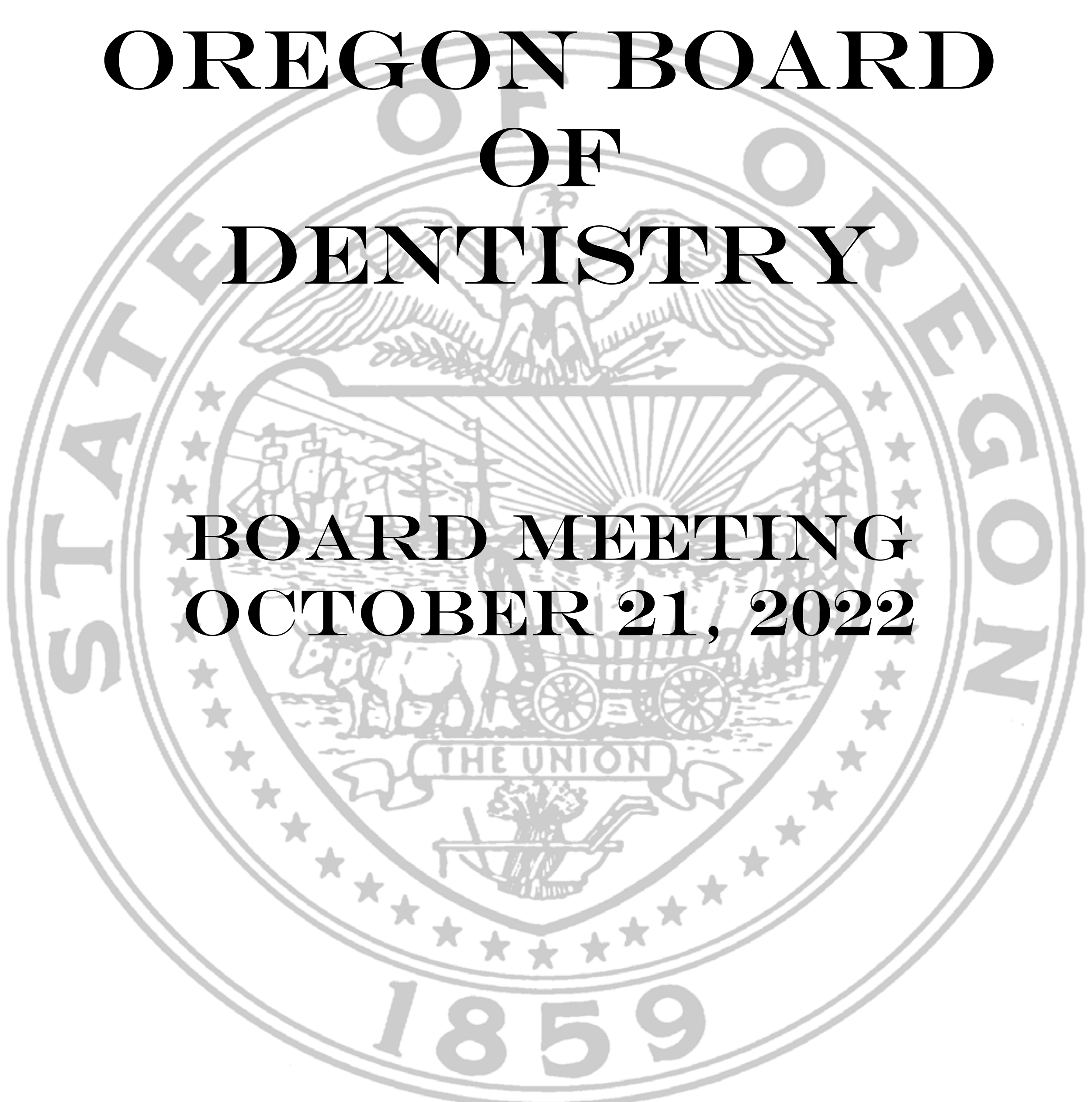
PUBLIC PACKET

OREGON BOARD OF DENTISTRY



BOARD MEETING
OCTOBER 21, 2022

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: **BOARD OFFICE & VIRTUAL VIA ZOOM**
DATE: **October 21, 2022**
TIME: **8:00 a.m. – 1:30 p.m.**

Call to Order – Jose Javier, D.D.S., President **8:00 a.m.**

OPEN SESSION (Via Zoom)
https://us02web.zoom.us/j/88397016298?pwd=ajVXZHNXUXdZWitISlhFV1J4QzU4dz09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 883 9701 6298 ● Passcode: 238369

Review Agenda

1. Approval of Minutes
   - August 19, 2022 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - November 16, 2022 Licensing, Standards and Competency Committee Meeting – Draft Agenda

4 Executive Director's Report
   - Board and Staff Updates
   - OBD 2023 -2025 Budget – Fee Memo & Current Budget Report
   - Customer Service Survey
   - Board and Staff Speaking Engagements
   - Dental Hygiene License Renewal
   - FY 2022 Annual Performance Progress Report
   - October Cybersecurity Awareness Month
   - HPSP – Year 12 Reports
   - DANB Workforce Forum Summary
   - Legislative Days - House Interim Committee On Health Care Meeting
   - AADA & AADB Annual Meetings & AADB West Caucus Agenda

5. Unfinished Business and Rules
   - New Pain Management Requirements

6. Correspondence
   - Memo to Governor - complaints & settlement

7. Other
   - LC 438 Removes Sunset for OHA Dental Pilot Project Program & OHA DPP Fact Sheet (2 documents here)

Notes:
(1) A working lunch will be served for Board members at approximately 11:45 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.

- CPEP 2021 Annual Report
- Memo & OBD 2022-2025 Strategic Plan
- Expanded Practice Dental Hygienist Reporting per ORS 680.210(2)
- 2022 Tribal-State Government-to-Government Summit - Overview with Haley Robinson
- Tribes – Invitation to address the Board on any issues

8. Articles & Newsletters (No Action Necessary)
   - ADA HPI - Dental Workforce Shortages – Webinar Slides
   - CODA Initial Accreditation - Dental Therapy Skagit Valley College
   - CSG Releases Draft of Dental and Dental Hygiene Licensure Compact
   - ADEA Summary Report Dentists of Tomorrow
   - California Senate Bill SB 501 Anesthesia Rule Changes for Dentistry

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

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, and to consult with counsel. No final action will be taken in Executive Session.

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

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

OPEN SESSION (Via Zoom) **1:00 p.m.**

https://us02web.zoom.us/j/88397016298?pwd=ajVXZHNXUXdZWitISIhFV1J4QzU4dz09

Dial-In Phone #: 1-253-215-8782 • Meeting ID: 883 9701 6298 • Passcode: 238369

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues

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

Notes:
(1) A working lunch will be served for Board members at approximately 11:30 a.m.
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(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660.
Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

APPROVAL OF MINUTES

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OREGON BOARD OF DENTISTRY
MINUTES
AUGUST 19, 2022

MEMBERS PRESENT:	Jose Javier, D.D.S., President Chip Dunn, Vice President Alicia Riedman, R.D.H. Reza Sharifi, D.M.D. Sheena Kansal, D.D.S. Aarati Kalluri, D.D.S. Jennifer Brixey Terrence Clark, D.M.D. Michelle Aldrich, D.M.D. Sharity Ludwig, R.D.H. (portion of meeting via teleconference)
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop "Bernie" Carter, D.D.S., Dental Investigator Angela Smorra, D.M.D., Dental Director/Chief Investigator Haley Robinson, Office Manager (portion of meeting) Shane Rubio, Investigator (portion of meeting) Samantha Plumlee, Examination and Licensing Manager (portion of meeting) Ingrid Nye, Investigator (portion of meeting) Kathleen McNeal, Office Specialist (portion of meeting)
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT IN PERSON & VIA TELECONFERENCE*:	Dr. Julie Spaniel, DMD, ODA Wellness Committee Chair; Jen Lewis-Goff, Oregon Dental Association (ODA); Don Girard, MD, MACP; Timothy Goldfarb, The Foundation for Medical Excellence; Mary Harrison, (ODAA); Lisa Rowley, (ODHA); Jill Lomax, Chemeketa Dental Assistant; Ginny Jorgenson, Dental Assistant

*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 Jose Javier, D.D.S. welcomed everyone to the meeting and had the Board Members, Lori Lindley, and Stephen Prisby introduce themselves.

NEW BUSINESS

Approval of Minutes

Dr. Sharifi moved and Mr. Dunn seconded that the Board approve the minutes from the June 17, 2022 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS
Oregon Dental Association (ODA)
Dr. Julie Spaniel, DMD, ODA Wellness Committee Chair presented the Oregon Wellness Program Overview for the OBD. Dr. Don Girard and Tim Gonsalves also spoke and fielded questions about the program.

Oregon Dental Hygienists' Association (ODHA)
Lisa Rowley, ODHA was present with nothing specific to report.

Oregon Dental Assistants Association (ODAA)
Mary Harrison reported that the ODAA has been working with the ODA to address the workforce shortage.

COMMITTEE AND LIAISON REPORTS
The latest Committee and Liaison Assignments were presented, updated with new OHA representative and DTRO participants.

The OHA shared that Sarah Kowalski will be the Interim OHA representative on the Dental Therapy Rules Oversight Committee until the OHA hires a new state dental director.

CDCA/WREB and CITA announced their intent to combine, starting August 1, 2022. The new organization is now CDCA-WREB-CITA.

The ADEX Examinations statistical report highlighted the examination overview and candidate performance scores for 2022.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates
Mr. Prisby reported that Dr. Angela Smorra had transitioned into the Dental Director/Chief Investigator role on July 1st, taking the baton over from Dr. Winthrop "Bernie" Carter. Dr. Carter will remain with the OBD as a Dental Investigator. These dental investigator positions require unique skills and specialized in-depth knowledge of Board of Dentistry licensing laws, rules, regulations, and procedures. Their commitment and willingness to continue to support the OBD is noteworthy and Mr. Prisby thanked them both on behalf of the Board.
He went on to share that the staff has been catching up on long delayed and well-earned vacations and life obligations. The workload has ramped up over the last three months with new license applications and complaints noticeably higher than a year ago. The patience, understanding and support has been appreciated from those interacting with the OBD.

OBD Budget Status Report
Mr. Prisby presented the latest budget report for the 2021 - 2023 Biennium. This report, which is from July 1, 2021 through June 30, 2022, shows revenue of $1,851,218.82 and expenditures of $1,686,266.30.

OBD 2023-2025 Agency Request Budget
Mr. Prisby submitted the OBD's 2023-2025 Budget materials to the DAS-CFO Office on July 29 per budget development instructions. This proposed budget is a step in the process before the

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Governor consolidates all agencies into the Governor's Budget. The Legislature finalizes and approves all agency spending for the upcoming 2023-25 biennium during the 2023 Legislative Session.

Customer Service Survey
Mr. Prisby highlighted the legislatively mandated survey results for FY 2022, which is July 1, 2021 – June 30, 2022. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Dental Hygiene License Renewal
Mr. Prisby reported on the dental hygiene license renewal period which started on June 23, 2022 and progressing well. He gave a reminder that audits of Continuing Education are planned to be conducted after the renewal period closes, as it did for the dentists who renewed earlier in the year.

OBD FY 2021 Accounts Receivable Honor Roll
Mr. Prisby happily shared that the OBD once again has earned the state's CFO A/R Honor Roll Certificate for FY 2021 due to the hard work of Office Manager, Haley Robinson and our support from the OMB.

Agency Head Financial Transactions Report July 1, 2021 – June 30, 2022
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. Ms. Riedman moved and Dr. Kansal seconded that the Board approve the Agency Head Financial Transactions Report for July 1, 2021 – June 30, 2022. The motion passed unanimously.

TriMet Contract 2022 -2023
Mr. Prisby presented the latest contract with TriMet, which will allow the OBD to provide transportation passes for employees that are eligible to receive such passes for transportation to and from work. Ms. Riedman moved and Ms. Brixey seconded that Mr. Prisby ratify the TriMet Contact for 2022-2023. The motion passed unanimously.

Board Best Practices Self-Assessment & Score Card
As a part of the legislatively approved Performance Measures, the Board needs to complete the Best Practices Self-Assessment Score Card so that it can be included as a part of the FY 2022 annual progress report. Mr. Prisby will provide the report at the October Board Meeting. Dr. Sharifi moved and Mr. Dunn seconded that the Board approve the Board Best Practices, Self-Assessment & Score Card with all criteria being met. The motion passed unanimously.

OBD Bylaws
Mr. Prisby highlighted the Mission statement that was updated in the bylaws at the June Board Meeting to align it with the change made in the OBD's 2022-2025 Strategic Plan.

OBD Board Meeting Dates 2022 - 2023
OBD Meeting Dates which were approved by the Board were shared.

