturer administers a drug take-back program as part of a risk evaluation and mitigation strategy under the oversight of the federal Food and Drug Administration;

(E) Drugs administered in a clinical setting;

(F) Drugs that are used for animal medicines, including but not limited to parasiticide drugs for animals;

(G) Exposed sharps, as defined in ORS 459.386, or other used drug products that are medical waste;

(H) Emptied injector products or medical devices and their components;

(I) Dialysis concentrates and solutions used for kidney dialysis in a patient’s home; or

(J) Biologics.

(6)(a) “Covered entity” means:

(A) A resident of this state;

(B) A nonbusiness entity located in this state; or

(C) An ultimate user as defined by 21 U.S.C. 802(27).

(b) “Covered entity” does not include a law enforcement agency or an entity that generates pharmaceutical waste, such as a hospital, health care clinic, office of a health care provider, veterinary clinic or pharmacy.

(7)(a) “Covered manufacturer” means a person that manufactures covered drugs that are sold within this state, including, but not limited to, a person that manufactures covered drugs for another manufacturer pursuant to an agreement.

(b) “Covered manufacturer” does not include:

(A) A person that:

(i)(I) Packages covered drugs that are sold within this state or that labels the containers of covered drugs that are sold within this state; or

(II) Repackages covered drugs that are sold within this state or that relabels the containers of covered drugs that are sold within this state, if the person informs the Department of Environmental Quality of the name of the original manufacturer of the covered drug; and

(ii) Does not produce, prepare, propagate, compound, convert or process drugs that are sold within this state; or

(B) A prepaid group practice [*described in ORS 441.229*] **that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services**.

(8) “Drop-off site” means the location where an authorized collector operates a secure repository for collecting covered drugs.

(9) “Drug” has the meaning given that term in ORS 689.005.

(10) “Drug take-back organization” means an organization designated by a covered manufacturer or a group of covered manufacturers to act as an agent of the covered manufacturer or group of covered manufacturers for the purpose of participating in a drug take-back program.

(11) “Drug take-back program” means a program developed and implemented by a program operator for the collection, transportation and disposal of covered drugs for which a plan has been approved under ORS 459A.209.

(12) “Mail-back service” means a method of collecting covered drugs from a covered entity by using prepaid, preaddressed mailing envelopes.

(13) “Manufacture” has the meaning given that term in ORS 689.005.

(14) “Pharmacy” has the meaning given that term in ORS 689.005.

(15) “Potential authorized collector” means:

(a) A person that:

(A) Is registered with the Drug Enforcement Administration of the United States Department of Justice; and

(B) Qualifies under federal law to collect and dispose of controlled substances, or qualifies under federal law to have the person’s registration modified in such a way that authorizes the person to collect and dispose of controlled substances.

(b) A law enforcement agency.

(16) “Program operator” means a covered manufacturer, group of covered manufacturers or drug take-back organization that develops and implements, or plans to develop and implement, a drug take-back program approved by the Department of Environmental Quality.

(17)(a) “Retail drug outlet” means a retail drug outlet, as defined in ORS 689.005, that is open to and accessible by the public.

(b) “Retail drug outlet” does not include a hospital that does not have an on-site pharmacy or a health care clinic that does not have an on-site pharmacy.

(18) “Therapeutic serum” means a product obtained from blood by removing the clot or clot components and the blood cells.

(19) “Toxin” means a product that contains a soluble substance poisonous to animals or humans in a dose of one milliliter or less, and that, after administration by injection of a nonlethal dose into an animal, causes to be produced within the animal another soluble substance that specifically neutralizes the poisonous substance, demonstrable in the serum of the immunized animal.

(20) “Virus” means a product containing the minute living cause of an infectious disease and that includes but is not limited to filterable viruses, bacteria, rickettsia, fungi and protozoa.

UNIT CAPTIONS

SECTION 16. The unit captions used in this 2021 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2021 Act.

Passed by House March 22, 2021

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 10, 2021

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

.....
Shemia Fagan, Secretary of State

818-021-0010 - Application for License to Practice Dentistry

(1) An applicant to practice general dentistry, in addition to the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination.

(2) An applicant who has not met the educational requirements for licensure may apply for examination if the Dean of an accredited school certifies the applicant will graduate.

(3) An applicant must pass a Board examination consisting of a clinical portion administered by the Board, or any clinical Board examination administered by any state, or regional testing agency, national testing agency or other Board-recognized testing agency and a jurisprudence portion administered by the Board. Clinical examination results will be recognized by the Board for five years.

(4) A person who fails any Board approved clinical examination three times must successfully complete the remedial training recommended by the testing agency. Such remedial training must be conducted by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association.

(5) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority.

818-021-0011 - Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Having passed the dental clinical examination conducted by a regional testing agency, by a state dental licensing authority, by a national testing agency or other Board-recognized testing agency; and

(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

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

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

(2) Applicants must pass the Board's Jurisprudence Examination.

(3) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority.

~~(3)~~ **(4)** A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.060, 679.065, 679.070, 679.080 & 679.090
History:
OBD 2-2019, amend filed 10/29/2019, effective 01/01/2020
OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17
OBD 1-2017, f. 2-13-17, cert. ef. 3-1-17
OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06
OBD 3-2004, f. 11-23-04 cert. ef. 12-1-04
OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04
OBD 1-2003, f. & cert. ef. 4-18-03
Reverted to OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02
OBD 1-2002(Temp), f. & cert. ef. 7-17-02 thru 1-12-03
OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02
OBD 14-2001(Temp), f. 8-2-01, cert. ef. 8-15-01 thru 2-10-02
Reverted to OBD 4-2001, f. & cert. ef. 1-8-01
OBD 12-2001(Temp), f. & cert. ef. 1-9-01 thru 7-7-01
OBD 4-2001, f. & cert. ef. 1-8-01
OBD 4-1999, f. 6-25-99, cert. ef. 7-1-99

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

(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;

(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and

(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.

(d) Passing the Board's jurisprudence examination.

(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:

(a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language, and evidence of active licensure as a general dentist in another state obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency; or

(b) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language and certification of having successfully passed the clinical examination administered by any state or regional testing agency within the five years immediately preceding application; and

(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; **and**

(d) Passing the Board's jurisprudence examination; and

(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority.

(3) An applicant who meets the above requirements shall be issued a specialty license upon:

(a) Passing a specialty examination approved by the Board within the five years immediately preceding application; or

(b) Passing a specialty examination approved by the Board greater than five years prior to application; and

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

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

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

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

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

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 includes an examination and the dentist passes the examination.

(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,** ~~A~~a**ll** 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. ~~All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.~~ **(Effective January 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).

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(9)
History:
OBD 2-2019, amend filed 10/29/2019, effective 01/01/2020
OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15
OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14
OBD 4-2011, f. & cert. ef. 11-15-11
OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11
OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09
OBD 3-2007, f. & cert. ef. 11-30-07
OBD 16-2001, f. 12-7-01, cert. ef. 4-1-02
OBD 9-2000, f. & cert. ef. 7-28-00
DE 1-1990, f. 3-19-90, cert. ef. 4-2-90
DE 1-1989, f. 1-27-89, cert. ef. 2-1-89, Renumbered from 818-020-0072
DE 1-1988, f. 12-28-88, cert. ef. 2-1-89
DE 4-1987(Temp), f. & cert. ef. 11-25-87
DE 3-1987, f. & cert. ef. 10-15-87

Oregon
Kate Brown, Governor

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

TO: OBD Board Members

FROM: Stephen Prisby, OBD Executive Director

DATE: August 2, 2021

SUBJECT: OBD Review of new rules adopted per ORS 183.405(I)

It is a requirement that state agencies review new rules within five years from the date the new rule was adopted. OBD Staff have reviewed the new rules adopted in 2016 and 2017. Attached you will find the DOJ's memo from 2010 advising agencies on this matter and the staff's review of the new rules that meet the criteria. OBD Staff will review these documents and answer any questions you have at the Board Meeting.

It is my recommendation that you discuss and make a motion to accept these reports memorializing that the OBD has conducted an official rule review per ORS 183.405.

See Attachments
.

JOHN R. KROGER
Attorney General

MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

MEMORANDUM

DATE: August 25, 2010

TO: Agency Heads, Board and Commission Chairs and Executive Directors

COPY: General Counsel Division Assistant Attorneys General and Rules Coordinators

FROM: David E. Leith, Associate Attorney General and Chief General Counsel

SUBJECT: Review of Agency Rules Adopted Since January 1, 2006

Agencies must review new rules adopted since January 1, 2006, within five years of the date the new rule was adopted. ORS 183.405. The first reviews will be due in January 2011, for rules adopted in January 2006.

The requirement for review does not apply to amendments or repeals of rules that were in existence as of January 1, 2006, but only to new rules adopted since that date. Nor does the review requirement apply to rules adopted to implement court orders or to settle civil proceedings; rules that adopt federal laws or rules by reference; rules adopted to implement legislatively-approved fee changes; or rules adopted to correct errors or omissions. ORS 183.405(4) and (5).

ORS 183.405(1) contains four criteria that agencies must apply to each rule that is reviewed:

(1) Did the rule have the intended effect?
(2) Was the anticipated fiscal impact of the rule underestimated or overestimated?
(3) Do subsequent changes in the law require the rule to be repealed or amended?
(4) Is the rule still needed?

Agencies should document review of each rule in writing. Agencies are permitted to use "available information" to address the criteria stated above. ORS 183.405(2). Agencies need not conduct original research to review the rules, but must consider information the agency already has in its control and provide some analysis of that information. The attached form can be used to document rule review.

Finally, if the agency appointed an advisory committee to consider the rule before it was adopted, the agency must give advisory committee members a copy of the report documenting the results of the review. ORS 183.405(3). The Statement of Need and Fiscal Impact that each agency files with the Secretary of State to begin rulemaking – and that each agency rules coordinator keeps on file – indicates whether an advisory committee was involved.

If you have questions about whether your agency must review a particular rule or about how to apply the review criteria, please feel free to contact your assigned General Counsel attorney.

DEL:naw/2201999v1

1162 Court Street NE, Salem, OR 97301-4096
Telephone: (503) 947-4540 Fax: (503) 378-3784 TTY: (800) 735-2900 www.doj.state.or.us

Rule number: OAR_____

Date adopted: _____

Date review due: _____

Advisory committee used? ____ yes ____ no

If yes, identify members. Members must be provided a copy of this completed form.

1. Did the rule achieve its intended effect? ____ yes ____ no

   a. What was the intended effect?

   b. How did the rule succeed or fail in achieving this effect?

2. Was the fiscal impact statement ____underestimated or ____overestimated or ____just about right or ___ unknown? (Check one)

   a. What was the estimated fiscal impact?

   b. What was the actual fiscal impact?

   c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ____ yes ____ no

   If yes, explain.

4. Is the rule still needed? ___ yes ____ no

   Explain.

Rules to be reviewed by Board at 8/20 Board Meeting

818-001-0083
Relief from Public Disclosure
Upon the receipt of a written request of an individual who has been disciplined by the Oregon Board of Dentistry, the Board shall remove from its website, and other publicly accessible print and electronic publications under the Board's control, all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the Board during the disciplinary proceeding, if:
(1) The request is made 10 years or more after the date on which any disciplinary sanction ended;
(2) The individual was not disciplined for financially or physically harming a patient as determined by the Board;
(3) The individual informed the Board of the matter for which the individual was disciplined before the Board received information about the matter or otherwise had knowledge of the matter;
(4) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the Board following the imposition of the disciplinary sanction; and
(5) The individual fully complied with all disciplinary sanctions imposed by the Board.

818-005-0050
Criminal Records Check for Employees, Volunteers and Applicants
(1) The Board may require a criminal records check and fitness determination for Board employees, volunteers or applicants for employment with the Board.
(2) Criminal records checks and fitness determinations are conducted pursuant to ORS 181A.170 to 181A.215 and OAR 125-007-0200 to 125-007-0310.
(a) To complete the criminal records check and fitness determination, the Board may require additional information from the employee, volunteer or applicant, such as, but not limited to, proof of identity or additional criminal, judicial or other background information.
(b) If the employee, volunteer or applicant has potentially disqualifying criminal offender information, the Board will consider factors listed in ORS 181A.195 before making a fitness determination.
(c) An approved fitness determination does not guarantee employment.
(d) An incomplete fitness determination does not entitle the employee, volunteer or applicant the right to appeal under OAR 125-007-0300.
(3) Pursuant to ORS 181A.195, 676.175, and OAR 125-007-0310, information obtained in the criminal records check is confidential and will not be disseminated by the Board except to persons with a demonstrated and legitimate need to know the information.
(4) The Board may charge a fee to the employee, volunteer or applicant for the criminal records check. The fee will not exceed the fee charged the Board by the OSP and the FBI to obtain such information.

818-012-0032
Diagnostic Records
(1) Licensees shall provide duplicates of physical diagnostic records that have been paid for to patient or patient's guardian within 14 calendar days of receipt of written request.
(A) Physical records include silver emulsion radiographs, physical study models, paper charting and chart notes.
(B) Licensees may require the patient or patient's guardian to pay in advance the fee reasonably calculated to cover costs of making the copies or duplicates.
(1) Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.
(2) Licensees shall provide duplicates of digital patient records within 14 calendar days of receipt of written request by the patient or patient's guardian.
(A) Digital records include any patient diagnostic image, study model, test result or chart record in digital form.
(B) Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.
(C) Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.
(D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.
(E) Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.
(F) Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
(G) Duplicated digital records shall be of the same quality as the original digital file.
(3) If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.

818-042-0112
Expanded Function Preventive Dental Assistants (EFPDA)
The following duties are considered Expanded Function Preventive Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0113: Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge.

818-042-0113

Certification — Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Infection Control examination, and Certified Preventive Functions Dental Assistant (CPFDA) examination, or the Expanded Function Dental Assistant (EFDA) examination, or the Coronal Polish (CP) examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six patients.

Rules number(s): OAR 818-001-0083 Relief from Public Disclosure

Date Adopted: 01/01/2017

Date Review Due: 8/20/2021

Advisory committee used? ■ Yes ☐ No

If yes, identify members *

Brandon Schwindt, D.M.D.
Amy Fine, D.M.D.
Lynn Ironside, R.D.H., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.
Jose Javier, D.D.S.

Members must be provided a copy of this complete form

1. Did the rules achieve its intended effect? ■ Yes ☐ No

a. What was the intended effect?

To remove disciplinary actions from an individual's public record if specific criteria are met, in response to HB 4095 (2016).

b. How did the rule succeed or fail in achieving this effect?

It succeeded by providing a pathway for licensees to have discipline removed from public record.

2. Was the fiscal impact statement:

☐ Underestimated , ☐ overestimated, ■ just about right or ☐ unknown? (Check only one)

a. What was the estimate fiscal impact?

None

b. What was the actual fiscal impact?

None

c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ☐ Yes ■ No

4. Is the rules still needed? ■ Yes ☐ No

Explain:

Provides relief to licensees who meet the qualifications to have disciplinary actions removed from public record; keep the Board in compliance with HB 4095-2016.

Rules number(s): OAR 818-005-0050

Date Adopted: March 1, 2017

Date Review Due: August 20, 2021

Advisory committee used? ■ Yes ☐ No

If yes, identify members *

Rules Oversight Committee: Brandon Schwindt, D.M.D., Amy Fine, D.M.D., Jose Javier, D.D.S., Alicia Riedman, R.D.H., Lynn Ironside, R.D.H.

Members must be provided a copy of this complete form

1. Did the rules achieve its intended effect? ■ Yes ☐ No

a. What was the intended effect?

To simplify and streamline Division 5 and to condense repeating information into one rule.

b. How did the rule succeed or fail in achieving this effect?

The rule succeeded in achieving this effect by consolidating the existing rules.

2. Was the fiscal impact statement:

☐ Underestimated , ☐ overestimated, ■ just about right or ☐ unknown? (Check only one)

a. What was the estimate fiscal impact?

The estimate fiscal impact was $0, since this rule consolidated existing rules.

b. What was the actual fiscal impact?

There was not a significant fiscal impact.

c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ☐ Yes ■ No

4. Is the rules still needed? ■ Yes ☐ No

Explain:

The rules are still necessary to require criminal records check for employees, volunteers, and applicants.

Rules number(s): OAR 818-012-0032

Date Adopted: 01/01/2017

Date Review Due: 08/20/2021

Advisory committee used? ■ Yes ☐ No

If yes, identify members *

Rules Oversight Committee: Brandon Schwindt, D.M.D., Chair; Amy Fine, D.M.D.; Lynn Ironside, R.D.H., ODHA Rep.; Alicia Riedman, R.D.H., E.P.P.; Jose Javier, D.D.S.

**Members must be provided a copy of this complete form*

1. Did the rules achieve its intended effect? ■ Yes ☐ No

a. What was the intended effect?

Modernize archaic language in the rules related to the release of records; adopt policies that recognize the fact that most dental patient records are digital at present. Ensure retained and released records are of diagnostic quality.

b. How did the rule succeed or fail in achieving this effect?

Rule made it easier for records to be transmitted at lower cost to the patient, with lower burden upon the licensees' office resources.

2. Was the fiscal impact statement:

☐ Underestimated , ☐ overestimated, ■ just about right or ☐ unknown? (Check only one)

a. What was the estimate fiscal impact?

None was expected.

b. What was the actual fiscal impact?

N/A

c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ☐ Yes ■ No

4. Is the rules still needed? ■ Yes ☐ No

Explain:

Digital records will only become more widespread as the dental profession modernizes.

Rules number(s): OAR 818-042-0112 - Expanded Function Preventive Dental Assistants (EFPDA)

Date Adopted: 01/01/2017

Date Review Due: 8/20/2021

Advisory committee used? ■ Yes ☐ No

If yes, identify members *

Brandon Schwindt, D.M.D.
Amy Fine, D.M.D.
Lynn Ironside, R.D.H., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.
Jose Javier, D.D.S.

Members must be provided a copy of this complete form

1. Did the rules achieve its intended effect? ■ Yes ☐ No

a. What was the intended effect?

Create a new EFPDA certification type for dental assistants practicing in Oregon; allow appropriately trained dental assistants to perform certain types of preventative treatment.

b. How did the rule succeed or fail in achieving this effect?

30 dental assistants have become certified as EFPDAs since the adoption of the new rule.

2. Was the fiscal impact statement:

☐ Underestimated , ☐ overestimated, ■ just about right or ☐ unknown? (Check only one)

a. What was the estimate fiscal impact?

As would be expected

b. What was the actual fiscal impact?

30 EFPDAs have been certified since the adoption of this rule, generating $450.00 in revenue.

c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ☐ Yes ■ No

4. Is the rules still needed? ■ Yes ☐ No

Explain:

Dental assistant shortage persists in Oregon; EFPDAs are an important asset in expanding preventative dental access to underserved communities.

Rules number(s): OAR 818-042-0113

Date Adopted: 01/01/2017

Date Review Due: 08/20/2021

Advisory committee used? ■ Yes ☐ No

If yes, identify members *

Rules Oversight Committee: Brandon Schwindt, D.M.D., Chair; Amy Fine, D.M.D.; Lynn Ironside, R.D.H., ODHA Rep.; Alicia Riedman, R.D.H., E.P.P.; Jose Javier, D.D.S.

Members must be provided a copy of this complete form

1. Did the rules achieve its intended effect? ■ Yes ☐ No

a. What was the intended effect?

Set educational and training standards/requirements for the new EFPDA certification offered by the Board; allow more appropriately trained dental assistants to perform certain types of preventative treatment.

b. How did the rule succeed or fail in achieving this effect?

30 dental assistants have become certified as EFPDAs since the adoption of the new rule.

2. Was the fiscal impact statement:

☐ Underestimated , ☐ overestimated, ■ just about right or ☐ unknown? (Check only one)

a. What was the estimate fiscal impact?

As would be expected

b. What was the actual fiscal impact?

30 dental assistants have been certified and paid the OBD, through the contract the OBD holds with DANB, approximately $450.00.

c. If the answer to question 2 is unknown, briefly explain why.

3. Have subsequent changes in the law required the rule be repealed or amended? ☐ Yes ■ No

4. Is the rules still needed? ■ Yes ☐ No

Explain:

Dental assistant shortage persists in Oregon; EFPDAs are an important asset in expanding preventative dental access to underserved communities.

At the August 20, 2021 Board Meeting the Oregon Board of Dentistry (OBD) shall consider establishing a new standing Committee named the “Dental Therapy Rules Oversight Committee” per ORS 679.280, to create, amend, review and discuss the implementation of dental therapy rules with the passage of HB 2528 (2021). This historic piece of legislation was signed by Governor Kate Brown on July 19, 2021.

This new Committee is being created because the OBD seeks a dedicated and focused group of committee members to draft new dental therapy rules in a deliberate, fair and equitable manner for the OBD to consider. This Committee will also consider cost of compliance and racial justice issues as well with the development of these rules.

The Dental Therapy Rules Oversight Committee shall be comprised of three current OBD Board Members, one who will serve as the Chair of the Committee.

The Committee shall include two representatives from the Oregon dental therapy community or organizations that represent dental therapists in Oregon. The Committee members must reside or work in Oregon and the OBD President will select the two members if more than two people volunteer to serve on this Committee. Ideally, Oregon licensed dental therapists will serve on this Committee in the future once licenses are issued.

The Committee shall include one representative form the Oregon Health Authority, ideally the Dental Director or their designee. This is to leverage their experience with dental pilot projects.

The Committee will also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists’ Association and the Oregon Dental Assistants Association.

Committee members shall be reimbursed for transportation costs to and from these meetings, limited to reimbursement for mileage as long as the Committee members complete the required reimbursement forms. All Committee meetings will be at the OBD’s conference room at 1500 SW. 1st Ave., Portland, OR 97201 and will also have a teleconference option as well. All OBD Committee and Board meetings are public meetings.

The Legislature requires that the OBD adopt rules necessary to administer certain provisions of the new legislation. In adopting rules, the board shall consult with dental therapists and organizations that represent dental therapists in Oregon.

The public, dental therapy communities and all interested parties can take part in the implementation of the new dental therapy rules as they will be subject to the OBD’s public rulemaking process.

DIVISION 1
PROCEDURES

818-001-0002
Definitions

As used in OAR chapter 818:

(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.

(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.

(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.

~~(6)~~ **(4)** "Hygienist" means a person licensed pursuant to ORS 680.010 to 680.170 to practice dental hygiene.

(5) "Dental Therapist" means a person licensed pursuant to ORS 679 to practice dental therapy.

(6) "Dental Therapy" means the provision of preventative care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described in ORS 679.

~~(4)~~ **(7)** "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

~~(5)~~ **(8)** "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

~~(7)~~ **(9)** "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

~~(8)~~ **(10)** "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.

~~(9)~~ **(11)** "Licensee" means a dentist**,** ~~or~~ hygienist **or dental therapist.**

(a) "Volunteer Licensee" is a dentist **or** hygienist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.

~~(10)~~ **(12)** "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene **or dental therapy** treatment in a dental office.

~~(11)~~ **(13)** "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.

(a) "Dental Anesthesiology" is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.

(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Orthodontics and Dentofacial Orthopedics" is the area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(h) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(i) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(j) "Prosthodontics" is the branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the

restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
~~(12)~~ (14) "Full-time" as used in ORS 679.025 ~~and 680.020~~ is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry, ~~or~~ dental hygiene **or dental therapy.**
~~(13)~~ (15) For purposes of ORS 679.020(4)(h) the term "dentist of record" means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
~~(14)~~ (16) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
~~(15)~~ (17) "Physical Harm" as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
~~(16)~~ (18) "Teledentistry" is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
~~(17)~~ (19) "BLS for Healthcare Providers or its Equivalent" the CPR certification standard is the American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial CPR course must be a hands-on course; online CPR courses will not be approved by the Board for initial CPR certification.
After the initial CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A CPR certification card with an expiration date must be received from the CPR provider as documentation of CPR certification. The Board considers the CPR expiration date to be the last day of the month that the CPR instructor indicates that the certification expires.

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390;
(B) Dental — retired — $0;
(C) Dental Faculty — $335;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $300;
(I) Dental Therapy - retired $0.
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40;
(B) Minimal Sedation Permit — $75;

(C) Moderate Sedation Permit — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(F) Radiology — $75;
(G) Expanded Function Dental Assistant — $50;
(H) Expanded Function Orthodontic Assistant — $50;
(I) Instructor Permits — $40;
(J) Dental Hygiene Restorative Functions Endorsement — $50;
(K) Restorative Functions Dental Assistant — $50;
(L) Anesthesia Dental Assistant — $50;
(M) Dental Hygiene, Expanded Practice Permit — $75;
(N) Non-Resident Dental Background Check - $100.00;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345;
(B) Dental Faculty — $305;
(C) Dental Hygiene — $180;
(D) **Dental Therapy - $250;**
~~(D)~~ **(E)** Licensure Without Further Examination — Dental**,** ~~and~~ Dental Hygiene **and Dental Therapy** — $790.
(d) Examinations:
(A) Jurisprudence — $0;
(e) Duplicate Wall Certificates — $50.
(2) Fees must be paid at the time of application and are not refundable.
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

818-012-0020
Additional Methods of Discipline for Unacceptable Patient Care
In addition to other discipline, the Board may order a licensee who engaged in or permitted unacceptable patient care to:
(1) Make restitution to the patient in an amount to cover actual costs in correcting the unacceptable care.
(2) Refund fees paid by the patient with interest.
(3) Complete a Board-approved course of remedial education.
(4) Discontinue practicing in specific areas of dentistry**, dental therapy,** or hygiene.
(5) Practice under the supervision of another licensee.

818-012-0030
Unprofessional Conduct
The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.

(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:
(A) Legible copies of records; and
(B) Duplicates of study models, radiographs of the same quality as the originals, and photographs if they have been paid for.
(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.

(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry or ~~or~~ ,dental hygiene **or dental therapy.**
(16) Practice dentistry ~~or~~ ,dental hygiene **or dental therapy** in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry ~~or~~ ,dental hygiene **or dental therapy.**
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program's electronic system if the Licensee holds a Federal Drug Enforcement Administration (DEA) registration.

818-021-00XX
Application for License to Practice Dental Therapy
(1)(a)The Oregon Board of Dentistry may require an applicant for a license to practice dental therapy to pass written, laboratory or clinical examinations to test the professional knowledge and skills of the applicant.
(b) The examinations may not be affiliated with or administered by a dental pilot project or a dental therapy education program described in section 3 of this 2021 Act.
(c) The examinations must:
(A) Be elementary and practical in character, and sufficiently thorough to test the fitness of the applicant to practice dental therapy; (B) Be written in English; and
(C) Include questions on subjects pertaining to dental therapy.

(2) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:
(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.
(b) To satisfy the laboratory or clinical examination authorized under this section:
A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and
(B) May accept the results of board-recognized testing agencies.
(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a period of at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure.

818-021-00XX
Application for License to Practice Therapy Without Further Examination
(1) The Oregon Board of Dentistry may grant a license without further examination to a dental therapist who holds a license to practice dental therapy in another state or states if the dental therapist meets the requirements set forth in ORS 679 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental therapy program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(c) Having passed the clinical dental therapy examination conducted by a regional testing agency or by a state dental or dental therapy licensing authority, by a national testing agency or other Board-recognized testing agency; and
(d) Holding an active license to practice dental therapy, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental therapy, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dental therapists employed by a CODA accredited dental therapy program with verification from the dean or appropriate administration of the institution documenting the length and terms of

employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dental therapy, and any adverse actions or restrictions; and
(f) Having completed 36 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

818-021-0026
State and Nationwide Criminal Background Checks, Fitness Determinations
(1) The Board requires fingerprints of all applicants for a dental**, dental therapy** or dental hygiene license to determine the fitness of an applicant. The purpose of this rule is to provide for the reasonable screening of dental and dental hygiene applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or hold a license that is issued by the Board.
(2) These rules are to be applied when evaluating the criminal history of all licensees and applicants for a dental**, dental therapy** or dental hygiene license and for conducting fitness determinations consistent with the outcomes provided in OAR 125-007-0260.
(3) Criminal records checks and fitness determinations are conducted according to ORS 181A.170 to 181A.215, ORS 670.280 and OAR 125-007-0200 to 127-007-0310.
(a) The Board will request the Oregon Department of State Police to conduct a state and nationwide criminal records check. Any original fingerprint cards will subsequently destroyed.
(b) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.
(c) The applicant or licensee must disclose all arrests, charges, and convictions regardless of the outcome or date of occurrence. Disclosure includes but is not limited to military, dismissed or set aside criminal records.
(4) If the applicant or licensee has potentially disqualifying criminal offender information, the Board will consider the following factors in making a fitness determination:
(a) The nature of the crime;
(b) The facts that support the conviction or pending indictment or that indicates the making of the false statement;
(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, employment, license, or permit; and
(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. Intervening circumstances include but are not limited to:
(A) The passage of time since the commission of the crime;
(B) The age of the subject individual at the time of the crime;
(C) The likelihood of a repetition of offenses or of the commission of another crime:
(D) The subsequent commission of another relevant crime;
(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and
(F) A recommendation of an employer.
(e) Any false statements or omissions made by the applicant or licensee; and

(f) Any other pertinent information obtained as part of an investigation.
(5) The Board will make a fitness determination consistent with the outcomes provided in OAR 125-007-0260.
(a) A fitness determination approval does not guarantee the granting or renewal of a license.
(b) An incomplete fitness determination results if the applicant or licensee refuses to consent to the criminal history check, refuses to be fingerprinted or respond to written correspondence, or discontinues the criminal records process for any reason. Incomplete fitness determinations may not be appealed.
(6) The Board may require fingerprints of any licensed Oregon dentist**, dental therapist** or dental hygienist, who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal records background check.
(7) All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.
(8) Additional information required. In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee/applicant as necessary, such but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.
(9) Criminal offender information is confidential. Dissemination of information received may be disseminated only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).
(10) The Board will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the individual, provide the individual with a copy of the individual's own state and national criminal offender records.
(11) The Board shall determine whether an individual is fit to be granted a license or permit, based on fitness determinations, on any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted a license or permit. The Board may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions upon licensure.
(12) An applicant or licensee may appeal a final fitness determination pursuant to OAR 125-007-0300. Challenges to the accuracy of completeness of criminal history information must be made in accordance with OAR 125-007-0030(7).

818-021-00XX
Continuing Education — Dental Therapists
(1) Each dental therapist must complete 36 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) Dental therapists 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 dental therapists is October 1 through September 30.) 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 six 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 includes an examination and the dental therapist passes the examination.
(d) Continuing education credit can be given for volunteer pro bono dental dental therapy 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 Dental Therapy Examination, taken after initial licensure; or test development for clinical dental therapy 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 two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) At least two (2) hours of continuing education must be related to infection control.
(6) At least two (2) hours of continuing education must be related to cultural competency.

818-021-0080 Renewal of License

Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every person holding a current license. The licensee must return the completed renewal application along with current renewal fees prior to the 9 - Div. 21 expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry, dental therapy or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085 "Reinstatement of Expired Licenses."
(1) Each dentist shall submit the renewal fee and completed and signed renewal application form by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.
(2) Each hygienist must submit the renewal fee and completed and signed renewal application form by September 30 every other year. Hygienists licensed in odd

numbered years shall apply for renewal in odd numbered years and hygienists licensed in even numbered years shall apply for renewal in even numbered years.
(3) The renewal application shall contain:
(a) Licensee's full name;
(b) Licensee's mailing address;
(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;
(e) Licensee's employer or person with whom the licensee is on contract;
(f) Licensee's assumed business name;
(g) Licensee's type of practice or employment;
(h) A statement that the licensee has met the educational requirements for renewal set forth in OAR 818-021-0060 or 818-021-0070;
(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and
(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

818-021-0085
Renewal or Reinstatement of Expired License
Any person whose license to practice as a dentist ~~or~~ , dental hygienist or dental therapist has expired, may apply for reinstatement under the following circumstances:
(1) If the license has been expired 30 days or less, the applicant shall:
(a) Pay a penalty fee of $50;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.
(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
(a) Pay a penalty fee of $100;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the continuing education requirements.
(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
(a) Pay a penalty fee of $150;
(b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500; and
(d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(4) If the license has been expired for more than one year but less than four years, the applicant shall:

(a) Pay a penalty fee of $250;
(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500;
(d) Pass the Board's Jurisprudence Examination;
(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(5) If a ~~dentist or dental hygienist~~ Licensee fails to renew or reinstate ~~her or his~~ their license within four years from expiration, the ~~dentist or dental hygienist~~ Licensee must apply for licensure under the current statute and rules of the Board.