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DANB Forum Meeting
Mr. Prisby reported on the Dental Assistant Stakeholder Forum on the Future Workforce (held 7/14). It was a productive day of learning, dialogue, and creativity with leaders from throughout the oral health and healthcare fields. DANB was to provide a summary report containing highlights, insights, and findings from our work together. It was not yet available when this report was compiled.

September Legislative Days – House Health Care Committee
Mr. Prisby announced that he was requested to attend and participate at an upcoming committee meeting. A Board member was also asked to attend as well. Dr. Javier and Dr. Clark expressed interest in attending.

AADA & AADB Annual Meetings
The annual meetings for the AADA and AADB in Asheville, NC between Oct 6 - 9, 2022 were presented along with the preliminary agendas

Newsletter
Mr. Prisby revealed the latest newsletter and announced that it is available on the OBD website. He thanked all that contributed with special thanks to the staff graphic artists, Haley Robinson and Samantha Plumlee, who assembled the newsletter.

UNFINISHED BUSINESS AND RULES
Representatives from the Dental Assisting Program at Chemeketa Community College propose allowing dentists in Oregon to delegate administration of local anesthesia to their dental assistants. Ms. Brixey moved and Mr. Dunn seconded that the Board move discussion of the proposed rule to the Licensing, Standards and Competency committee. The motion passed unanimously.

The Secretary of State filing of new Dental Therapy on June 21, 2022 was presented.

OTHER ISSUES
Mr. Prisby updated the Board on work that is fulfilling the objectives for the latest OBD Strategic Plan 2022-2025. Work has progressed on strategic priorities A, C, D and E.

Juliet Valdez, the Affirmative Action Manager with the Office of Cultural Change made an in-person presentation on the State of Oregon's Diversity, Equity and Inclusion Action Plan.

A standing invitation to address the Board was offered to the Federal Tribes of Oregon, but no comments were made.

The new ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students was presented. Dr. Sharifi moved and Ms. Riedman seconded that the Board move to send new ADA 'Guidelines for Teaching Pediatric Pain Control' to the Anesthesia Committee for review and discussion. The motion passed unanimously.

The OHA's Follow-up report on the Prescription Drug Monitoring Program was highlighted.
The initial draft of the Dentist and Dental Hygienist Compact, along with Compact Draft Rules and Materials from the December 2021 meeting were shown with information about offering feedback

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to the Council of State Governments.

ARTICLES AND NEWSLETTERS
The CODA Summer Meeting Announcement was shared.

The CRDTS News and Introduction of New Staff was presented.

The DANB and the Dale Foundation shared a report from their July forum to address the dental assistant workforce.

The Oregon Health Authority reported the resignation of State Dental Director, Kaz Rafia.

Expansion of the Mobile Medical, Dental Care clinics in Oregon and Washington was announced.

The Board entered into Executive Session pursuant to ORS 192.345(4); 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, to consult with counsel, and to conduct the annual review and performance evaluation of the executive director.

OPEN SESSION: The Board returned to Open Session at 2:55 p.m.

CONSENT AGENDA

2023-0004, 2022-0121, 2022-0128, 2023-0002, 2022-0114
Mr. Dunn 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

2022-0103, 2022-0122, 2022-0109, 2022-0104, 2022-0079, 2022-0130
Mr. Dunn moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Further Action or No Violation. The motion passed unanimously.

2022-0123
Dr. Sharifi moved and Mr. Dunn seconded to close the matter with a Letter of Concern reminding Licensee to assure that all radiographs are reviewed appropriately to determine a proper diagnosis. The motion passed unanimously.

2022-0107
Ms. Brixey moved and Mr. Dunn seconded to close the matter with a Letter of Concern reminding Licensee to assure that he maintains records of successful completion of continuing education for at least four licensure years consistent with his licensure cycle. Licensee will need to take two additional hours of infection control continuing education for his April 1, 2022 thru March 31, 2024 renewal cycle. The motion passed unanimously.

Clark, Riley D., D.M.D.; 2022-0077

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Ms. Riedman moved and Dr. Sharifi seconded that the Board issue a notice of proposed disciplinary action and offer Licensee a Consent Order incorporating a reprimand, pay a civil penalty in the amount of $ 1,500.00 within 120 days of the effective date of the Order; take and pass the Dental Jurisprudence Test within 30 days of the effective date of the Order; and complete four hours of Board approved continuing education in dental record keeping and eight hours of continuing education in thorough documentation of parenteral moderate sedation records within 120 days of the effective date of the Order. The motion passed unanimously.

2022-0092
Dr. Kansal moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure he improves his patient records, by (1) documenting all relevant radiographic findings, and (2) documenting discussions when informing the patient, or guardian, of relevant radiographic findings. The motion passed unanimously.

2022-0101
Dr. Aldrich moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee that importance of case selection, comprehensive treatment planning and reviewing appropriate referral options when providing complex interdisciplinary dental care.

Sullivan, John K., D.D.S.; 2022-0095
Dr. Clark moved and Dr. Sharifi seconded that the Board issue a Notice of Proposed Disciplinary Action, and offer Licensee a Consent Order incorporating a reprimand, pay patient AM a refund in the amount of $ 8,392.50 within 120 days of the effective date of the Order; restriction from surgical placement of any and all dental implants until Licensee completes a Board approved Mentorship Program on surgical procedures and the placement of interoxious implants UNTIL Mentorship is completed; take and pass the Dental Jurisprudence Test within 30 days of the effective date of the Order; complete six hours of Board approved continuing education in dental record keeping, with emphasis on implant record keeping, within 90 days of the effective date of the Order. The motion passed unanimously.

John D. Laseter, D.M.D.; 2023-0029
Dr. Kalluri moved and Ms. Riedman seconded that the Board issue an Order of Immediate Emergency Dental License Suspension. The motion passed unanimously.

LICENSE & EXAMINATION ISSUES

Request for approval of Soft Reline Course – Shawna Welch, EFDA
Dr. Sharifi moved and Mr. Dunn seconded that the Board approve the Soft Reline Course as presented. The motion passed unanimously.

Request for temporary non-resident permit – Joseph Hull, D.D.S.
Ms. Brixey moved and Mr. Dunn seconded that the Board ratify the issuance of temporary non-resident permit for Dr. Joseph Hull, D.D. S. The motion passed unanimously.

Request for temporary non-resident permit – Thomas Ostler, D.D.S.
Ms. Riedman moved and Dr. Kansal seconded that the Board ratify the issuance of temporary non-resident permit for Dr. Thomas Ostler, D.D.S. The motion passed unanimously.

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Request for reinstatement of retired license – Nichol Stewart, R.D.H.
Dr. Kansal moved and Mr. Dunn seconded that the Board reinstate the license for Nichol Stewart, R.D.H. The motion passed unanimously.

Request for reinstatement of expired license – Anton Conklin, D.M.D.
Dr. Aldrich moved and Ms. Riedman seconded that the Board reinstate the license for Anton Conklin, D.M.D. The motion passed unanimously.

RATIFICATION OF LICENSES
Dr. Clark moved and Dr. Kalluri seconded that the Board ratify the licenses presented in tab 16. The motion passed unanimously.

Request for approval of Pacific University ITR Curriculum
Ms. Riedman moved and Dr. Sharifi seconded that the Board approve the Pacific University ITR curriculum

Executive Director Performance Evaluation
Dr, Sharifi moved and Mr. Dunn seconded that the Board rate Mr. Prisby an “outstanding” on his performance review, and accept his 2022-2023 goals as presented. The motion passed unanimously.

ADJOURNMENT

The meeting was adjourned at 2:20 p.m. Dr. Javier stated that the next Board Meeting would take place on October 21, 2022.

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Jose Javier, D.D.S.
President

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ASSOCIATION REPORTS

COMMITTEE REPORTS

Kate Brown, Governor

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

MEETING NOTICE

LICENSING, STANDARDS AND COMPETENCY COMMITTEE MEETING

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

ZOOM MEETING INFORMATION
https://us02web.zoom.us/j/87632943255?pwd=MldtNGEyUG8xcERGSFBza1ZaVEs5UT09
Dial-In Phone #: 1-253-215-8782 • Meeting ID: 876 3294 3255 • Passcode: 382763

November 16, 2022
5:00 p.m. – 6:30 p.m.

Committee Members:
Chair, Jose Javier, D.D.S.
Sheen Kansal, D.D.S.
Sharity Ludwig, R.D.H.
Jennifer Brixey
Olesya Salathe, D.M.D. - ODA Rep.
Susan Kramer, R.D.H. - ODHA Rep.
Ginny Jorgensen, CDA, EFDA, EFODA, AAS - ODAA Rep.
Yadira Martinez, R.D.H. – DT Rep.

AGENDA

Call to Order: Dr. Jose Javier, Chair

1. Review and approve Minutes of October 7, 2020 Committee Meeting.
   - October 7, 2020 Minutes – **Attachment #1**

2. Review and discuss amending the effective date of OAR 818-012-0005(4)(5).The Board voted on June 17, 2022 to move the effective date of this rule out from July 1, 2022 to Jan 1, 2024.
   - OAR 818-012-0005(5) - **Attachment #2**

3. Review and discuss refining the referenced rules for clarification. At the April 22, 2022 Board meeting the potential amendments to the Dental Implant Rule and CE updates were moved to this committee for further review, refinement and recommendations. (Staff recommendations).
   - OAR 818-012-0005(4)(5) - **Attachment #3**

4. Review and discuss and make possible recommendations to the Board regarding OAR 818-012-0007 only fine-tuning title of rule. (Staff recommendation).
   - OAR 818-012-0007 - **Attachment #4**

5. Review and discuss and make possible recommendations to the Board regarding OAR 818-012-0030 due to the passage of HB 2358 regarding Healthcare Interpreters.
   - HB 2358 – Healthcare Interpreter – Update to rule - **Attachment #5**
   - OAR 818-012-0030 with new language - **Attachment #6**

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

6. Review, discuss and make possible recommendations to the Board regarding OAR 818-012-0032 – Diagnostic Records. (Staff recommendations).
    - OAR 818-012-0032 - **Attachment #7**

7. Review, discuss and make possible recommendations to the Board regarding OAR 818-012-0070 – Patient Records (Staff recommendations).
    - OAR 818-012-0070 – Patient Records - **Attachment #8**

8. Review and discuss Health Professional Services Program (HPSP) due to passage of Measure #110, to add Class E crimes and Board discussed more flexibility of time in program.
    - Measure 110 – **Attachment #9**
    - OAR 818-013-0015 – **Attachment #10**
    - OAR 818-013-0020 – **Attachment #11**

9. Review and discuss and make possible recommendations to the Board regarding Specialty Advertising due to DOJ settlement and terms of agreement.
    - OAR 818-015-0007(1) & (3) – **Attachment #12**
    - OAR 818-021-0012 – **Attachment #13**
    - OAR 818-021-0015 – **Attachment #14**
    - OAR 818-015-0005 – **Attachment #15**

10. Review, discuss and make possible recommendations to the Board regarding OAR 818-021-0017 – Application to Practice as a Specialist (Staff recommendations).
    - OAR 818-021-0017 – Application to Practice as a Specialist - **Attachment #16**

11. Review and discuss and make possible recommendations that the Board repeal OAR 818-021-0030 and OAR 818-021-0040 as they are outdated and do not apply now.
    - OAR 818-021-0030 & OAR 818-021-0040 – **Attachment #17**

12. Review and discuss amending the effective date of OAR 818-021-0060(8).The Board voted on June 17, 2022 to move effective date of this rule out from July 1, 2022 to Jan 1, 2024.
    - OAR 818-021-0060(8) – **Attachment #18**

13. Review and discuss and make possible recommendations that the Board update all three Licensees' CE Rules: OAR 818-021-0060, OAR 818-021-0070, and OAR 818-021-0076. At the December 2020 Board meeting during the height of the pandemic the Board voted that no quiz was required on correspondence courses and that zoom, or web based education would be acceptable for CE.
    - OAR 818-021-0030, OAR 818-021-0040 & OAR 818-021-0076 – **Attachment #19**

14. Review and discuss and make possible recommendations to the Board regarding draft attestation form due to the passage of HB 4096 which is effective Jan 1, 2023
    - HB 4096 – **Attachment #20**
    - Draft Rule – **Attachment #21**
    - Form for Licensee to attest they meet criteria to volunteer, and specifics and directed by HB 4096 – **Attachment #22**
    - OAR 818-021-0088 Volunteer License (for reference) – **Attachment #23**

15. Review and discuss Pacific University Dental Hygiene Students March 2021 proposal of adding a Local Anesthesia Endorsement for Dental Assistants, which was moved to this Committee at the April 2021 Board Meeting. At the August 2022 Board Meeting correspondence and draft rules from Ms. Lomax, Ms. Lewelling & Ms. Jorgenson which was similar was also moved to this Committee for review and discussion.
    - Pacific University Letter & Proposal – **Attachment #24**
    - Draft Rules & Letter from Ms. Lomax, Ms. Lewelling & Ms.Jorgenson – **Attachment #25**
    - OAR 818-035-0040 (for reference) – **Attachment #26**

16. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0040 – Prohibited Acts (Staff recommendations).
   - Staff Recommendations for rule change- **Attachment #27**
   - OAR 818-042-0040 – Prohibited Acts (for reference) - **Attachment #28**

17. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0050 – Taking of X-Rays — Exposing of Radiographic Images and OAR 818-042-0060 - Certification — Radiologic Proficiency
   - Recommendations for rule change - **Attachment #29**
   - OAR 818-042-0050 – Taking of X-Rays — Exposing of Radiographic Images (for reference) - **Attachment #30**
   - OAR 818-042-0060 – Certification — Radiologic Proficiency - **Attachment #31**
   - OAR 333-106-0055 - General Requirements: X-ray Operator Training - **Attachment #32**
   - DANB Radiology Pathway I – Application - **Attachment #33**

18. Review, discuss and make possible recommendations to OAR 818-042-0080 Certification – Expanded Function Dental Assistant (EFDA), OAR 818-042-0110 – Certification – Expanded Function Orthodontic Assistant (EFODA) and OAR 818-042-0113 – Certification – Expanded Function Preventive Dental Assistants (EFPDA). All three were referred back to this Committee from the October 7, 2020 Licensing, Standards and Competency Committee because the Committee felt that in the midst of the pandemic, they did not want to create any new or additional barriers to care at that time.
   - OAR 818-042-0080 - Certification – EFDA - **Attachment #34**
   - OAR 818-042-0110 - Certification – EFODA - **Attachment #35**
   - OAR 818-042-0113 - Certification – EFPDA - **Attachment #36**

19. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0115 Expanded Functions – Certified Anesthesia Dental Assistant and OAR 818-042-0117 – Initiation of IV Line. Referred from Staff for discussion. This was discussed at October 23, 2020 Meeting that Anesthesia Dental Assistants could perform phlebotomy for dental procedures such as PRP/PRF.
   - OAR 818-042-0115 - Expanded Functions — Certified Anesthesia Dental Assistant - **Attachment #37**
   - OAR 818-042-0117 - Initiation of IV Line - **Attachment #38**
   - Phlebotomy course letter from June Board Meeting - **Attachment #39**
   - Phlebotomy MEMO – Staff Recommendations - **Attachment #40**

20. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0113 - Certification – EFPDA and OAR 818-042-0114 - Additional Functions of EFPDAs (Staff recommendations).
   - Staff Recommendations for rule change- **Attachment #41**

21. At the Dec 17, 2021 Board Meeting, Board moved discussion of Instructor requirements to teach Radiologic Proficiency to dental assistants and dental therapists to this Committee for review and discussion.
   - Instructor Application Form - **Attachment #42**

Any Other Business

Adjourn

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
October 21, 2022

Board and Staff Updates
The Board is adjusting to their new assigned state emails and laptops.

OBD 2023-2025 Budget - Fee Memo & Current Budget Report
Attached is a memo with information and detail on a possible fee increase added to OBD 2023 -2025 Budget. Also attached is the budget report for the 2021 – 2023 Biennium. This report, which is from July 1, 2021 through August 31, 2022 shows revenue of $2,161,745.69 and expenditures of $1,978,721.17. **Attachment #1 – FOR ACTION & DISCUSSION**

Customer Service Survey
Attached are the legislatively mandated survey results from July 1, 2021 – September 30, 2022. 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**

Board and Staff Speaking Engagements
Samantha Plumlee and Ingrid Nye gave a Licensing application virtual presentation to the graduating dental hygiene students at PCC on August 22, 2022.

I gave a Board Updates presentation with Dr. Reza Sharifi to a Dental Study Club in Portland on September 8, 2022.

Dental Hygiene License Renewal
The renewal period started on July 26th and ended September 30th. At the time of compiling this report I did not have the final numbers to report on. They will be included in the December Board Meeting packet.

FY 2022 Annual Performance Progress Report
Attached is the OBD's FY 2022 Annual Performance Progress Report which was submitted to the Legislative Fiscal Office before the due date. Most state agencies are required to complete this report annually. **Attachment #3**

October Cybersecurity Awareness Month
Governor Kate Brown has proclaimed October 2022 to be Cybersecurity Awareness Month, encouraging all Oregonians to learn about cybersecurity and put that knowledge into practice in their homes, schools, workplaces, and businesses. In support of the Governor's proclamation, Enterprise Information Services Cyber Security Services (CSS) works toward the following objectives:

- Improve the security culture of the enterprise.
- Reduce cybersecurity risk by increasing awareness of cybersecurity.
- Reduce human vulnerabilities that could result in a breach of confidentiality, integrity, and availability of state information assets, thereby increasing the overall security posture of the state.

HPSP - Year 12 Reports
The 12th Annual HPSP Reports are included for review.
Attachment #4

DANB Workforce Forum Summary
A summary report from July 14, 2022 DANB meeting that I participated in is attached for review. **Attachment #5**

Legislative Days - Meeting
The meeting agenda and OBD Presentation I gave on September 21st is provided for your review. **Attachment #6**

AADA & AADB Annual Meetings & AADB West Caucus Agenda
The American Association of Dental Administrators (AADA) and American Association of Dental Boards (AADB) annual meetings were held in Asheville, NC October 6 – 9, 2022. Lori Lindley led the Attorneys' Roundtable presentation yet again. I attended both meetings and led the AADA Meeting in my capacity as AADA President. I also served as the AADB West Caucus Chair and attached the meeting agenda. The Board should review and look at item #4 on the agenda for possible discussion at this meeting. **Attachment #7**

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

TO: OBD Board Members, Licensees & Interested Parties

FROM: Stephen Prisby, OBD Executive Director

DATE: October 3, 2022

SUBJECT: OBD 2023 - 2025 Budget Info & Fee Increase Overview

Based on updated budget projections and discussions with DAS. The OBD should consider a fee increase to ensure we have adequate resources throughout the 2023-2025 Biennium, and end with a sufficient ending balance.

I have included the March 2022 Revenue forecast document for informational purposes. That document was distributed in the April 22, 2022 Board Meeting packet. The revenue projections and licensing statistics are accurate and inform us on our projected revenue leading into the next biennium. The revenue appears to be stable, but not increasing to keep up with the increase in OBD fixed costs and expenses.

I also referenced this in the August 2022 OBD Newsletter- *a short excerpt*:

> Every even numbered year state agencies like the OBD start the budget preparation and planning process for the next budget biennium. At this time, it appears the OBD will be reviewing closely the need for a fee increase in 2024 or 2025. The OBD last raised fees in 2015 at that time to support the need for a second full time dental investigator. The investigator was needed due to caseload and that investigations on average were taking approximately 12 months to complete. The new investigator made a significant impact on cases in reducing the backlog. The average disposition of a case is down to six or seven months, which is a good thing. The fee increase requested would be to support the OBD due to the systematic increase in costs for pay equity, inflation, statute changes, technology upgrades, regulating dental therapists and new reporting requirements. The number of OBD Licensees has essentially remained flat over the last 6 years, and that trend is forecasted to continue even with the addition of dental therapists. Therefore, an increase in costs steadily over the years, and a flat revenue source, with no meaningful way to cut costs; all this points to a future fee increase.

There is widespread support for the OBD to help fund the Oregon Wellness Program, which is estimated to be an additional $80,000 expense in the 2023 -2025 biennium. The Oregon Wellness Program would be available to support all licensees of the OBD.

The Prescription Drug Monitoring Program (PDMP) fee has risen 40% to $35 ($70 per license period) from $25 ($50 per license period).The OBD has absorbed the added cost and did not raise dental licensure fees at all. The OBD is required to transfer 90% of the fee collected to the OHA to administer the PDMP.

The regular costs associated with any business have steadily increased since 2015, which was when the OBD last raised fees. State agencies are also challenged to address pay equity issues, PERS expenses and mandated inflation adjustments. A healthy revenue balance at the start of the current biennium will be used up through the next 30 months, as expected. It was possible that a fee increase would not be needed until the 2025 -2027 Biennium. It is not recommended that the OBD budget be so tight and only end the 2023-2025 Biennium with 1 to 2 months of surplus revenue depending on final numbers. The OBD expends on average about $145,000 per month in its operation. An agency that is funded by its licensees should end closer to a minimum of 3 months ending balance to ensure adequate funds for its operation as the funding of the OBD is uneven and varies with new applications received and the renewal cycles of the licensees. The OBD will review closer some cuts and strategies to reduce costs, but to ensure all the work and priorities are addressed, it is difficult to offset the added costs without raising fees.

Options for fee increases take in account that inaugural dental therapy fees were effective July 1, 2022. Also that dentist and others incomes vary as well. Some possible fee increase options (there may be better ones in the future) being discussed include:

Option 1. Effective July 1, 2023
Raise Dental license application fee $100 – generate an additional $36,000
Raise Dental 2-year license fee $50 – generate an additional $180,000
No other fee increases

Option 2. Effective July 1, 2024 (this would only provide one year of additional revenue in the 2023-2025 biennium)
Raise Dental 2-year license fee $50 generate an additional $90,000
Raise Dental Hygiene 2-year license fee $30 generate an additional $90,000
Raise Dental Therapist 2-year license fee $30 generate an additional $750
No other fee increases

Current fee schedule:

Licensure Type	Application Fee	2 year Biennial Licensure Fee
Dental (General & Specialty) by Exam	$340.00	$336.00
Dental (General & Specialty) Without Further Exam	$790.00	$336.00
Faculty - License	$305.00	$281.00
Dental Hygiene by Exam	$180.00	$226.00
Dental Hygiene without Further Exam	$790.00	$226.00
Dental Therapist by Exam	$180.00	$226.00
Dental Therapist without Further Exam	$790.00	$226.00
Recent graduates usually apply by exam (the lower cost)		

The PDMP fee currently assessed to all Oregon Licensed Dentists is $50.

California:
- Dental Application fee $672, Renewal for one year license is $650
- Dental Hygiene Application fee $200, Renewal for two year license is $300

Washington:
- Dental Application fee $500 ($1000 LWFE), Renewal for one year license is $400
- Dental Hygiene Application fee, $100 Renewal for one year license is $50

Idaho:
- Dental Application fee $300, Renewal for one year license is $375
- Dental Hygiene Application fee $150 , Renewal for two year license is $175
- Dental Therapist Application Fee $250 Renewal for two year license is $250

Oregon fees seem reasonable compared to our neighboring states. It is not the OBD's intent to raise fees unnecessarily or create any additional barriers to our dedicated and hardworking licensees. We have not had a fee increase since 2015.

It would be challenging and impractical for the OBD to increase fees annually to keep up with inflation (especially the last two years). I doubt anyone would support the OBD undertake annual rulemaking, update forms, website instructions and impact applicants who might submit application materials on cut off dates before a new fee increase, etc…

YEAR	2015	2016	2017	2018	2019	2020	2021	2022	2023
FEE	$400.00	$412.00	$424.00	$437.00	$450.00	$463.00	$477.00	$491.00	$506.00

Hypothetical Fee Increase 3% year, numbers rounded for example

Periodically, the fees must be increased to reflect annual increased costs of running a state agency. The proposed fee increases appear to be high and percentage-wise, quite an increase. The OBD rarely proposes fee increases, but I believe the options to be reasonable and necessary. The State's health regulatory boards are set up to be funded without any additional tax payer support. The Licensees fund the health regulatory agency. I appreciate feedback and discussion on the topic of fee increases or any budget matters at the October 21st Board Meeting and in future meetings.

Sincerely,
Stephen Prisby
OBD Executive Director

TO: DAS Analyst, LFO Analyst & OMB Budget Personnel

FROM: Stephen Prisby, OBD Executive Director

DATE: March 31, 2022

SUBJECT: OBD 2023 - 2025 Revenue Forecast

The Oregon Board of Dentistry (OBD) was created by an Act of the Legislature in 1887. The authority and responsibilities of the Board are contained in Oregon Revised Statutes

Chapter 679 (Dentists and Dental Therapists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the OBD with the responsibility to regulate the practice of dentistry, dental therapy, and dental hygiene by enforcing the standards of practice established in statute and rule. The statutes define the practice of dentistry, dental therapy, and dental hygiene and require that any person practicing any of those professions do so only while holding a license duly issued by the Board. The statutes require that the Board examine and license dentists, dental therapists, dental instructors and dental hygienists; establish and enforce regulations regarding sedation in dental offices; investigate complaints regarding the practice of dentistry, dental therapy, and dental hygiene; discipline Licensees found to have violated the provisions of the Dental Practice Act; regulate and monitor continuing education requirements for Licensees; and establish training, examination and certification standards for dental auxiliaries. The OBD has eight full-time staff members, one limited duration staff member for IT Project and 10 volunteer Board Members.

The Mission of the OBD is to promote quality oral health care and protect all communities in the state of Oregon by equitably and ethically regulating dental professionals.