818-021-0090
Retirement of License
(1) A ~~dentist or dental hygienist~~ Licensee who no longer practices in any jurisdiction may retire ~~her or his~~ their license by submitting a request to retire such license on a form provided by the Board.
(2) A license that has been retired may be reinstated if the applicant:
(a) Pays a reinstatement fee of $500;
(b) Passes the Board's Jurisprudence Examination;
(c) Passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(d) Submits evidence of good standing from all states in which the applicant is currently licensed; and
(e) Submits a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(3) If the ~~dentist or dental hygienis~~t Licensee fails to reinstate ~~her or his~~ their license within four years from retiring the license, the ~~dentist or dental hygienist~~ Licensee must apply for licensure under the current statute and rules of the Board.

818-021-0095
Resignation of License
(1) The Board may allow a dentist ~~or~~ , dental hygienist or dental therapist who no longer practices in Oregon to resign ~~her or his~~ their license, unless the Board determines the license should be revoked.
(2) Licenses that are resigned under this rule may not be reinstated.

818-021-0110
Reinstatement Following Revocation

(1) Any person whose license has been revoked for a reason other than failure to pay the annual fee may petition the Board for reinstatement after five years from the date of revocation.
(2) The Board shall hold a hearing on the petition and, if the petitioner demonstrates that reinstatement of the license will not be detrimental to the health or welfare of the public, the Board may allow the petitioner to retake the Board examination.
(3) If the license was revoked for unacceptable patient care, the petitioner shall provide the Board with satisfactory evidence that the petitioner has completed a course of study sufficient to remedy the petitioner's deficiencies in the practice of dentistry**, dental therapy** or dental hygiene.
(4) If the petitioner passes the Board examination, the Board may reinstate the license, place the petitioner on probation for not less than two years, and impose appropriate conditions of probation.

818-026-0055
Dental Hygiene, Dental Therapy and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation
(1) Under indirect supervision, dental hygiene **and dental therap**y procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or
(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

818-026-0080
Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.

(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist, a dental hygienist, **dental therapist** or an Expanded Function Dental Assistant (EFDA) who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document the patient's condition at discharge as required by the rules applicable to the level of anesthesia being induced. A copy of the anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.
(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.
(8) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of ~~her or his~~ **their** intent. Such notification need only be submitted once every licensing period.

Division 38
DENTAL THERAPY

818-038-0001
Definitions

(1) "Dental Therapist" means a person licensed pursuant to ORS 679 to practice dental therapy.
(2) "Dental Therapy" means the provision of preventative care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described in ORS 679.
(3) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

(4) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(5) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(7) "Collaborative Agreement" means a written, signed and dated agreement entered into between an Oregon Licensed Dentist and an Oregon Licensed Dental Therapist meeting the requirements of ORS 679.

818-038-0010
Authorization to Practice
(1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist's practice.
(2) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

818-038-0020
Prohibited Acts
A dental therapist may not:
(1) Administer Nitrous Oxide
(2) Place or Restore Dental Implants
(3) Prescribe any drugs
(4) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(5) Perform any dental therapy procedure unless it is documented in the collaborative agreement and rendered under appropriate Oregon Licensed Dentist supervision.

818-038-0050
Record Keeping
(1) A dental therapist shall annually submit a signed copy of their collaborative agreement (s) to the Oregon Board of Dentistry. If the collaborative agreement(s)

are revised in between annual submissions, a signed and dated copy of the revised collaborative agreement(s) must be submitted to the board as soon as practicable after the revision is made.

(2) The annual submission of the collaborative agreement shall coincide with lthe license renewal period between August 1 and September 30 each year.

(3) A dental therapist shall purchase and maintain liability insurance as determined sufficient by the board.

DIVISION 42
DENTAL ASSISTING

818-042-0010
Definitions

(1) “Dental Assistant” means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, **dental therapist**, dental technician or another dental assistant or renders assistance under the supervision of a dental hygienist providing dental hygiene services.
(2) “Expanded Function Dental Assistant” means a dental assistant certified by the Board to perform expanded function duties.
(3) “Expanded Function Orthodontic Assistant” means a dental assistant certified by the Board to perform expanded orthodontic function duties.
(4) “Direct Supervision” means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(5) “Indirect Supervision” means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) “General Supervision” means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

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 and a dentist has authorized it.
(4) The supervising dentist ~~or~~ **,** dental hygienist **or dental therapist** is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.
~~(4)~~ **(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.

818-042-0030

Infection Control

The supervising dentist **and dental therapist** shall be responsible for assuring that dental assistants are trained in infection control, bloodborne pathogens and universal precautions, exposure control, personal protective equipment, infectious waste disposal, Hepatitis B and C and post exposure follow-up.

818-042-0040

Prohibited Acts

No licensee may authorize any dental assistant to perform the following acts:

(1) Diagnose or plan treatment.

(2) Cut hard or soft tissue.

(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty OAR 818-042-0113 and OAR 818-042-0114 or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.

(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.

(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.

(6) Administer any drug except fluoride, topical anesthetic, desensitizing agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)(a), OAR 818-026-0060(11), OAR 818-026-0065(11), OAR 818-026-0070(11) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.

(7) Prescribe any drug.

(8) Place periodontal packs.

(9) Start nitrous oxide.

(10) Remove stains or deposits except as provided in OAR 818-042-0070.

(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.

(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.

(13) Use lasers, except laser-curing lights.

(14) Use air abrasion or air polishing.

(15) Remove teeth or parts of tooth structure.

(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.

(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.

(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.

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

(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(22) Perform periodontal probing.
(23) Place or remove healing caps or healing abutments, except under direct supervision.
(24) Place implant impression copings, except under direct supervision.
(25) Any act in violation of Board statute or rules.

818-042-0050
Taking of X-Rays — Exposing Radiographic Images
(1) A ~~dentist~~ **Licensee** may authorize the following persons to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under general supervision:
(a) A dental assistant certified by the Board in radiologic proficiency; or
(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.
(2) A dentist or dental hygienist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist ~~or~~ **,** dental hygienist **or dental therapist** that the assistant is proficient to take radiographic images.

CORRESPONDENCE

Oregon Board of Dentistry
1500 SW 1st Avenue, suite 770
Portland, Oregon 97201-5837

Dear Board members,

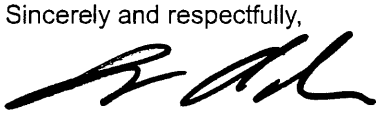
Yesterday I sadly received your letter denying me privilege to practice dentistry in Oregon. Currently I have an up to date active dental license in the state of Washington, and if I so desired I could open up an office to practice dentistry, unlimited, in Washington, a sister/brother state of Oregon, merely to demonstrate my capacity to do so. This however, will not happen as I am now a proud Oregonian. I have kept up taking required continuing education courses for the last 51 years to date to demonstrate my ongoing level of dental competency.

I am simply asking for a limited license as a practicing orthodontist to only provide Invisalign treatment to patients, as I have a potential position awaiting me with a highly respected dentist in Bend, Oregon. All I am asking for is what millions of lay people are already doing online, Smiledirect, BUT as an orthodontist , with a greater scientific and professional technique, which would involve actual diagnosis, treatment planning, and proven professional treatment, which would consider necessary skeletal implications, and also not the unacceptable, unstable labial expansion of dental arch components which are surely destined for relapse and failure.

I realize what I am now about to say is totally selfish, and has nothing to do with affecting your decision, however, I find it necessary to so say it. My dear daughter, Lynn, passed away a year ago, after many years of my wife and I trying to help her survive from the brutal ravages of cancer. That caused me to stop working actively as an orthodontist to fight with her. Thus I did not fulfill your requirement to be working in an ongoing manner as an orthodontist. That seems to be the only factor preventing me to resume practicing in Oregon on a limited basis as I am a healthy, ethical, competent man. Currently both my wife and I are struggling to forget, to divert our thoughts away from her passing, it is however difficult , and thought selfishly how therapeutic it would be for me to get back to a profession that I love and was forced to stop working at in order to try to save my brave daughter. Again, this is no reason to give someone a dental license, but I thought Id vent.

I pray the Board would re-consider their possibly and hopefully granting me the privilege to continue in a limited capacity if you wish to practice my profession of orthodontics that I have loved for 46 years. Thank you.

Sincerely and respectfully,



Irving Anders, D.M.D., M.S.

June 30, 2021

6. Board Approval of Restorative Dental Hygiene Curriculum – Dixie State University.

Brenda L. Armstrong, a representative of Dixie State University in St. George, Utah, is requesting the Board approve the Dixie State University restorative course for dental hygienists who wish to obtain a Restorative Functions Endorsement.

Applicable Rules

818-035-0072 - Restorative Functions of Dental Hygienists

(1) The Board shall issue a Restorative Functions Endorsement (RFE) to a dental hygienist who holds an unrestricted Oregon license, and has successfully completed:
(a) A Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, and successfully passed the Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board within the last five years; or
(b) If successful passage of the Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.
(2) A dental hygienist may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):
(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration(s) by a Restorative Functions Endorsement dental hygienist;
(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

Statutory/Other Authority: ORS 679 & 680
Statutes/Other Implemented: ORS 679.010(3) & 679.250(7)
History:
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13
OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07

DSU DIXIE STATE UNIVERSITY
ST. GEORGE, UTAH

College of Health Sciences
Department of Dental Hygiene
Brenda Armstrong MDH RDH
Department Chair/Associate Professor

June 22, 2021

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

Dear Oregon Board of Dentistry:

Allie Ellerman graduated from the Dixie State University Dental Hygiene program on May 7, 2021. During the program's course of instruction, this student completed Pain Control Anesthesia and Nitrous Oxide Sedation lecture and clinic courses on December 11, 2020. The lecture and clinical courses consisted of 16 hours of didactic instruction and 48 hours of clinical experience.

Ms Ellerman also completed two restorative dental hygiene courses within our curriculum. The first semester of restorative dental hygiene was a lab using simulation models and totaled 60 hours of lab practice. The second course was a clinic providing restorations for patients with 60 hours of clinic time. Ms Ellerman completed these courses on May 1, 2021. I have attached the syllabi for both courses.

These anesthesia and restorative dental hygiene courses and the DSU Dental Hygiene program are accredited by the Commission on Dental Accreditation through the American Dental Association.

I recommend Allie Ellerman for local anesthesia, nitrous oxide, and restorative dental hygiene licensure in the State of Oregon. Should you need further information, please do not hesitate to contact me by phone or the email below.

Thank you,

Brenda Armstrong

Brenda L Armstrong RDH, MDH
DSU Taylor Health Science Building
225 South University Avenue
St. George, Utah 84770

(435) 879-4909
barmstrong@dixie.edu

DIXIE STATE UNIVERSITY DENTAL HYGIENE
DHYG 3055 Expanded Functions
Fall 2020

COURSE DIRECTOR:	Viki Austin, RDH, MPH
Instructors:	Dr. Wagner Dr. DeMille Ms. Atkinson Ms. Cope
CONTACT INFORMATION:	viki.austin@dixie.edu
OFFICE HOURS:	Monday 11:00 – 12:00 Thursday 10:00 – 12:00 Friday 1:00 – 3:00
TIME AND PLACE OF INSTRUCTION:	Monday 1:00 – 4:50 Taylor Bldg: Room 151
COURSE CREDIT:	1 credit
PREREQUISITE:	Acceptance into the DH program
REQUIRED TEXT:	No text required

I. COURSE DESCRIPTION:
Clinical application of expanded duties for the dental hygienist, including anesthesia, placing and removing rubber dams; matrix and wedge; placing bases and liners; placing, carving, and finishing amalgam restorations; placing and finishing tooth-colored restorations; placing temporary restorations; and four-handed dentistry. Course fee required.

II. DSU INSTITUTIONAL LEARNING OUTCOMES AND DENTAL HYGIENE PROGRAM LEARNING OUTCOMES: Partially fulfilled through DHYG 3055 Expanded Functions.

Successful completion of this course contributes toward achieving the following Competencies as stated in the Dixie State University, Department of Dental Hygiene Competency Document:

Institutional Learning Outcomes

Skills: Develop discipline-specific skills and foundational skills in information literacy, quantitative reasoning, critical and creative thinking, inquiry and analysis, teamwork, leadership, and varied modes of communication.

Knowledge: Achieve comprehensive knowledge of discipline-specific area(s) of study and of human cultures and the physical and natural world, through engagement with contemporary and enduring questions

Responsibility: Acquire civic, community, and intercultural knowledge and develop social competence while engaging as a responsible, global citizen.

Innovation: Synthesize and collaborate across general and discipline-specific studies for innovative solutions of complex and unscripted problems.

G.R.I.T:

Growth Mindset**:** The belief that personal attributes can be developed through effort and education.

Relationship Building: The practice of cultivating trusting, collaborative and inclusive relationships.

Intentional Learning: The purposeful, deliberate process to acquire and use a variety of strategies to attain and apply knowledge.

Tenacity: The habit of persevering, adapting and staying engaged for a sustained period of time to achieve goals.

Program Learning Outcomes (Competencies for Entry into the Profession of Dental Hygiene)

PLO #1: Customized Patient-Centered Care

At the successful conclusion of this program, students will be able to: Execute all steps in the dental hygiene process of care.

1.1 Perform a comprehensive patient assessment utilizing critical decision making skills to construct and document a dental hygiene care plan for all types of patients based on data collected.
1.2 Perform and document comprehensive patient care to promote patient health and wellness for all patient types and classifications.
1.3 Provide appropriate life support measures for medical emergencies that may be encountered in practice of dental hygiene.

PLO #2 Code of Ethics and Professional Conduct

At the successful conclusion of this program, students will be able to: Apply a professional code of ethics as stated in the ADHA Code of Ethics.

2.1 Apply a professional code of ethics and conduct to all aspects of dental hygiene.
2.2 Comply with state laws, recommendations and regulations, governing the practice of dental hygiene.
2.3 Achieve high levels of ethical consciousness, decision making, and practice to carry into the profession.

PLO #3: Health Care Systems

At the successful conclusion of this program, students will be able to: Promote oral health through education and service in public health and alternative settings.

3.1 Administer oral health services and education, individualized to patients' cultures and special needs, in a variety of community settings.
3.2 Assess, plan, implement, and evaluate community based oral health programs with respect to the oral health needs of the community.
3.3 Employ inter-professional partnerships to encourage health promotion and disease prevention within the community.

PLO# 4 Critical Thinking and Research

At the successful conclusion of this program, students will be able to: Analyze and apply research to facilitate evidence-based decisions.

4.1 Search and critically examine medical/dental databases for current information for evidenced based decision making.
4.2 Evaluate the safety and efficacy of oral health products, interventions and treatments.
4.3 Utilize principles of research methodology to evaluate the scientific literature, synthesize the information in a critical and effective manner to apply evidence-based approaches to patient care.
4.4 Apply self-assessment skills to prepare for lifelong learning.

PLO #5 Communication and Collaboration

At the successful conclusion of this program, students will be able to: Develop effective communication and collaboration skills for interacting with diverse population groups, healthcare professionals, and health care teams to contribute to increased health and health behaviors.

5.1 Demonstrate effective communication skills when providing oral health education to patients and populations from diverse backgrounds.
5.2 Collaborate with the patient and the inter-professional healthcare team in the formulation of evidence based, comprehensive, patient centered, dental hygiene care.
5.3 Employ effective written and verbal communication skills to provide oral health education and promotion in a variety of settings.

III. COURSE OBJECTIVES/GOALS

- Describe restorative armamentarium along with its' use and care (ILO Skills, Knowledge, Grit) (PLO 4.2)
- Explain the necessity of checking the patient 's functional occlusion before and after placing and carving a restoration (ILO Skills, Knowledge, Grit) (PLO 1.2)
- Summarize and demonstrate the basic placement and carving steps for both amalgam and composite restorations (ILO Skills, Knowledge, Grit) (PLO 4.2)

- Describe the most common errors made when placing, carving and manipulating both amalgam and composite materials – and how to both avoid these errors and correct them if they occur (PLO 4.2)
- Discuss need for and demonstrate placement of rubber dams on both a typodont and patients (ILO Skills, Knowledge, Grit) (PLO 1.2, 4.2)
- State the two main reasons for using a wedge (ILO Skills, Knowledge, Grit) (PLO 4.2)
- Demonstrate the placement of both the Mylar and Toffelmire matrix systems with correct adaptation, contour and contact (ILO Skills, Knowledge, Grit) (PLO 4.2)
- Explain how adhesives and composites bond to the tooth (ILO Skills, Knowledge, Grit) (PLO 4.2)
- Describe the benefits of low and high speed amalgam polishing (ILO Skills, Knowledge, Grit) (PLO 1.2, 4.2)
- Utilize the principles of
    - four-handed dentistry
    - patient, operator, and assistant positioning
    - four-handed instrument transfer (ILO Skills, PLO 1.2, 3, 5.2)

IV. INSTRUCTION AND EVALUATION

Instructional Methods:

- Discussion/review
- Demonstration
- Video presentation
- Laboratory practice on prepared typodont teeth

Evaluation Criteria:

Assignment 1 – Jurisprudence and Regulation **(Due Nov 23 @ 5pm)**

Restorative hygiene is allowed in select states throughout the U.S. For this assignment you will research the Rules and Regulations for the State of Oregon. Then compare and contrast those regulations to the state where you plan to begin practicing your hygiene career. Write a *narrative* paper of sufficient length to cover topic. Content should include but not be limited to

- Scope of restorative practice
- Dental team members allowed to practice restorative placement
    - Include criteria for
        - Dentists
        - Dental Hygienists
        - Dental Assistants
- Testing requirements
- Additional CE requirements related to Restorative Endorsement

Skill evaluations:

Skill evaluations assess quality of skills. Skill evaluations must be completed under the supervision of an instructor. Skill evaluations are Pass/Fail, however 80% is required to pass. Students may repeat Skill Evaluations until achieving a passing grade. No individual Skill Evaluation may be attempted more than once during a lab session.

Required skill evaluations:

- Dental dam placement (2 typodont)
- Matrix band and wedge placement – posterior tooth (2) (one Tofflemire, one Rings and Beans)
- 2 surface amalgam restoration (1) (maxillary or mandibular arch)
- 2 surface composite restoration (1) (maxillary or mandibular arch **posterior**)
- 2 surface composite restoration (1) (maxillary or mandibular arch **anterior**)
- Amalgam polishing (4) (2 high speed, 2 slow speed)

Quantity/Quality:

In addition to the above skill evaluations students are required to submit the following typodont restorations. These additional restorations will be evaluated using the WREB restorative grading criteria.

WREB Grading Criteria will be used as follows:

- Occlusal: 30% (5=15; 4=13; 3=11; 2=9; 1=6; 0=4)
- Proximals: 35% (5=18; 4=15; 3=13; 2=10; 1=7; 0=5)
- Margins: 35% (5=18; 4=15; 3=13; 2=10; 1=7; 0=5)

Example grading:
51 points = 100% 38.25 points = 75% (passing)
Occlusal score 13 + Proximal score 18 + Margins score 15 = 46 points = PASS

All restorations will be graded by two instructors and the final grade for that restoration will be an average of the two grades. Students must achieve 75% or better for the restoration to qualify for quantity points. Completed restorations will be graded in place during class. Students will sign up for an instructor to come and grade a restoration. Only one restoration can be graded at a time.

Additional restoration requirements

- 6 Class II posterior amalgam restorations (3 of 6 must be maxillary)
- 6 Class II posterior composite restorations (3 of 6 must be maxillary)
- #6 F composite
- 2 (#8 DL) composite
- 2 (#9 DIFL) composite

Review Wilkin's pp 275 for Black's Caries Classifications

Attendance: Attendance is mandatory at all lab sessions. You will not be able to make up lab sessions if you are absent. Attendance and early departure will be documented. Early departure may impact your final course grade. If a prolonged absence is expected both the course coordinator and program coordinator need to be informed.

COVID-19: Due to the ongoing pandemic, all students will be assigned seats and be required to wear masks at all times. Students will take the seat that corresponds to their clinic OP#. Students will enter the lab individually with social distancing, remain in their seats for the duration of class, and exit individually with social distancing at the end of class.

Make-up Examination Policy: All skill evaluations will be completed during lab time. There is no provision for making up the mid-term exam.

Assignment submission: Jurisprudence & Regulation paper Completed assignments must be submitted in the assignment submission via Canvas. ***The instructor must be able to open your file attachments or the assignment will be considered late.***

Late Assignment Policy:
Any assignments submitted after the due date/time will be considered late but should still be submitted. There will be a 15% grade deduction for each day an assignment is late. Students may find it necessary to complete quantity/quality restorations outside of class time. Should this occur please make an appointment with Ms. Austin for supervision. You may not work on Quantity/Quality or SE restorations without supervision.

V. GRADE DISTRIBUTION
Grade Breakdown (% for each component)

- 11 Skill evaluations will be graded as Pass/Fail. All must be completed with a final passing grade. (40% of final grade)
- 18 additional typodont restorations must be completed at 75% or better using the WREB grading criteria provided. (40% of final grade)
- Restorative Jurisprudence research paper (5% of final grade)
- Midterm Exam (15% of final grade)

Grade Scale %

94-100%	A	74-76.9%	C
90-93.9%	A-	70-73.9%	C-
87-89.9%	B+	67-69.9%	D+
84-86.9%	B	64-66.9%	D
80-83.9%	B-	60-63.9%	D-
77-79.9%	C+	0-59.9%	F

Final grade of less than 74% results in a failure of the course.

VII. ACADEMIC INTEGRITY

Academic and personal integrity throughout the program is expected. Cheating is not tolerated. Cheating is defined as taking credit for work you did not do. This includes getting the answers to homework problems from someone else, copying information from a library or internet sources and presenting it as if it were your own words (plagiarism, looking at someone else's answers on an exam, and asking someone who has already taken a test about the questions it contains. The faculty member may impose the following sanctions: Require that the work be redone, an exam retaken, or an alternate assignment substituted. Reduce the grade for the assignment or other academic activity. Reduce the grade for the course, issue a grade of "F" for the paper, project, test, exam or other academic activity in which the misconduct occurred. Issue a failing grade for the course. A grade of "F" may be given for the course in the cases of cheating, plagiarism, violating patient rights and confidentiality/HIPAA and/or withholding or falsifying records/information during clinical and/or community experience. A failing grade in any course is grounds for dismissal from the Dental Hygiene Program.

Please see the DSU policy library for the Student Rights and Responsibilities policy:

https://dixiestate.sharepoint.com/sites/pl/_layouts/15/WopiFrame.aspx?docid=0f797aa9646894b10bf938f041d67c79f&authkey=AdD6yFh9tp9Ppb2r8fR4wO0&action=view

VIII. UNIVERSITY INFORMATION

Click on this link - http://academics.dixie.edu/syllabus/ - for comprehensive information on the Semester Dates, the Final Exam Schedule, university resources such as the library, Disability Resource Center, IT Student Help Desk, Online Writing Lab, Testing Center, Tutoring Center, and Writing Center. In addition, please review DSU policies and statements with regards to Academic Integrity, Disruptive Behavior and Absences related to university functions.

If you suspect or are aware that you have a disability that may affect your success in the course you are strongly encouraged to contact the Disability Resource Center (DRC) located at the North Plaza Building. The disability will be evaluated and eligible students will receive assistance in obtaining reasonable accommodations. Phone # 435-652-7516

IX. DSU STUDENT ACADEMIC CONDUCT POLICY:
http://catalog.dixie.edu/codeofstudentrightsresponsibilities/

X. SEXUAL HARASSMENT, SEXUAL DISCRIMINATION, AND/OR SEXUAL ASSAULT COMPLAINTS

DSU seeks to provide an environment that is free of bias, discrimination, and harassment. If you have been the victim of sexual harassment/misconduct/assault we encourage you to report this to the college's Title IX Director, Cindy Cole, (435) 652-7731, cindy.cole@dixie.edu. If you report to a faculty member, she or he must notify the Title IX Director about the basic facts of the incident.

XI. DMAIL

You are required to frequently check your Dmail account. Important class and university information will be sent to your Dmail account, including DSU bills, financial aid/scholarship notices, notices of cancelled classes, reminders of important dates and deadlines, and other information critical to your success at DSU and in your courses. To access your Dmail account, visit go.dixie.edu/dmail. Your Dmail username is your DixieID (e.g. D00111111) If you have forgotten your PIN, visit go.dixie.edu/mydixie and click the Forgot Pin button.

XII. FIT FOR DUTY STATEMENT

This is a service-learning class and is therefore subject to specific physical and mental minimum performance parameters as outlined in the Dixie State University Dental Hygiene Fitness for Duty statement documented in the Dixie State University Dental Hygiene Policies and Procedures Manual and the Dixie State University Clinical Policies and Procedures manual. If you are perceived to be unfit to perform service-learning duties as outlined in the fitness for duty policy you may be asked to leave the class and may not be permitted to return until you are deemed fit to do so.

XIII. DSU ACADEMIC CALENDAR

Visit the following link for the DSU Academic Calendar, including important dates to remember: https://old.dixie.edu/reg/?page=calendar&page=calendar

Course Requirements Student Tally

Student name_____

Requirement	Tooth #	Surfaces	Points possible	Percent required for passing	Points required for passing	Points achieved
Skill Evaluations						
Dental dam placement - typodont			10	80	8	
Dental dam placement - typodont			10	80	8	
Matrix and wedge placement (Tofflemire)			10	80	8	
Matrix and wedge placement (Palodent)			10	80	8	
2 surface amalgam (max or mand)			10	80	8	
2 surface composite posterior(max or mand)			10	80	8	
2 surface composite anterior (max or mand)			10	80	8	
Amalgam polish (high speed)			10	80	8	
Amalgam polish (high speed)			10	80	8	
Amalgam polish (slow speed)			10	80	8	
Amalgam polish (slow speed)			10	80	8	
Quantity (75% = passing)						
Posterior amalgam Class II			51	75	38	
Posterior amalgam Class II			51	75	38	
Posterior amalgam Class II			51	75	38	
Posterior amalgam Class II (maxillary)			51	75	38	
Posterior amalgam Class II (maxillary)			51	75	38	
Posterior amalgam Class II (maxillary)			51	75	38	
Posterior composite Class II			51	75	38	
Posterior composite Class II			51	75	38	
Posterior composite Class II			51	75	38	
Posterior composite Class II (maxillary)			51	75	38	
Posterior composite Class II (maxillary)			51	75	38	
Anterior composite Class II (maxillary)			51	75	38	
#6 F			18	75	13	
#8 DL			36	75	27	
#8 DL			36	75	27	
#9 DIFL			51	75	38	
#9 DIFL			51	75	38	
Total restoration points			914			
Regulation & Jurisprudence assignment			25			
Midterm Exam						
Course total			934			

XII. COURSE SCHEDULE

DHYG 3055 Expanded Functions Course Schedule Fall 2020

Dates	Topic	Recommended resources	Learning activities	Learning outcomes/competencies
Week 1 Monday Aug 24	Syllabus review Receive instruments and typodonts Dental dam placement	Dam-it It's Easy https://www.youtube.com/watch?v=pnx3QKDsroU	Orientation Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 2 Monday Aug 31	**Matrix and Wedge** • Discussion of burs and hand instruments used in tooth preparations • Introduction to placing and removing matrix and wedge • Set up armamentarium for dental dam and matrix and wedge • Trade out tooth #19 for MO restoration • Place dental dam on mandibular left quadrant • Practice placing and removing traditional matrix and wedge on #19 • Practice placing and removing Palodent matrix and wedge on #19 • Clean up	Tofflemeier https://www.youtube.com/watch?v=XfL7vzfa0gY Rings and Beans https://www.youtube.com/watch?v=OG_FsDc41gI	Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 3 Monday Sept 7	**Labor Day – No classes**			
Week 4 Monday Sept 14	**Anatomy review** **Composite material review** **Composite restorations** • Introduction for placing and finishing composite restorations • Set up armamentarium for dental dam, matrix and wedge, and composite restorations • Trade out tooth #19 for MO restoration • Place dental dam on mandibular left quadrant • Place matrix and wedge for #19 MO • Restore #19 MO • Instructor evaluation • Finish/polish #19 MO • Instructor evaluation	Composite placement https://www.youtube.com/watch?v=Vepcq-Mi1rU	Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2

	• Continue practice on additional teeth • Clean up			
Week 5 Monday Sept 21	**Composite restorations (cont)** • Set up teeth to be restored • Set up armamentarium for dental dam, matrix and wedge, and composite restorations • Place dental dam on maxillary right quadrant • Place and cure composite material • Instructor evaluation • Place dental dam on maxillary anteriors • Section instructors demonstrate matrix and wedge placement on anterior tooth and describe placement of anterior composite • Place composite on anterior tooth • Instructor evaluation • Finish/polish anterior composite • Instructor evaluation • Continue practice on additional teeth • Clean up		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 6 Monday Sept 28	**Practice, Skill Evaluations**		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 7 Monday Oct 5	**Practice, Skill Evaluations**		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 8 Monday Oct 12	**Practice, Skill Evaluations**		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 9 Monday Oct 19	**Amalgam material review** **Amalgam restorations** • Instructions for condensing and carving amalgam restorations • Set up teeth to be restored • Set up armamentarium for dental dam, matrix and wedge, amalgam restorations • Place dental dam on mandibular quadrant • Place matrix and wedge for restoration	https://www.youtube.com/watch?v=urQMEtfZxlE	Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2

	• Place, condense, pack and carve amalgam • Instructor evaluation • Clean up			
Week 10 Monday Oct 26	**Amalgam restorations continued** • Set up teeth to be restored • Set up armamentarium for dental dam, matrix and wedge, amalgam restorations • Place dental dam in maxillary quadrant • Place matrix and wedge on selected tooth • Place, condense, pack and carve amalgam • Instructor evaluation • Continue practice • Clean up		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 11 Monday Nov 2	**Amalgam polishing** • Polish previously placed amalgam restorations • Practice the removal of overhanging restorations • Practice, Skill Evaluations		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 12 Monday Nov 9	**Practice, Skill Evaluations** **Midterm exam**		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 13 Monday Nov 16	**Practice, Skill Evaluations**		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 14 Monday Nov 23	**Discussion of 4-handed dentistry** • Each set of partners will EQUALLY split the remainder of the time • Help each other clean up		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2
Week 15 Monday Nov 30	**Final Session** • Replace all typodont teeth with virgin teeth Assure all skill evaluation, and any additional grade sheets are turned in. Check tracking sheet for accuracy.		Review Hands-on learning	Institution – ILO – Skills, Knowledge, Grit CODA - PLO 4.2

Dixie State University
Dental Hygiene Program
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Amalgam Polishing

Student_____Date_____

Patient/ Typodont ***(circle one)*** High Speed/Slow Speed ***(circle one)*** Tooth#_____Surfaces:_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Demonstrates proficiency in the sequence of steps for polishing amalgam restorations		
Anatomy and contour of restoration are functionally adequate		
Surfaces are smooth lustrous		
Cavosurface margin is smooth		
No damage to adjacent tooth or soft tissue		
Occlusion is functionally correct		
Infection control is adhered to throughout procedure		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature_____ Grade: PASS/NO PASS

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Dixie State University
Dental Hygiene Department
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Amalgam Placement

Student_____Date_____

Patient/ Typodont ***(circle one)*** Tooth#_____Surfaces_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Triturates amalgam to correct consistency		
Demonstrates proficiency placing and condensing amalgam		
Adequately overfills restoration		
Demonstrates proficiency carving amalgam (anatomy and contour are functionally correct)		
Correctly disposes of waste (Bag under typodont to collect amalgam scraps) directs assistant for suction when necessary on live patient		
Occlusion is functionally correct		
Infection control and mercury hygiene is adhered to throughout procedure		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature _____ GRADE:PASS/NOPASS

Rev 7-17 VP

Dixie State University
Dental Hygiene Program
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Composite Placement

Student_____Date_____

Patient/ Typodont ***(circle one)*** Tooth#_____Surfaces_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Demonstrates proficiency in etching and placing bonding agent to the necessary structures when applicable		
Demonstrates proficiency in placing and manipulating the composite curing the composite in layers		
Demonstrates proficiency in sculpting adequate functional occlusal morphology		
Demonstrates proficiency in sculpting adequate proximal morphology avoiding excessive proximal overhangs or underfills		
Demonstrates proficiency polishing composite without causing soft tissue trauma. Surface is functionally smooth with no excessive flash or voids		
Checks occlusion		
Infection control is adhered to throughout procedure		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature _____ GRADE: PASS/NO PASS

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Dixie State University
Dental Hygiene Program
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Matrix and Wedge Placement - **Tofflemeier**

Student_____Date_____

Patient/ Typodont ***(circle one)*** Tooth#_____Surfaces_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Selects correct size of band and wedge		
Properly places band into retainer for correct tooth		
Band is situated correctly for type of restoration		
Wedge is seated correctly to obtain proper seal of gingival floor		
Test band and wedge for proper contour and stability		
Infection control is adhered to throughout procedure		
Demonstrate proficiency in wedge and band removal		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature _____ Grade: PASS / NO PASS

Dixie State University
Dental Hygiene Program
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Matrix and Wedge Placement – **Rings and Beans**

Student_____Date_____

Patient/ Typodont *(circle one)* Tooth#_____Surfaces_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Places and removes system with minimal trauma to the soft tissue		
Demonstrates proficiency in seating the Palodent band system		
Band and wedge are situated correctly		
Test band and wedge for proper contour and stability		
Band and wedge are stable enough to maintain during operative procedures		
Infection control is adhered to throughout procedure		
Demonstrate proficiency in Palodent band system removal		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature_____GRADE: PASS/NOPASS

Rev 7-17 VP

Dixie State University
Dental Hygiene Program
DHYG 3055/3555 Expanded Functions
Skill Evaluation: Dental Dam Placement/Removal

Student_____Date_____

Patient/ Typodont ***(circle one)*** Tooth#____Surfaces_____

Criteria	**Meets expectations**	**Does not meet expectations**
Armamentarium is properly assembled and organized		
Explains procedure to patient when applicable		
Correctly prepares dental dam for placement on applicable arch (correct number, size, and spacing of holes)		
Correct clamp is selected and seated without impinging on soft tissue		
Demonstrates proficiency in seating the dental dam		
Dam is situated correctly for operator access and patient comfort		
Test dam for leakage and stability of clamp		
Clamps and dam are retained by floss/ ligatures		
Demonstrates correct and safe removal of dental dam		
Procedure is correctly recorded when applicable		

Fall Sem. EFC: (80%) Student must meet expectations in 8 out of the 10 categories to pass skill evaluation
Spring Sem. EFC: (90%) Student must meet expectations in 9 out of the 10 categories to pass skill evaluation

Instructor Signature_____Grade: PASS / NO PASS

Rev 7-17 VP

COLLEGE OF HEALTH SCIENCES

DIXIE STATE UNIVERSITY DENTAL HYGIENE

DHYG 4555 Expanded Functions
Spring 2021

COURSE DIRECTOR:	Viki Austin, RDH, MPH
Instructors:	Dr. McLin Dr. Nielson Dr. Peterson Dr. Sanford
CONTACT INFORMATION:	viki.austin@dixie.edu
OFFICE HOURS:	Tuesday: 7:30 – 8:00; 5:00 – 6:00 Thursday: 7:30 – 8:00; 4:5:00 – 6:00 Friday: 7:30 – 8:00; 11:30 – 12:00
TIME AND PLACE OF INSTRUCTION:	Taylor Bldg: Dental Hygiene Clinic
COURSE CREDIT:	1 credit
PREREQUISITE:	Acceptance into the DH program
REQUIRED TEXT:	No text required

I. COURSE DESCRIPTION:
Clinical application of expanded duties for the dental hygienist, including anesthesia, placing and removing rubber dams; matrix and wedge; placing bases and liners; placing, carving, and finishing amalgam restorations; placing and finishing tooth-colored restorations; placing temporary restorations; and four-handed dentistry. Course fee required.