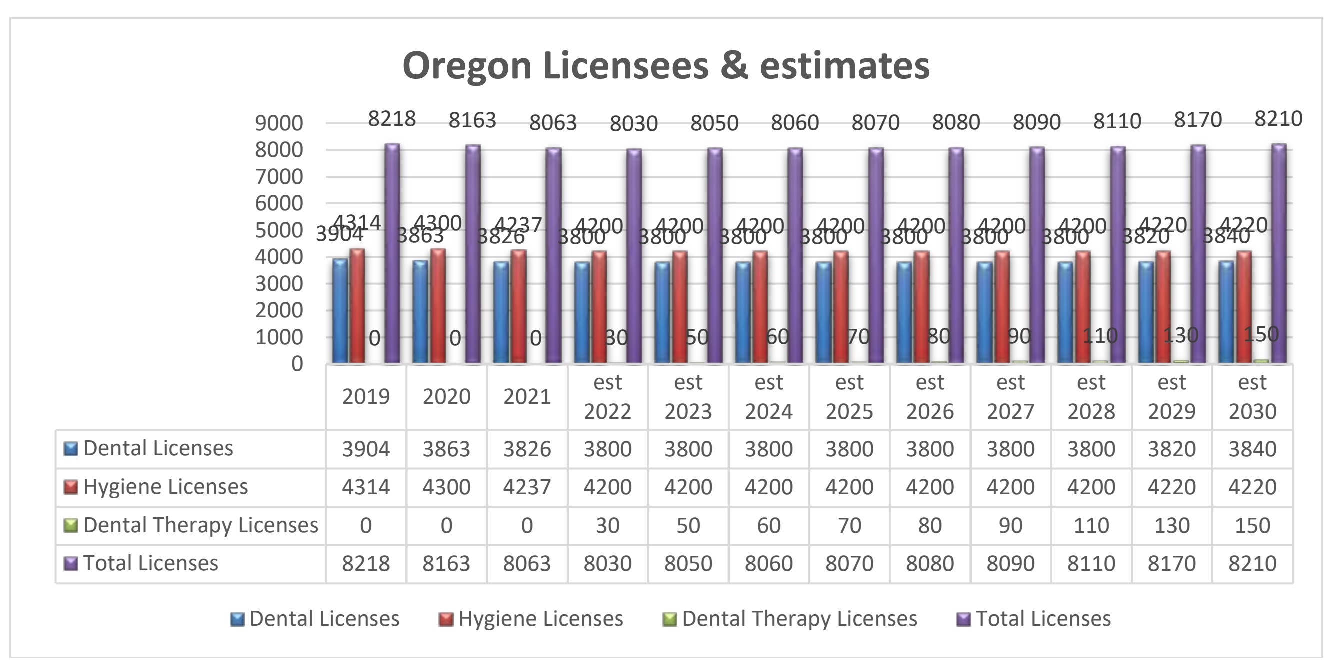
The Board of Dentistry's funding is 100% Other Funds generated primarily from fees paid by Licensees and applicants for new licenses, license renewals and various permits. A small portion (generally less than six percent) of the Board's revenue is from miscellaneous revenues generated from civil penalties, the sale of documents, late fees and interest.

Issues

1. The Board has historically required six months of beginning balance, for planning purposes for a new budget biennium

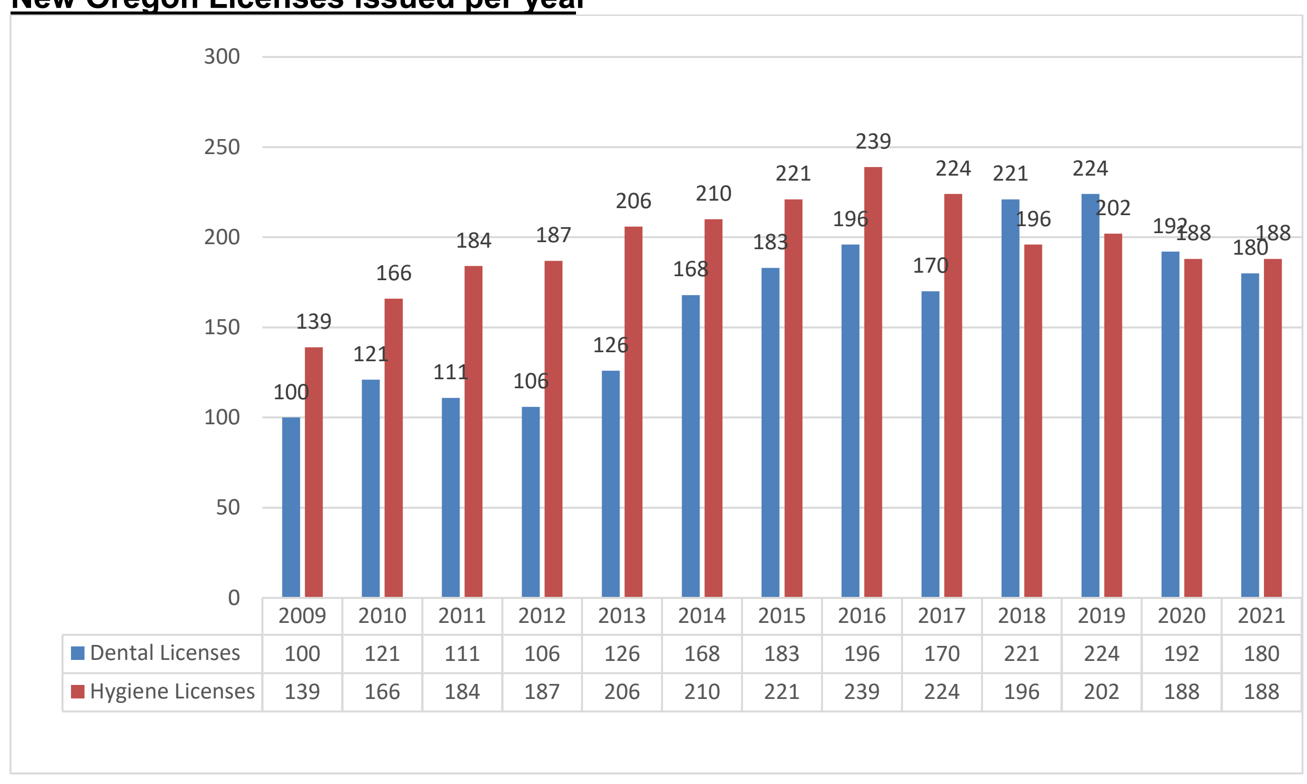
Licenses regulated by the Board are issued to expire and be renewed every year in two distinct timeframes. The result is that our biennial revenue is primarily received at different times during each biennium. Half of the dentists renew spring each year and half our hygienists and dental therapists renew in the fall each year. Thus, the agency requires a minimum beginning balance equal to six months of operating expenses at the beginning of every biennium.

2. COVID-19 Pandemic Impact – A preliminary review shows that total Licensees dropped 1.2% year over year. A reduction of 100 Licensees from 2020 to 2021. The last few years of projections has been consistent and accurate, calling for almost no growth in total Licensees. Even accounting for a new Licensee in late 2022 (Dental Therapists), minor growth is projected out in the foreseeable future.



	2019	2020	2021	est 2022	est 2023	est 2024	est 2025	est 2026	est 2027	est 2028	est 2029	est 2030
Dental Licenses	3904	3863	3826	3800	3800	3800	3800	3800	3800	3800	3820	3840
Hygiene Licenses	4314	4300	4237	4200	4200	4200	4200	4200	4200	4200	4220	4220
Dental Therapy Licenses	0	0	0	30	50	60	70	80	90	110	130	150
Total Licenses	8218	8163	8063	8030	8050	8060	8070	8080	8090	8110	8170	8210

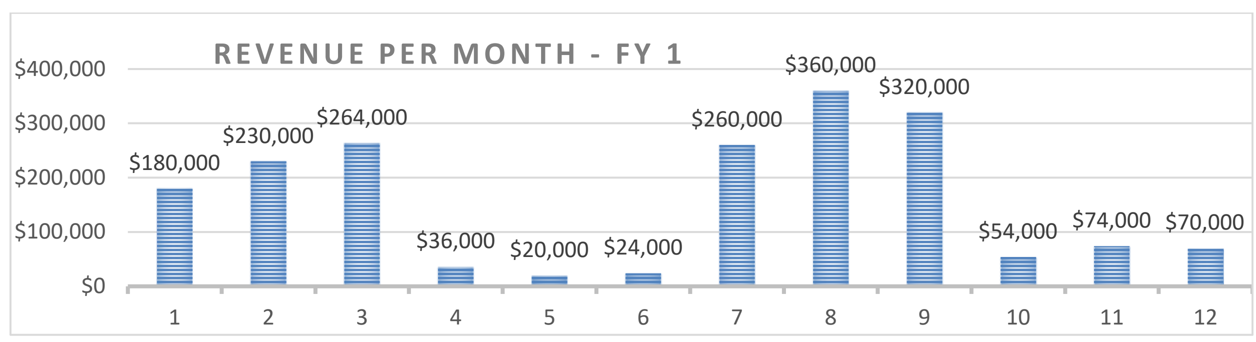
New Oregon Licenses issued per year

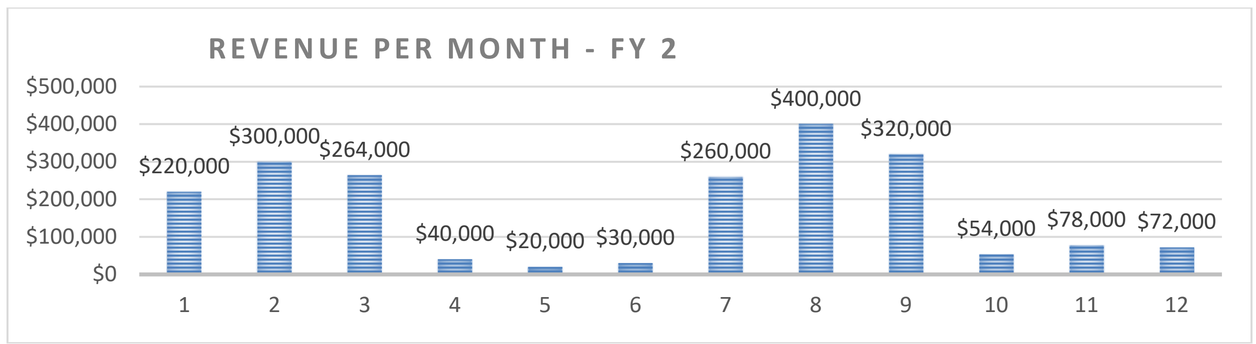


	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Dental Licenses	100	121	111	106	126	168	183	196	170	221	224	192	180
Hygiene Licenses	139	166	184	187	206	210	221	239	224	196	202	188	188

Revenue stream- uneven every year due to Licensees renewing in spring & fall

Every year one half of our dentists renew their 2-year license between Jan – March 31. Every year one half of our dental hygienists and dental therapists renew their 2-year license between July – Sept 30. Example of the uneven revenue typically received per Fiscal Year (FY) shown below. The OBD will begin licensing dental therapists later in 2022 and we forecast that it will have a minimal impact on revenue in the current biennium or in the 2023-2025 biennium.



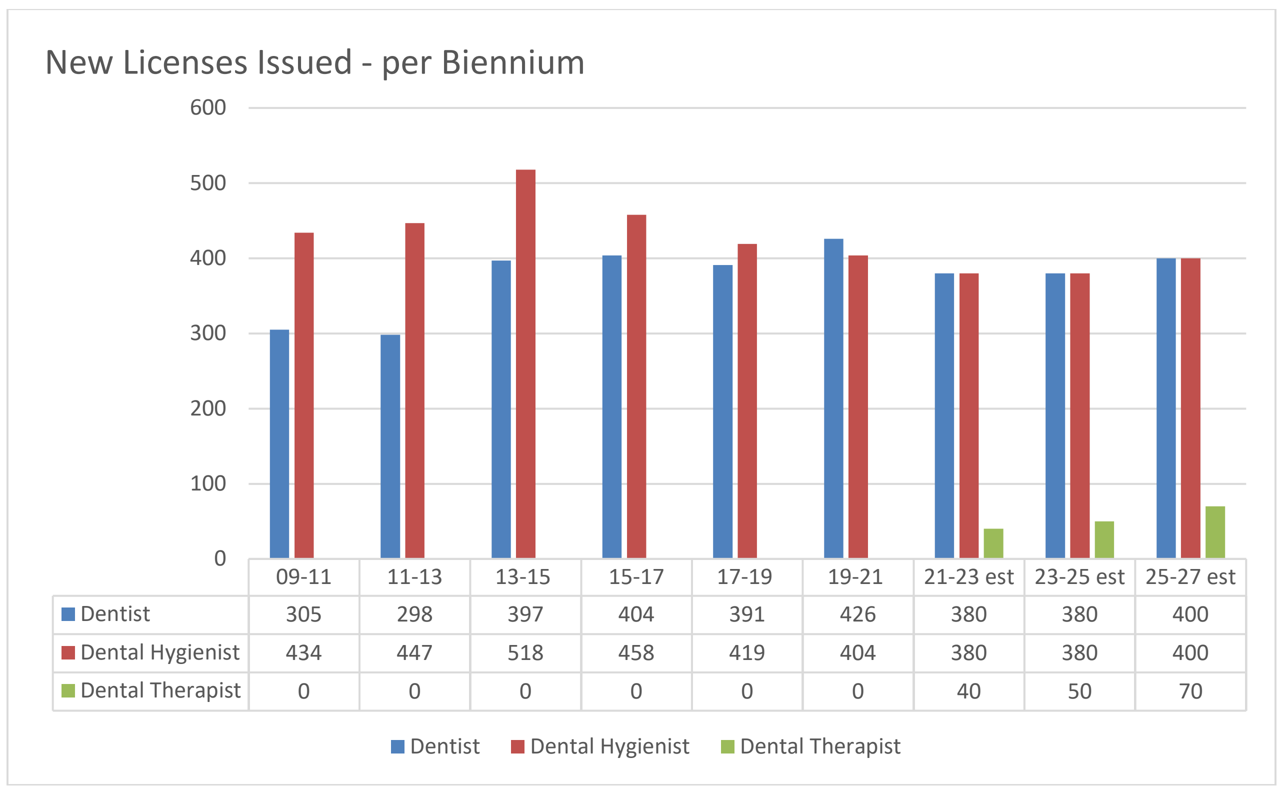


Revenue Estimates

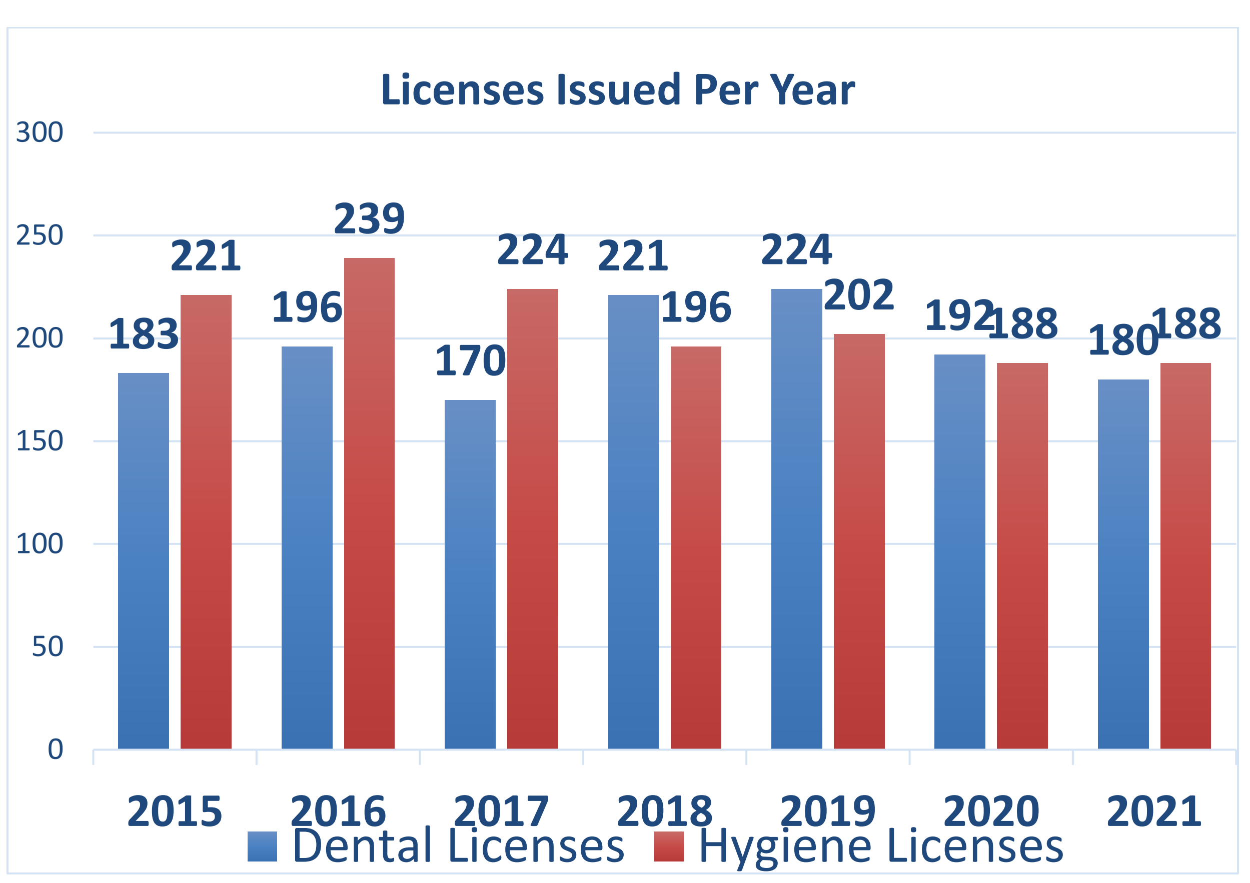
At this point we are projecting revenue for 2023-2025 Biennium to be similar to the 2021-2023 budget biennium.

Revenue	FY 17-19 Actual	FY 19-21 Actual	FY 21-23 ESTIMATE	FY 23-25 ESTIMATE
OTHER BUSINESS LICENSES	3,220,245	3,197,000	3,100,000	3,100,000
OTHER NONBUSINESS LIC & FEES	13,604	14,900	14,900	14,900
CHARGES FOR SERVICES	24,475	25,100	25,100	25,100
FINES AND FORFEITS	420,796	243,000	240,000	240,000
INTEREST AND INVESTMENTS	59,339	49,000	60,000	60,000
OTHER REVENUE	14,820	14,700	14,000	14,000
TOTAL	3,753,279	3,543,700	3,452,000	3,452,000

Data on Licensees

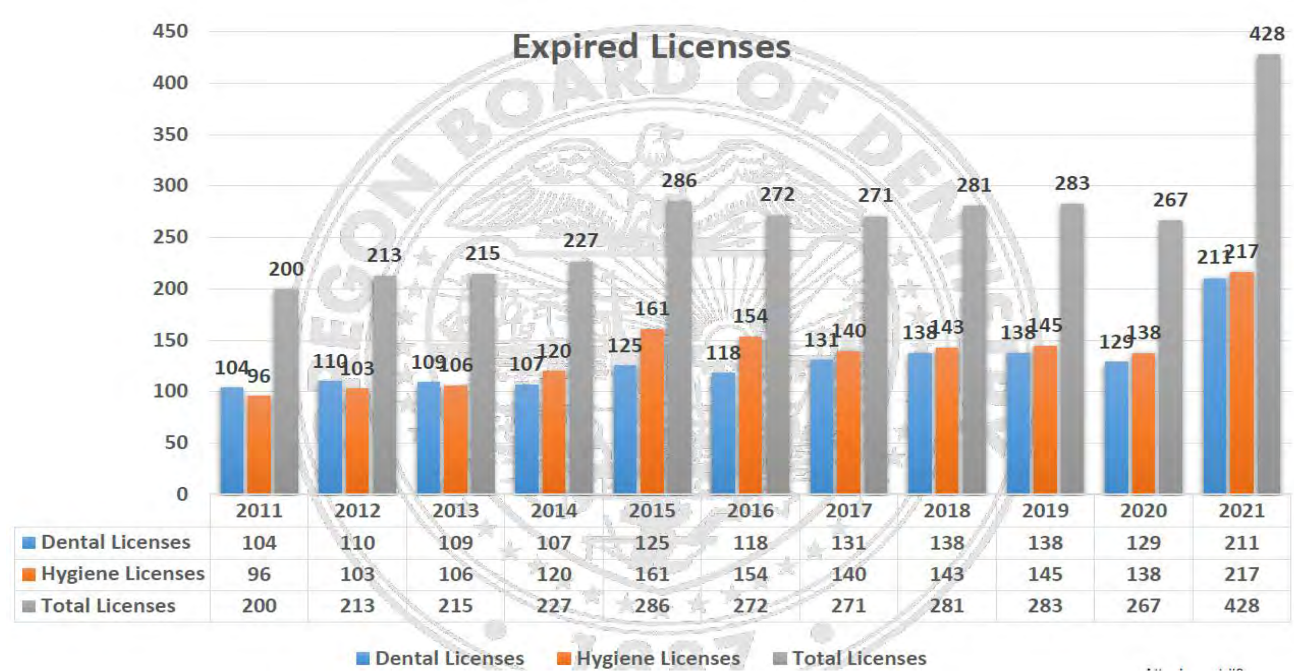


	09-11	11-13	13-15	15-17	17-19	19-21	21-23 est	23-25 est	25-27 est
Dentist	305	298	397	404	391	426	380	380	400
Dental Hygienist	434	447	518	458	419	404	380	380	400
Dental Therapist	0	0	0	0	0	0	40	50	70

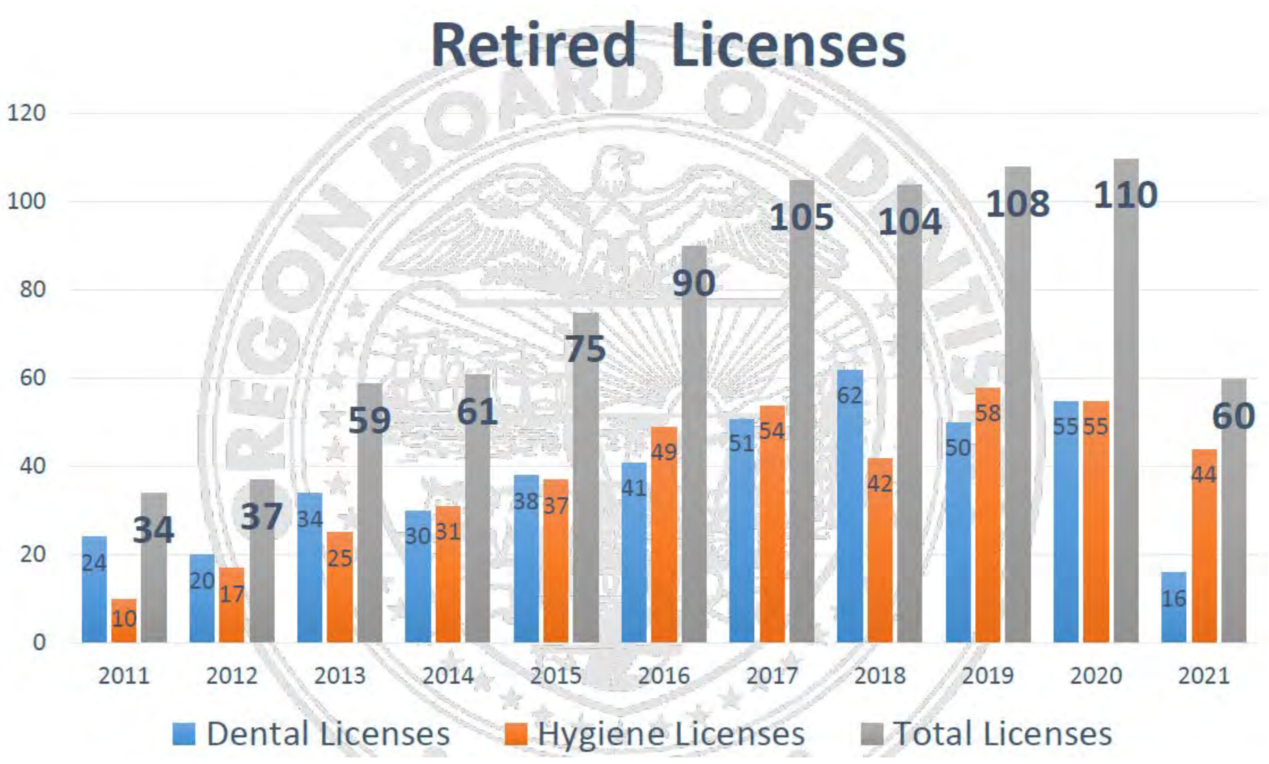


Expiration and Retirements of Licenses:

A spike in Licensees letting their licenses expire was not a surprise given the pandemic. When Licensees choose to stop practicing in Oregon they generally let their license expire instead of retiring it. When they retire, they are confirming that they are not practicing in any other state or jurisdiction in the U.S.



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



As noted in revenue projection memo two years ago:
"Projecting total licenses to slightly decline from 2021 – 2025, due to the impacts of Covid-19 Pandemic and the ability of new dental and dental hygiene graduates to take clinical licensing exams and then apply to get licensed. An aging population of our Licensees, should accelerate retirements and total licenses expiring every year over the next few years. Some older Licensees let their licenses expire, and do not retire them. We have seen the number of licenses issued per year stabilize for 2021-2023, but now expect that to decrease due to Covid-19 Pandemic. The total number of retired and expired licenses per year, almost matches new licenses issued per year."