II. COURSE OBJECTIVES/GOALS

- Explain the necessity of checking the patient 's functional occlusion before and after placing and carving a restoration (PLO 1.2)
- Summarize and demonstrate the basic placement and carving steps for both amalgam and composite restorations (PLO 4.2)
- Describe the most common errors made when placing, carving and manipulating both amalgam and composite materials – and how to both avoid these errors and correct them if they occur (PLO 4.2)
- Discuss need for and demonstrate placement of rubber dams on patients (PLO 1.2, 4.2)
- Demonstrate the proper use of a wedge (PLO 4.2)
- Discuss indications and contraindications for the placement of various liners (PLO 4.2)
- Demonstrate the mixing and placement of liners in a cavity preparation (PLO 4.2)
- Demonstrate the placement of both the Mylar, Sectional and Toffelmire matrix systems with correct adaptation, contour and contact (PLO 4.2)
- Produce amalgam and composite restorations that are functional in the mouth. (PLO 1.2, 4.2)
- Utilize the principles of

- four-handed dentistry
- patient, operator, and assistant positioning
- four-handed instrument transfer

III. PROGRAM COMPETENCIES/PROGRAM LEARNING OUTCOMES (PLOs)
Successful completion of this course contributes toward achieving the following Competencies
as stated in the Dixie State University, Department of Dental Hygiene Competency Document:

1.2 Perform and document comprehensive patient care to promote patient health and wellness for all patient types and classifications.

4.2 Evaluate the safety and efficacy of oral health products, interventions and treatments.

IV. DIXIE STATE UNIVERSITY CORE THEMES SUPPORTED BY THIS COURSE
Dixie State University Core Themes supported through this course:

- SKILLS: Develop discipline-specific skills and foundational skills in information literacy, quantitative reasoning, critical and creative thinking, inquiry and analysis, teamwork, leadership, and varied modes of communication.
- KNOWLEDGE: Achieve comprehensive knowledge of discipline-specific area(s) of study and of human cultures and the physical and natural world, through engagement with contemporary and enduring questions.
- INNOVATION: Synthesize and collaborate across general and discipline-specific studies for creative resolution of complex and unscripted problems within and beyond the university campus.
- RESPONSIBILITY: Acquire civic, community, and intercultural knowledge and develop social competence while engaging as a responsible, global citizen.
- GRIT: Develop passion and perseverance towards long-term goals despite significant obstacles.

V. INSTRUCTION AND EVALUATION

<u>Evaluation Criteria:</u>

- Successful completion of all skill evaluations listed
- 6 patient clinics as a clinician
    - Because this course relies heavily on patients you will receive points based on having a patient in the chair and providing treatment to that patient.
    - Patient encounters will be evaluated using the digital evaluation sheets. Clinicians and Assistants will be graded individually. Points will be earned and entered for your grade.
    - Once your 6 patient clinics have been completed you may exchange a clinician day with someone who still needs that requirement.
- Patient no-show evaluation/points.

- In the case of a no-show event, both the assistant and the clinician will be expected to set up typodonts individually and practice placing restorations.
- No quality/quantity points will be awarded during a non-patient session.

Assignments:

Skill evaluations (90% or better)
Skill evaluations will assess quality of skills. Students must achieve 90% or better to pass a skill evaluation. Skill evaluations are Pass/Fail.

Required skill evaluations: Instructor observed

- Rubber dam placement (2)
- Matrix band and wedge placement – posterior tooth (2) (one Tofflemire, one Rings and Beans)
- 2 surface amalgam restoration (1) (maxillary or mandibular arch)
- 2 surface composite restoration (1) (maxillary or mandibular arch posterior)
- 2 surface composite restoration (1) (maxillary or mandibular arch anterior)

Quantity/Quality:
In addition to Skill Evaluation points you will be evaluated on your interaction with your patient, the quality of your anesthesia/restoration/dental dam/matrix and wedge. You will be evaluated both as a clinician and as an assistant using the Expanded Functions Clinic Evaluation. 6 clinician/assistant evaluations are expected.

Professionalism:
Professionalism is critical during patient interaction, whether as a clinician or assistant. A Clinical Management/Professional Judgement (CMPJ) form will be completed for each clinical session – regardless of your assigned duties that session. Each CMPJ is worth 10 points.

Reflection paper:

a. Write a 4 – 5page (double spaced, 1" margins) paper addressing
    i. Existing opportunities for dental hygienists related to restorative hygiene nation/world-wide
    ii. Roadblocks to restorative hygiene opportunities
    iii. Aspirations for the dental hygiene profession related to restorative hygiene (dream big)
    iv. Reflection on your experience with Expanded Functions II (reflect on a specific patient experience) and how/if you intend to use this knowledge/experience in the future
b. Paper will be graded for content, effort, grammar, APA format. A grading rubric will be used and entered into Canvas

VI. STERILIZATION:

Ultimately sterilization is the responsibility of each student individually. Because we have an even number of students and a limited number of possible patient days no

student will be assigned specifically to sterilization duties. If you do not have a patient for a clinic session you will be expected to help in the sterilization area in addition to working on a typodont. Please work together as a team so that sterilization is accomplished in an acceptable manner.

VII. SCHEDULING:

- Students will work in pairs and alternate between clinician and assistant duties.
- Students are individually responsible for identification and scheduling of patients. A schedule is posted on Google Classroom to facilitate scheduling of patients.
- This semester there are 13 weeks of possible patient interactions. Each student that hopes to be credentialed in Restorative Hygiene needs 24 hours of actual patient care in restorative hygiene. That equates to 6 clinical sessions of patient care. If you are a student hoping to become credentialed as a restorative hygienist and you need an additional patient interaction as a clinician you may switch with a fellow classmate during the last clinic session.
    - Clinical assistant duties involve: setting up for the scheduled procedure, assisting clinicians during the procedure, and locating/procuring needed supplies.

VIII. ATTENDANCE

A. Spring 2021 University attendance policy
    1. Students will be required to attend and participate in each class, whether in-person or through live streaming. So, if you are scheduled to participate in a class in-person, you must attend and actively participate to receive full credit for attendance. Absences may count against your grade.

B. DSU DH attendance policy
    1. Attendance: It is imperative that you participate in all course sessions to gain the knowledge and skills needed to pass the national board and become a competent dental hygienist. Absenteeism exceeding 20% of class lectures will result in a 5% point deduction from the student's final grade. **Any student not present within 10 minutes of the starting of class time will be considered absent for the class session.** Please refer to the DSUDH Policy and Procedure Manual for more information regarding excused absences and unexcused absences.

C. Patient Sessions: Attendance at all sessions is required. There are maximum opportunities for learning and lost opportunities for a variety of reasons, legitimate or not. It is the student's responsibility to choose if they can afford to miss critical clinic time, and to accept the natural result of that missed time. For students that use time and perform well when attending, a single sick day will likely not translate to incomplete requirements. Make smart choices in your attendance. You will not be able to make up lab sessions if you are absent. If a prolonged absence is

expected both the course coordinator and program coordinator need to be informed.

D. Unexcused absences will result in a 5point deduction for Professionalism on that days' CMPJ.
    1. Excused absences: Sometimes events happen that are beyond our control. Students must notify the Clinic Lead AND Elyse for any unanticipated absences. This would include accidents, and illness. You may be required to produce an accident report and/or a physician's note to the department.
        a) Although every attempt should be made to schedule Board Examinations other than during clinic sessions, sometimes this is not possible. Attendance for Board examinations will constitute an excused absence. The Clinic Lead must be notified prior to the event. You may not schedule Board examinations during a clinic session when you are on rotation.
    - Unexcused absences: Sometimes events come up that the student would like to participate in. While I understand and fully support that life events are important, it is up to the student to determine whether or not to attend and miss out on the opportunity to advance their clinical expertise

- Students are expected to be in clinic setting up at 8:00, seating their patient at 8:30 and 8:40. Patient dismissal is11:30.
- Plan on leaving the clinic by 12:00.
    - State licensing requires at least 24 actual patient hours. We can count set up and tear down time so 8:00 – 12:00 = 4 hours x 6 patient clinician times = 24 hours.
- If your patient is a no-show or late cancellation, you are required to set up a typodont and practice restorations. Ask for the needed lab supplies for this activity.

Make-up Examination Policy: April 23 is an optional clinic. You may use this clinic to make-up for patient time or points that have been missed due to a non-patient session.

Late Assignment Policy: Any assignment submitted after the due date/time will be considered one day late but should still be submitted. There will be a 15% grade deduction for each day an assignment is late. You will still receive adjusted points up to one week after the due date.

GRADE DISTRIBUTION

Grade Breakdown (% for each component)

Assignment	Quantity	Points	% of Final Grade
Skill Evaluations	7 @ 10 pts ea.	70	20 %
Clinician evaluations	6 @ 23 pts ea.	138	30%
Assistant evaluations	6 @ 23pts ea.	138	30 %
CMPJ Evaluations	12 @ 10 pts ea.	120	10%
Reflection	1 @ 20 pts	20	10%
Total Points possible		486	100%

Course grade scale %

94-100%	A	74-76.9%	C
90-93.9%	A-	70-73.9%	C-
87-89.9%	B+	67-69.9%	D+
84-86.9%	B	64-66.9%	D
80-83.9%	B-	60-63.9%	D-
77-79.9%	C+	0-59.9%	F

Final grade of less than 74% results in a failure of the course.

IX. ACADEMIC INTEGRITY

a. Academic and personal integrity throughout the program is expected. Cheating is not tolerated. Cheating is defined as taking credit for work you did not do. This includes getting the answers to homework problems from someone else, copying information from a library or internet sources and presenting it as if it were your own words (plagiarism, looking at someone else's answers on an exam, and asking someone who has already taken a test about the questions it contains. The faculty member may impose the following sanctions: Require that the work be redone, an exam retaken, or an alternate assignment substituted. Reduce the grade for the assignment or other academic activity. Reduce the grade for the course, issue a grade of "F" for the paper, project, test, exam or other academic activity in which the misconduct occurred. Issue a failing grade for the course. A grade of "F" may be given for the course in the cases of cheating, plagiarism, violating patient rights and confidentiality/HIPAA and/or withholding or falsifying records/information during clinical and/or community experience. A failing grade in any course is grounds for dismissal from the Dental Hygiene Program.
b. Please see the DSU policy library for the Student Rights and Responsibilities policy:
c. https://dixiestate.sharepoint.com/sites/pl/_layouts/15/WopiFrame.aspx?docid=0f797aa9646894b10bf938f041d67c79f&authkey=AdD6yFh9tp9Ppb2r8fR4wO0&action=view

X. UNIVERSITY INFORMATION

a. Click on this link - http://academics.dixie.edu/syllabus/ - for comprehensive information on the Semester Dates, the Final Exam Schedule, university resources such as the library, Disability Resource Center, IT Student Help Desk, Online Writing Lab, Testing Center, Tutoring Center, and Writing Center. In addition, please review DSU policies and statements with regards to Academic Integrity, Disruptive Behavior and Absences related to university functions.
b. Here is a link for the DSU master calendar:
c. https://academics.dixie.edu/academic-calendars/#finalshttps://academics.dixie.edu/academic-calendars/#finals
d. *If you suspect or are aware that you have a disability that may affect your success in the course you are strongly encouraged to contact the Disability Resource Center (DRC) located at the North Plaza Building. The disability will be evaluated and eligible students will receive assistance in obtaining reasonable accommodations. Phone # 435-652-7516*

XI. DSU STUDENT ACADEMIC CONDUCT POLICY:
http://catalog.dixie.edu/codeofstudentrightsresponsibilities/

XII. SEXUAL HARASSMENT, SEXUAL DISCRIMINATION, AND/OR SEXUAL ASSAULT COMPLAINTS

a. DSU seeks to provide an environment that is free of bias, discrimination, and harassment. If you have been the victim of sexual harassment/misconduct/assault we encourage you to report this to the college's Title IX Director, Cindy Cole, (435) 652-7731, cindy.cole@dixie.edu. If you report to a faculty member, she or he must notify the Title IX Director about the basic facts of the incident.

XIII. DMAIL

a. You are required to frequently check your Dmail account. Important class and university information will be sent to your Dmail account, including DSU bills, financial aid/scholarship notices, notices of cancelled classes, reminders of important dates and deadlines, and other information critical to your success at DSU and in your courses. To access your Dmail account, visit go.dixie.edu/dmail. Your Dmail username is your DixieID (e.g. D00111111) If you have forgotten your PIN, visit go.dixie.edu/mydixie and click the Forgot Pin button.

XIV. DSU ACADEMIC CALENDAR

a. Visit the following link for the DSU Academic Calendar, including important dates to remember: https://old.dixie.edu/reg/?page=calendar&page=calendar

XV. FIT FOR DUTY STATEMENT

This is a service-learning class and is therefore subject to specific physical and mental minimum performance parameters as outlined in the Dixie State University Dental Hygiene Fitness for Duty statement documented in the Dixie State University Dental Hygiene Policies and Procedures Manual and the Dixie State University Clinical Policies and Procedures manual. If you are perceived to be unfit to perform service-learning duties as outlined in the fitness for duty policy you may be asked to leave the class and may not be permitted to return until you are deemed fit to do so.

FITNESS FOR DUTY POLICY

It is the policy of the Dixie State University Dental Hygiene Program to protect the health and safety of students, patients, faculty, and staff while in class and at the various facilities that we serve by providing an environment where students are "Fit for Duty" when performing on campus or at a rotational site. When there is a concern expressed by faculty, staff, patient, another student, or member of the community, that a student is not able to perform safely and effectively, she/he will not be permitted to stay on site and will be sent home immediately until "fitness" is determined. In determining "fitness", students will be required to have a drug screen done at the dental hygiene department's expense before being allowed in clinical or community lab courses. Periodic random screening requests will be made throughout the year at the program's expense. Students must report to WorkMed for the test within 48 hours of the request. Pending faculty review, and in accordance to Dixie State University Student Policies 5.33 and 3.37, the student will be subject to disciplinary action up to

and including university or program dismissal. All other affiliation agreement policies will be strictly adhered to.

"Fit for Duty" means that a student is able to perform the standards related to a dental hygienist as outlined in the DSUDH Policies and Procedures Manual in a safe and effective manner, unimpaired by some medical conditions, personal problems, medications, sleep deprivation, alcohol and/or drugs.

Course Requirements Student Tally – Spring 2021

	Requirement	Tooth #	Surfaces	Points possible	Points required for passing	Points achieved
Skill Evaluations	Rubber dam placement			10	9	
	Rubber dam placement			10	9	
	Matrix and wedge placement (Tofflemire)			10	9	
	Matrix and wedge placement (Rings and Beans)			10	9	
	2 surface amalgam (max or mand)			10	9	
	2 surface composite posterior(max or mand)			10	9	
	2 surface composite anterior (max or mand)			10	9	

	Patient name	Tooth /surfaces	Amalgam	Composite	Date	Points
Quantity/Quality Clinician	1.					
	2.					
	3.					
	4.					
	5.					
	6.					
Quantity/Quality Assistant	1.					
	2.					
	3.					
	4.					
	5.					
	6.					

	Date	Points	Date	Points	Date	Points	Date	Points	Date	Points	Date	Points		
CMPJ	1/22		2/5		2/19		3/5		3/26		4/9		4/23	
	1/29		2/12		2/26		3/19		4/2		4/16		**Total points**	

XII. COURSE SCHEDULE: DHYG 4555 Expanded Functions Course Schedule Spring 2021

Dates	Topic	Learning activities
Friday 1/11	Syllabus review Discuss patient flow and expectations	Orientation
Friday 1/22	Clinical patient duties as assigned	Hands-on learning
Friday 1/29	Clinical patient duties as assigned	Hands-on learning
Friday 2/5	Clinical patient duties as assigned	Hands-on learning
Friday 2/12	Clinical patient duties as assigned	Hands-on learning
Friday 2/19	Clinical patient duties as assigned	Hands-on learning
Friday 2/26	Clinical patient duties as assigned	Hands-on learning
Friday 3/5	Clinical patient duties as assigned	Hands-on learning
Friday 3/19	Clinical patient duties as assigned	Hands-on learning
Friday 3/26	Clinical patient duties as assigned	Hands-on learning
Spring Break – No class		
Friday 4/2	Clinical patient duties as assigned	Hands-on learning
Friday 4/9	Clinical patient duties as assigned	Hands-on learning
Friday 4/16	Clinical patient duties as assigned	Hands-on learning
Friday 4/23	Clinical patient duties as assigned	Hands-on learning

Request for Approval of a Local Anesthesia Course – Salt Lake Community College.

Renee Mendenhall of Salt Lake Community College is requesting that the Board approve Salt Lake Community College's continuing education program for local anesthesia.

Relevant Rules:

OAR 818-035-0040 – Expanded Functions of Dental Hygienists
(1) Upon 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 dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents under the general supervision of a licensed dentist.

Renee Mendenhall, RDH, MBA
Salt Lake Community College Dental Hygiene Program
3491 W. Wights Fort Rd., HTC 135B
W. Jordan, UT 84088
May 31, 2021

Dear Ms. Nye,

This letter is to request that the Oregon Board of Dentistry recognize the local anesthesia course and lab offered at Salt Lake Community College (SLCC) as part of the AAS Dental Hygiene program curriculum. This request is to enable graduates of SLCC to apply for professional licensure as a Dental Hygienist in the State of Oregon.

Course descriptions for these concurrent courses are as follows:

DH 2340 Local Anesthesia Lecture
Catalog Description:

Pain control in the dental office including administration of local anesthetic/nitrous oxide and anxiety management. Completion of this course qualifies students to take Western Regional Examination Board for local anesthesia.

DH 2340 Local Anesthesia Lab
Catalog Description:

Demonstration and administration of all local and regional blocks are experienced in a supervised lab setting. Minimum competence is verified through successful completion of proficiency evaluations.

Also find attached separate syllabi for each course, including course outlines, schedules, and assignments. Please do not hesitate to contact me with any other questions.

Sincerely,

Renee Mendenhall, RDH, MBA

Program Coordinator
Salt Lake Community College Dental Hygiene Program
renee.mendenhall@slcc.edu
801-957-6070 Office

NYE Ingrid * OBD

From: Renee Mendenhall <renee.mendenhall@slcc.edu>
Sent: Monday, May 31, 2021 7:48 AM
To: NYE Ingrid * OBD
Cc: Rebecca Montz
Subject: RE: Local Anes Verification
Attachments: DH 2340 Local Anes Lec Syllabus Fall 2020.docx; DH 2341 Loc Anes Lab Syllabus Fall 2020.docx; Local Anes Verification--Oregon Board of Dentistry 5-31-2021.docx

Hello Ms. Nye,

I am attaching our syllabi for the Local Anesthesia lecture and lab courses taught at Salt Lake Community College Dental Hygiene Program. This includes course descriptions as stated in the College catalog, along with course schedules and assignments.

I am also including a letter requesting approval from the Oregon Board of Dentistry.

Please advise if there is additional information required. I am hoping to get this squared away by today so it can be included on your June Board meeting.

Thank you for your help in this so our 2021 graduate (and future grads!) who live in Oregon may obtain licensure as a Registered Dental Hygienist.

Please call me directly on my cell phone with any questions--801-558-0594.

Sincerely,

Renee Mendenhall, RDH, MBA
Dental Hygiene Program Coordinator

From: NYE Ingrid * OBD <ingrid.nye@oregondentistry.org>
Sent: Thursday, May 27, 2021 3:45 PM
To: Renee Mendenhall <renee.mendenhall@slcc.edu>
Subject: RE: Local Anes Verification

Hi Renee,

Our records do not show that this course has previously been approved by the Oregon Board of Dentistry (OBD). If you would like to apply for OBD approval, we would need a complete course description (including a syllabus, outline, etc.) and a letter officially requesting that the OBD approve Salt Lake Community College's local anesthesia course. If I could get all of that before May 31st I can get it onto the agenda for the June Board Meeting. If it arrives later than May 31st it will have to wait until the August Board Meeting.

Please let me know if you have any questions!

Ingrid Nye

Examination & Licensing Manager

Pronouns: she, her, hers

OREGON BOARD OF DENTISTRY
1500 S.W. 1ST AVENUE, SUITE #770
PORTLAND, OR 97201
PHONE: 971-673-3200
FAX: 971-673-3202
www.Oregon.gov/Dentistry

IMPORTANT NOTICE ABOUT COVID-19/NOVEL CORONAVIRUS: At this time, the Oregon Board of Dentistry (OBD) intends to remain fully operational, with OBD staff reporting to work. However, the OBD anticipates the possibility that individual staff members may abruptly be absent from work and unable to respond to email, possibly for long periods of time, due to a quarantine after exposure to COVID-19, an illness, or a need to care for a family member. **Please allow 1-2 business days for a response to your email**. If you have not received a response, please email information@oregondentistry.org or call 971-673-3200 and any available OBD staff member will respond. Thank you for your patience.

THE OBD OFFICE IS CURRENTLY CLOSED TO THE PUBLIC.
EXAMINATION & LICENSING MANAGER CURRENT OFFICE HOURS: **MONDAY – THURSDAY, 6:00AM – 4:30PM.**
OBD TELEPHONE HOURS: **MONDAY – FRIDAY, 7:30AM – 4:00PM.**

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

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From: Renee Mendenhall <renee.mendenhall@slcc.edu>
Sent: Wednesday, May 26, 2021 6:16 AM
To: NYE Ingrid * OBD <ingrid.nye@oregondentistry.org>
Cc: Ashley Troutt <ashtroutt@gmail.com>
Subject: Local Anes Verification

Hello Ingrid,

Attached is a letter verifying successful completion of a local anesthesia course by Ashely Troutt. Please contact me if additional information is required.

Thank you.

Sincerely,

Renee Mendenhall, RDH, MBA
Salt Lake Community College Dental Hygiene Program Coordinator
801-957-6070-Office

Salt Lake Community College

Dental Hygiene Program

DH 2340 Local Anesthesia Lecture

Fall Semester 2020

Instructor: Kristen Hall RDH, BS

Table of Contents

SLCC DEPARTMENT: Dental Hygiene

PROGRAM CONTACT INFO:

Renee Mendenhall, RDH, MBA
Dental Hygiene Program Coordinator
Renee.mendenhall@slcc.edu
(801) 957-6070

Erica Wight, M.Ed., R.T. (R) (M) (QM)
Dean, Health Sciences
erica.wight@slcc.edu
Office Phone: (801) 957-6321

Rebecca Montz, Ed.D, R.T. (N) (CT), CNMT, PET, NMTCB (RS)
Associate Dean, Division of Allied Health
rebecca.montz@slcc.edu
Office Phone: (801) 957-6217

COURSE NUMBER: DH 2340
Local Anesthesia

SEMESTER: Fall 2020

CREDIT: 2 hours

DAY & TIME: Thursday, 8-9:50 am

COURSE INSTRUCTOR:
Kristen Hall RDH, BS

CONTACT INFO:
Office: HTC 164B
Office phone: 801-957-6074
Cell: 801-946-4274
Email: Kristen.hall@slcc.edu

OFFICE HOURS:
Tues, Thurs 7 am – 8 am
Tues – Thurs Noon – 1 pm
Additional hours by appointment

COURSE DESCRIPTION: Pain control in the dental office including administration of local anesthetic/nitrous oxide and anxiety management. Completion of this course qualifies students to take Western Regional Examination Board for local anesthesia.

Prerequisite: DH1540 Corequisite: DH2341.

- ***Due to the uncertainties of Covid-19, course delivery (such as moving to Online) is subject to change at any point during the semester if recommended or mandated by State/National Government Officials.***

COURSE LEARNING OUTCOMES

At the end of this course, the student will be able to:

1. Review and identify structures of head and neck anatomy
2. Explain the pharmacology of local anesthetics and vasoconstrictors.
3. Differentiate the clinical actions of specific anesthetic agents.
4. List local and systemic complications that could arise from use of local anesthetics.
5. Utilize the medical history and do an appropriate physical examination of a patient and apply assessment results to select the most appropriate pain control technique for the individual patient.
6. Show how to handle emergencies stemming from local anesthetic administration.
7. Identify different types of syringes, needles and anesthetic containers.
8. Identify and assemble the different parts of the syringe, needle, and dental cartridge.
9. List and identify additional components to the anesthetic armamentarium.
10. Properly assemble the armamentarium.
11. Describe the anatomy, physiology of the respiratory, cardiovascular and central nervous system, as they relate to the effects of inhalation sedation.
12. Describe the basic components of the inhalation sedation equipment and the function of each.
13. List and discuss the advantages and disadvantages of inhalation sedation with nitrous oxide/oxygen.
14. List and discuss the indications and contraindications for the use of nitrous oxide/oxygen sedation.
15. List the complications associated with nitrous inhalation sedation.
16. Discuss the prevention, recognition and management of these emergency complications.

SLCC STUDENT LEARNING OUTCOMES

SLCC is committed to fostering and assessing the following College-wide student learning outcomes in its programs and courses:

1. Communicate effectively
2. Develop quantitative literacies
3. Think critically & creatively
4. Develop civic literacy and the capacity to be community-engaged learners who act in mutually beneficial ways with community partners
5. Develop knowledge and skills to work with others in a professional constructive manner
6. Develop computer & informational literacy
7. Develop the attitudes and skills for lifelong wellness

Dental Hygiene Competencies That Have a Major Focus In This Course

COMPETENCY		
I. Core Competencies (C) reflect the ethics, values, skills, and knowledge integral to the profession of dental hygiene. The entry-level dental hygienist must be capable of discerning and managing oral health therapy and ethical issues in a rapidly changing environment influenced by regulatory action, economics, social policy, health care reform, cultural diversity, scientific discovery and emerging technologies. Consequently, dental hygienists must be able to acquire and synthesize information in a systematic and critical manner. As oral health professionals, dental hygienists are required to respect and adhere to the state and federal laws, regulations and established standards that govern their practice.		**ASSESSMENT METHOD(S)**
C.1	Apply a professional code of ethics in all endeavors. a. Apply principles of ethical behavior in decision-making, in interactions with patients, staff, and peers, in personal conduct. b. Provide ethical dental hygiene care to promote patient health and wellness, and assume responsibility for dental hygiene interventions.	Successful completion of the course as a result of adherence to course standards/codes of conduct and completion of the course requirements.
C.3	Use critical thinking and comprehensive problem-solving to provide oral health care that promotes patient health and wellness in the provision of evidenced-based practice.	Chapter Questions/Homework Exams/Quizzes
C.4	Use evidence-based decision making to evaluate emerging technology and treatment modalities to integrate into patient dental hygiene care plans to achieve high-quality, cost-effective care.	Chapter Questions/Homework Exams/Quizzes
II. Health Promotion and Disease Prevention (HP). The entry level dental hygienist must be competent in the performance and delivery of oral health promotion and disease prevention services in private practice, public health and other alternative settings. Dental hygienists play an active role in the promotion of optimal oral health and its relationship to general health.		**ASSESSMENT METHOD(S)**
HP.3	Identify individual and population oral health needs and risk factors and assist in the development, implementation and evaluation of appropriate health promotion strategies.	Chapter Questions/Homework Exams/Quizzes
HP.4	Evaluate factors that can be used to promote patient adherence to disease prevention and encourage patients to assume responsibility for health and wellness.	Chapter Questions/Homework Exams/Quizzes

HP.5	Evaluate and implement methods to ensure the health and safety of the patient and the oral health professional in the delivery of care.	Chapter Questions/Homework Exams/Quizzes
IV. Patient Care (PC). The entry level dental hygienist is prepared to provide safe, culturally competent, comprehensive patient centered care for members of diverse populations. These populations include; child, adolescent, adult, geriatric, medically compromised, and special needs patients. Program graduates are capable of effecting all steps in the dental hygiene process of care which includes; Assessment, Diagnosis, Planning, Implementation, and Evaluation.		**ASSESSMENT METHOD(S)**
PC.1	Assessment – Systematically collect, analyze and record data on the general, oral and psychosocial health status of a variety of patient populations using methods consistent with medico legal principles. This component of the dental hygiene Process of care includes: a. Identify predisposing and etiologic risk factors that require intervention to prevent disease. b. Recognize the relationships among systemic disease, medications, and oral health that impact overall patient care and treatment outcomes. c. Manage patients identified as at risk for a medical emergency in a manner that prevents an emergency; be prepared to handle an emergency situation.	Chapter Questions/Homework Exams/Quizzes
PC. 3	Planning- Utilize reflective judgment in developing a comprehensive patient dental hygiene care plan. This aspect of the dental hygiene process of care involves: a. Collaborate with the patient and other health professionals as indicated to formulate a comprehensive dental hygiene care plan is patient-centered and based on the best scientific evidence and professional judgment. b. Communicate the plan for dental hygiene services to the dentist or other interdisciplinary health team members to determine its congruence with the overall plan for the patient's oral healthcare.	Chapter Questions/Homework Exams/Quizzes

	c. Make referrals to professional colleagues and other health care professionals as indicated in the patient care plan. d. Determine priorities and establish oral health goals with the patient/family and/or guardian as an active participant. e. Using a problem-based approach, formulate a planned sequence of educational and clinical services to facilitate optimal oral health. f. Obtain the patient's informed consent based on a thorough case presentation.	
PC. 4	Implementation - Provide specialized treatment that includes educational, preventive, and therapeutic services designed to achieve and maintain oral health. Partner with the patient in achieving oral health goals. This step in the dental hygiene standard of care includes: a. Provide selected adjunct preventive and therapeutic dental hygiene services that can be legally performed. b. Efficiently deliver effective preventive and therapeutic dental hygiene care.	Chapter Questions/Homework Exams/Quizzes

TEXTBOOKS AND RESOURCES

REQUIRED TEXT BOOK:

Local Anesthesia for Dental Professionals. Bassett, DiMarco, Naughton. 2nd ed. Prentice Hall (Pearson). 2015.

RESOURCE TEXTS:

Malamed, Stanley F., Handbook of Local Anesthesia, 6th ed. St. Louis, Mo.: Mosby, 2013.

Malamed, Stanley F., Medical Emergencies in the Dental Office. 7th edition. 2006.

COURSE REQUIREMENTS

- Each student is responsible for reading the assigned materials prior to lecture and mastering the information taught in the lecture, PowerPoints, objectives provided in syllabus and the textbooks. Be prepared to discuss the information in your reading material in class.
- Discussions and examinations will cover all assigned materials and lectures.
- Specific instructions for additional assignments will be provided at a later time if needed.

QUIZZES
Quizzes will be given each week and completed in Canvas. Retakes are not offered but the lowest score is dropped at the end of the semester. Quizzes will be 20 questions consisting of multiple choice, matching and true /false. Late quizzes will receive 75% credit. After one week, no credit will be given for that quiz.

EXAMS
Exams must be taken on day they are scheduled. A student will not be allowed to re-take an exam.. There will be no curve given in this class as this class is a preparation for it's own WREB (Western Regional Examination Board).
Exams will be 50-100 questions consisting of multiple choice, true false and possibly short answer.

Homework
Chapter questions are to be submitted on Canvas by Wednesday night at 11:59pm. Questions submitted after this time will receive 75% credit until one week past the due date. After one week, no credit will be given for that homework.

PREPARATION
This is a rigorous course. In order to be successful you must read each chapter assigned BEFORE the lecture is given. Study and take notes on assigned readings, and review the subject matter regularly (several times a week to every day to put the material in long term memory).

ATTENDANCE AND PARTICIPATION
ONE unexcused absence or tardy more than 15 minutes in either clinic or lecture constitutes academic probation. More than one absence or tardy may result in dismissal from the dental hygiene program as explained in the SLCC Dental Hygiene Policies and Procedures Handbook. Attendance at all classes is expected.
GRADING SCALE AND POLICY

A = 95 – 100 %	B = 83 – 86 %	C = 75 – 77 %	D = 64 - 66%
A- = 94 – 90 %	B- = 80 – 82 %	C- = 71 - 74%	D- = NONE
B+ = 87 – 89 %	C+ = 78 - 79 %	D+ = 67- 70%	F = 63 & BELOW

In the Dental Hygiene Program, no letter grade below "C" is considered passing.
This course requires a minimum of 75% to pass this course.

If there is a discrepancy of a score on a quiz, assignment or exam, it must be taken care of immediately with instructor (within 10 days of receiving the grade)

EVALUATION METHODS AND GRADING CRITERIA
Each of the major areas of evaluation will be computed as follows:

Exam I	20%
Exam II	20%
Final Examination	30%
Quizzes	20% (Drop lowest)

Homework	10%
Total	100%

Late work will be accepted up to 1 week for 75% credit. No work will be accepted after 7 days.

EXTRA CREDIT & LATE WORK
Extra credit may/maynot be offered throughout the course.

STUDENT AFFAIRS CODE OF STUDENT RIGHTS AND RESPONSIBILITIES
Students are expected to follow all provisions of the Student Code of Conduct available here: http://www.slcc.edu/policies/docs/Student_Code_of_Conduct.pdf

EMERGENCY EVACUATION PROCEDURE
When instructed to evacuate the building, always leave immediately. The Dental Hygiene Department will meet in front of the LDS Institute (northeast corner of the building) for a head count and further instructions. As a rule, it is recommended that you evacuate the building at a distance of one and a half times the size of the building to avoid harm.
Any question, please contact (801) 957-4963 www.slcc.edu/riskmanagement/docs/2011

PLAGIARISM
Students are expected to reference all sources of information. Any plagiarism will result in failure of the assignment and possible failure of the course. Information must not be copied from other students work, textbooks or internet sources.

ELECTRONIC/WIRELESS DEVICES IN CLASSROOM
The advent of technology use in the classroom as an instructional tool has caused both opportunities and distractions. The expectations for this course are that you are engaged and present during class time, which means that you will be free from technological distractions. Research has shown that these distractions cause individual inattentiveness and can make it difficult for others to stay focused on the immediate discussions. The following policies are in effect during our time together:
1. Cell phones, iPods, pagers, High-Resolution DVR Spy Pens with webcam and microphone or any device (excluding ADA authorized devices) that may distract from the class should be silenced before entering the classroom and may not be on the desk during class or exams. If you have an emergency and must use your cell phone, please exit the classroom to take the call. If you are discovered reading/sending text messages during class, you could be asked to leave the class and will be counted absent for that class session.
2. You are expected to engage in discussion for the class. You may use your computer to access your textbook, take notes, and research the discussion topic. However, some students may find it difficult to refrain from reading emails, surfing the web, and engaging in other activities not related to the class. Therefore, if you are discovered engaging in computer activities not directly related to the class, you will be asked to leave the class and will be counted absent for that class session.
3. You may not record or publish information from the class without written authorized use from the instructor. If used without authorization you have violated PRIVACY/INTELLECTUAL PROPERTY RIGHTS.

PROFESSIONALISM:

Professionalism is expected and includes at a minimum the following capabilities and traits :

1. **Appearance**: Displays appropriate professional appearance and is appropriately groomed as defined in the SLCC Dress Code.
2. **Attitudes**: Is actively concerned about others. Maintains a positive outlook toward others and toward assigned tasks. Recognizes and admits mistakes. Seeks and accepts feedback to improve performance.
3. **Dependability**: Completes tasks promptly and well. Arrives on time and actively participates in clinical and didactic activities. Follows through and is reliable.
4. **Function under stress**: Maintains professional composure and exhibits good personal and clinical judgment in stressful situations. Recognizes the importance of maintaining professional behavior in the clinical setting, in spite of inappropriate action on the part of others.
5. **Initiative**: Independently identifies tasks to be performed and makes sure that tasks are completed satisfactorily. Performs duties promptly and efficiently. Is willing to spend additional time and to assume new responsibilities. Recognizes when help is required and when to ask for guidance.
6. **Integrity**: Displays honesty in all situations and interactions; is able to identify information that is confidential and maintain its confidentiality.
7. **Interpersonal relationships**: Provides support and is empathetic and considerate in interactions with peers, patients, faculty, and staff. Interacts effectively with "difficult individuals." Demonstrates respect for and complements the roles of other professionals. Is cooperative and earns respect.
8. **Tolerance**: Demonstrates ability to accept people and situations. Acknowledges his/her biases and does not allow them to affect patient care or contribute to inappropriate interactions with others.

For college wide student resources please see the Institutional Syllabus located in Canvas.

SLCC COVID-19 Face Covering Addendum

Salt Lake Community College is firmly committed to helping protect the health and safety of our students, staff and faculty, and to serving our communities. We are closely monitoring the changing situation due to the global pandemic and complying with Public Health guidance. Students, faculty, staff, and others that are participating in DH 1340 Dental Anatomyunderstand that wearing a face covering that covers the mouth and nose is required at all times in the class.

Student Signature: _____Date: _____

Salt Lake Community College Dental Hygiene Program Course Verification of Agreement

I _____ have read the DH 2340 Fall
(Print your name)
syllabus for Local Anesthesia For the Dental Hygienist. I have been given the opportunity to have any questions I had regarding the contents of this syllabus answered; thus, I understand that I am responsible for ALL the material contained in this syllabus.

I also agree to comply with all course requirements and program standards contained within the Salt Lake Community College Course DH 2340 syllabus document.

Student Signature: _____Date: _____

Salt Lake Community College

Dental Hygiene Program

DH 2341 Local Anesthesia Lab

Fall Semester 2020

Instructor: Kristen Hall RDH, BS

Table of Contents

SLCC DEPARTMENT: Dental Hygiene

PROGRAM CONTACT INFO:

Renee Mendenhall, RDH, MBA
Dental Hygiene Program Coordinator
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Rebecca Montz, Ed.D, R.T. (N) (CT), CNMT, PET, NMTCB (RS)
Associate Dean, Division of Allied Health
rebecca.montz@slcc.edu
Office Phone: (801) 957-6217

COURSE NUMBER: DH 2341
Local Anesthesia Lab

SEMESTER: Fall 2020

CREDIT: 2 hours

DAY & TIME:
Group 1: Thursday, 11-1:50 am
Group 2: Thursday, 12-12:50

COURSE INSTRUCTOR:
Kristen Hall RDH, BS

CONTACT INFO:
Office: HTC 164B
Email: Kristen.Hall@slcc.edu
Alt email: kristenjones3@hotmail.com
Office Phone: 801-957-6072
Cell Phone: 801-946-4274

OFFICE HOURS:
Tues, Thurs 7 am – 8 am
Tues – Thurs Noon – 1 pm
Additional hours by appointment

Clinical Instructors: Tracy Thompson, Sandra Wilkie, Dr. Vekter

COURSE DESCRIPTION: Demonstration and administration of all local and regional blocks are experienced in a supervised lab setting. Minimum competence is verified through successful completion of proficiency evaluations.

Prerequisite: DH1540 Corequisite: DH2340.

- ***Due to the uncertainties of Covid-19, course delivery (such as moving to Online) is subject to change at any point during the semester if recommended or mandated by State/National Government Officials.***

COURSE LEARNING OUTCOMES

1. Under direct supervision of Registered Dental Hygienist (RDH) or Doctor of Dental Science (DDS/DMD) demonstrate administration of the following injections to clinical competency at least 3 times:
   a. Posterior Superior Alveolar Injection (PSA)
   b. Middle Superior Alveolar Injection (MSA)
   c. Anterior Superior Alveolar Injection (ASA)
   d. Greater Palatine Injection (GP)
   e. Nasopalatine Injection (NP)
   f. Inferior Alveolar Nerve Injection (IAN) including Lingual (L)
   g. Long Buccal Injection (LB)
   h. Mental/Incisive Injection (Mental /Incisive)
   i. Intraseptal
2. Under direct supervision administer nitrous inhalation sedation in a clinically competent manner to a minimum of three times in a clinical setting, in a safe and effective manner clinical competency.
3. Evaluate whether local anesthesia is appropriate using medical histories and physical exam and choose the appropriate topical and injectable anesthetic, evaluating drug interactions, health status, and physical status learned in didactic course to determine what is best for the patient.
4. Student will perform all injections with appropriate asepsis technique being prepared to handle situations arising in a professional manner like dropping needle cap, harpoon not engaged, harpoon sticking to plunger, positive aspiration, premature osseous contact etc.
5. Student will be able to perform all injections using board verbiage, knowing proper technique according to competency, be able to describe landmarks, point of penetration, optimum depth and angle, dose, possible complications and contraindications and alternatives to each injection.
6. Student will handle patient's anxiety and fear by explaining the procedure, and talking the procedure through in a calm and assuring manner.

SLCC STUDENT LEARNING OUTCOMES

SLCC is committed to fostering and assessing the following College-wide student learning outcomes in its programs and courses:

1. Communicate effectively
2. Develop quantitative literacies necessary for their chosen field of study
3. Think critically & creatively
4. Develop civic literacy and the capacity to be community-engaged learners who act in mutually beneficial ways with community partners

5. Develop knowledge and skills to work with others in a professional & constructive manner
6. Develop computer & informational literacy
7. Develop the attitudes and skills for lifelong wellness

Dental Hygiene Competencies That Have a Major Focus In This Course

COMPETENCY		
I. Core Competencies (C) reflect the ethics, values, skills, and knowledge integral to the profession of dental hygiene. The entry-level dental hygienist must be capable of discerning and managing oral health therapy and ethical issues in a rapidly changing environment influenced by regulatory action, economics, social policy, health care reform, cultural diversity, scientific discovery and emerging technologies. Consequently, dental hygienists must be able to acquire and synthesize information in a systematic and critical manner. As oral health professionals, dental hygienists are required to respect and adhere to the state and federal laws, regulations and established standards that govern their practice.		
		ASSESSMENT METHOD(S)
C.1	Apply a professional code of ethics in all endeavors. a. Apply principles of ethical behavior in decision-making, in interactions with patients, staff, and peers, in personal conduct. b. Provide ethical dental hygiene care to promote patient health and wellness, and assume responsibility for dental hygiene interventions.	Successful completion of the course as a result of adherence to course standards/codes of conduct and completion of the course requirements.
C.3	Use critical thinking and comprehensive problem-solving to provide oral health care that promotes patient health and wellness in the provision of evidenced-based practice.	Learning Experiences Competency Experience
C.5	Assume responsibility for professional actions and care based on accepted scientific theories, research, and the accepted standard of care.	Learning Experiences Competency Experience
C.10	Accurately document recommended, planned, and provided oral health services and maintain patient records as confidential, legal entities.	Learning Experiences (Patient notes)
II. Health Promotion and Disease Prevention (HP). The entry-level dental hygienist must be competent in the performance and delivery of oral health promotion and disease prevention services in private practice, public health and other alternative settings. Dental hygienists play an active role in the promotion of optimal oral health and its relationship to general health.		
		ASSESSMENT METHOD(S)
HP.5	Evaluate and implement methods to ensure the health and safety of the patient and the oral health professional in the delivery of care.	Learning Experiences Competency Experience

TEXTBOOKS AND RESOURCES

REQUIRED TEXTBOOK

Local Anesthesia for Dental Professionals. Bassett, DiMarco, Naughton. 2nd ed. Prentice Hall (Pearson). 2015.

RESOURCE TEXT BOOKS

Handbook of Local Anesthesia, Malamed, Stanley F., 6th ed. St. Louis, MO: Mosby, 2014.
Medical Emergencies in the Dental Office. Malamed, Stanley F., 7th edition. 2016.
Handbook of Nitrous Oxide and Oxygen Sedation. Clark. Fourth edition

COURSE REQUIREMENTS

Each student is responsible for reading the assigned material from the textbooks and PowerPoints and being prepared to perform the injections outlined.

EXAMS

Final Exam is performing the Inferior Alveolar Injection and Posterior Superior Alveolar Injection with the appropriate verbiage, technique and asepsis as needed for boards.

PREPARATION

This is a rigorous course. Students have found in the past to be successful to read, study and take notes on assigned reading, and review the day of class to clarify any new material learned that day, and study the subject manner regularly (several times a week to every day to put the material in long term memory) and memorize MRD, pertinent information for dose calculations and injection material,(point of penetration, landmarks, dose, technique etc) Student must be prepared daily by studying the appropriate injections and being ready to perform them on their student partner. Student must have armamentarium sterilized and ready to perform them daily. Student must practice on skulls prior to performing injections on their student partner.

ATTENDANCE AND PARTICIPATION

Attendance is mandatory. ONE unexcused absence or tardy more than 15 minutes in either clinic or lecture constitutes academic probation. More than one absence or tardy may result in dismissal from the dental hygiene program as explained in the SLCC Dental Hygiene Policies and Procedures Handbook. If you are absent from a class or miss and exam, it is your responsibility to notify the course instructor and coordinator immediately.

GRADING SCALE AND POLICY

A = 95 – 100 %	**B = 83 – 86 %**	**C = 75 – 77 %**	**D = 64 - 66%**
A- = 94 – 90 %	**B- = 80 – 82 %**	**C- = 71 - 74%**	**D- = NONE**
B+ = 87 – 89 %	**C+ = 78 - 79 %**	**D+ = 67- 70%**	**F = 63 & BELOW**

This clinical course requires a *minimum grade of 75%* in order to pass. *Any* retake, redirection, or stoppage of a "pass off" injection will receive a one point deduction *except* the final exam with a five point deduction

GRADING

MSA	10 pt (1 point deduction for EACH retake, redirection, stoppage)
ASA	10 pt (1 point deduction for EACH retake, redirection, stoppage)
PSA	10 pt (1 point deduction for EACH retake, redirection, stoppage)
NP	10 pt (1 point deduction for EACH retake, redirection, stoppage)
GP	10 pt (1 point deduction for EACH retake, redirection, stoppage)
Intraseptal	10 pt (1 point deduction for EACH retake, redirection, stoppage)
IA/L and LB	10 pt (1 point deduction for EACH retake, redirection, stoppage)
Mental Incisive	10 pt (1 point deduction for EACH retake, redirection, stoppage)
Nitrous Oxide	10 pt (1 point deduction for EACH retake, redirection, stoppage)
Mock Board/ Final Exam	20 pt (5 Point deduction for any retake)

110 POINTS

EXTRA CREDIT

NO EXTRA CREDIT WILL BE GIVEN

STUDENT AFFAIRS CODE OF STUDENT RIGHTS AND RESPONSIBILITIES
Students are expected to follow all provisions of the Student Code of Conduct available here: http://www.slcc.edu/policies/docs/Student_Code_of_Conduct.pdf

EMERGENCY EVACUATION PROCEDURE
When instructed to evacuate the building, always leave immediately. The Dental Hygiene Department will meet in front of the LDS Institute (northeast corner of the building) for a head count and further instructions. As a rule, it is recommended that you evacuate the building at a distance of one and a half times the size of the building to avoid harm.
Any question, please contact (801) 957-4963 www.slcc.edu/riskmanagement/docs/2011

PLAGIARISM
Students are expected to reference all sources of information. Any plagiarism will result in failure of the assignment and possible failure of the course. Information must not be copied from other students work, textbooks or internet sources.

ELECTRONIC/WIRELESS DEVICES IN CLASSROOM
The advent of technology use in the classroom as an instructional tool has caused both opportunities and distractions. The expectations for this course are that you are engaged and present during class time, which means that you will be free from technological distractions. Research has shown that these distractions cause individual inattentiveness and can make it difficult for others to stay focused on the immediate discussions. The following policies are in effect during our time together:
1. Cell phones, iPods, pagers, High-Resolution DVR Spy Pens with webcam and microphone or any device (excluding ADA authorized devices) that may distract from the class should be silenced before entering the classroom and may not be on the desk during class or exams. If you have an emergency and must use your cell phone, please exit the classroom to take the call. If you are discovered reading/sending text messages during class, you could be asked to leave the class and will be counted absent for that class session.
2. You are expected to engage in discussion for the class. You may use your computer to access your textbook, take notes, and research the discussion topic. However, some students may find it difficult to refrain from reading emails, surfing the web, and engaging in other activities not related to the class. Therefore, if you are discovered engaging in computer activities not directly related to the class, you will be asked to leave the class and will be counted absent for that class session.
3. You may not record or publish information from the class without written authorized use from the instructor. If used without authorization you have violated PRIVACY/INTELLECTUAL PROPERTY RIGHTS.

PROFESSIONALISM:

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DH 2340 LOCAL ANESTHESIA
INSTRUCTIONAL OBJECTIVES

Safety, Armamentarium & Site Preparation. LA Write-up	1. Demonstrate effective syringe assembly, . 2. Perform ONE-HANDED recapping of needle 3. Demonstrate careful and safe needle disassembly and proper sharps disposal. 4. Show positive aspiration and conclude how to handle being in a blood vessel 5. Control local anesthetic cartridge delivery over one minute and conclude why delivery rate is so critical to patient health 6. Position patient for local anesthetic delivery and deduce why positioning is pertinent to the administration of LA 7. Verbally communicate with the patient expectations during the injection process 8. Palpate landmarks for optimal site of injection and visualize this spot. 9. Prepare tissue for painless injection and judge how much topical is effective for tissue pain control. 10. Retract tissue with mouth mirror/Minnesota and gently enter tissue 11. Judge proper depth, angle of needle and amount of anesthesia given for individual injection based on patient's anatomy, health history, and nerve being anesthetized. 12. Construct local anesthetic record note
Landmarks for M/I, ASA, & MSA Injections. LA Calculations & Importance	1. Perform all of Monday's objectives 2. Analyze factors limiting either local anesthesia or vasoconstrictor for patient safety 3. Compute amounts of LA or vasoconstrictor delivered to any given patient 4. Deduce amounts of LA that may be given when CHANGING LAs during patient treatment 5. Determine when and why the needle must be replaced during patient treatment 6. Perform M/I, ASA, and MSA
Landmarks for PSA, GP, & NP Injections. Review Head and	1. Perform all of Monday & Tuesday's objectives

Neck Anatomy for PSA. Hematoma Treatment. Troubleshooting PSA. Cardiac Dosing and Diseases Requiring Alteration to Anesthesia	2. Formulate an anesthetic prescription for patients with different medical conditions 3. Evaluate reasons a hematoma may develop during a PSA 4. Initiate treatment protocol for possible hematoma for the PSA 5. Name, palpate, and locate the three anatomical landmarks necessary for the PSA 6. Demonstrate the upward, inward, backward direction for the PSA in one movement 7. Perform PSA, NP, and GP 8. "Pass-off" M/I, GP, & NP
Landmarks for IA & LB Injections. Review of Head and Neck Anatomy for IA & Adjusting Penetration Location Based on Individual Anatomy. Troubleshooting IA	1. Perform all objectives given over the week 2. Name, palpate, and locate the three anatomical landmarks needed to implement a successful IA 3. Analyze reasons an IA may not be successful and formulate a plan for generating profound anesthesia 4. Evaluate reasons a hematoma may develop during the administration of an IA 5. Initiate treatment protocol for possible hematoma for the IA 6. Perform IA & LB 7. "Pass-off" PSA, GP, & NP
Signs and Symptoms of LA and Vasoconstrictor Overdose, Telling the Difference & Treatment. Advanced Local Anesthetic Techniques and Reasons for Use	1. Expertly model all local anesthesia safety protocols performed over the past week. 2. "Pass-off" IA & LB 3. PRACTICAL FINAL: IA & PSA of choice 4. Compare and contrast signs and symptoms of LA vs. vasoconstrictor overdose & treatment for each. 5. Anticipate alternative injection procedures per situational patient treatment and justify use

Failure to complete ALL assignments & coursework contained herein or assigned by the course director will result in a failing grade in this course

SLCC COVID-19 Face Covering Addendum

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Student Signature: _____Date: _____

Salt Lake Community College Dental Hygiene Program
Course Verification of Agreement

I _____ have read the DH 2341 Fall
(Print your name)
Syllabus for Dental Hygiene, Local Anesthesia Lab. I have been given the opportunity to have any questions I had regarding the contents of this syllabus answered; thus, I understand that I am responsible for ALL the material contained in this syllabus.

I also agree to comply with all course requirements and program standards contained within the Salt Lake Community College Course DH 2341 syllabus document.

Student Signature: _____ Date:_____

OTHER ISSUES

Board Introduction

Strategic Plan 2022-2025

Oregon Board of Dentistry
August 20, 2021

The PEAK Fleet

Creating an engaged workforce that thrives together

Purpose of Today's Session

- *Introductions*
- *PEAK Fleet Background*
- *Approach to Strategy*
- *Themes emerging so far*
- *Plan for Oct 23rd Strategy FTF*
- *Inputs & Questions from OBD*

ThePEAKFleet

Dedicated to creating a new renaissance where creative, inclusive environments abound.

We believe the Future of Work begins with People.

For purpose, not just profit.

PERSISTENCE

EMPATHY

AUTHENTICITY

KINDNESS

PEAK Values®

About Us:

ThePEAKFleet

Jen Coyne
CEO & Co-Founder

Theresa Trelstad
PEAK Fleet Consultant

Brian Stinson
Co-Founder

Our Focus Areas:

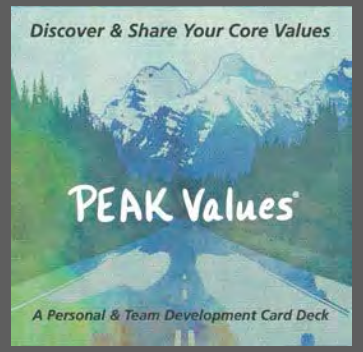
Strategy Development

Equity, Justice, Diversity & Inclusion

Effective Meetings

Team & Leadership Development

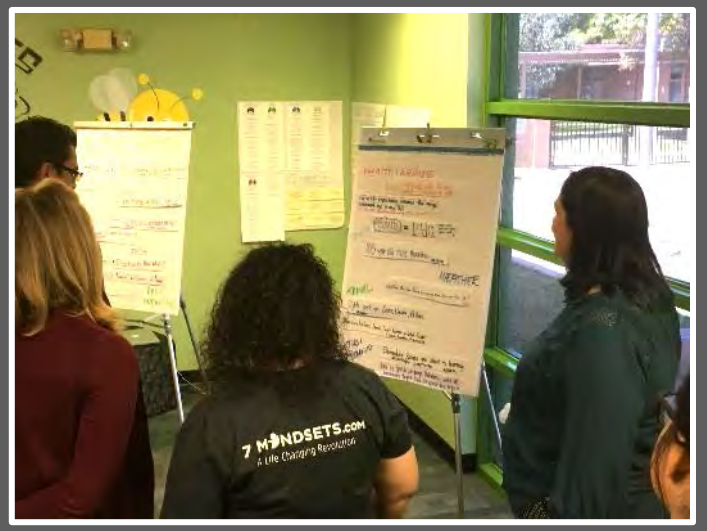
Individual & Organizational Values



Problem Solving & Innovation

Our Formats:

Workshops



Leadership Retreats

Consulting

We also offer:
Speakerships +
Events

Our Approach to Strategy

- Set a pace for OBD's Strategy Process
- Empathy & Listening at the forefront
- Incorporate additional research and perspective
- Evaluate the data – quantitative & qualitative
- Facilitation to maximize participation and use of staff and board member time

OBD Strategic Plan Journey

Goal – Late Nov/ Early Dec 2021

Intros & Research

July

Communicate Plan & Research Summary

August 20th

Set themes & goals

Onsite Meeting: Strategy Inputs

Oct 22-23rd

Strategy Draft & Iterations

November

Publish Strategy

Background/research so far

- Introductory meeting with OBD Staff
- Interviews with each Staff member
- Coding and analysis of Surveys from Board and Members

Additional work to be done

- Peer Dental organization research, themes
- Understand OHA Strategic Themes
- Potential impacts of Governor's office change

Themes Emerging

- Corporate Dentistry
- Dental Therapy
- Technology & Processes
  - Data & analytics capabilities
  - Operational processes & systems
- Workplace Environment & Engaged Workforce
- Community / Constituent Outreach: Diversity, Equity & Inclusion Considerations

A taste of upcoming events…

- Write down any additional ideas for themes or specific issues you'd like addressed – post on "Additional Themes" poster
- Read info about each of the themes
  - Add any questions you want to make sure are answered
  - Give a +1 to any themes you especially want to spend focused time
  - Any comments you have now to build out the initiatives

Next up: In-Person Joint Working Session, Oct 23rd

Draft Agenda (Subject to Change)

Start	End	Duration	Topic
8:00 AM	8:45 AM	0:45:00	Open mtg Values exercise
8:45 AM	8:50 AM	0:05:00	Objectives and Goals for the Day
8:50 AM	8:55 AM	0:05:00	Point in time/Map "we are here"
8:55 AM	9:40 AM	0:45:00	Organizational Values => As lens for reviewing OBD Mission
9:40 AM	10:25 AM	0:45:00	Discussion and Analysis of OBD Opportunities and Threats
10:25 AM	10:40 AM	0:15:00	BREAK
10:40 AM	11:25 AM	0:45:00	Strengths and Weaknesses, small group discussion
11:25 AM	12:10 PM	0:45:00	Posters of Like Items
12:10 PM	12:55 PM	0:45:00	LUNCH
12:55 PM	1:40 PM	0:45:00	Strategic Themes, Goals within each theme
1:40 PM	2:10 PM	0:30:00	Criteria/level of difficulty to achieve goals
2:10 PM	2:40 PM	0:30:00	Stack rank Prioritization
2:40 PM	2:55 PM	0:15:00	Wrap up & Final comments

Inputs & Questions

CODA Commission on Dental Accreditation

CODA Alert

2021 CODA Summer Meeting to be Virtual

Dear Community of Interest,

The Commission on Dental Accreditation 2021 Summer Meeting, scheduled for August 5 and 6, 2021, will be held virtually. The meeting on August 5 is a Closed Session and not open to the public.

The meeting on August 6, which will begin at 10:00am Central Daylight Time, is an Open Session. You may register for the Open Session as a Registered Observer directly through the Zoom Webinar link provided in the button below. When you register, you will receive a confirmation email which will contain the login data, unique to you, so that you can listen to the August 6 Open Session either through a computer or through a phone line.

Please keep in mind, this is NOT a required meeting for the Commission's accredited Programs and other Communities of Interest. This is CODA's bi-annual public discussion of policy and other accreditation matters, which will be held virtually.

If you have multiple personnel in your organization whom you wish to listen to the Open Session, please forward this email to them and have each person click the button below to register for themselves, so that they each receive their own unique login data. Do not forward your confirmation email, as it contains login data unique to you.

One week prior to the Open Session, as well as one day prior, you will receive a reminder email which will include the same unique login data. Again, please do not forward either of these emails, as the login is unique to you.

Please keep the login and password information handy at the beginning of the Open Session on August 6, as CODA Staff will be unavailable that day to provide technology assistance related to your unique meeting login information. For CODA Meeting Materials, as available, please visit https://www.ada.org/en/coda/accreditation/coda-meeting-material.

As with all Open Sessions of the Commission, observers will be silent during the Open Session and will not be allowed to ask questions or offer comments. Recording of CODA meetings is strictly prohibited.

A summary of Commission Actions will be published to the Post-Meeting Actions page of the Commission website within a few weeks after the Session for those who are unable to listen in to the virtual meeting. Please email Open Session questions to hooperm@ada.org.

JCNDE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

2020 Technical Report

Dental Licensure Objective Structured Clinical Examination (DLOSCE)

211 East Chicago Avenue
Chicago, Illinois 60611-2637
800.232.1694 | ADA.org/JCNDE

Technical Report

Dental Licensure Objective Structured Clinical Examination (DLOSCE)

2020

Executive Summary
Technical Report: Dental Licensure Objective Structured Clinical Examination

The Technical Report for the Dental Licensure Objective Structured Clinical Examination (DLOSCE) is the main source of validity evidence available to state licensing boards and other users of DLOSCE results. Validity is the most important consideration for any examination program. For the DLOSCE, validity refers to the degree to which logic and evidence support the use and interpretation of examination results for making pass/fail decisions affecting candidates for licensure to practice dentistry. The technical report contains both direct evidence and references to other documents and sources of information that contribute to this body of validity evidence. The background and historical information in this report allow users to understand the development of this program.