The time frame between 2022 – 2026 should see total Licensees stabilized coming out of the pandemic. The regular turnover of Licensee's choosing to stop practicing in Oregon is offset with new graduates and individuals moving into Oregon, so that the total number of Licensees should be close to 8000 to 8100 from 2022 – 2026.

Estimated Starting Balance for 2023-2025 is anywhere between $900,000 to $1.3 million.
Our dental license period for ½ of our dentists concludes March 31. 2022. It is too soon to review the data and see if there will be a material impact on revenue, but we are conservatively estimating the renewals to be 1 - 3% lower than last year's renewal totals. We anticipated approximately 1800 dentists to renew their licenses.

Late July 2022 through Sept 2022 is the next license renewal period for ½ of our dental hygienists, which is approximately 2156 Licensees.

Estimated Ending Balance for 2023-2025 estimated to be $400,000 – $700,000.
Payroll adjustments higher, added inflation costs, technology support, additional transfers to the OHA for the PDMP, misc are driving up our operating expenses. This revenue forecast does not focus on expenses. That area will be addressed in more detail in the agency 2023-2025 budget request due later in the year.

Summary
The OBD like all state agencies is charged with being a good steward of its resources and also to plan for upcoming challenges. We should plan ahead with revenue expectations equal to the previous budget biennium in developing an accurate budget. I expect there to be revisions and changes as more information becomes available

Stephen Prisby
OBD Executive Director

Agency 834

Fund	Budget Obj	Budget Obj Title	2023 Monthly Activity	2023 Biennium to Date	2023 Budget
3400	1000	REVENUES	201,443.06	2,161,745.69	3,452,000.00
	2500	TRANSFER OUT	0.00	98,509.00	226,800.00
	3000	PERSONAL SERVICES	105,465.54	1,263,188.33	2,187,917.00
	4000	SERVICES AND SUPPLIES	43,094.86	715,532.84	1,671,337.00
3400 Total			**350,003.46**	**4,238,975.86**	**7,538,054.00**
Grand Total			**350,003.46**	**4,238,975.86**	**7,538,054.00**

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2023
Rpt Fiscal Mm	02
Rpt Fiscal Mm Name	AUGUST 2022
Load Date Gl	9/16/2022

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	1000	REVENUES	0205	OTHER BUSINESS LICENSES	195,250.00	1,849,500.50	3,100,001.00
				0210	OTHER NONBUSINESS LICENSES AND FEES	920.00	11,160.00	10,000.00
				0410	CHARGES FOR SERVICES	2,121.00	15,727.50	18,000.00
				0505	FINES AND FORFEITS	0.00	267,326.70	250,000.00
				0605	INTEREST AND INVESTMENTS	1,963.55	12,611.61	60,000.00
				0975	OTHER REVENUE	1,188.51	5,419.38	13,999.00
			REVENUES Total			**201,443.06**	**2,161,745.69**	**3,452,000.00**
		2500	TRANSFER OUT	2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	98,509.00	226,800.00
			TRANSFER OUT Total			**0.00**	**98,509.00**	**226,800.00**
		3000	PERSONAL SERVICES	3110	CLASS/UNCLASS SALARY & PER DIEM	71,287.48	857,858.69	1,397,859.00
				3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,400.00
				3170	OVERTIME PAYMENTS	0.00	292.89	6,400.00
				3190	ALL OTHER DIFFERENTIAL	563.35	10,409.75	39,836.00
				3210	ERB ASSESSMENT	19.20	240.00	464.00
				3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	12,668.39	135,926.76	236,896.00
				3221	PENSION BOND CONTRIBUTION	3,841.38	43,216.91	75,620.00
				3230	SOCIAL SECURITY TAX	5,455.78	65,949.16	111,384.00

Agency	834		
Agency Title	BOARD OF DENTISTRY		
Appn Year	2023		
Rpt Fiscal Mm	02		
Rpt Fiscal Mm Name	AUGUST 2022		
Load Date Gl	9/16/2022		
	Monthly Activity	Biennium to Date	Budget

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	3000	PERSONAL SERVICES	3250	WORKERS' COMPENSATION ASSESSMENT	16.83	194.99	368.00
				3260	MASS TRANSIT	411.56	5,013.96	8,834.00
				3270	FLEXIBLE BENEFITS	11,201.57	144,085.22	305,856.00
			PERSONAL SERVICES Total			**105,465.54**	**1,263,188.33**	**2,187,917.00**
		4000	SERVICES AND SUPPLIES	4100	INSTATE TRAVEL	1,504.15	13,557.25	52,968.00
				4125	OUT-OF-STATE TRAVEL	0.00	0.00	7,888.00
				4150	EMPLOYEE TRAINING	2,485.96	11,270.40	56,553.00
				4175	OFFICE EXPENSES	2,866.82	30,549.50	95,153.00
				4200	TELECOMM/TECH SVC AND SUPPLIES	1,449.12	16,690.84	25,997.00
				4225	STATE GOVERNMENT SERVICE CHARGES	829.05	42,647.62	73,273.00
				4250	DATA PROCESSING	5,503.18	44,790.58	186,234.00
				4275	PUBLICITY & PUBLICATIONS	1,154.69	2,466.31	15,494.00
				4300	PROFESSIONAL SERVICES	10,186.55	187,355.41	270,498.00
				4315	IT PROFESSIONAL SERVICES	0.00	0.00	148,013.00
				4325	ATTORNEY GENERAL LEGAL FEES	3,663.00	165,375.85	306,725.00
				4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	735.00
				4400	DUES AND SUBSCRIPTIONS	0.00	8,883.88	10,874.00
				4425	LEASE PAYMENTS & TAXES	7,721.18	88,369.33	186,798.00
				4475	FACILITIES MAINTENANCE	0.00	0.00	608.00
				4575	AGENCY PROGRAM RELATED SVCS & SUPP	519.35	23,438.62	107,494.00
				4650	OTHER SERVICES AND SUPPLIES	4,893.69	45,773.30	95,453.00
				4700	EXPENDABLE	0.00	0.00	6,087.00

Attachment #1

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2023
Rpt Fiscal Mm	02
Rpt Fiscal Mm Name	AUGUST 2022
Load Date Gl	9/16/2022

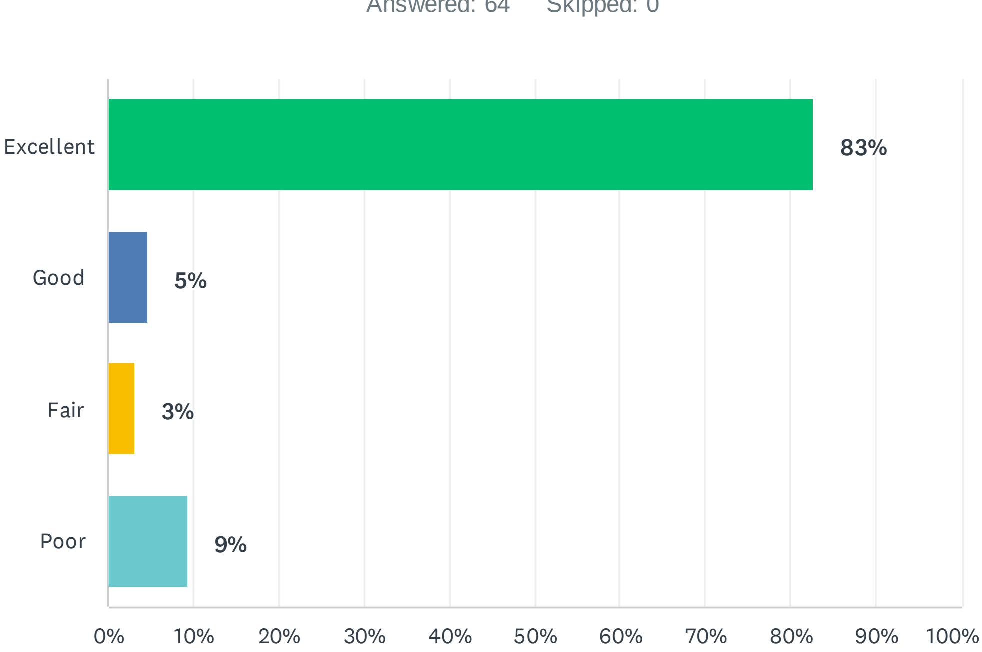
Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	4000	SERVICES AND SUPPLIES		PROPERTY $250-$5000			
				4715	IT EXPENDABLE PROPERTY	318.12	34,363.95	24,492.00
			SERVICES AND SUPPLIES Total			**43,094.86**	**715,532.84**	**1,671,337.00**

DAFR9210 Agency 834 - month end

Attachment #1

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

Answered: 64 Skipped: 0

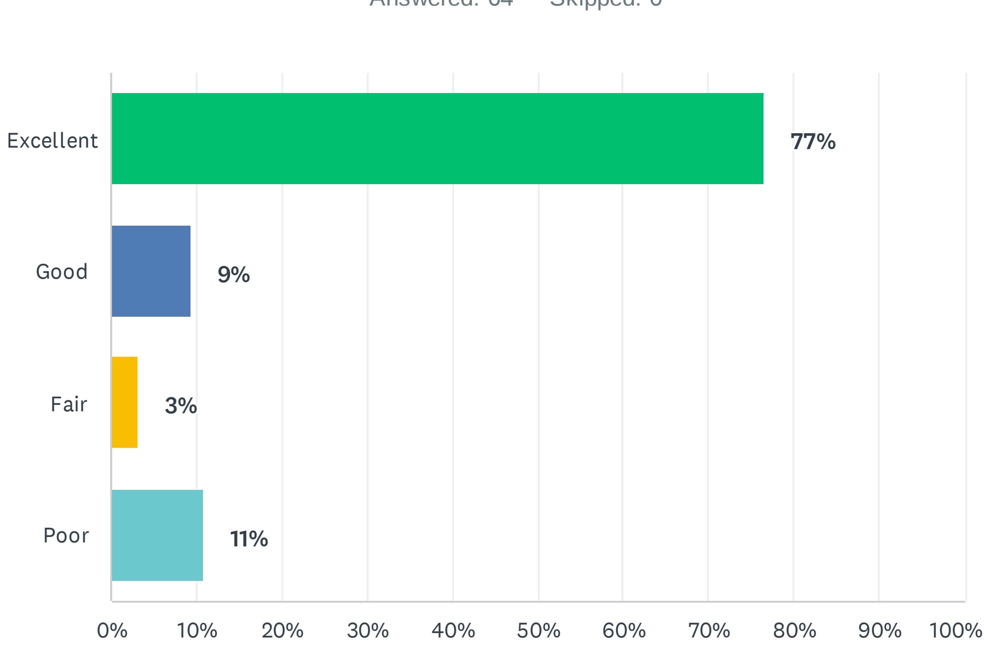


ANSWER CHOICES	RESPONSES	
Excellent	83%	53
Good	5%	3
Fair	3%	2
Poor	9%	6
TOTAL		64

Attachment #2

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

Answered: 64 Skipped: 0

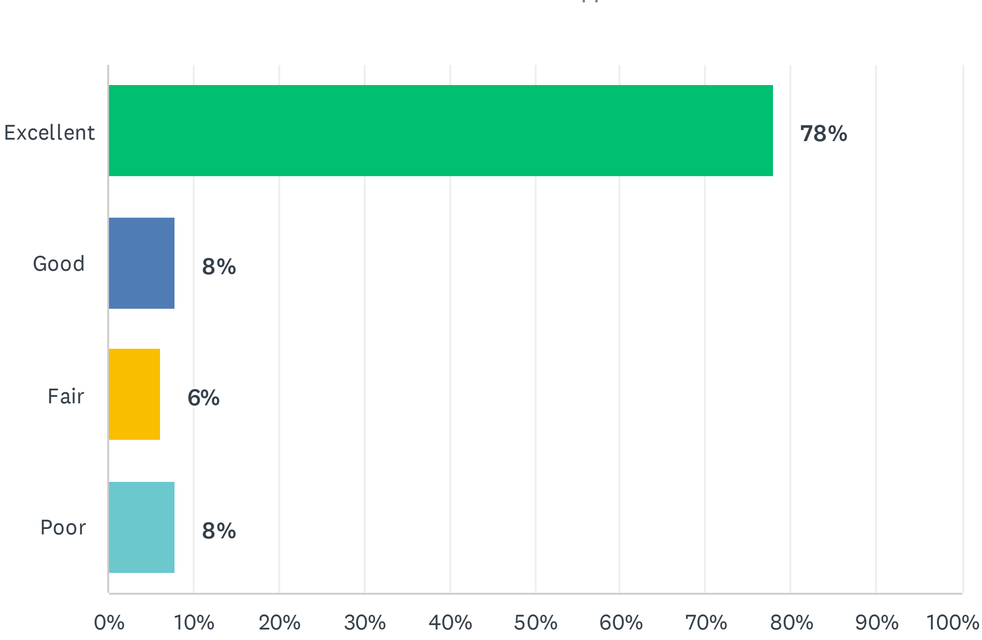


ANSWER CHOICES	RESPONSES	
Excellent	77%	49
Good	9%	6
Fair	3%	2
Poor	11%	7
TOTAL		64