The content of the Technical Report is presented to address professional standards regarding the validity of credentialing examinations (American Educational Research Association (AERA), American Psychological Association (APA), and the National Council on Measurement in Education (NCME), 2014). Some of the principal information presented in the Technical Report is summarized below.

Purpose: The purpose of the DLOSCE program is to measure whether a candidate possesses the clinical judgment and skills required for the safe, independent practice of entry-level general dentistry.

Content: Content specifications for the DLOSCE are based on subject matter expert judgment, and validity studies involving practice analyses. Test constructors are responsible for recommending minor modifications during the interim period between practice analyses. The American Dental Association's (ADA) Joint Commission on National Dental Examinations (JCNDE), with input from its Committee on Examination Development, approves all changes to the content specifications.

Item and Examination Development: Test construction teams are responsible for the development of items and forms/editions of the DLOSCE using JCNDE guidelines for writing high-quality items.

Standard Setting and Scoring: The DLOSCE standard is criterion-referenced (not norm-referenced). This means examination results are determined by specific criteria and not by the process sometimes known as "grading on a curve." A panel of expert educators and practitioners recommend the minimum passing score, which was ultimately established by the JCNDE. The DLOSCE standard is maintained across examination forms through the use of equating procedures designed to control for small differences in the difficulty of items from one examination form to another. The equating process places examination results on a common metric regardless of which particular examination form was administered.

Administration: The JCNDE maintains a high level of security on all examination materials. Strict precautions in place at the Joint Commission's offices and testing centers help ensure test content remains secure. The Joint Commission offers the DLOSCE via computer at Prometric professional level testing centers throughout the United States, and its territories. Once eligible, candidates can schedule an examination for any business day, conditional on testing center availability.

In addition to the items above, this report provides information on the history of the examination program, reliability of results, and examination security, among other matters. A copy of this Technical Report is available for download on the JCNDE website, ada.org/JCNDE.

References

American Educational Research Association, American Psychological Association, and National Council on Measurement in Education (2014). *Standards for Educational and Psychological Testing*. Washington, DC: Author.

Table of Contents

1. Introduction

Purpose of the DLOSCE Technical Report

High-stakes examination programs must be concerned with validity. Validity refers to the degree to which logic and evidence support the use and interpretation of examination results in accordance with the purpose of the examination (AERA, APA, & NCME, 2014). The Joint Commission has an obligation to inform dental boards and communities of interest concerning its efforts to provide the highest quality examination programs possible. Established professional standards provide useful guidance to improve the quality of examinations. Testing programs must adhere to these standards and provide evidence their policies and procedures conform to them to help ensure confidence in the examination program.

The Standards for Educational and Psychological Testing, most recently published by AERA, APA, and NCME in 2014, provide professional standards for testing organizations. Chapter 7 of the Standards describes the importance of documented validity evidence in technical reports so examination users can evaluate the validity of examination results they interpret and use.

This technical report provides a comprehensive summary of DLOSCE validation efforts, as well as background information which allows the reader to understand the program's development to its present state. The Joint Commission endeavors to provide the highest quality examination programs possible.

The Joint Commission on National Dental Examinations

The Joint Commission is the agency that oversees DLOSCE examination design, administration, scoring, and reporting. The ADA's Department of Testing Services (DTS) provides operational and technical support for the corresponding outlined activities. The mission of the Joint Commission is as follows:

> *Protecting public health through valid, reliable and fair assessments of knowledge, skills, and abilities to inform licensure and certification decisions that help ensure safe and effective patient care by qualified oral healthcare team members.*

The Rules of the JCNDE provide descriptions of Joint Commission membership and the standing committees that serve the Joint Commission. Each of the Joint Commission's standing committees is charged with making specific recommendations to the Joint Commission concerning areas of focal interest. The Committee on Administration focuses on operational matters, including security, and budgetary considerations. The Committee on Dental Hygiene focuses on the National Board Dental Hygiene Examination (NBDHE), including examination content and specifications, test construction procedures, scoring and reporting of scores, dissemination of information related to the examination process, validity, and matters affecting finance. The Committee on Examination Development focuses on the dental examination programs, including examination content and specifications, test construction procedures, scoring procedures, and reporting. It also concerns itself with the dissemination of information about examination procedures and validity. The Committee on Research and Development focuses on research and development activities (e.g., psychometric investigations) related to both the dental and dental hygiene examination programs. The Committee on Communications and Stakeholder Engagement plans communication activities in support of JCNDE Programs, to help ensure that JCNDE communications are strategic, informative, timely, relevant, and considerate of the needs of external stakeholders.

2. DLOSCE Overview

The first and most fundamental step in the development of any examination program is to establish a purpose. **The purpose of the DLOSCE program is to measure whether a candidate possesses the clinical judgment and skills required for the safe, independent practice of entry-level general dentistry.** The intended examinee population for the DLOSCE consists of candidates who are seeking a license to practice general dentistry in any state, district or other jurisdiction of the United States. The intended interpretation of DLOSCE results concerns the candidate's ability to apply clinical judgment and skills in the provision of patient care. A passing score on the DLOSCE indicates that a candidate is able to apply the aforementioned judgment and skills at the level required for the safe, independent practice of entry-level general dentistry. DLOSCE results are used by dental boards in determining qualifications of dentists who seek licensure to practice in any state, district or other jurisdiction of the United States, which recognizes the DLOSCE.

3. Historical Perspective

In 2016, the ADA's Council on Dental Education and Licensure (CDEL) requested that the ADA's Department of Testing Services develop a business plan for development and implementation of a Dental Licensure OSCE. CDEL reviewed the plan at their December 2016 meeting and recommended the ADA's Board of Trustees provide funding to develop the DLOSCE. In January 2017 a National Licensure Task Force, jointly sponsored by the ADA and ADEA, unanimously endorsed the development of the DLOSCE. During its February 2017 meeting, the ADA Board of Trustees discussed the DLOSCE business plan written by DTS. At that time, the Board of Trustees authorized the formation of a DLOSCE Steering Committee charged with developing and validating the DLOSCE. Dr. Gary L. Roberts, ADA President, appointed a set of highly qualified individuals to the Steering Committee based on criteria established by the Board of Trustees. The DLOSCE Steering Committee held its inaugural meeting in July 2017 at the ADA headquarters in Chicago.

Throughout the development and validation process—and particularly during its first meetings—the Committee devoted considerable time and energy to discussions concerning the establishment of the DLOSCE content domain, and in what form and by which methods DLOSCE content should be presented to candidates. Subsequent to thorough review, in March 2018, the DLOSCE Steering Committee determined that the DLOSCE should be a virtual (i.e., computer-based) examination that would not directly measure psychomotor skills. The Committee also approved preliminary content areas and test specifications for the DLOSCE. Detailed information concerning the factors considered are provided in Section 6, "*Content Basis for the Examination,*" and in a published article entitled "*The Dental Licensure OSCE: A Modern Licensure Examination for Dentistry*" (Ziebert and Waldschmidt, 2020). At this time, the Committee also authorized the formation of a DLOSCE Working Committee composed of dental subject matter experts, to recommend structures for DLOSCE test construction teams, and to guide the development of DLOSCE content during test construction meetings.

The first DLOSCE test construction meeting took place in November 2018, and a large number of additional test construction meetings were held in the six month period that followed. In 2019, the DLOSCE Steering Committee approved modifications to the initial test specifications, and determined that the examination would contain questions involving lifelike, three-dimensional

(3D) models that could be interacted with and manipulated (magnified, moved, and rotated) by the candidate. Development of the 3D models began shortly thereafter.

In January 2020, the ADA Board of Trustees approved the JCNDE as the governing body for the DLOSCE Program – an action consistent with the wishes of both the DLOSCE Steering Committee and the JCNDE, as expressed through formal communications between the two groups beginning in 2018 and continuing through 2019. In February 2020, the JCNDE voted to accept governance responsibilities pertaining to the DLOSCE, and the DLOSCE Steering Committee became an *ad hoc* Committee of the JCNDE at that time. In February 2020, the DLOSCE Steering Committee and several DTS staff travelled to a Prometric testing center to review an initial completed version of the DLOSCE. Subsequent to their review, the Steering Committee members expressed overwhelmingly positive feedback regarding the quality of the examination. In April 2020, the JCNDE announced that the DLOSCE would be made available for use by dental boards in the United States, beginning in June 2020. Shortly thereafter, the JCNDE published a summary of validity evidence supporting the intended use and interpretation of DLOSCE results, and conducted a series of webinars for dental board members, dental educators, and dental students. Dental boards from a number of US states subsequently indicated they would accept DLOSCE results as either fully or partially fulfilling their clinical examination requirement. The DLOSCE was updated to incorporate minor changes recommended by the Committee in February, and then administered for the first time from June 15 through July 17, 2020. Results from the first administration were released to candidates, dental boards, and dental schools in August 2020.

4. Professional Test Standards

Large testing organizations responsible for developing, administering, and scoring examinations need criteria, or standards upon which to judge their effectiveness. Three professional organizations – AERA, APA, and NCME – joined forces and resources to create the latest version of The Standards for Educational and Psychological Testing (AERA, APA, NCME, 2014). These standards provide useful information to guide testing organizations in the validation of their test score interpretations and uses. Throughout this technical report, validity evidence is identified and connected to testing standards. Many sections of this technical report correspond to chapters in the *Standards* (AERA, APA, NCME, 2014).

5. Overview of Validity

Validity is defined in the *Standards* as “the degree to which evidence and theory support the interpretations of test scores for purposed uses of tests” (AERA, APA, & NCME, 2014, p. 11). Validation involves the investigative process of creating a validity argument and collecting evidence relevant to this argument, the examination purpose, and the intended interpretation of results. When acquired validity evidence reveals weaknesses or deficiencies, the testing organization is expected to take steps to address the deficiencies to strengthen the validity of the test.

The intended interpretation of DLOSCE results concerns the candidate’s ability to apply clinical judgment and skills in the provision of patient care. A passing score on the DLOSCE indicates that a candidate is able to do so at the level required for the safe, independent practice of entry-level general dentistry. DLOSCE results are used by dental boards in determining qualifications of dentists who seek licensure to practice in any state, district or other jurisdiction of the United

States, which recognizes the DLOSCE. This technical report presents validity evidence and additional references that support the intended interpretation and use of DLOSCE results.

This report is organized to address major categories of validity evidence. Each section contains narrative and validity documentation. In some instances, data are provided, as appropriate. The report addresses the following important categories of validity evidence, presented with corresponding section numbers:

6. Content Basis for the Examination
7. Test Design and Development
8. Scoring and Equating Methods
9. Standard Setting
10. Reliability
11. Test Administration
12. Results Reporting
13. Convergent Validity Evidence
14. Test Security
15. Rights and Responsibilities of Test Takers
16. Candidate Performance

The information provided in this technical report covers the entire span of DLOSCE development through September 2020, including DLOSCE administrations that occurred in the summer of 2020.

Legal Issues

All examination programs where results are used for high-stakes decisions run the risk of legal challenge based on validity. As a result, examination programs must be designed to withstand legal challenges.

This technical report represents an effective way to present the examination validity argument and corresponding validity evidence. This document organizes, describes, and presents a large amount of validity evidence. In so doing, boards can have confidence that the Joint Commission has acted responsibly in its duty to develop and administer an examination program capable of fulfilling its intended purpose.

6. Content Basis for the Examination

Content-oriented validity evidence is a critical source of validity evidence supporting the interpretation and use of DLOSCE results. The Standards indicate that developers of licensure examinations should provide a thorough description of the examination's content domain, along with evidence that the domain reflects the requirements of the profession for which candidates are seeking licensure (AERA, APA, NCME, 2014, p. 178-179). This chapter details the DLOSCE content domain and describes the theoretical rationale and empirical evidence that support it. In short, the content domain for the DLOSCE consists of the clinical tasks that a dentist performs while providing direct, chair-side treatment to patients. The content domain is formalized in the DLOSCE test specifications, which were established using the methods and procedures described below.

Establishing the DLOSCE Test Specifications

In 2018, the DLOSCE Steering Committee convened a review panel of subject matter experts to recommend test specifications for the DLOSCE. The recommended test specifications would describe the topic areas the DLOSCE should cover and the percentage of test items that should be allocated to each topic area. The review panel consisted of 11 dental subject matter experts, including general dentists, and specialists with expertise in the following areas: Prosthodontics, periodontics, oral radiology, oral diagnosis, oral surgery, endodontics, behavioral science, orthodontics, pharmacology, and dental anesthesia. The panel included three members of the DLOSCE Steering Committee as well as an individual who had served on the Committee for an Integrated Examination (CIE) (the committee that developed and validated the Joint Commission's Integrated National Board Dental Examination (INBDE)). The panel met for 1½ days at the ADA building in Chicago.

As a first step, the panelists studied the results of a dental practice analysis survey conducted by the JCNDE in 2016. The purpose of the practice analysis survey was to gather feedback from a nationally representative sample of practicing dentists, concerning the importance of various tasks that general dentists perform. The first section of the survey gathered information about the dentist and their practice environment. The second section consisted of a list of 56 clinical content areas (see Appendix A). In this section, responding dentists were asked to rate each clinical content area with respect to its importance to patient care, and its frequency of use in patient care. The levels of the rating scale were defined as follows:

Importance to Patient care:

5. Extremely important
4. Very important
3. Important
2. Somewhat important
1. Not important

Frequency of Use in Patient Care:

6. More than 5 times per day
5. 3-5 times per day
4. 1-2 times per day
3. 1-4 times per week
2. Less than once per week
1. Never

The JCNDE distributed the practice analysis survey to a total of 34,441 dentists. Among those, 2,542 (7.4%) provided valid responses. The mean importance rating and mean frequency rating were calculated for each clinical content area. The mean importance ratings across clinical content areas ranged from 3.22 to 4.82. The mean frequency ratings ranged from 1.7 to 5.92. The multiplicative model (Kane, Kingsbury, Colton, & Estes, 1989) was used to provide an overall index of importance for each clinical content area.

The members of the DLOSCE test specifications review panel studied the 56 clinical content areas from the practice analysis survey, along with the mean importance rating and mean frequency rating for each area. The panel members then engaged in a group discussion through which they 1) established a preliminary list of topic areas that the DLOSCE should cover (e.g., endodontics, periodontics), and 2) made a preliminary determination regarding the percentage of test items that should be allocated to each topic area. Once the panel had established the

preliminary percentages as a group, each panelist separately reviewed the percentages, and suggested changes as needed. The recommended changes were then summarized across the panelists, and presented to the group for consideration.

A key step in establishing the recommended DLOSCE test specifications involved articulating areas of commonality and important differences between the DLOSCE and the JCNDE's Integrated National Board Dental Examination (INBDE). As part of this discussion, the review panel established a preliminary scope and boundaries for skills it felt the DLOSCE should assess (i.e., the DLOSCE skill domain). A statement concerning this scope is provided below.

> *The DLOSCE covers the clinical tasks that a dentist performs while providing direct, chair-side treatment to patients in a clinical environment. This includes addressing issues that arise during the performance of a dental procedure.*

To further clarify the DLOSCE content domain, the panelists scrutinized the 56 clinical content areas included on the Joint Commission's practice analysis survey, which were broken down into three component sections: 1) Diagnosis and Treatment Planning, 2) Oral Health Management, and 3) Practice and Profession. Panel members then selected the clinical content areas they believed fit within the description of the DLOSCE skill domain they established in the previous step. Each panelist did this separately. Then, the panel worked as a group in an attempt to reach a consensus for each clinical content area.

Next, the panelists completed an exercise that required them to link the preliminary topic areas to the clinical content areas from the JCNDE practice analysis. As part of this exercise, panelists were asked to identify the topic areas that were related to each of the 56 clinical content areas. Results of the linking exercise demonstrated a strong relationship between the preliminary topic areas and the tasks that entry level general dentists perform, as indicated by the 56 clinical content areas from the practice analysis. This provided support for the appropriateness and comprehensiveness of the DLOSCE topic areas identified by the panel.

Just prior to the close of the meeting, panelists were given an opportunity to recommend changes to the percentages allocated to the established DLOSCE topic areas. Five of the eleven panelists recommended no changes to the percentages. No panelist recommended a change larger than two percent for any topic area. After discussing their individual recommendations as a group, the panel decided to retain the original percentages. The resulting topic areas and corresponding percentages represented the review panel's recommendation concerning preliminary test specifications for the DLOSCE. The DLOSCE Steering Committee reviewed and approved the review panel's recommendation in March 2018. This established the preliminary test specification for the DLOSCE.

In 2019 the DLOSCE Steering Committee revisited the preliminary DLOSCE test specifications and made modifications based on feedback from the DLOSCE Working Committee, DLOSCE test constructors and DTS staff. In 2020, the JCNDE reviewed and approved the test specifications, which appear in Appendix B. Each DLOSCE form is built to meet the specifications, ensuring that candidates who attempt the DLOSCE encounter an examination that is comprehensive and parallel in its coverage of the content domain. The JCNDE conducts comprehensive practice analyses on a periodic basis, and will continue to use practice analysis results, in combination with subject matter expert judgments, to ensure that the DLOSCE test specifications reflect clinical dental practice. In the time period between practice analyses, DLOSCE test constructors evaluate the specifications and – accompanied by appropriate justification – recommend minor changes as needed, for consideration by the JCNDE.

DLOSCE Content and the Question of Psychomotor Skill Evaluation

The preceding discussion focuses largely on the procedures used to determine the DLOSCE test specifications. An important question that has been present throughout DLOSCE development involves whether to include or not include a psychomotor skill evaluation component within DLOSCE administrations. The DLOSCE Steering Committee specifically and carefully considered this important question. In so doing, the following factors were thoroughly discussed:

- research evidence as it pertains to current clinical licensure examinations, which include both patient-based and manikin components
- research from the National Dental Examining Board (NDEB) of Canada, which had for decades utilized an Objective Structured Clinical Examination (OSCE) instead of a patient-based clinical examination
- the fidelity of existing manikin and dental simulation technology, as it relates to the day-to-day experience of practicing dentists
- ethical considerations pertaining to the use of patients in clinical examinations for licensure purposes
- the pre-eminent role of clinical judgment as it relates to the application of psychomotor skills
- the standards for dental education as promulgated by the Commission on Dental Accreditation (CODA), and the corresponding dental subject matter expert site visitors who scrutinize the quality of educational training provided at US dental schools
- the educational training provided by dental schools in accordance with CODA standards
- the evaluative tools and methods used by dental schools to understand whether a given student has demonstrated the necessary level of clinical judgment and skills
- the focal reasons for board disciplinary actions
- the applied experience of dental educators
- the need for comprehensive assessment of a candidate's clinical knowledge, skills, and abilities, at the time of licensure
- the validity and reliability of available and proposed solutions, from a rigorous psychometric perspective and in accordance with professional standards and guidelines

The DLOSCE Steering Committee fully acknowledged the critical importance of psychomotor skills in dental practice. Dentists rely heavily on psychomotor skills in treating their patients. Having noted this, the Committee was dismayed to see the dearth of research evidence supporting the validity of current clinical licensure examinations, whose focus primarily rested upon the measurement of these psychomotor skills (see, for example, Chambers, 2011; Formicola et al., 1998; Gadbury-Amyot et al., 2014; Hangorsky, 1981; Ranney et al., 2004). The Committee noted in particular a published editorial appearing in the Journal of Dental Education, offered by Dr. Steven Friedrichsen, Dean and Professor of the College of Dental Medicine of the Western University of Health Sciences. Consistent with the Committee's findings, Dr. Friedrichsen (2016) indicated the following:

> "There is no peer-reviewed scientific evidence that correlates [clinical licensure examination] outcomes with other validated assessments of clinical competence … the process yields no verifiable value in its ultimate objective of providing for the protection of the public." (p. 640)

The Committee was acutely aware of the essentiality of validity, particularly in high-stakes

licensure testing in health care, where the public health is at risk. The following opening statements from the first chapter of the Standards for Educational and Psychological Testing (2014) were germane:

> "Validity refers to the degree to which evidence and theory support the interpretations of test scores for proposed uses of tests. Validity is, therefore, the most fundamental consideration in developing tests and evaluating tests.
>
> …
>
> Evidence of the validity of a given interpretation of test scores for a specified use is a necessary condition for the justifiable use of the test." (p. 11).

In considering these matters, the Committee's review yielded the following core findings:

- peer-reviewed research evidence fails to provide adequate support for the use of patient-based and manikin-based clinical licensure examinations (Chambers, 2011; Formicola et al., 1998; Gadbury-Amyot et al., 2014; Hangorsky, 1981; Ranney et al., 2004); these examinations unfortunately do not appear to protect the public.
- peer-reviewed research evidence has supported use of the NDEB Canada OSCE (see Gerrow et al., 2003; Gerrow et al., 2006); additionally, Canada has relied on their OSCE and written examination for decades, without apparent issue.
- existing dental simulation technology was interesting but did not yet possess the level of fidelity necessary to warrant application in licensure testing; this technology should continue to be monitored and considered in the future.
- current manikins also lacked reasonable fidelity from the Committee's perspective. Manikin utilization was regarded as perhaps useful in the early stages of dental education, but represented a step backward when used for licensure purposes. As one member of the DLOSCE Steering Committee noted "drilling on plastic teeth just shows that an individual can drill on plastic teeth."
- in the past, there were varying points of view regarding the perceived rigor of the CODA accreditation process, and questions were present concerning the scope and rigor of school-based assessment procedures. However—thanks to over 25 years of hard work and the adoption and evolution of competency-based education in accredited dental schools, as well as the identification of new, effective pathways for dental clinical assessment—the situation has changed and strong accreditation standards are now in place and uniformly enforced throughout the US (American Dental Association, American Dental Education Association, American Student Dental Association, 2018).
- consistent with CODA standards, dental students are currently evaluated on their psychomotor skills and performance on hundreds of occasions during their enrollment in dental programs accredited by CODA (American Dental Association, American Dental Education Association, American Student Dental Association, 2018). This evaluation can take place using a variety of proven methods of skill evaluation and assessment, including patient-based, manikin-based, simulations, and OSCEs.
- current and former dental board members serving on the DLOSCE Steering Committee indicated that board disciplinary actions appear to predominantly focus upon issues involving mistakes arising from poor clinical judgment, substance abuse, and ethical failures, as opposed to deficiencies in psychomotor skills
- numerous dental educators have indicated to Committee members and staff that current clinical examinations appeared to be failing candidates arbitrarily:
    - the strongest students sometimes failed clinical licensure examinations while less skilled students passed without issue

    - virtually all students who failed a clinical licensure examination passed on their next attempt, in many cases without any remediation
- with respect to ethical issues, the Committee noted that the American Dental Association, American Dental Education Association, and American Student Dental Association had all adopted policies seeking to end the use of patients in dental clinical licensure examinations. These three associations in turn formed a joint Task Force on Assessment of Readiness for Practice, and issued a report (Sept 2018) indicating the following:

  > "… the Task Force opposes single, encounter, procedure-based examinations on patients, which virtually all states currently use to fulfill the clinical examination requirement. This approach has been demonstrated to be subject to random error; does not have strong validity evidence; is not reflective of the broad set of skills and knowledge expected of a dentist; and poses ethical challenges for test-takers, dental schools, and the dental profession … this single focus is typically in lieu of the patient's comprehensive and most severe or urgent needs, resulting in a standard of care that may well be below today's acceptable level … the Task Force calls upon state dental boards to eliminate the single encounter, procedure-based patient exams, replacing these with clinical assessments that have stronger validity and reliability evidence." (p2)

  This task force set the stage for the Coalition for Modernizing Dental Licensure, which has moved forward to help achieve the desired changes.
- current clinical examinations are not adequately comprehensive, focusing only on a narrow set of procedures conducted on an extremely small number of patients (e.g., often just two or three) with an extremely limited sample of performance obtained.

In light of these findings, the Steering Committee determined that the new examination should be computer-based and not directly measure psychomotor skills (i.e., due to the unfortunate deficiencies associated with current methods of psychomotor skill evaluation in dentistry). Given the positive research findings associated with OSCEs, the Committee felt that a hybrid or "virtual OSCE" should be pursued, with lifelike 3D models to emulate the experience in the dental clinic. Utilization of 3D models in lieu of live patients could provide further benefits through increased standardization of the testing experience, improving the reliability and validity of the examination with respect to its intended purpose. Extended multiple choice questions to accompany these 3D models could reduce the impact of guessing and provide candidates with a simulated clinical situation possessing greater fidelity and requiring sound clinical judgment, to truly understand whether a candidate "thinks like a doctor." In short, the Committee determined that the public would be far better served by a comprehensive examination focused upon clinical judgment. The quality of clinical judgments made by practicing dentists have a causal effect on patient outcomes, and psychomotor behaviors themselves. The Steering Committee concluded that utilization of manikins and patient-based demonstrations of performance should be unnecessary given the questionable evidence that is present even after decades of use of these examinations by boards.

7. Test Design and Development

Having established the content basis for the DLOSCE, the next considerations involved test design and development. The overall design of an examination is a crucial step in test development. The DLOSCE is designed with the full participation of content expert teams and supervised by staff specialists working in the Department of Testing Services test development

area. This process ensures that the expertise of highly qualified, licensed dentists is brought to bear during the examination design process. Joint Commission staff in the Department of Testing Services provide technical support and guidance to help ensure the desired technical qualities are achieved during the examination design phase.

Examination Format

The DLOSCE is a comprehensive examination consisting of 150 items. This includes 148 multiple choice items, and two prescription tasks. Pre-examination materials (e.g., the DLOSCE Candidate Guide) provide candidates with information concerning the format and scoring rules for each item type.

Multiple choice items. Multiple choice items appearing on the DLOSCE represent clinical problems that the candidate must solve. Each multiple-choice item consists of a stem, which poses a clinical problem, followed by a list of possible answers. The stem of an item is usually either a question or an incomplete statement. The two types of multiple choice items that appear on the DLOSCE are described below.

Single correct answer (i.e. single select). These multiple choice items consist of a stem, which poses a clinical problem, followed by a list of possible options. A candidate can only select one option, and only one of the possible options is correct. If the candidate selects the correct option, they earn full credit for the question; otherwise they earn no credit.

One or more correct answers (i.e., multi-select). These multiple choice items consist of a stem, which poses a clinical problem, followed by a list of possible options. One or more of the possible options is correct. To earn full credit, a candidate must select all of the correct options and avoid selecting any of the incorrect options. A candidate who selects an incorrect option automatically earns no credit for the item. A candidate can earn partial credit if they select one or more of the correct options and avoid selecting any of the incorrect options. When multiple correct options are present within an item, DLOSCE test constructors assign a point value to each correct option. Some options may also be designated as unscored. Candidates neither gain credit nor lose credit for selecting an unscored option. An option can be designated as unscored, for example, if it cannot be judged definitively based on the information presented in the item, or if subject matter experts disagree on whether or not it is correct. DLOSCE test constructors determine which options, if any, will be unscored.

Prescription Tasks. As noted previously, the DLOSCE contains two prescription tasks. These tasks require a candidate to review a Patient Box and determine an appropriate prescription for the patient described therein. For each prescription task, a candidate must

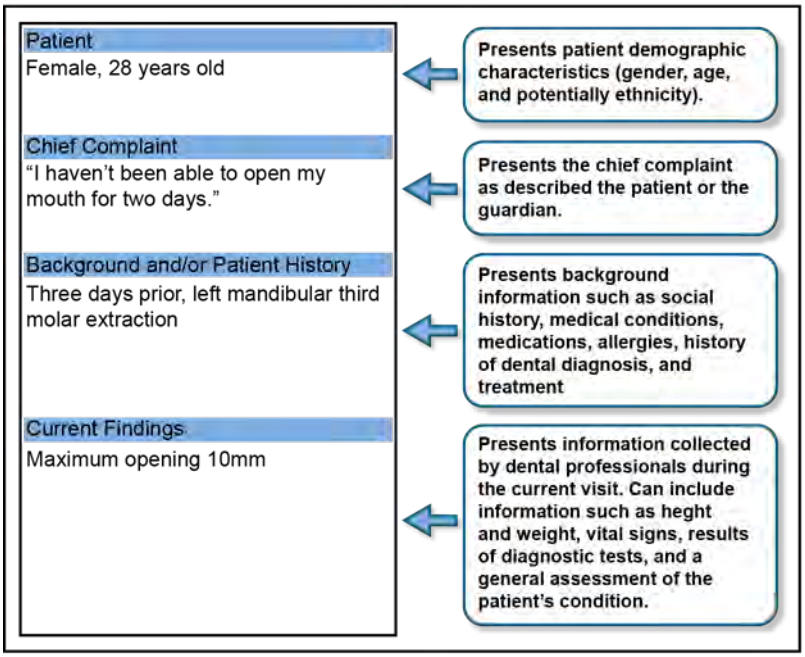
1. review a Patient Box, which provides information about the patient for whom the prescription will be written;
2. select appropriate medication(s) from a list;
3. specify the strength of the tablet/capsule (e.g., 500 mg);
4. specify the total number of tablets/capsules that should be dispensed;
5. identify the number of tablets/capsules that should be taken per administration;
6. specify whether or not the patient should take a loading dose; and

7. identify the frequency of administration (e.g., once a day until finished, twice a day as needed)

Prescription task responses are evaluated against a scoring key established by subject matter experts. Based on the combination of responses selected by the candidate, it is possible for the candidate to receive no credit, partial credit, or full credit for each prescription task.

Three-dimensional models. The DLOSCE contains items involving three-dimensional (3D) models that can be interacted with and manipulated (magnified, moved, and rotated). The JCNDE has made an online tutorial available, so that candidates can practice interacting with a sample 3D model before they attempt the examination. A tutorial provided at the beginning of the examination instructs examinees on how to manipulate the model. Items involving 3D models include a help feature that displays similar instructions for the candidate to reference during the examination.

Patient Box. Many DLOSCE items include a Patient Box. The Patient Box presents information available to the dentist at the time of the visit. The elements of the Patient Box are described below.



There are a number of benefits associated with using the Patient Box format to present patient information. Specifically, the Patient Box:

- permits the candidate to focus on the concept tested, as opposed to question wording (thereby reducing construct-irrelevant variance),
- simplifies the item writing process for test constructors, allowing them to focus on concepts for evaluation, and
- presents concepts to be tested within the context of an actual patient, thereby

increasing the correspondence between test content and the actual experiences of practicing entry-level dentists.

In short, the Patient Box is intended to maximize construct-relevant variance and minimize construct-irrelevant variance. Candidates are instructed to always consider the Patient Box in their responses, and a tutorial provided at the beginning of the examination instructs examinees on how to appropriately interpret information provided in the Patient Box. Similarly, pre-examination materials (e.g., the DLOSCE Candidate Guide) also includes information concerning the Patient Box.

DLOSCE Test Constructors

The Joint Commission relies on subject matter expert test constructors to develop and review DLOSCE items and examination forms. The role of test constructors is fundamental to the examination's validity argument. Test constructors are responsible for developing a clear, precise, and comprehensive set of items for each examination form; in accordance with established test specifications and utilizing rigorous procedures. Together these efforts providing content-related validity evidence in support of test usage. The Standards indicate that examination developers should describe the qualifications and characteristics of test constructors, and provide information about the training and materials test constructors receive (AERA, APA, NCME, 2014, p. 88). The section below presents this information, as it pertains to the DLOSCE.

Test constructors meet in teams to engage in test development activities. Test constructors use their subject-matter expertise—including their experience and understanding of dental practice and familiarity with the curriculum in accredited dental schools—to create, review, and finalize examination content. The following is a list of the responsibilities of every test constructor.

- Submit test development materials (e.g., images, items), in compliance with JCNDE guidelines, within the designated time frame. The number of materials that test constructors are expected to submit varies according to the needs of the examination program.
- Attend each test construction meeting for the duration of the session.
- Construct examination forms according to JCNDE guidelines, test specifications, and content outlines, within the designated time frame.
- Construct additional items for JCNDE item banks as necessary.
- Assign ownership of all examination materials to the ADA and JCNDE, by agreeing to the terms of the copyright assignment.
- Inform the Joint Commission of changes in dental practice, dental procedures, and dental education curricula, suggesting modifications to the test specifications as appropriate.
- Consider special issues and make recommendations at the request of the JCNDE.
- Safeguard the security and confidentiality of the examination by declining offers to assist with review courses and examination preparation materials while serving as a test constructor, and for at least one year following the final term of their appointment.
- Comply with the ADA's policy on professional conduct. This policy includes prohibitions against sexual harassment and other forms of unlawful conduct.

The DLOSCE test specifications provide core information to new test constructors. New test constructors receive an orientation which provides information about the DLOSCE program, and the item development and review process.

Test Construction Teams. DLOSCE test constructors work in teams, referred to as Test Construction Teams (TCTs), to develop DLOSCE items. In 2018, the DLOSCE Steering Committee authorized the formation of a DLOSCE Working Committee, composed of dental subject matter experts, to recommend structures for DLOSCE TCTs, and to guide the development of DLOSCE content during test construction meetings. The Working Committee proposed structures for DLOSCE TCTs, based on the DLOSCE test specifications and the needs of the examination program, and the structures were accepted by the DLOSCE Steering Committee and implemented shortly thereafter. Most DLOSCE TCTs meet multiple times per year, with most meetings approximately 2½ days in duration. TCT meetings are typically facilitated by one or more members of the DLOSCE Working Committee, in collaboration with DTS staff facilitators. The main categories of DLOSCE TCTs are described in detail below. Additional teams may also be created on an *ad hoc* basis to meet the targeted needs of the examination program.

Item Writing and Review Teams. Item Writing and Review teams typically consist of three to ten test constructors. Depending upon item development needs, multiple teams may be formed. Each team is responsible for developing items and reviewing newly written items to ensure content accuracy, currency, and validity, as well as adherence to the test specifications and item guidelines outlined by the Joint Commission. Item Writing and Review teams are typically organized according to the major areas of the DLOSCE test specifications (e.g., Oral Surgery, Periodontics). In order to serve on an Item Writing and Review team, a test constructor must be currently licensed as a dentist in the United States, and a graduate of an accredited advanced education program in the specialty area for which they develop items.

Clinical Relevance Review Teams. Each Clinical Relevance Review team consists of five to ten General Dentists. This team confirm the appropriateness of examination items in terms of their relevance to day-to-day clinical practice. The teams are also responsible for the final categorization of items, relative to the DLOSCE test specifications and in support of the general needs of the DLOSCE program. In order to serve on a Clinical Relevance Review Team, a test constructor must be a full-time or part-time practitioner or clinician/scientist with at least five years of experience, who is in practice at least 20 hours per week (inclusive of clinical teaching), and who is currently licensed as a dentist in the United States.

Form Review Teams. Form Review teams provide a final review of DLOSCE items and images identified for placement on examination forms, with respect to clinical relevance and the activities of a practicing general dentist. They ensure that the content being tested is comprehensive, meets the test specifications, and that there is no unintended overlap among the items included on each form.

Test Constructor Selection. On an annual basis the Joint Commission advertises and promotes its need for test constructors. A letter explaining the online application materials and selection criteria is emailed to dental schools, dental boards, constituent dental societies, and other institutions and individuals each year. All applications are processed by staff and presented to the Joint Commission's Committee on Examination Development, which is responsible for recommending individuals to serve in the DLOSCE Test Constructor Pool.

On an annual basis the Joint Commission's Committee on Examination Development approves and reapproves test constructors to serve in the DLOSCE Test Constructor Pool. An individual who has completed five years of service in the pool may be considered for re-approval as dictated by the needs of the examination program. DTS staff place approved test constructors

onto specific TCTs based on the expertise of the individual, the recommendations of the Committee on Examination Development at the time of the individual's selection, and the needs of the TCT and examination program. A team is formed for each specific meeting, and disbands at the end of that meeting. These teams are flexible and may or may not consist of the same test constructors each year. Teams may be rearranged as needed in the event that a given volunteer is not able to attend. If a volunteer is invited but is unable to attend, an alternate volunteer is identified and invited. Additionally, if a volunteer is invited to attend a meeting and does not respond in a timely manner, an alternative volunteer is identified and invited to attend the meeting. This process helps ensure teams have a sufficient number of volunteers with the required expertise, so that meeting goals can be accomplished efficiently and effectively.

Item Validation

The Standards indicate that examination developers should document the process used to develop, review, and evaluate items (AERA, APA, NCME, 2014, p. 87-88). This section describes the item validation process that the JCNDE has implemented for the DLOSCE.

Content accuracy review. During content accuracy review, test constructors review items for accuracy and currency. In some cases, this review is conducted by the members of the original Item Writing and Review team who developed the item. In other cases, the review is conducted by test constructors who are external to the original Item Writing and Review team.

Item classification. Item classification review is performed to specify the areas of content expertise identified for the item. This review is similar to how a librarian classifies material into subject areas using a defined taxonomy. The classification review includes the review or specification of all metadata for the item.

Editorial review. During editorial review, items are reviewed for grammar, style, formatting, and alignment with DTS item writing guidelines. Similarly, item stimulus materials are reviewed to ensure the information is of diagnostic quality and in accordance with modern dental practice.

Legal/intellectual property (IP) review. Joint Commission staff seek counsel from the ADA Division of Legal Affairs concerning the articulation of guiding principles that might inform procedures and help avoid legal issues involving examination content. This includes, for example, issues arising around privacy and the use of intellectual property. Individuals who submit images and materials to the Joint Commission are responsible for verifying intellectual property rights.

Clinical relevance review. The DLOSCE is designed for licensure purposes, to help state boards understand whether a candidate possesses the necessary clinical judgment to enter the profession and safely practice dentistry. The general dentist is thus of focal importance to the DLOSCE Program. During the clinical relevance review, corresponding review teams scrutinize items to help confirm item content is clinically relevant and applicable to the work of practicing dentists. This review helps reduce the likelihood of an examination form containing trivial and/or esoteric content.

Item performance review. Items that survive the reviews described above are eligible to be placed on examination forms. Once an item has been placed on a form, and once the form has been administered to a sufficient number of candidates, DTS calculates the following statistics for each item:

1) The mean score for the item; and
2) The item-total correlation, defined as the Pearson correlation between performance on the item and performance on the examination.

The mean score for the item is an indicator of an item's difficulty, and the item-total correlation is an indicator of an item's ability to discriminate among candidates of different ability levels. Items that fail to discriminate among candidates of different ability levels are scrutinized by staff and then routed to appropriate test constructors for review. Items that do not perform appropriately are removed from scoring. Subsequent to administration, test constructors review examination content and relevant psychometric information and determine whether items can and should be revised. The revision process could, for example, involve rewording the stem or changing the distractors. If an item is revised, it is returned to the item bank where it becomes a candidate for placement on a future examination form. If test constructors determine that an item cannot be improved through revision, the item is designated as unusable.

8. Scoring and Equating Methods

Scoring Approach

There are two common approaches to scoring licensure examinations. Under the first approach, the pass/fail decision is based on a single score that is determined from the candidate's performance on the entire examination. Under the second approach, an examination is divided into separately scored sections, and the candidate must pass each section in order to pass the examination. The latter approach is often used when the topic areas on an examination are substantially distinct from one another and candidate competence on each topic area must be verified separately. When examination topic areas are highly correlated, on the other hand, the former approach is often used, because a single score based on all the test items will be more reliable than the scores determined for the individual topic areas.

Analysis of data from administration of the DLOSCE strongly suggests that a candidate's DLOSCE result (i.e., pass or fail) should be based on a single score derived from the candidate's performance on the entire examination. Exploratory factor analysis of candidate scores on the nine DLOSCE topic areas suggests they are indicators of a common underlying ability that can be well represented with a single score; the ratio of the first to second eigenvalue from the factor analysis was 9.8, and a parallel analysis (Horn, 1965), scree test (Cattell, 1966), and the application of Kaiser's (1960) criterion all converged on the finding that a single underlying factor was present. Based on this, the JCNDE has adopted a scoring approach for the DLOSCE whereby a candidate's result is determined based on their overall performance on the examination. The section below describes how the overall score and corresponding pass/fail result is determined for each DLOSCE candidate.

Scoring Methods

DLOSCE results are determined through a multi-step process. In the first step, non-performing items are identified and removed so that they do not count toward candidate scores. Non-performing DLOSCE items are identified based on two statistics: the mean score for the item, which is an indicator of an item's difficulty, and the item-total correlation, which is an indicator of the item's ability to discriminate among candidates of different ability levels.

In the second step, a *raw score* is determined for each candidate. The raw score represents the total number of points the candidate earned on the examination, after removing the non-performing items. Each raw score is also expressed as a *percent correct* score, which is calculated as the raw score divided by the total number of points possible. As mentioned previously, the DLOSCE contains three types of items: 1) single-select items 2) multi-select items, and 3) prescription tasks. Candidates can earn a maximum of 1 point for each single-select and multi-select item, and a maximum of 4 points for each prescription task. Partial credit is possible for multi-select items and prescription tasks. When multiple forms of the DLOSCE are administered, percent correct scores are adjusted through a psychometric process known as equating, to statistically adjust for any differences in the difficulty of the examination forms (for details, see the section titled Equating Methods). The equating process helps ensure that all DLOSCE candidates are held to the same performance standard, regardless of which examination form they attempt.

In the third step, each candidate's equated percent correct score is converted to a scale score. DLOSCE scale scores can range from 49 to 99 and are expressed as whole numbers (e.g., 49, 50, 51). A scale score of 75 represents the minimum level of clinical judgment and skills required for the safe, independent practice of entry-level general dentistry, as determined through standard setting activities (see Chapter 9). A candidate must earn a scale score of 75 or higher to pass the DLOSCE. Candidates who receive a scale score of 75 or higher receive a status of "Pass," while candidates who receive a scale score below 75 receive a status of "Fail."

Equating Methods. Multiple forms of the DLOSCE are available for administration. The JCNDE takes care to ensure that all DLOSCE forms meet the DLOSCE test specifications and are as parallel as possible. However, because the forms contain different items, small form-to-form differences in difficulty are typically present. The JCNDE uses a process called *equating* to statistically adjust for these differences. The equating process helps ensure that all DLOSCE candidates are held to the same performance standard, regardless of which examination form they attempt. The Standards indicate that test developers should provide evidence supporting the claim that results from different forms of an examination may be used interchangeably (AERA, APA, NCME, 2014, p. 105). The discussion provided herein is intended to help provide that supporting evidence.

The JCNDE uses a common-item nonequivalent groups design to equate DLOSCE scores. In the common-item nonequivalent groups design, there are two samples of candidates, each of which is administered a different form of the examination. There are also some items that are common to both examination forms. The common items comprise an *anchor test* which ultimately forms the basis for the score adjustments. Due to their importance, the anchor test items are carefully chosen based on the guidelines described in Kolen and Brennan (1995). According to these guidelines, the anchor test should meet the test specifications proportionally, and have a sufficient number of items (e.g., 20 percent of the length of a full examination form, or at least 30 items).

The *Tucker linear method* (Angoff, 1971) is used to place scores from different DLOSCE forms on the same measurement scale. The Tucker linear equating method is intended for use when a common-item nonequivalent groups equating design is employed. Under the Tucker method, scores from Form X are placed on the Form Y scale using the following equation:

$$Y' = \frac{\sigma(Y_T)}{\sigma(X_T)}[X - \mu(X_T)] + \mu(Y_T), \quad 8.1$$

where Y' is the Form X score expressed on the Form Y scale, and $\mu(X_T)$, $\mu(Y_T)$, $\sigma(X_T)$, and $\sigma(Y_T)$ are the means and standard deviations of the scores on Forms X and Y for the combined population of candidates (i.e., the candidates who take Form X combined with the candidates who take Form Y). Because the candidates who take Form X do not have scores on Form Y, and vice versa, the means and standard deviations in Equation 8.1 are estimated using information about candidate performance on the anchor test items (for the algebraic formulas used to estimate the parameters in Equation 8.1, see Angoff, 1971 or Kolen, 1985).

Quality Assurance. The Standards indicate that those responsible for scoring examinations should establish and document quality assurance measures (AERA, APA, NCME, 2014, p. 118). Accordingly, the JCNDE has established strict quality control measures to facilitate accurate scoring of the DLOSCE. At the close of each DLOSCE administration window, a roster of candidates scheduled to complete the DLOSCE is compared with the candidates appearing in result files, to ensure no result files are missing. Examinations are independently scored by two separate DTS analysts, and the resulting scores are compared against one another to ensure they are identical before results are released to candidates. DTS staff maintain documentation related to the examination scoring process, and corresponding quality assurance procedures.

9. Standard Setting

A critical step in the development of any licensure examination involves the establishment of the cut score that separates passing and failing candidates (AERA, APA, NCME, 2014, p. 100-101). The Standards indicate that subject matter experts involved in setting cut scores should be qualified, and that the process for setting the cut score should be well described and documented (AERA, APA, NCME, 2014, p. 107-108). The information provided below is presented in fulfilment of this requirement.

Standard Setting Procedures

In August 2020, the JCNDE convened a standard setting panel to recommend a performance standard (i.e., cut score) for the DLOSCE. The panel identified its recommended cut score using a modified version of the Bookmark standard setting method (Lewis, Mitzel, Mercado, & Schulz, 2012). The modified method was inspired by Angoff's (1971) "Yes/No" method of cut score establishment (see Impara & Plake, 2006), and had been successfully implemented previously as reported by Buckendahl et al. (2006). The standard setting activities involved the following steps:

1. A standard setting panel was convened. The panel was composed of seven members who were diverse with respect to practice experience, gender, areas of specialized knowledge, and geographic region.

2. The panel members received a thorough overview of the purpose and content of the DLOSCE. This included a description of the test specifications, test construction methods, and scoring methods. As a reference, panel members were also provided with information concerning recent failure rates for several existing dental licensure examinations.

3. Prior to the meeting, panel members completed an abbreviated version of the DLOSCE that was approximately representative of a full version of the DLOSCE with respect to content, difficulty level, timing, and item formats. During the meeting, panel members self-scored their abbreviated examinations and subsequently discussed the items as a group.

4. The panel members engaged in a complete and thorough discussion of the characteristics and skills of the "just qualified" (i.e., minimally competent) candidate, focusing on candidate skills in the specific topic areas covered on the DLOSCE.

5. Following the discussion phase, panel members were trained in the Bookmark standard setting method and given an opportunity to practice the method using provided practice materials.

6. Next, panel members reviewed a large set of examination items that had been placed into an Ordered Item Booklet (OIB) assembled as follows:
    - Each page of the OIB contained one item.
    - The items included in the OIB spanned a representative range of difficulty levels.
    - Items within the OIB were presented in ascending order of difficulty such that the item on the first page was the least difficult and the item on the last page was the most difficult.
    - Single-select items appeared once within the OIB. The "success criteria" for these items involved the candidate answering the question correctly, thereby earning the candidate full credit for the item.
    - Each partial credit item represented in the OIB appeared twice within the booklet:
        1) When an item involving partial credit appeared in the OIB for the first time, the difficulty value for that item was based on the proportion of candidates who earned at least partial credit for the item.
        2) When an item involving partial credit appeared for the second time, the difficulty value for that item was based on the proportion who earned full credit for the item.
    - Given the preceding—and for purposes of the OIB—partial credit items therefore involved two separate "success criteria" levels (i.e., partial credit and full credit).

7. After reviewing the OIB, each panel member was asked to independently "bookmark" the page number in the OIB of the last item for which a minimally competent candidate would have at least a 50 percent probability of meeting the aforementioned OIB item success criteria. The cut score associated with the bookmarked OIB page was then defined as the score earned by a hypothetical candidate who succeeded on all of the items up to and including the marked page, and failed on all of the items thereafter. The median OIB page placement (across panelists) and corresponding cut score was used to represent the group's recommendation.

8. After making their judgments, panel members engaged in group discussion regarding their bookmark placements and the rationales for their judgments. During this phase panel members were provided with information about the bookmark placements of the other panel members, and the anticipated impact of using the cut score associated with the median bookmark placement (i.e., the percent of candidates who would fail under that cut score).

9. Steps 7 and 8 as described above were repeated three times. After each replication, panel members were provided an opportunity to ask questions, request clarification, express any concerns, and engage in group discussion. Subsequently, each panel member was asked to provide a final recommended OIB page placement. The final recommended cut score for the examination was based on the median of the panelists' page placements.

10. At the conclusion of the activities, panel members were asked to complete a questionnaire regarding their impressions of the process. Most panel members strongly agreed with the following statement: "Overall, I support the final group-recommended cut score as fairly representing the appropriate performance standard for the DLOSCE." On a five-point rating scale, ranging from 1=Strongly Disagree to 5=Strongly Agree, the mean rating for this question was 4.14.

The recommended performance standard resulting from the 2020 DLOSCE standard setting activities was accepted and implemented by the Joint Commission in August 2020. As a matter of practice, the JCNDE revisits performance standards periodically, conducting new standard setting activities as needed (e.g., if substantial changes are made to the DLOSCE test specifications, and as dental practice evolves in substantive ways).

10. Reliability

Score reliability is an important indicator of examination quality. Test developers strive to ensure test scores provide a stable and precise measurement of a candidate's knowledge, skills, and abilities. Despite efforts to eliminate possible sources of measurement error, random factors can affect candidate performance and subsequent examination results. Reliability indices assess the degree to which random error affects scores. When scores on an examination demonstrate low reliability, they are strongly influenced by random sources of measurement error. Conversely, when scores on an examination demonstrate high reliability, they are less subject to random sources of error. The Standards highlight the importance of reporting the reliability of test-based decisions for high stakes licensing examinations (AERA, APA, NCME, 2014, p. 46-47). A strategy that is commonly used to increase reliability is to lengthen examinations. Having uniformly high-quality items also contributes to reliability.

Internal Consistency Reliability

The Joint Commission uses the alpha reliability coefficient (Cronbach, 1951) as one index of score reliability for the DLOSCE. Coefficient alpha is an index of internal consistency reliability, and can range from zero to one, with higher values indicating higher reliability. Once an estimate of score reliability has been obtained, the standard error of measurement for the examination scores can be estimated as follows:

$$SEM = s\sqrt{1 - r_{xx}} \qquad 10.1$$

where *s* is the standard deviation of the scores, and r_{xx} is the reliability estimate. Under the assumption that random errors are normally distributed, test users can construct a 95 percent confidence interval around a candidate's score by adding and subtracting 1.96 standard errors of measurement from the score. Table 10.1 presents alpha reliability coefficients and standard errors of measurement for recent administrations of the DLOSCE.

Table 10.1
Alpha Reliability and Standard Error of Measurement

Year	Candidates	Alpha Reliability	Standard Error of Measurement
2020	245	.75 - .83	3.10 - 3.41

Note. The values presented represent the range of estimates calculated across examination forms and/or test administration windows. Estimates are based on data from candidates who were attempting the DLOSCE for the first time.

Classification Accuracy and Classification Consistency

When scores on an examination are used as a basis for making pass/fail decisions, it is important for the test developer to demonstrate that the pass/fail decisions are reliable (AERA, APA, NCME, 2014, p. 46-47). To evaluate reliability, testing programs typically estimate *classification accuracy* and *classification consistency*. Classification accuracy is the probability that a candidate's pass/fail result on an examination reflects the decision that would be made had their true skill level been known. Classification consistency is the probability that a candidate would receive the same pass/fail result on two hypothetical, successive administrations of an examination. The JCNDE estimates classification accuracy and consistency for the DLOSCE using a Classical Test Theory-based version of the method described in Rudner (2001), whereby a common standard error of measurement is used for each candidate (see Equation 10.1). Table 10.2 presents estimates of classification accuracy and classification consistency for recent administrations of the DLOSCE.

Table 10.2
Classification Accuracy and Classification Consistency

Year	Candidates	Classification Accuracy	Classification Consistency
2020	245	.941 - .948	.916 - .921

Note. The values presented represent the range of estimates calculated across examination forms and/or test administration windows. Estimates are based on data from candidates who were attempting the DLOSCE for the first time.

11. Test Administration

The DLOSCE is administered during fixed administration windows throughout the year. Prometric administers the examination at its Professional Level Testing Centers located throughout the United States and its territories. Once eligible, candidates can schedule an examination for any business day within the administration window, conditional on testing center availability. The administration schedule for the DLOSCE is provided in Table 11.1.

Table 11.1
DLOSCE Administration Schedule

Section	Minutes
Tutorial (optional)	25
Section 1 (37 items)	75
Scheduled break (optional)	10
Section 2 (37 items)	75
Section 3 (2 prescription tasks)	10
Scheduled break (optional)	10
Section 4 (37 items)	75
Scheduled break (optional)	10
Section 5 (37 items)	75
Post-examination survey	20
Total Time	6 hr. 45 min.

The DLOSCE Candidate Guide details DLOSCE candidate eligibility requirements and the DLOSCE application process. The guide is made available to candidates through the JCNDE website (ada.org/JCNDE).

12. Results Reporting

Reporting DLOSCE Results to Candidates

DLOSCE results are reported to candidates through a secure, password protected electronic portal. Results are typically made available to the candidate within four weeks of the close of the corresponding DLOSCE administration window, barring unusual circumstances (e.g., a candidate's results are being voided or withheld).

DLOSCE candidates who pass the examination receive a report indicating their result is "Pass," but do not receive numeric scores. Candidates who fail the DLOSCE receive a report indicating their result is "Fail" along with their numeric overall DLOSCE scale score. DLOSCE scale scores can range from 49 to 99 in one-point increments; candidates must earn a scale score of 75 or higher to pass the examination. For remediation purposes, candidates who fail the DLOSCE are also provided with a graphical depiction of their performance in the following areas:

- Restorative Dentistry
- Prosthodontics
- Oral Pathology, Pain Management, and Temporomandibular Dysfunction
- Periodontics
- Oral Surgery
- Endodontics
- Orthodontics
- Medical Emergencies

The numeric scores represented in the graphic are placed on a common scale so candidates can compare their relative performance in the different areas and identify areas where they are most in need of remediation. Consistent with best practices outlined in the Standards, the

results report issued to candidates who fail the DLOSCE contains explanatory text that is intended to help candidates interpret their results accurately.

Reporting DLOSCE Results to Dental Boards

When candidates apply to take the DLOSCE, they also indicate which dental boards should receive their official results. The JCNDE reports Pass/Fail results to the requested dental boards through a secure, password protected electronic portal. A history of the candidate's Pass/Fail results is made available to each dental board requested to receive results. Numeric scores are not reported to dental boards.

Reporting DLOSCE Results to Dental Schools

A candidate's Pass/Fail results are reported to the candidate's dental school, provided that the school is accredited by the Commission on Dental Accreditation (CODA). Results are reported to the school's dean or designee through a secure, password protected electronic portal. CODA accredited dental schools receive periodic reports that describe how their students on average perform on the examination, as compared to the national student average.

13. Convergent Validity Evidence

Convergent validity evidence is established when scores on an examination are positively correlated with scores from other measures of similar constructs. The following section provides convergent validity evidence in support of the DLOSCE.

Correlation with National Board Dental Examination Scores

The JCNDE used data from 2020 administrations of the DLOSCE to examine the relationships between scores on the DLOSCE, and scores on Parts I and II of the National Board Dental Examination (NBDE). The observed Pearson correlations are provided in Table 13.1. Performance on the DLOSCE showed a moderately strong correlation with performance on NBDE Part II, which measures knowledge and cognitive skills in the clinical sciences. Performance on the DLOSCE showed a moderate correlation with performance on NBDE Part I, which measures knowledge and cognitive skills in the biomedical sciences.

Table 13.1
Observed Pearson Correlations among DLOSCE and NBDE Scores: 2020
N=245 candidates

Score	DLOSCE	NBDE Part I	NBDE Part II
DLOSCE	1.00		
NBDE Part I	.36	1.00	
NBDE Part II	.54	.60	1.00

Note. Estimates are based on data from candidates who were attempting the examination for the first time.

Table 13.2 shows the fully disattenuated Pearson correlations between scores on the DLOSCE, and scores on NBDE Parts I and II. The fully disattenuated correlations correct for unreliability in

the measured variables and represent estimates of what the correlations would be if the variables were measured with perfect reliability.

Table 13.2
Fully Disattenuated Pearson Correlations among DLOSCE and NBDE Scores: 2020
N= 245 candidates

Score	DLOSCE	NBDE Part I	NBDE Part II
DLOSCE	1.00		
NBDE Part I	.41	1.00	
NBDE Part II	.62	.66	1.00

Note. Disattenuated correlations were estimated using the following reliability coefficients: DLOSCE=.83; NBDE Part I=.93; NBDE Part II=.90. Estimates are based on data from candidates who were attempting the examination for the first time.

The correlations presented in Tables 13.1 and 13.2 provide strong convergent validity evidence in support of the intended interpretation and use of DLOSCE results. As expected, DLOSCE scores correlated more strongly with NBDE Part II scores than with NBDE Part I scores (DLOSCE and NBDE Part II both focus on the clinical sciences, while NBDE Part I focuses on the biomedical sciences). In reviewing the disattenuated correlations, it should be noted that perfect correlations between the DLOSCE and NBDE scores would not be desirable, since perfect correlations would indicate that the DLOSCE and NBDEs measure an identical construct. The DLOSCE is intended to measure a construct that is related, but not identical to those measured by NBDE Parts I and II.

Correlation with Clinical Performance in Dental School

The JCNDE conducted a study to understand the relationship between candidates' scores on the DLOSCE and their clinical performance in dental school. To do so, the JCNDE collected dental school performance information for 40 DLOSCE candidates who attempted the examination in the summer of 2020. All 40 candidates in the sample were students in the graduating class of 2020 in the same CODA-accredited dental education program in the United States. The study focused on two indicators of candidate performance in dental school: 1) performance in clinical courses in the third-year of dental school, and 2) final clinical performance, as rated by the program's senior associate dean for academic affairs. Results of the correlational analyses are described in the section that follows.

Clinical performance in third-year dental courses. Candidate clinical performance in third-year dental courses was evaluated using course performance data provided by the dental education program that participated in the study.[1] For each third-year course, students had an opportunity to earn a letter of commendation (LOC) by demonstrating superior performance. For the present study, third-year performance was defined as the total number of LOCs earned during the year (referred to hereafter as the LOC Sum Score). The third-year curriculum included 14 courses, so LOC Sum Scores could range from zero to 14. The third-year courses covered the following areas: Oral Pathology, Oral Surgery, Pediatric Dentistry, Prosthodontics, Endodontics, Orthodontics, Medical Emergencies, Management of Medically Compromised Patients, Health Promotion, and Dental Practice Operations.

[1]Performance information for fourth-year courses was not available.

Table 13.3 presents the observed and disattenuated correlations between DLOSCE scale scores, and the LOC Sum Scores for third-year dental courses. As shown in the table, the observed Pearson correlation between the two outcomes was .37 ($p < .05$), which represents a moderate positive relationship. Visual inspection of the scatter plot of the two variables, however, revealed that a single outlier exerted a strong influence on the correlation. For this reason, Table 13.3 also presents the Pearson correlation calculated with the aforementioned outlier removed. After removing the outlier, the observed Pearson correlation was .57 ($p < .05$). The partially disattenuated correlations presented in Table 13.3 correct for unreliability in the LOC Sum Scores, and represent estimates of what the correlations between the two variables would be if the LOC Sum Scores were perfectly reliable. The fully disattenuated correlations correct for unreliability in both the LOC Sum Scores and the DLOSCE scores, and represent estimates of what the correlations would be if the LOC sum scores and the DLOSCE scores were both perfectly reliable.

Table 13.3
Correlation between DLOSCE Scale Scores and Clinical Performance in Third-Year Dental Courses: 2020

	Observed Pearson Correlation	Partially Disattenuated Pearson Correlation	Fully Disattenuated Pearson Correlation
Full Study Sample (N=40)	.37*	.46*	.51*
Study Sample with Outlier Removed (N=39)	.57*	.70*	.76*

Note. The partially disattenuated correlations were estimated assuming a reliability coefficient of .66 for the letter of commendation (LOC) sum scores. The fully disattenuated correlations were estimated assuming reliability coefficients of .66 for the LOC sum scores and .83 for the DLOSCE scores.
*$p < .05$

Final clinical performance in dental school. The concurrent validity study also examined the relationship between candidates' performance on the DLOSCE, and their clinical performance in dental school, as rated by the program's senior associate dean for academic affairs. For this portion of the study, the senior associate dean was asked to categorize the 40 students in the analytic sample into one of three groups based on their final clinical performance in dental school, relative to their 4th year peers.[2] The question posed to the dean appeared as follows:

> *Please place each student into one of the following categories, with regard to their final clinical performance in dental school, relative to their 4th year peers.*
>
> *Top 20%* *Middle 60%* *Bottom 20%*

The 40 DLOSCE candidates from the participating school were classified by the dean into one of the three performance groups. Table 13.4 presents a summary of the DLOSCE scale scores for the candidates in each group. Prior to calculating the means, the DLOSCE scale scores for

[2]The student performance ratings were collected after the pass/fail DLOSCE results had been released to the dental education program that participated in the study. However, the senior associate dean did not have access to candidates' numeric DLOSCE scores at any time.

the 40 candidates in the sample were standardized to have a mean of zero and a standard deviation of one.[3]

Table 13.4
Descriptive Statistics for Standardized DLOSCE Scale Scores, by Group
(N=40)

Academic Dean's Rating of the Candidate's Final Clinical Performance in Dental School†	Candidates	Mean of Standardized DLOSCE Scale Scores	Standard Deviation of Standardized DLOSCE Scale Scores
Top 20% of Class	8	0.59	0.90
Middle 60% of Class	24	0.03	0.95
Bottom 20% of Class	8	-0.69	0.92

†Each candidate was classified into a performance category by their senior associate dean for academic affairs.

On average, candidates rated as being in the top 20% of their class in terms of their final clinical performance scored .59 standard deviations above the mean on the DLOSCE, while candidates rated as being in the bottom 20% of their class scored .69 standard deviations below the mean on the DLOSCE. This amounts to a difference of 1.28 standard deviations between the lowest and highest performing groups. Stated slightly differently, the preceding indicates that candidates demonstrating the strongest clinical performance in dental school achieved DLOSCE scores that were on average 1.28 standard deviation units higher than those demonstrating the weakest clinical performance in dental school. This is a sizable performance difference on the DLOSCE, and is interpreted as representing a very large effect size by commonly applied interpretive guidelines within the field of psychological measurement. The polyserial correlation between the clinical performance ratings and the DLOSCE scale scores was .47 ($p < .05$), which is also understood as representing a strong effect size.[4]

Overall, the results presented in Tables 13.3 through 13.4 indicate that performance on the DLOSCE is positively correlated with clinical performance in dental school. Again, these findings provide strong convergent validity evidence in support of the intended interpretation and use of DLOSCE results. Notably, the correlations observed here are substantially stronger than those observed in similar convergent validity studies involving clinical licensure examinations that

[3]A data sharing agreement was established with the dental school that participated in the validity study. The agreement stipulated that the study results reported in this technical report would not contain specific information about the school's performance on the examination. The DLOSCE scale scores were standardized as a means of abiding by the terms of the agreement. The standardized scores can only be interpreted normatively, and therefore provide no information about the participating school's examination performance relative to the DLOSCE performance standard.