Attachment #2

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

Answered: 64 Skipped: 0

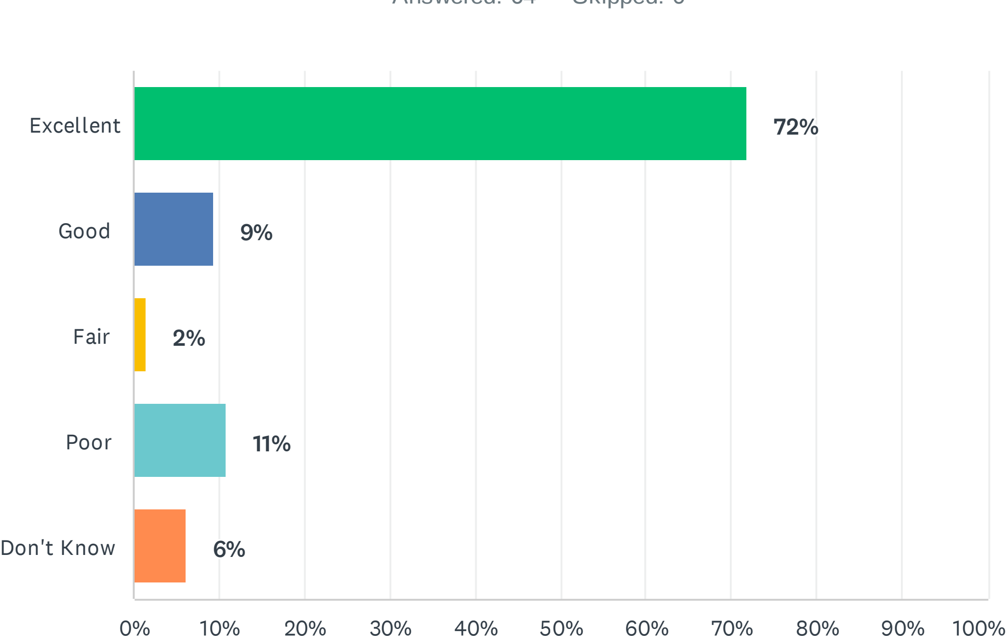


ANSWER CHOICES	RESPONSES	
Excellent	78%	50
Good	8%	5
Fair	6%	4
Poor	8%	5
TOTAL		64

Attachment #2

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

Answered: 64 Skipped: 0

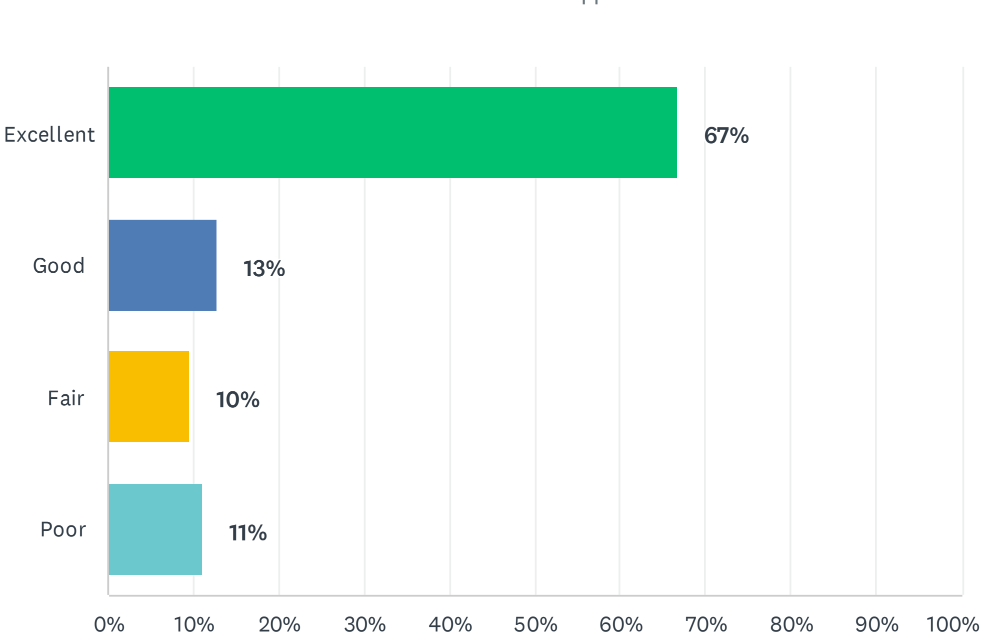


ANSWER CHOICES	RESPONSES	
Excellent	72%	46
Good	9%	6
Fair	2%	1
Poor	11%	7
Don't Know	6%	4
TOTAL		64

Attachment #2

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

Answered: 63 Skipped: 1

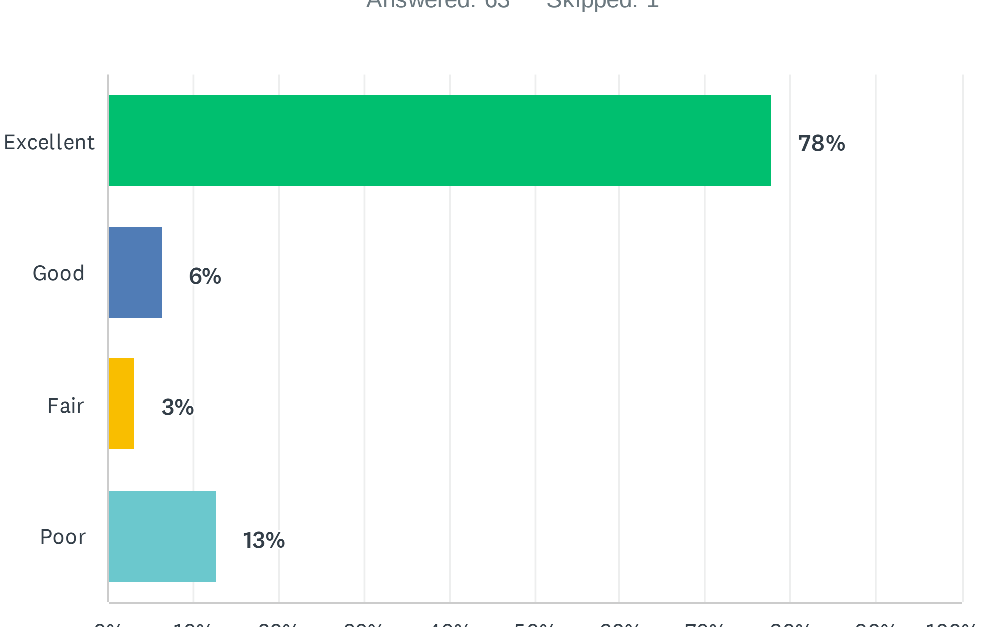


ANSWER CHOICES	RESPONSES	
Excellent	67%	42
Good	13%	8
Fair	10%	6
Poor	11%	7
TOTAL		63

Attachment #2

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

Answered: 63 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	78%	49
Good	6%	4
Fair	3%	2
Poor	13%	8
TOTAL		63

Dentistry, Board of

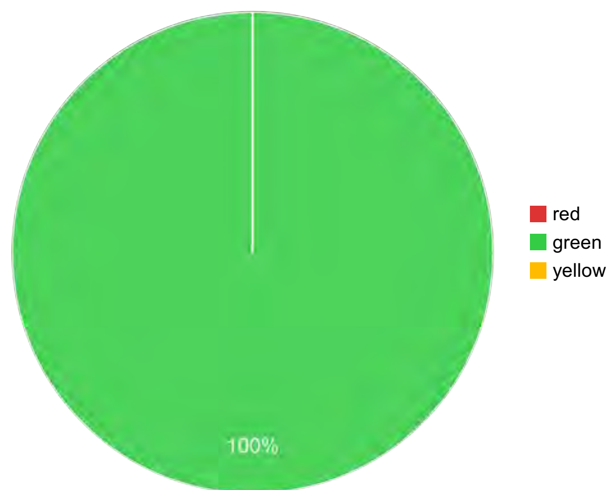
Annual Performance Progress Report

Reporting Year 2022

Published: 9/26/2022 1:19:18 PM

Attachment #3

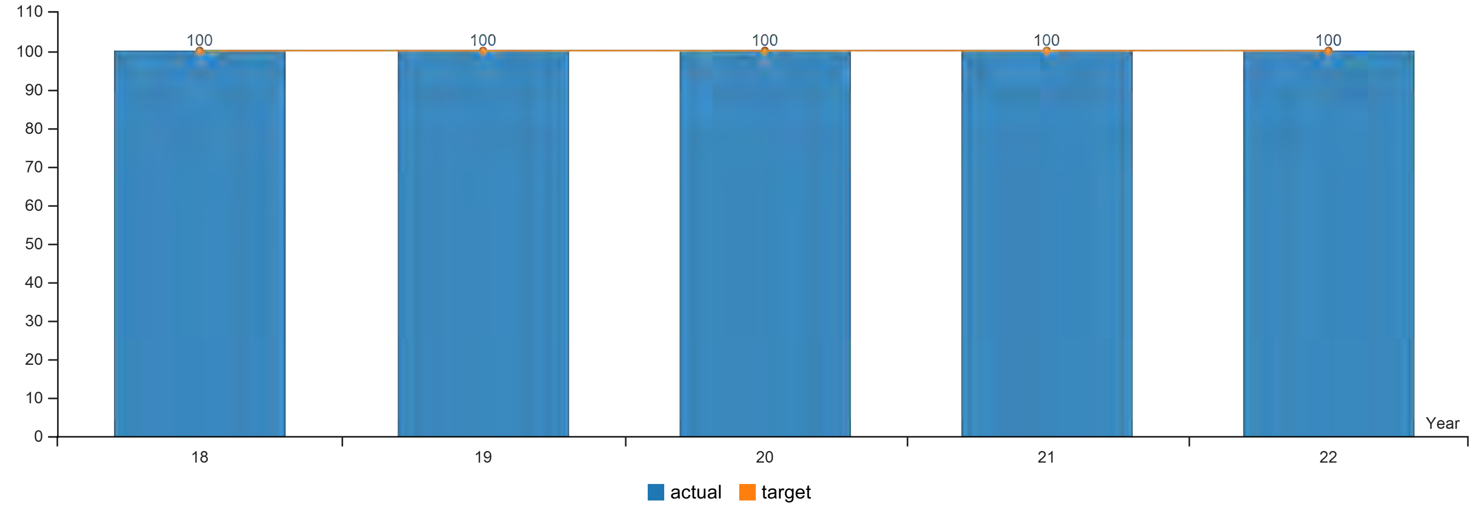
KPM #	Approved Key Performance Measures (KPMs)
1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
2	Time to Investigate Complaints - Average months from receipt of new complaints to completed investigation.
3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
4	Customer Satisfaction with Agency Services - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
5	Board Best Practices - Percent of total best practices met by the Board.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	100%	0%	0%

KPM #1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2018	2019	2020	2021	2022
Percent of Licensees in Compliance with Continuing Education Requirements					
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

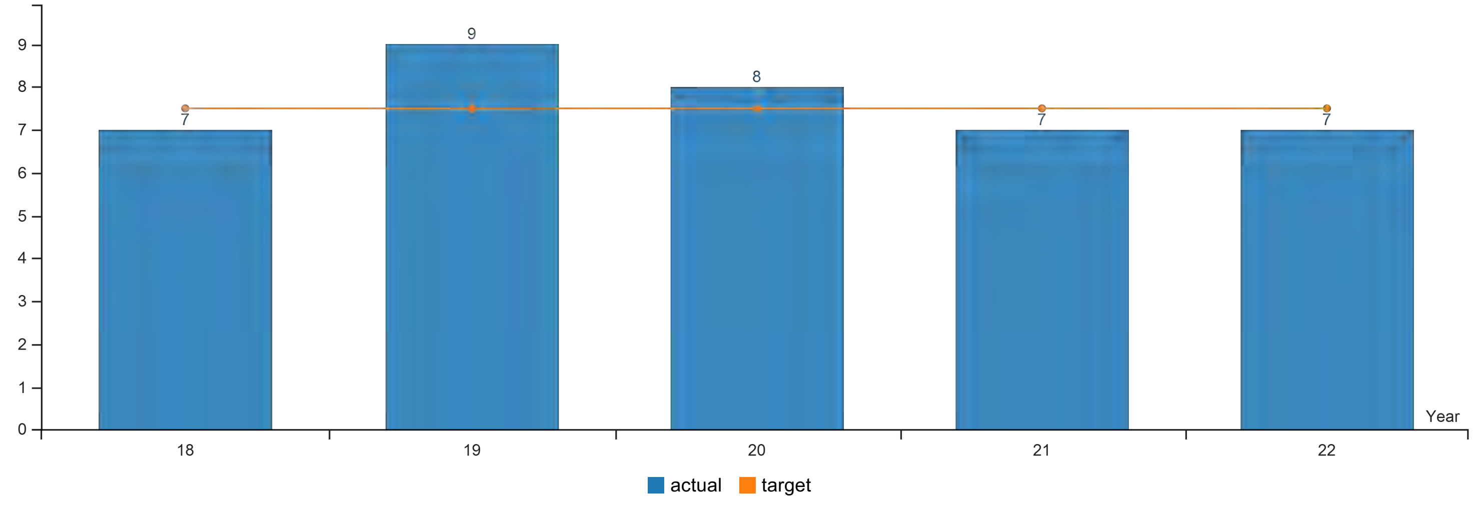
For FY 2022 we accomplished this goal by requiring our licensees complete and comply with continuing education requirements. The Board's view is that licensees should keep current on practice issues. One way to do this is to take continuing education courses during their two-year licensure period. The Board monitors their compliance with questions on their license renewal forms, it is requested in investigations and also verified in audits each renewal cycle. Board Staff follows up and ensures all licensees meet their CE requirement.