[4]As noted in discussions involving Table 13.3, an outlier was present in the analytic sample that exerted a strong influence on the correlation between LOC Sum Scores and DLOSCE scale scores. While this particular candidate was an outlier in the LOC analysis, this candidate did not have a large impact on results of the analysis involving faculty ratings of candidate performance. For completeness, the analysis involving faculty ratings was also performed after removing this individual from the data set. After removing the individual, the mean difference between DLOSCE scale scores for the Top 20% and Bottom 20% clinical performance groups increased from 1.28 to 1.34 standard deviations, and the polyserial correlation between clinical performance ratings and DLOSCE scale scores increased from .47 to .49.

include patient-based and manikin components (Chambers, 2011; Formicola et al., 1998; Gadbury-Amyot et al., 2014; Hangorsky, 1981; Ranney et al., 2004).

14. Test Security

General Principles

Effective examination security procedures are critical to the success of any examination program. Responsibilities for examination security are clearly defined for test developers, test administrators, and examination users. Examination security is maintained through test development and test administration procedures in a variety of ways. DTS policies address issues related to examination security and are reviewed periodically by the Joint Commission and its staff.

Security Audit

In 2008, Caveon Test Security, an independent organization, conducted a security audit of DTS. This audit was conducted to identify potential security risks, propose specific measures to ameliorate or diminish any potential risks, and provide recommendations to support security planning. The findings of the audit supported the overall security measures implemented within DTS.

Identification of Secure Materials

The Standards highlight the importance of maintaining appropriate data security, including protections for candidate score information and sensitive ancillary information (AERA, APA, NCME, 2014, p. 121). Accordingly, the Joint Commission has identified certain materials as secure. These include the following:

1. individual items and item materials (e.g. radiographs, clinical photographs);
2. scoring materials (e.g., item analyses, answer keys, and statistical analyses);
3. computer scoring software;
4. standard setting materials and meeting notes;
5. item banks; and
6. candidate personal information.

Departmental Procedures

The Joint Commission and DTS have a number of procedures in place that are designed to increase examination security. Relevant procedures are described in the section below.

Policies and legal issues. All items and examinations are copyrighted to establish ownership and restrict their use or dissemination through unauthorized means. Policies and procedures for handling secure materials require continuous secure custody of materials and a chain of evidence attesting to the status and location of secure materials.

Personnel. The team that maintains the security of examination materials includes Joint Commission staff, vendors, and volunteers. Personnel who handle examination materials must be screened at the time of hire or selection for assignment to disqualify individuals who could represent an unacceptable risk. All staff members are trained in procedures for handling secure materials and are required to comply with policies on confidentiality and conflict of interest. The

examination development staff maintain security on examination materials during the development process.

All vendors are responsible for maintaining security of examination materials. Joint Commission staff review vendors' operations to ensure compliance with security policy. Service agreements with vendors must reasonably adhere to the Joint Commission's security procedures.

Volunteers who assist in the development of items and editions of the examination must complete agreements regarding confidentiality, copyright assignment, and conflicts of interest. Volunteers are prohibited from releasing information about examination content.

Facilities. Access to the offices of the Joint Commission is restricted and secure.

Security of Test Materials in Electronic Format. Departmental and vendor computers are protected with firewalls, login identifications, passwords and other current forms of security. Access to electronic files is limited to authorized individuals.

Testing Procedures. Examinations are administered by Prometric at its nationwide, professional level testing centers. The DLOSCE Candidate Guide describe procedures for identification of candidates, including requirements for positive identification through biometrics. Candidate conduct is closely monitored during the testing appointment. Examination regulations and testing center policies are designed to deter cheating and prevent security breaches.

Policies and Procedures for Dealing with Breaches in Security

The Joint Commission provides specific procedures for observing and reporting security breaches and communicates them to test administrators. The Joint Commission promptly investigates reports of security breaches and responds appropriately given the nature and severity of the breach. When the source of a security breach is identified, the Joint Commission takes legal action or imposes appropriate sanctions.

15. Rights and Responsibilities of Test Takers

Documentation Provided to Candidates

The Standards indicate that information about an examination should be provided to all test takers, free of charge and in accessible formats (AERA, APA, NCME, 2014, p. 133-134). Accordingly, the Joint Commission annually publishes the DLOSCE Candidate Guide. This document provides detailed information related to Joint Commission policy, rules and conduct, the format and content of the examination, eligibility requirements, examination regulations, the appeal process, examination scoring, and examples of item formats. The JCNDE also makes publicly available a set of DLOSCE practice questions that is provided free of charge. Each year the DLOSCE Candidate Guide is updated and amended as necessary. The guide and DLOSCE practice questions are available through the Joint Commission's website at ada.org/JCNDE. This technical report also serves as a source of documentation that is freely available to all DLOSCE candidates through the JCNDE website.

Fair Treatment and Recourse

According to the Standards, candidates are entitled to fair treatment. This includes the right to information regarding available means of recourse pertaining to irregularities and appeals (AERA, APA, NCME, 2014, p. 137). For the DLOSCE, candidates whose results are subject to being voided are notified by written correspondence and provided with a copy of the Limited Right of Appeal for Examination Candidates. Candidates are notified of the appeal decision approximately 60 days after receipt of the appeal. When considering an appeal, the JCNDE strives to ensure that examination results accurately reflect candidates' skills, and that the appealing candidate has an opportunity to gain DLOSCE certification equal to, but not greater than, the opportunity provided to other candidates. The JCNDE strives to handle irregularities and their investigation in a professional, fair, objective, and confidential manner.

16. Candidate Performance

Table 16.1 provides DLOSCE administration volumes and failure rates, by candidate group and year. Table 16.2 provides descriptive statistics for DLOSCE scale scores, by candidate group and year.

Table 16.1
DLOSCE Administration Volumes and Failure Rates, by Candidate Group and Year

	Accredited†				Non-Accredited‡				Total	
	First Attempt		Retake		First Attempt		Retake		First Attempts and Retakes	
Year	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2020	231	9.5	2	0.0	14	57.1	1	100.0	248	12.5

† Indicates candidates educated by dental education programs accredited by CODA.
‡ Indicates candidates educated by dental education programs not accredited by CODA. Failure rates for this group should be interpreted with caution due to the small sample size present.

Table 16.2
Descriptive Statistics for DLOSCE Scale Scores, by Candidate Group and Year

	Accredited†				Non-Accredited‡				Total	
	First Attempt		Retake		First Attempt		Retake		First Attempts and Retakes	
Year	Number	Mean	Number	Mean	Number	Mean	Number	Mean	Number	Mean
2020	231	83.5	2	82.5	14	73.8	1	68.0	248	82.8

† Indicates candidates educated by dental education programs accredited by CODA.
‡ Indicates candidates educated by dental education programs not accredited by CODA. Descriptive statistics for this group should be interpreted with caution due to the small sample size present.

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Appendix A

Clinical Content Areas for General Dentistry

#	Diagnosis and Treatment Planning
1	Interpret patient information and medical data to assess and manage patients.
2	Identify the chief complaint and understand the contributing factors.
3	Perform head and neck and intraoral examinations, interpreting and evaluating the clinical findings.
4	Use clinical and epidemiological data to diagnose and establish a prognosis for dental abnormalities and pathology.
5	Recognize the normal range of clinical findings and distinguish significant deviations that require monitoring, treatment, or management.
6	Predict the most likely diagnostic result given available patient information.
7	Interpret diagnostic results to inform understanding of the patient's condition.
8	Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
9	Recognize the interrelationship between oral health and systemic disease, and implement strategies for improving overall health.
10	Select the diagnostic tools most likely to establish or confirm the diagnosis
11	Collect information from diverse sources (patient, guardian, patient records, allied staff, and other healthcare professionals) to make informed decisions.
12	Formulate a comprehensive diagnosis and treatment plan for patient management.
13	Discuss etiologies, treatment alternatives, and prognoses with patients so they are educated and can make informed decisions concerning the management of their care.
14	Understand how patient attributes (e.g., gender, age, race, ethnicity, and special needs), social background and values influence the provision of oral health care at all stages of life.
15	Interact and communicate with patients using psychological, social, and behavioral principles.

#	Oral Health Management
16	Prevent, recognize and manage medical emergencies (e.g., cardiac arrest).
17	Prevent, recognize and manage dental emergencies.
18	Recognize and manage acute pain, hemorrhage, trauma, and infection of the orofacial complex.
19	Prevent, diagnose and manage pain during treatment.
20	Prevent, diagnose and manage pulpal and periradicular diseases.
21	Prevent, diagnose and manage caries.
22	Prevent, diagnose and manage periodontal diseases.
23	Prevent, diagnose and manage oral mucosal and osseous diseases.
24	Recognize, manage and report patient abuse and neglect.
25	Recognize and manage substance abuse.
26	Select and administer or prescribe pharmacological agents in the treatment of dental patients.
27	Anticipate, prevent, and manage complications arising from the use of therapeutic and pharmacological agents in patient care.
28	Diagnose endodontic conditions and perform endodontic procedures.
29	Diagnose and manage the restorative needs of the partially or completely edentulous patient.
30	Restore tooth function, structure, and esthetics by replacing missing and defective tooth structure, while promoting soft and hard tissue health.
31	Perform prosthetic restorations (fixed or removable) and implant procedures for the edentulous and partially edentulous patient.
32	Diagnose and manage oral surgical treatment needs.
33	Perform oral surgical procedures.
34	Prevent, diagnose and manage developmental or acquired occlusal problems.
35	Prevent, diagnose and manage temporomandibular disorders.

#	Oral Health Management
36	Diagnose and manage patients requiring modification of oral tissues to optimize form, function and esthetics.
37	Evaluate outcomes of comprehensive dental care.
38	Manage the oral esthetic needs of patients.

#	Practice and Profession
39	Evaluate and integrate emerging trends in health care.
40	Evaluate social and economic trends and adapt to accommodate their impact on oral health care.
41	Evaluate scientific literature and integrate new knowledge and best research outcomes with patient values and other sources of information to make decisions about treatment.
42	Practice within the general dentist's scope of competence and consult with or refer to professional colleagues when indicated.
43	Evaluate and utilize available and emerging resources (e.g., laboratory and clinical resources, information technology) to facilitate patient care, practice management, and professional development.
44	Conduct practice activities in a manner that manages risk and is consistent with jurisprudence and ethical requirements in dentistry and healthcare.
45	Recognize and respond to situations involving ethical and jurisprudence considerations.
46	Maintain patient records in accordance with jurisprudence and ethical requirements.
47	Conduct practice related business activities and financial operations in accordance with sound business practices and jurisprudence (e.g., OSHA and HIPAA).
48	Develop a catastrophe preparedness plan for the dental practice.
49	Manage, coordinate and supervise the activity of allied dental health personnel.
50	Assess one's personal level of skills and knowledge relative to dental practice.
51	Adhere to standard precautions for infection control for all clinical procedures.
52	Use prevention, intervention, and patient education strategies to maximize oral health.
53	Collaborate with dental team members and other health care professionals to promote health and manage disease in communities.
54	Evaluate and implement systems of oral health care management and delivery that will address the needs of patient populations served.
55	Apply quality assurance, assessment and improvement concepts to improve outcomes.
56	Communicate case design to laboratory technicians and evaluate the resultant restoration or prosthesis.

Appendix B

DLOSCE Test Specifications

Topic	Percent

Restorative Dentistry
- Diagnosis
- Preparations
- Restorations
  - Direct
  - Indirect
	24%

Prosthodontics
  - Removable
  - Fixed
  - Implants
	19%

Oral Pathology, Pain Management, and Temporomandibular Dysfunction - Pathology - Oral medicine - Orofacial pain - Temporomandibular dysfunction	13%
Periodontics - Diagnosis - Treatment planning - Etiology	10%
Oral Surgery - Diagnosis - Treatment planning - Extractions	9%
Endodontics - Diagnosis - Treatment planning - Emergency management - Post-treatment evaluation	8%
Orthodontics - Treatment screening - Space management	6%
Medical Emergencies - Diagnosis - Management	6%
Prescriptions	5%
	100%

Additional Notes:

- Diagnosis and Treatment Planning—as well as Occlusion—are covered across the topics listed above.
- The DLOSCE includes questions involving patients of various types and backgrounds, including pediatric, geriatric, special needs, and medically complex patients.

From: Braxton, Tierra <braxtont@ada.org>
Sent: Thursday, July 22, 2021 2:27 PM
To: Braxton, Tierra <braxtont@ada.org>
Cc: Hart, Karen <hartk@ada.org>
Subject: Dentistry and Dental Hygiene Interstate Compact Kickoff Meeting

Sent on behalf of Ms. Karen Hart, director of the Council on Dental Education and Licensure.

Dear Colleagues,

As you know, the ADA has partnered with the Council of State Governments, the Department of Defense and the American Dental Hygienists' Association in an initiative to develop interstate licensure compact legislation for the dental and dental hygiene professions.

Attached is a flyer with information for the "Compact Kickoff Meeting" on Tuesday, August 24th at 2:00pm EDT. This webinar will be hosted by the Council of State Governments and the link for registration is included in the flyer. This is an exciting initiative that will continue to develop in the next few years and will be of interest to many in the dental and dental hygiene communities.

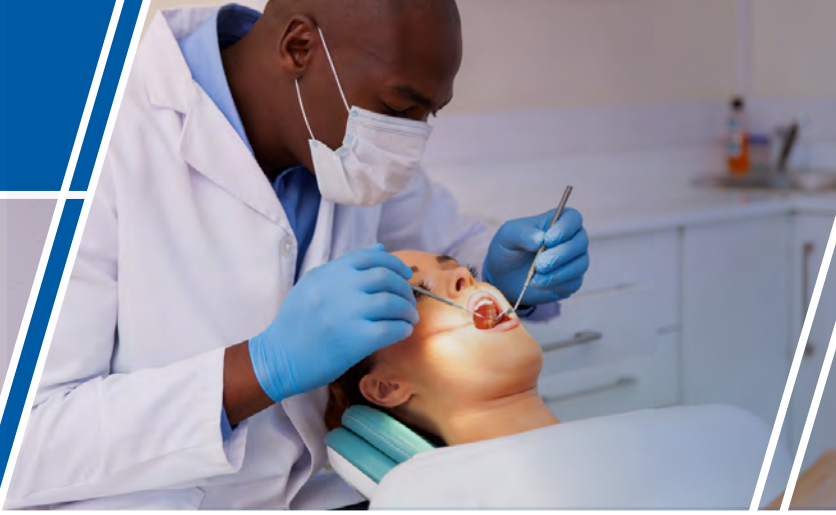
Please share this information with your members/constituencies.

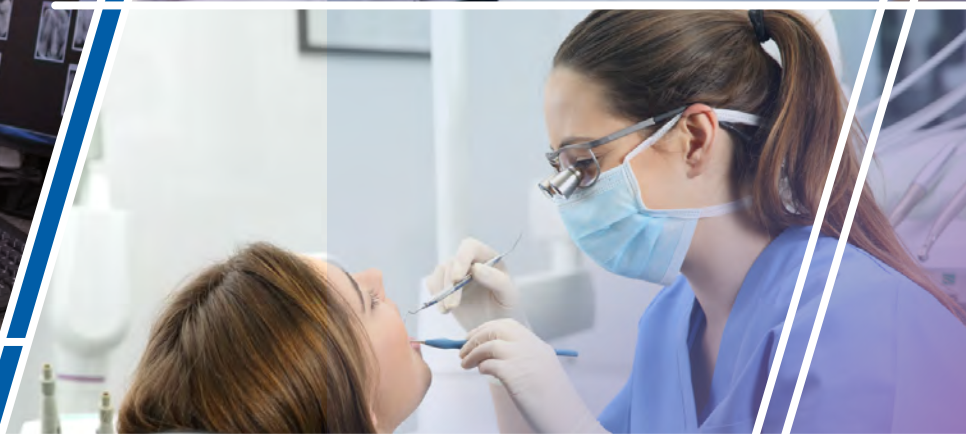
As always, thank you for your support.

Karen M. Hart hartk@ada.org
Senior Director, Education Operations and
Director, Council on Dental Education and Licensure
312.440.2825 800.621.8099 x 2825

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

The Council of State Governments





Dentistry and Dental Hygiene

Compact Kickoff Meeting: ***Tuesday, August 24, 2021***

WHO:

- Department of Defense
- The Council of State Governments
- American Dental Association
- American Dental Hygienists Association
- Practitioners and Regulators
- Other Dentistry and Dental Hygiene Industry Stakeholders

WHAT:

Dentistry and Dental Hygiene Interstate Compact Kickoff Meeting

WHEN:

Tuesday, August 24, 2021 at 2 p.m. EDT

WHERE:

Zoom. Link to register here.

The Council of State Governments (CSG) is partnering with the Department of Defense (DoD), American Dental Association (ADA) and American Dental Hygienists Association (ADHA) to support the mobility of licensed dentists and dental hygienists through the development of new interstate compacts. These compacts will create reciprocity among participant states to reduce the barriers to license portability and employment.

CSG, DoD, ADA, and ADHA invite dentists and dental hygienists, dentistry and dental hygiene regulators, and other industry stakeholders to a kickoff meeting to launch the initiative on **Tuesday, August 24, 2021 at 2 p.m. EDT via Zoom**.

Participants will learn about the background and aspirations for the project; the form and function of interstate compacts and the compact development process; and the need for license reciprocity in the dentistry and dental hygiene professions.

Please click on the registration link below. We look forward to seeing you on Tuesday, August 24!

NEWSLETTERS & ARTICLES OF INTEREST

ADEA THE VOICE OF DENTAL EDUCATION

ADEA ADVOCATE

AMERICAN DENTAL EDUCATION ASSOCIATION

Volume 2, No. 15, June 22, 2021

ED Extends Title IX Protections to LGBTQ Students

The Department of Education (ED) issued a Notice of Interpretation extending Title IX protections to LGBTQ students. Title IX is the federal law that prohibits sex discrimination at federally funded institutions. This new interpretation will be effective on the date the notice is officially published in the *Federal Register*, which will be within the coming weeks.

The Biden administration's interpretation of Title IX brings it in alignment with the U.S. Supreme Court's ruling in *Bostock v. Clayton* County, which determined that under Title VII "sex" should be interpreted to include LGBTQ people, when they face discrimination based on their sexual orientation or gender identity. Though the *Bostock* ruling was narrow because it only applied to workplace discrimination, many legal scholars believe this ruling can plausibly be applied to other situations.

The Biden administration's interpretation of the law reverses the prior Trump administration's interpretation. Prior to President Trump leaving office, the ED released a policy memo which stated that LGBTQ students are not expressly included in protections under Title IX. ED maintained that under Title IX, "sex" should only be interpreted to mean "biological sex, male and female."

There have been at least 31 states that have introduced or passed bills that would ban transgender students from playing sports that correspond with their gender identity. These laws could be contested under Title IX.

ED Holds Public Hearings on Title IX

The Department of Education (ED) held five days of public hearings on Title IX. In advance of the hearings, ED received over 15,000 written comments and over 700 individuals and organizations registered to testify. Both supporters and opponents of the current Title IX regulations participated in the hearings or submitted comments to ED. The hearings were a fact-finding effort to receive testimony from all stakeholders impacted by Title IX and get their input on any changes to Title IX regulations that are needed. The hearings' topics ranged from sexual assault and harassment

prevention to transgender athletes, from fairness issues surrounding the Title IX hearing process to Title IX jurisdictional issues.

In May, ED announced virtual public hearings to gather input on improving enforcement of Title IX of the Education Amendments of 1972. The hearings, which are being held in accordance with ED's planned review of current Title IX regulations, stem from President Biden's Executive Order on *Guaranteeing an Educational Environment Free from Discrimination on the Basis of Sex, Including Sexual Orientation or Gender Identity* signed on March 8. The order explicitly directed the Department to evaluate Title IX regulation changes implemented during the Trump administration to determine if they are inconsistent with the Biden administration's policies. The hearings are also in line with the Biden administration's overarching policy towards gender, gender identity and sexual orientation as set out in Biden's Executive Order on *Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation*. The order's policy directive was "to prevent and combat discrimination on the basis of gender identity or sexual orientation, and to fully enforce Title VII and other laws that prohibit discrimination on the basis of gender identity or sexual orientation."

ED will consider information gathered from the hearings as it drafts its proposed changes to Title IX regulations. The proposed draft will likely be released before the fall.

Maryland Adds Comprehensive Dental Benefits for Pregnant and Postpartum People Enrolled in Medicaid

On May 30, a bill became law in Maryland that will add comprehensive dental benefits for pregnant and postpartum people enrolled in Medicaid. Specifically, the bill requires the Maryland Medical Assistance Program to provide coverage for medical and other health care services, including comprehensive dental benefits, to all eligible pregnant people whose family income is at or below 250% of the poverty level. This coverage must be provided for the duration of the pregnancy and for one year immediately following the end of the pregnancy, as permitted by the federal law. The state currently provides Medicaid coverage to pregnant women for 60 days postpartum.

Texas Governor Signs Teledentistry Bill

On June 16, Texas Gov. Greg Abbott (R) signed a bill that would add a definition of teledentistry to the state's telehealth laws. The following are among the changes made by the bill:

- Teledentistry would include both synchronous and asynchronous communication as described in the bill.

- The state's Medicaid program would be required to reimburse dentists at the same rate as in-person dental service.
- Private insurers would be required to provide coverage for a covered service or procedure delivered by a preferred or contracted health professional on the same basis and to the same extent that the plan provides coverage for the service or procedure delivered in an in-person setting.
- The Texas State Board of Dental Examiners (TSBDE) would be permitted to adopt rules to address specified teledentistry topics that include allowing dentists to simultaneously delegate to and supervise through a teledentistry dental service up to five health professionals who are not dentists.
- TSBDE would also be required to adopt rules that prohibit a dentist from prescribing an opiate for more than a two-day period or a controlled substance other than an opiate for more than a five-day period. (These periods may be extended by a day if the period for which the prescription is prescribed includes a weekend or a national holiday.)

Earlier this year, TSBDE determined that teledentistry could not be practiced under current law. The bill has been sent to the State Senate for consideration.

Michigan Governor Signs Bills to Increase Licensure Portability for Members of the Military and Their Dependents

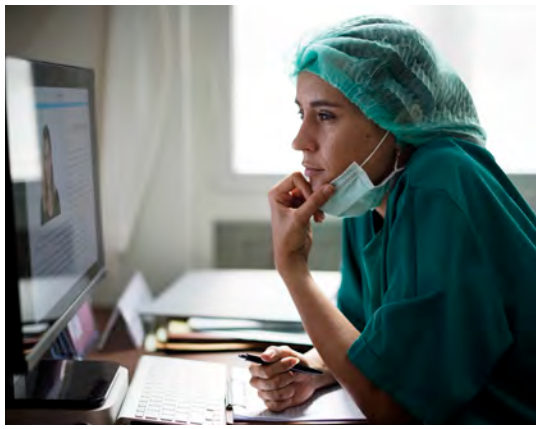
On June 10, Michigan Gov. Gretchen Whitmer (D) signed a pair of bills that would increase licensure portability for members of the military, veterans and their dependents. SB 312 and SB 157 are tie-barred bills that address similar topics, and both bills were required to become law in order for either to become effective.

Together, the bills will require the state to issue an occupational license to any member of the military, a veteran or their dependent, if that person has held an active license granted by another jurisdiction for at least one year. Any person seeking licensure under the provisions of the bills must not have had a license revoked or suspended, unresolved discipline imposed or a complaint, any allegation or any investigation pending. Dependents are defined as a spouse, a surviving spouse, a child under 26 years of age or a surviving child under 26 years of age.

June 2021

HealthProChoices

A newsletter for participants in the Health Professionals' Services Program (HPSP)



Outreach

What do Legacy Health, St. Charles Health System (Bend), the Oregon Department of Corrections, Oregon State Hospital, Mt. Hood Community College, and Walla Walla University School of Nursing have in common? They have all benefited from a presentation on the Health Professionals' Services Program in the last 6 months. We would love to present for your practice, organization, or school as well. Benefits include a greater understanding and appreciation of the program so that you and other participants can be better supported and so that other licensees can access services more easily when needed. If you know of an interested group, reach out to your agreement monitor who will pass the message along to Kate Manelis, Program Manager.

Addiction and Poetry

JAMA published a poem about addiction that you may appreciate. Check it out by clicking **here**.

Travel

It is officially summer! It is a great time to travel and take vacations! However, please remember that travel requests need to be made two weeks in advance in order to guarantee appropriate site allocation and chain of custody form distribution. The Guideline for Toxicology Testing Exemptions and all Guidelines can be found at www.hpspmonitoring.com under the resources tab.

Also, when packing for your trip don't forget to pack your chain of custody forms, just in case. Have fun and safe travels!

IBH POPULATION HEALTH SOLUTIONS
MONITORING

July Testing Holiday

Monday, July 5, 2021, is a test exemption day in honor of Independence Day. As a reminder you do NOT need to check in to see if a test is required on this day. Please be aware that HPSP's main office will also be closed on July 5th. Our answering service will be available and/or you can reach us through our after-hours emergency number at (503) 802-9818. Leave a message if there is no answer and your call will be returned quickly.

Supporting Your Teenagers

Caron Treatment Program recently provided some helpful tools and information about supporting teenagers that IBH is passing along. This should not be interpreted as an endorsement for or against their services; IBH has no affiliation with Caron Treatment Program.

From Caron Treatment Program:
Summer is a time to relax and recharge. After the year we've just had, it is greatly needed. With summer comes the Fourth of July, barbeques, senior week, graduations, and (hopefully) vacations. In other words, it is party season.

For teens with more time on their hands and less responsibility, this can equal a time of greater risk for substance use. Binge drinking and its many potential consequences are just one of the things we need to be talking with teens about and setting rules and expectations around.

The teen years are a time of exploration and navigating a desire for more independence. As a result, some teens make the risky decision to engage in binge drinking. Gretchen Hagenbuch, Caron SAP Coordinator, shares information and tips on how to help your teen have a safe and alcohol-free summer. Watch the video by clicking **here**.

It can be challenging for parents to know what to do when they discover their teen is using substances. To help provide some guidance, we have developed a parent resource guide outlining some steps to take. Get the resource guide **here**.

Finding "Normal" After the Pandemic

"Normal" is the buzz word of the day. Our country is eager for a "return to normal," but that is not so easy after all that we have experienced.

The pandemic represents a chronic, long-term and on-going tragedy. When any tragedy strikes, normal human reactions follow a pattern called "crisis response." This happens naturally in all of us and encompasses a range of both physical and emotional responses. Initially, our instincts take over and we experience "Fight, Flight or Freeze" reactions to threats or danger. In these moments, physical reactions include increased adrenaline, heightened senses, increased heart rate, hyperventilation, sweating, etc. We experience a variety of emotional reactions as well. These may include shock, disbelief, denial, anger, fear, sorrow, confusion, frustration, and guilt.

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Signs of Stress

Physical Reactions*

- Insomnia, recurrent dreams, difficulty falling/staying asleep
- Fatigue
- Hyperactivity
- Pain in the back or neck
- Headaches
- Heart palpitations*
- Dizzy spells*
- Appetite changes
- Stomachaches or diarrhea
- Sweating or chills
- Tremors or muscle twitches

*If symptoms persist, see a physician

Emotional Reactions

- Flashbacks or reliving the event
- Excessive jumpiness or tendency to be startled
- An increase in irritability, with outbursts of anger and frequent arguing
- Feelings of anxiety, helplessness or vulnerability
- Feelings of guilt
- Feeling depressed or crying frequently
- Feeling heroic, euphoric, or invulnerable
- Not caring about anything

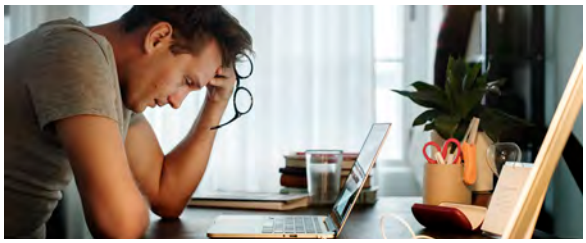
Behavioral Reactions

- An increase or decrease in energy and activity levels
- A change in tobacco use
- An increase in temptation to relapse through use of alcohol and/or other drugs
- Worrying excessively
- Wanting to be alone most of the time
- Blaming other people for everything
- Having difficulty communicating or listening
- Having difficulty giving or accepting help
- An inability to feel pleasure or have fun

Effects on Productivity

- Inability to concentrate
- Increased incidence of errors
- Lapses of memory
- Increased absenteeism
- Tendency to overwork
- Feeling confused
- Having trouble thinking clearly and concentrating
- Having difficulty making decisions

Looking at the pandemic through this lens, as a nation we may have been in (or in and out of) crisis response for more than a year. For health care providers on the front line, this is even more true. To put it mildly, this has been exhausting, both physically and emotionally. It is helpful to discuss what happened in retrospect in a supportive and safe environment. Validation of your experiences and acknowledgement of your emotional and physical reactions is helpful.



After any crisis, most people show signs of stress. These symptoms are typically a normal reaction to an abnormal situation. Some of the predictable reactions that may persist now that the pandemic is having less of an impact here in the United States are listed to the left.

In addition, there are some pandemic-specific crisis response reactions people may be experiencing as federal, state, and local guidelines are becoming more relaxed. It can feel like there is an expectation to return quickly to pre-pandemic activities and responsibilities. This may be a welcome change, but there may also be difficulties and challenges during this process. After more than 15 months of being encouraged to stay home and avoid contact with those outside of your family or "pod," you may feel uneasy about resuming activities like eating in a restaurant, attending a movie or performance, going to an outdoor festival or parade, traveling, or many other activities that have not been a part of "normal" life since early 2020. You may welcome the opportunity to forego wearing a mask in some spaces as guidelines and policies change, but it may also make you feel uneasy or unsafe. You may be ready to jump back into pre-pandemic life with both feet, but you may also feel anxious about doing so (or likely, somewhere in the middle).

Being familiar with these signs of stress in yourself and your loved ones can be helpful. These signs are normal and should decrease over time. That said, it is important to know how to relieve stress in a healthy way and know when to get help. The first step is to prioritize self-care.

Keep Yourself Healthy

- Eat healthy foods and drink water.
- Avoid excessive amounts of caffeine.
- Do not use alcohol or tobacco. Do not use other drugs that have not been prescribed by your physician.
- Increase self-help meeting attendance, contact with your sponsor or other supports as needed.
- Get enough sleep and rest.
- Get physical exercise.

Use Practical Ways to Relax

- Relax your body often by doing things that work for you—take deep breaths, stretch, meditate, wash your face and hands, or engage in pleasurable hobbies.
- Pace yourself between stressful activities. Do a fun thing after a hard task.
- Use time off to relax—eat a good meal, read, listen to music, take a bath, or talk to family.
- Talk about your feelings to loved ones and friends often.

Pay Attention to Your Body, Feelings, and Spirit

- Recognize and heed early warning signs of stress.
- Recognize how your own past experiences affect your way of handling this event and think of how you handled past events.
- Know that feeling stressed, depressed, guilty, or angry is common after a traumatic event.
- Connect with other who experienced the pandemic in a similar way as you did.
- Take time to renew your spirit through meditation, prayer, or helping others in need.

It may take time to feel like you've regained control over your life. Be patient with yourself. Sometimes things become so overwhelming that you need help from a professional. Also remember that those around you have experienced the stressors of the pandemic in their own unique way.

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You may be able to support them:

- Offer your assistance and show a willingness to listen even if you haven't been asked for help.
- Don't take stress reactions experienced by others personally.
- Spend time together.
- Reinforce at appropriate intervals that you are available for emotional support.
- Be ready to talk about what happened when you are both ready.

If you are having thoughts of harming yourself or someone else, please call the National Suicide Prevention Hotline at 1-800-273-TALK (8255), contact a member of your care team, or talk to a trusted friend.

Just because life is coming back to normal doesn't mean that you will immediately "feel" normal. Be patient with yourself, take extra self-care measures and reach out for help when you need it!

2020-2021 DENTAL ASSISTANTS SALARY AND SATISFACTION SURVEY

DENTAL ASSISTING NATIONAL BOARD

THE DANB CERTIFICATION ADVANTAGE

The latest results from DANB's Dental Assistants Salary and Satisfaction Survey show that earning and maintaining DANB Certified Dental Assistant (CDA) certification brings a wealth of personal and professional advantages, including higher hourly wages.

"HOLDING DANB CERTIFICATION MAKES ME FEEL VERY PROUD. IT SHOWS THAT I HAVE THE KNOWLEDGE. I ALWAYS ENCOURAGE OTHERS TO EARN CREDENTIALS WHENEVER POSSIBLE."

DANB CDA CERTIFICANTS EARN MORE

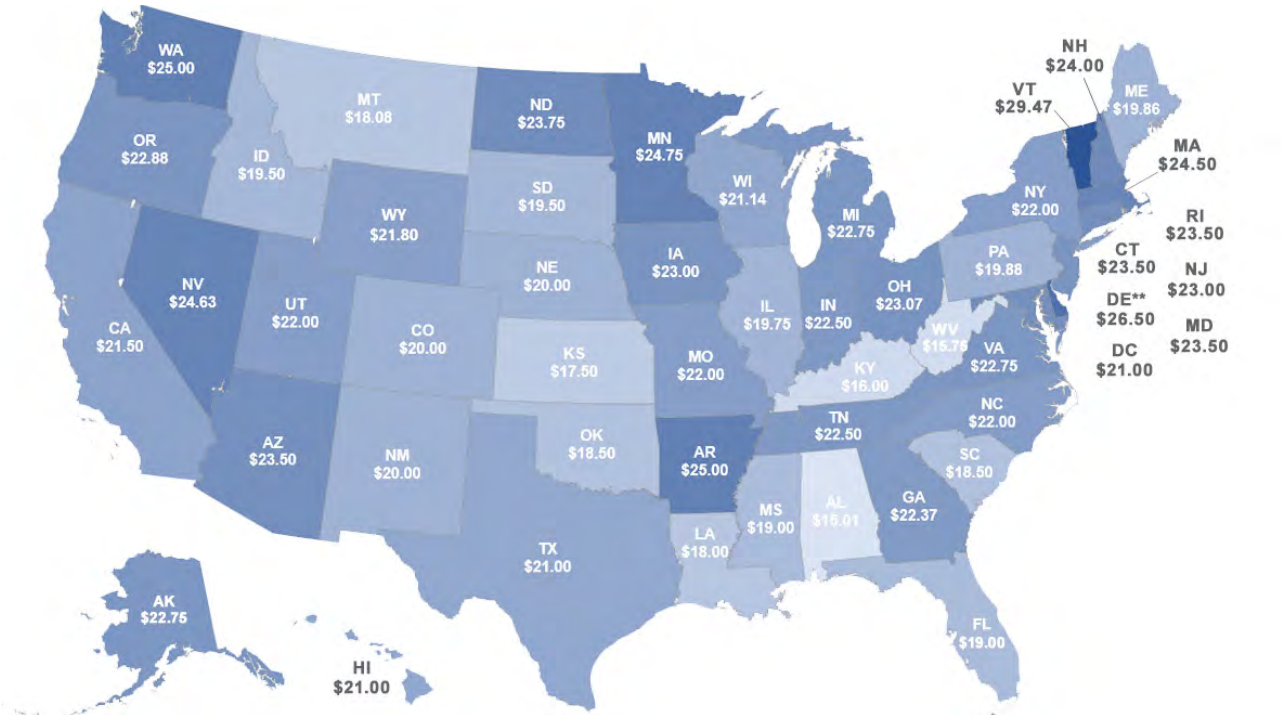
Surveyed DANB CDA certificants reported earning over $2 more per hour compared to all dental assistants, most of whom are not DANB certified.

$22.09

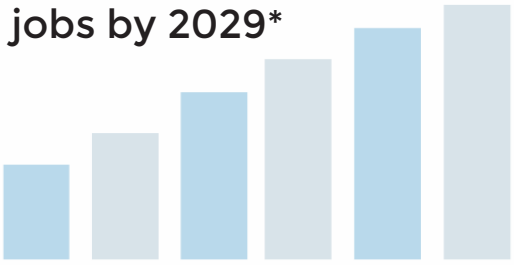
Median hourly pay for CDA certificants

$19.80*

Median hourly pay for all dental assistants



7% expected increase in dental assisting jobs by 2029*



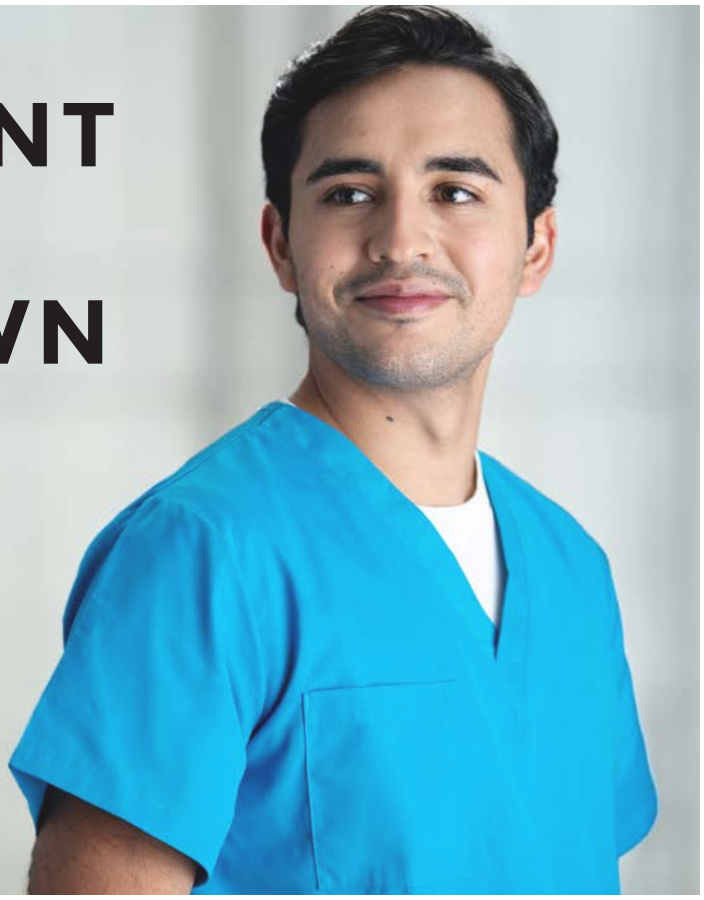
CAREER OUTLOOK

Dental assisting is a fast-growing profession, and DANB CDA certificants are positioned for success.

* Data is from the 2020 Occupational Outlook Handbook, published by the U.S. Department of Labor's Bureau of Labor Statistics.

**Data from DE is from 2018 due to insufficient data collected from the 2020 survey.

CERTIFICANT SALARY BREAKDOWN



If you're a Certified Dental Assistant certificant, your salary may be the result of many factors, including years of experience, practice setting or location, and education. The charts below break down the median hourly wages DANB CDA certificants earn based on these various employment details.

YEARS OF EXPERIENCE

<1 year	$17.50
1-2 years	$19.50
3-5 years	$19.54
6-10 years	$22.00
11-15 years	$23.00
16-19 years	$22.75
20+ years	$24.00

EDUCATION

High school	$23.00
Some college	$23.00
Associate degree	$22.50
Bachelor's degree	$21.25
Master's degree	$20.00
Doctorate degree	$29.21

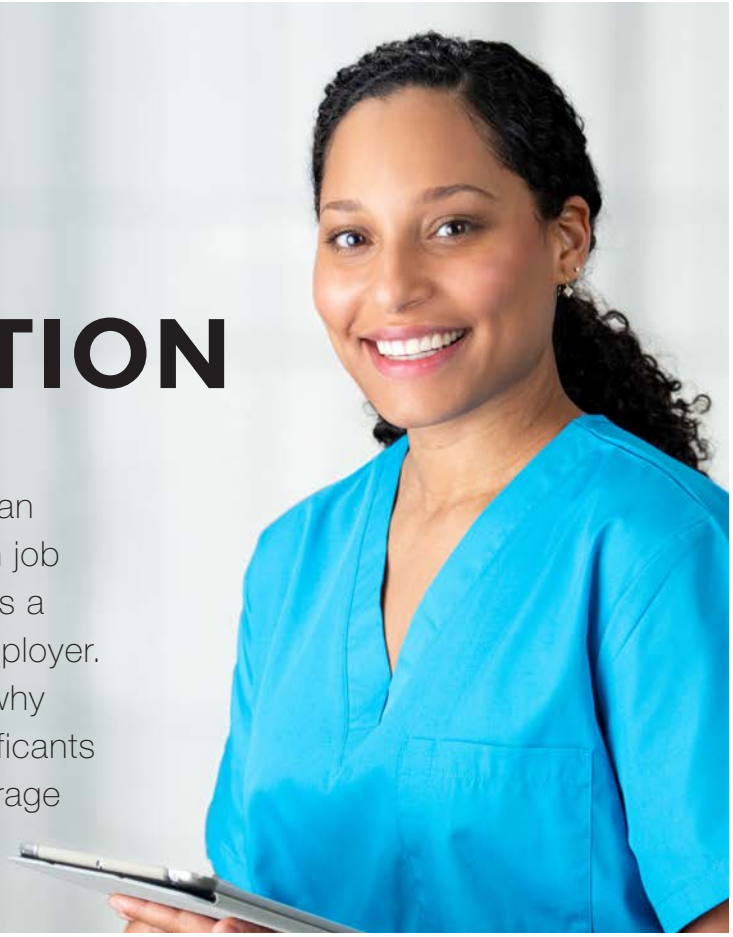
LOCATION

Rural area	$22.00
Town/city	$22.00
City/suburb	$23.00
Large city	$23.00
Metropolitan area	$23.50

PRACTICE TYPE

General dentistry	$22.50
Pediatric	$22.50
Orthodontic	$23.50
Multi-specialty	$22.00

BENEFITS OF DANB CERTIFICATION



DANB certificants were more likely than non-certified assistants to report high job satisfaction, to see dental assisting as a career, and to feel valued by their employer. These are just some of the reasons why DANB Certified Dental Assistant certificants maintain their certification and encourage others to earn it, as well.

★★★★★ TOP JOB FACTORS

- Salary
- Work/life balance
- Feeling part of a team

CERTIFICATION BENEFITS

- Pride
- Increased knowledge
- Standing out when applying for a job
- Higher pay
- Greater confidence

MOST REWARDING ASPECTS

- Making a difference in patients' lives
- Helping patients improve oral health
- Relationships with patients
- Gratitude from patients

"EVERY TIME A PATIENT SAYS THANK YOU, IT PUTS A SMILE ON MY FACE."

JOB SATISFACTION

78% of CDA certificants report high or very high job satisfaction

84% of CDA certificants agree or strongly agree that dental assisting is a career

72% of CDA certificants say they feel valued by their employer

7.7 Average number of years CDA certificants have been with the same employer

DANB CDA CERTIFICANTS VALUE CERTIFICATION

91% of CDA certificants would encourage others to earn certification

99% of CDA certificants plan to renew their certification

60% of DANB CDA certificants said earning certification was a personal goal

OTHER BENEFITS

Certificants are more likely than non-certified assistants to receive benefits, such as:

- Paid vacation
- Paid holidays
- 401(k)/pension plan
- Health insurance
- Paid sick leave
- Bonuses

"EARNING CDA CERTIFICATION HELPED ME BECOME AN EFDA IN MY STATE. IT LED TO A HIGHER SALARY FOR ME, AS WELL."

THE CDA CERTIFICATION DIFFERENCE

Dental assistants who hold DANB's CDA certification are educated and experienced professionals who are committed to the profession and passionate about lifelong learning.

EDUCATION

Hold an associate's degree or higher

44% of CDA certificants

27% of non-certified dental assistants

"EARNING DANB CERTIFICATION IS A GREAT ACCOMPLISHMENT AS A DENTAL ASSISTANT. GET IT!"

EXPANDED FUNCTIONS

Hold a state-specific expanded functions credential

42% of CDA certificants

22% of non-certified dental assistants

PERFORM EXPANDED FUNCTIONS

63% of CDA certificants

37% of non-certified dental assistants

ABOUT THE SURVEY

DANB's 2020-2021 Dental Assistants Salary and Satisfaction Survey was conducted in November and December 2020. The findings in this report are based on a 15% total response rate from a stratified random sample of 6,000 CDA certificants. Survey researchers consider this response rate sufficient to generalize the results to the population surveyed.

Salary figures are reported as the median response (the median is the point in a data set at which about 50% of the responses fall above and 50% fall below). Salary figures are reported as hourly wages, without including the dollar value of any employee benefits.

DANB has conducted a salary survey every two years since 2004. The consistency of data over these years supports the conclusion that these results are representative of the population.

CONTACT US

Dental Assisting National Board, Inc.
444 N. Michigan, Suite 900
Chicago, IL 60611
www.danb.org
1-800-367-3262

IBH POPULATION HEALTH SOLUTIONS
MONITORING

Finding "Normal" After the Pandemic

"Normal" is the buzz word of the day. Our country is eager for a "return to normal," but that is not so easy after all that we have experienced.

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- Take time to renew your spirit through meditation, prayer, or helping others in need.

It may take time to feel like you've regained control over your life. Be patient with yourself. Sometimes things become so overwhelming that you need help from a professional. If you are concerned about the changes you are experiencing, reach out to your Employee Assistance Program or a local behavioral health counselor. As a licensed health professional, if you are concerned about your own mental health and/or substance use, you may also be eligible for Oregon's Health Professionals' Services Program. Visit hpspmonitoring.com for more information.

Also remember that those around you have experienced the stressors of the pandemic in their own unique way. You may be able to support them:

- Offer your assistance and show a willingness to listen even if you haven't been asked for help.
- Don't take stress reactions experienced by others personally.
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OHA Announces New Dental Director

The Oregon Health Authority and Department of Human Services sent this bulletin at 07/06/2021 11:35 AM PDT

Oregon Health Authority NEWS RELEASE

oregon.gov/oha/erd

July 6, 2021

Contact: Philip Schmidt, PHILIP.SCHMIDT@dhsoha.state.or.us

OHA Announces New Dental Director

Dr. Kaz Rafia to lead oral health policy and strategy beginning July 6.

The Oregon Health Authority's Health Policy and Analytics Division has a new dental director who joined the agency on July 6.

Dr. Kaz Rafia has a combined 25 years of dental experience spanning international non-profit work at Partnership for International Medical Access-Northwest, academics at OHSU, private practice, and leadership at Permanente Dental Associates.

"I am pleased to have Dr. Rafia join our team and know that he will serve an important role as we work towards eliminating health inequities in Oregon," said Dana Hargunani, MD, MPH, OHA's Chief Medical Officer. "Further integrating oral health into our health care system is a high priority, and we believe he will bring great knowledge and passion to that work."

Dr. Rafia echoed the enthusiasm for further integration of oral health into Oregon's health care system.

"I am honored to be joining the OHA policy team and very much look forward to applying all that I've learned over my career towards advancing oral health policy on behalf of all people in Oregon," he said. "We know that good oral health care is largely synonymous with good overall health care, and the inequities that we see in this area must also be tackled with diligence and passion."

As OHA Dental Director, Dr. Rafia will be responsible for:

- Leading the cross-agency OHA Oral Health Team and setting the strategic direction for the OHA Oral Health Roadmap with consideration of OHA's 10-year goal to eliminate health inequities;
- Providing oral health consultation and expertise to OHA, including programmatic oversight, administration, policy, planning and execution of oral and health prevention-based activities;
- Serving as the OHA Medicaid oral health expert;
- Facilitating coordination of oral health services with local and statewide oral health organizations;
- Informing quality metrics to measure oral health care, ensuring they are focused on achieving health equity;
- Planning and determining strategies for meeting current and projected statewide oral health service needs; and
- Acting as a liaison between OHA and Oregon's dental community.

Dr. Rafia is a graduate of the Ohio State University College of Dentistry, OHSU hospital dental residency, and the MBA program at University of Illinois. He will earn his MPH from Johns Hopkins University in early 2022.

OHA's focus on oral health will continue to span divisions and programs, with a particular focus on quantifying and addressing the root causes of health inequities in oral health. Dr. Rafia will lead all coordination and strategic planning in service of this mission and will also work with the Legislature as it further develops Oregon's oral health priorities.

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STATE OF OREGON
Office of the Governor
KATE BROWN

NEWS RELEASE

August 4, 2021

Media Contact:
Charles Boyle, 503-931-7773

Governor Kate Brown Announces New Health and Safety Rule for Employees in Health Care Settings to Help Prevent Delta Variant Spread

Health care workers have a choice to protect staff and patients from COVID-19: weekly testing or verifying vaccination status

(Salem, OR) — Governor Kate Brown announced today that she has directed the Oregon Health Authority (OHA) to issue a rule outlining new, required health and safety measures for personnel in health care settings. The rule requires weekly COVID-19 testing for personnel in health care settings to prevent the spread of COVID-19 in health care settings, which can be waived with a proof of vaccination. The new rule will be issued this week and the requirement to be vaccinated or undergo weekly testing will apply starting September 30th. This will give employers time to prepare for implementation, and will give currently unvaccinated health care workers time to become fully vaccinated.

“The more contagious Delta variant has changed everything. This new safety measure is necessary to stop Delta from causing severe illness among our first line of defense: our doctors, nurses, medical students, and frontline health care workers. Protecting our frontline health care workers through vaccination will also enhance the safety of the patients in their care,” said Governor Brown. “Severe illness from COVID-19 is now largely preventable, and vaccination is clearly our best defense. Vaccination and weekly testing ensure Oregonians can safely access health care and employees can go to work in an environment that maximizes health and safety measures for COVID-19.”

Scott Palmer of the Oregon Nurses Association (ONA) said: "This is a reasonable and sensible approach which respects the individual choices of health care workers while also protecting public health. ONA believes COVID-19 vaccinations are critical to protecting our members, our patients, our families and our communities and we urge all Oregonians who can get vaccinated to do so now.

"ONA is also gratified to note that Oregon’s current law provides the state the flexibility necessary to respond to public health emergencies via regulation. ONA is eager to

continue our work with hospitals and community groups to encourage vaccinations through a wide range of options including free vaccine clinics, vaccine education, vaccination incentives and community outreach to improve vaccination rates and address the rampant disinformation that is creating uncertainty and fueling vaccine hesitancy. Vaccination is a critical tool to keep Oregonians healthy and safe and Governor Brown's announcement today will help close the gap in vaccination rates for Oregon's valuable health care workers."

The new rule applies to personnel in health care settings who have direct or indirect contact with patients or infectious materials. The Governor's Office continues to look at additional health and safety options to protect Oregonians against the highly contagious Delta variant, including vaccination and testing policies for state workers, with conversations continuing with stakeholders about how similar protective measures can be implemented in various state workplaces.

Governor Brown called on other public and private employers in Oregon to consider measures to facilitate their employees' access to vaccines: "As we have throughout this pandemic, we are learning to adapt to the new reality the Delta variant has created. I am encouraging Oregon cities, counties, businesses, and employers to think creatively, and to consider measures such as paid time off for vaccination, and incentives for employees, in addition to instituting masking requirements and other health and safety measures in the workplace. I am doing the same with the State of Oregon's workforce, as we look for ways to remove barriers to easy access to vaccination."

State law currently prohibits employers from independently mandating vaccines for certain limited categories of workers, including health care workers, an issue the Governor intends to work with stakeholders and legislators to address in the February 2022 session.

A video statement from Governor Brown is available here.

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LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8239	SIERRA DAWN SCHIPPER , R.D.H.	6/10/2021
H8240	ALISON LEE FREEMAN , R.D.H.	6/10/2021
H8241	ASHLEY J GREGG , R.D.H.	6/10/2021
H8242	JESSICA JOY ISZLER , R.D.H.	6/17/2021
H8243	KAELYN NOEL TRADER , R.D.H.	6/17/2021
H8244	STEPHANIE DAWN SLAGLE , R.D.H.	6/17/2021
H8245	MORGAN E BOOTS , R.D.H.	6/17/2021
H8246	HAILEY SCHREYER , R.D.H.	6/17/2021
H8247	PERLA Y TELLEZ ESPINOSA , R.D.H.	6/17/2021
H8248	WENDY DIANNE WHERRY , R.D.H.	7/9/2021
H8249	ZHU LI , R.D.H.	7/9/2021
H8250	AMANDA JOY MACKAY , R.D.H.	7/9/2021
H8251	HOLLY ANN SIDLO , R.D.H.	7/9/2021
H8252	ENGLISH HUSTON , R.D.H.	7/9/2021
H8253	ALLISON SWEDMAN , R.D.H.	7/26/2021
H8254	CHRISTINE MARIE HERNANDEZ , R.D.H.	7/26/2021
H8255	AMANDA N MARQUEZ , R.D.H.	7/26/2021
H8256	VANESSA WEBSTER , R.D.H.	7/26/2021
H8257	BEVAN S CARR , R.D.H.	7/27/2021
H8258	BREEANA M ORESKOVIC , R.D.H.	7/27/2021
H8259	CORYNN R JORGENSEN , R.D.H.	7/27/2021
H8260	COURTNEY BIELAWSKI , R.D.H.	7/27/2021
H8261	ERIKA NELSON , R.D.H.	8/4/2021
H8262	RAYNA BANTA , R.D.H.	8/4/2021
H8263	ANDREA C LECLAIRE , R.D.H.	8/4/2021
H8264	RACHEL PETTIT , R.D.H.	8/4/2021
H8265	BRITTANY D MCCALL , R.D.H.	8/4/2021
H8266	JACQUELINE HALLEMAN , R.D.H.	8/4/2021
H8267	ASHLEY TROUTT , R.D.H.	8/4/2021
H8268	BRITNEY HELMANDOLLAR , R.D.H.	8/4/2021
H8269	CINDY VOSON , R.D.H.	8/4/2021
H8270	ALLISON ELLERMAN , R.D.H.	8/4/2021
H8271	HOPE MCBRIDE , R.D.H.	8/4/2021
H8272	MIKINZIE GREGORY , R.D.H.	8/4/2021
H8273	SHELLEY R POULTON , R.D.H.	8/4/2021

DENTISTS

D11443	TEMBRÉ E DELONG , D.M.D.	6/10/2021
D11444	RANDY HIEN CONG TRAN , D.D.S.	6/10/2021
D11445	WILLIAM E GRAVES , D.M.D.	6/10/2021
D11446	MACY LEE HUETTL , D.M.D.	6/10/2021
D11447	DUSTIN M DAVIS , D.D.S.	6/10/2021
D11448	LEAH NICHOLE BARSHINGER , D.D.S.	6/10/2021

D11449	BROCK WESLEY NICHOLS , D.D.S.	6/10/2021
D11450	GEETHA VANI OMMI , D.D.S.	6/10/2021
D11451	BRENNAN R BAHNSON , D.M.D.	6/17/2021
D11452	ADRIANA REPPELL , D.M.D.	6/17/2021
D11453	MADELINE ROSE BEINLICH , D.D.S.	6/17/2021
D11454	ALVIN LORENO LYM , D.M.D.	6/24/2021
D11455	CAMERON WOOLSEY , D.D.S.	6/25/2021
D11456	DARCY KAE OLANDER , D.M.D.	6/25/2021
D11457	JACOB GROOM , D.M.D.	6/25/2021
D11458	VU TONG , D.M.D.	6/25/2021
D11459	CODY JACKSON , D.M.D.	6/25/2021
D11460	KODY QUENTIN OSBORNE , D.M.D.	6/25/2021
D11461	ALLEN SHOSO YOSHINAGA , D.M.D.	6/25/2021
D11462	JEFFREY NELSON STEED , D.M.D.	6/25/2021
D11463	THALIA-RAE CRIDDLE , D.M.D.	6/25/2021
D11464	RYAN LAND , D.M.D.	6/25/2021
D11465	JEFFREY F DORIUS , D.D.S.	6/25/2021
D11466	KYLE THOMAS O'HARA , D.M.D.	6/25/2021
D11467	RYAN M JOHNSON , D.M.D.	6/25/2021
D11468	KAREN ZHOU , D.M.D.	6/25/2021
D11469	VALERIE TRUHAN , D.M.D.	7/8/2021
D11470	SARAH M KOLANDER , D.M.D.	7/9/2021
D11471	TU ANH NGUYEN , D.D.S.	7/9/2021
D11472	CHRISTINE OLSON , D.M.D.	7/9/2021
D11473	STEVEN W OLSON , D.D.S.	7/9/2021
D11474	JENNY CHEYEON LEE , D.M.D.	7/9/2021
D11475	RITTA AKEL KARAM , D.M.D.	7/9/2021
D11476	JONMICHAL H BILECKI , D.M.D.	7/9/2021
D11477	GRETCHEN LOUISE HARRIS , D.M.D.	7/9/2021
D11478	ELIZABETH FREDA SCHULER , D.M.D.	7/9/2021
D11479	BRETT DUNFORD DAVIS , D.M.D.	7/9/2021
D11480	NEEKA NASROLAHI , D.M.D.	7/27/2021
D11481	SANDRA KATANIC , D.D.S.	7/27/2021
D11482	WILLIAM J GARCIA , D.D.S.	7/27/2021
D11483	LUKE C ALLENDER , D.M.D.	7/27/2021
D11484	JUSTIN R LANGFORD , D.M.D.	7/27/2021
D11485	GREGORY P MALONEY , D.M.D.	7/27/2021
D11486	TAYLOR J MULLANEY , D.M.D.	7/27/2021
D11487	RIZA THAIBA , D.D.S.	7/27/2021
D11488	LAUREN ASHLEY DAVIS , D.M.D.	7/27/2021
D11489	HIBERY N HO , D.M.D.	7/27/2021
D11490	AARON E BERGER , D.D.S.	8/4/2021
D11491	CELINA LEE , D.M.D.	8/4/2021
D11492	RAFFAELE VITELLI , D.D.S.	8/4/2021
D11493	KYAHN R DARAEE , D.M.D.	8/4/2021
D11494	BRADLEY J THOMSON , D.M.D.	8/4/2021
D11495	EMILY JEAN-LOY JOHNSON , D.M.D.	8/4/2021
D11496	RONALD D LE , D.M.D.	8/4/2021
D11497	TAYLOR J SCHNELL , D.M.D.	8/4/2021
D11498	GEOFFREY N PURCELL , D.D.S.	8/4/2021
D11499	MANIZHA REZAYEE , D.M.D.	8/4/2021
D11500	KERRI A SMITH , D.M.D.	8/4/2021
D11501	CHRISTOPHER HUFF , D.M.D.	8/4/2021
D11502	STEVEN JAMES PAULOVICH , D.M.D.	8/4/2021
D11503	RAMESH DAVID RAO , D.D.S.	8/5/2021

LICENSE, PERMIT & CERTIFICATION

7. Request for a letter to be sent to WREB approving Daniel Martinez, R.D.H. to become WREB Examiner

Pursuant to WREB's requirements, licensees who wish to become WREB Examiners must be approved by the regulatory agency for the state in which they practice. Daniel Martinez (H6253) is requesting the Board approve him to become WREB Examiner (Attachment #1).

Relevant Rules (WREB Requirements):

For All Other Practicing, Non-Educator Dentists and Dental Hygienists:

1) Provide a current CV
2) Provide two professional letters of recommendation, including one letter from a current WREB examiner
3) **Be approved by the State Board in which they practice.**
4) Must observe one WREB exam at own expense, with prior approval of the WREB office. Observation includes participating in a full calibration day as well as one clinical day of the exam.
5) Be a licensed practitioner, and actively practicing for five years in the state that is approving them.

Dental Hygiene Educators:

1) Receive a letter of approval as an examiner from the State Board in the state where they teach and a recommendation from the Director or Program Chair of the school where they teach

OR

2) Have served on a WREB Committee and receive a recommendation from the Director or Program Chair at the School where they teach.

AND

3) Must observe one WREB exam at their expense, with prior approval of the WREB office. Observation includes participating in a full calibration day as well as one clinical day of the exam.

WREB does not guarantee that all designated examiners will be assigned to examine. WREB will create teams in the manner that provides the most equitable balance among the key factors considered in the examination assignment process.

Probationary Period

All examiners are considered to be probationary for the first year that they examine and may be dismissed at any time without cause and at the discretion of WREB. Examiners will be notified if issues arise that will cause WREB to discontinue using their services, such as failure to be prepared, follow WREB criteria, or meet the minimum commitment for attendance at exams.

June 9, 2021

Oregon Board of Dentistry
President Reidman

Hello President Reidman,

My name is Daniel Martinez Tovar and I am asking for a recommendation from the Board of Dentistry to be a WREB examiner. Yadira Martinez has also wrote me a letter of recommendation. Attached you will find my resume and I'd be happy to answer any questions.

Thank you for your consideration,

Daniel Martinez Tovar, EPDH, MBA

Daniel Martinez Tovar

Portland, OR · dmartineztovar@gmail.com · (503)-545-3097

EDUCATION

- **Oregon Health Science University-** MBA Healthcare Management **2019**
- **Oregon Institute of Technology-** Bachelors of Science Dental Hygiene **2015**
- **Mt. Hood Community College-** Associates of Applied Science Dental Hygiene **2012**

PROFESSIONAL EXPERIENCE

Virginia Garcia Memorial Health Center **Jan. 2017- Present**
Dental Operations Manager **Apr. 2019- Present**

- Strong understanding of VG's mission, values, and strategic goals.
- Evaluate, plan, and manage clinic's $2.5M operational budget. Forecast future projections of revenue.
- Reversed $.5M deficit by decreasing no show appointment rate, increasing member engagement and utilization, and maximizing payment collections.
- Increased access by introducing teledentistry visits while also keeping our in-office visits.
- Manager on Duty for the Yamhill County COVID-19 screening site.
- Aided in the implementation of our COVID-19 vaccine at VGH Primary Care.
- Administered vaccines at VGH Primary Care and with Mobile Core Team.
- Supported our VG Covid-19 Vaccine community Listening Sessions in English and Spanish.
- Aid in ensuring dental staff participates in our camp outreach events.
- Led various committees to safely restructure and reopen our dental clinic to protect staff and patients.
- Strong understanding of Care Coordinated Organizations and Dental Care Organization contracts
- Fully managed and executed a $100K remodel construction project with multiple external contractors.
- Intermediate understanding of grant agreements.
- Proficient understanding of Federal Qualified Health Center and Health Resources & Services Administration operations.
- Actively looking to increase awareness, understanding and appreciation of the Health Center.

Mt. Hood College- Dental Hygiene Program **Jan. 2020- Present**

- Part-time remote instructor for dental public health and dental research courses.
- Part-time instructor for first year radiology lab.
- Implemented first inaugural continuing education program for alumni.

Expanded Practice Dental Hygienist (EPDH) **Jan. 2017-Mar. 2019**

- Supported a new teledentistry pilot in two schools that allowed us to launch teledentistry into our SBHCs. Also expanded the services into our women's clinic by integrating an EPDH into the primary care team. Successfully integrated EPIC into these programs to sustain programs long-term.
- Supported project design and implementation focused on optimization of care delivery operations across our School-Sealant Programs & School-Based Health Centers (SBHC). Aided in the planning with clinicians, administrative staff and partners in the integration of medical, dental, mental health, and pharmacy at each clinic.
- Cost-Benefit- Analysis to grow our dental assistants into Certified Healthcare Interpreters.

Nevills Family Dentistry PC **Sep. 2014- Dec.2016**

- Lead Dental Hygienist/Supervisor- Maintain a full schedule for optimizing dental services and revenue.

Woodburn Community Dental & Orthodontics **Oct. 2012- Feb. 2015**

- Dental Hygienist for two offices owned by the same dentist in Portland & Woodburn OR.
- Expert in all responsibilities and duties as a dental hygienist.
- Aided in creating orthodontic service line.
- Exceptional chairside communication regarding treatment options, oral hygiene instruction, and state of their oral health.

SKILLS

- Native Spanish Speaker
- Green Belt Lean Certification for Healthcare
- Proficient in Electronic Medical Records (EPIC & Wisdom), Microsoft Office Software Suite, Outlook, and Zoom.
- Competent in cultural competency and trauma informed care.
- Excellent Record Keeping Skills

- Proficient in making sure policies are patient centered to reduce barriers to care.
- Current Dental Hygiene License
- CPR