Factors Affecting Results

Board staff work with licensees to communicate the requirements to be in compliance with Board rules.

KPM #2	Time to Investigate Complaints - Average months from receipt of new complaints to completed investigation.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = negative result*



Report Year	2018	2019	2020	2021	2022
Average time to Investigate Complaints					
Actual	7	9	8	7	7
Target	7.50	7.50	7.50	7.50	7.50

How Are We Doing

For FY 2022 we accomplished this goal. The investigators worked hard to close the cases and the regularly scheduled Board meetings remained on schedule in spite of the pandemic. Due to the pandemic and the closure of dental offices for a period of time, the number of new cases dropped from the prior 12 month period. An investigation can sometimes take longer than usual because of a number of reasons: the number of treatment providers involved in the case, the complexity of the case, the timely responses of all involved and their cooperation as well.

Factors Affecting Results

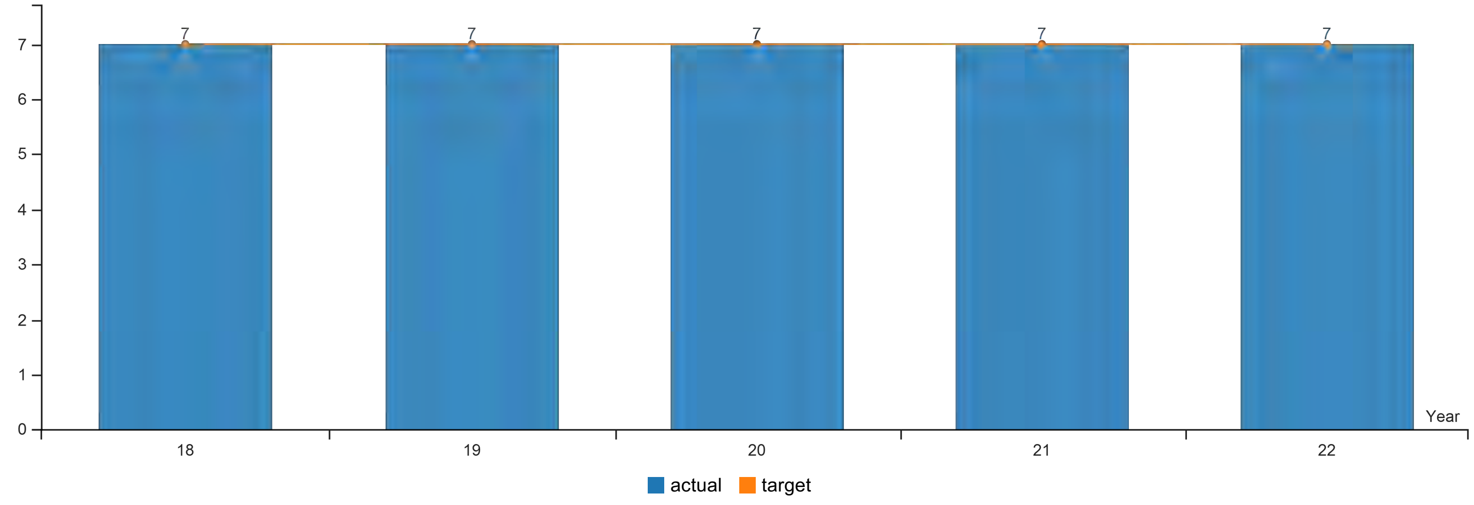
The total number of investigations opened in FY 2022 was 150 compared to 195 in FY 2021.

The number of cases closed in FY 2022 was 154 compared to 205 in FY 2021.

All new complaints are addressed quickly and investigated in a timely manner.

KPM #3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2018	2019	2020	2021	2022
Average Number of Working Days to Issue license after Paperwork is Completed.					
Actual	7	7	7	7	7
Target	7	7	7	7	7

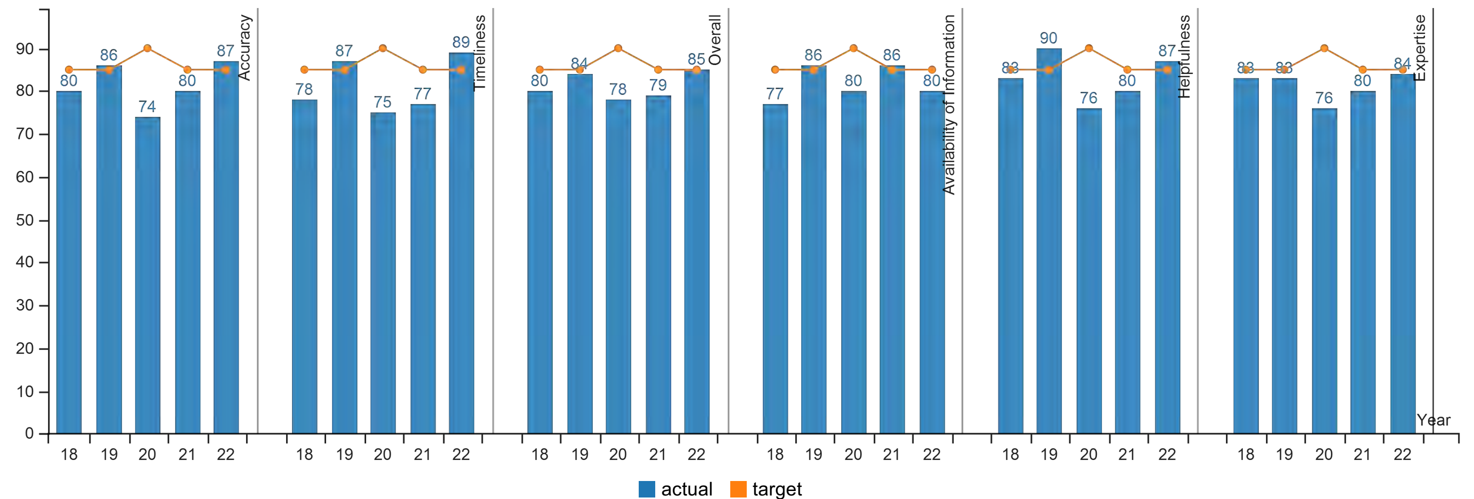
How Are We Doing

For FY 2022 we accomplished this goal. Although there were delays due to the pandemic and other agencies and entities working remotely. OBD Staff continued to work in the downtown Portland office and transitioned to a hybrid work model in spring of 2022. All staff were designated "essential personnel" back in March 2020 and remain so at the time of this report. Once all required documentation and paperwork is completed, then licenses were issued with minimal delay due to OBD Staff.

Factors Affecting Results

It is one of our priorities that applications and renewals be processed accurately and efficiently. The delay in processing (not issuing) was due to a number of factors beyond OBD Staff control: US Postal Service delays, schools delaying classes and transmitting transcripts, testing agencies modifying tests and other issues due to the pandemic.

KPM #4	Customer Satisfaction with Agency Services - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2018	2019	2020	2021	2022
Accuracy					
Actual	80%	86%	74%	80%	87%
Target	85%	85%	90%	85%	85%
Timeliness					
Actual	78%	87%	75%	77%	89%
Target	85%	85%	90%	85%	85%
Overall					
Actual	80%	84%	78%	79%	85%
Target	85%	85%	90%	85%	85%
Availability of Information					
Actual	77%	86%	80%	86%	80%
Target	85%	85%	90%	85%	85%
Helpfulness					
Actual	83%	90%	76%	80%	87%
Target	85%	85%	90%	85%	85%
Expertise					
Actual	83%	83%	76%	80%	84%
Target	85%	85%	90%	85%	85%

How Are We Doing

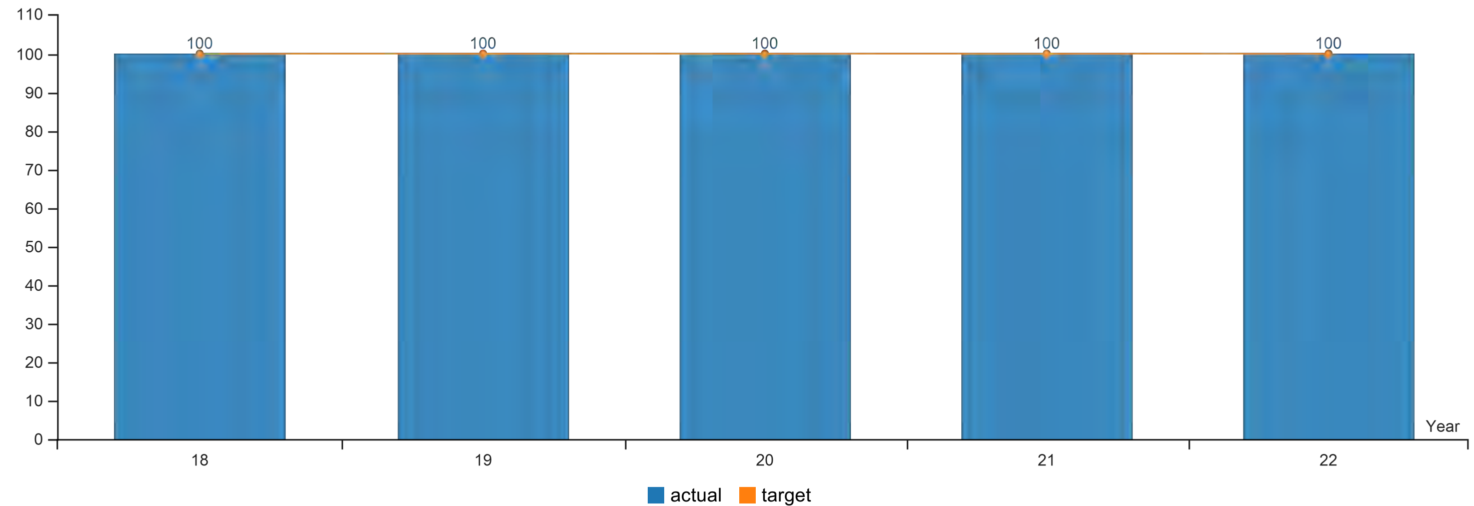
For FY 2022 we had better results overall than last year. In compliance with the Oregon Legislatures directive, the Board conducts a Customer Service Survey as one tool to determine the customer satisfaction with the accuracy of carrying out the statutory requirements and Mission of the Board.

Factors Affecting Results

People choose to respond to surveys and we will continue to promote the survey and encourage feedback. We receive direct feedback outside the survey and it is good to know how the OBD's actions are impacting others and the information received is always useful.

KPM #5	Board Best Practices - Percent of total best practices met by the Board.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2018	2019	2020	2021	2022
Compliance with Best Practices Performance Measurement					
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

For FY 2022 the Board accomplished this goal. Annually at the August Board Meeting the Board reviews these metrics and conducts the performance review of the Executive Director. The Board is in 100% compliance with Best Practices Performance Measurements for Governing Boards and Commissions.

Factors Affecting Results

The Board Members are engaged and dedicated to their responsibilities, duties and obligations serving Oregon in their capacity. The Board reviewed the Board Best Practices at its August 19, 2022 Board Meeting.

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	15	
Percentage of total:	100%	

At the August 19, 2022 Board Meeting, the Board reviewed the best practices self-assessment documents and unanimously agreed that all Best Practices were met for fiscal year 2022.

Health Professionals' Services Program Summary Annual Report
Highlights of Year Twelve 7/1/2021-6/30/2022

The purpose of this report is to provide a summary of the highlights of the twelfth 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, 2021, through June 30, 2022.

Table 1: Enrollment Overview: Year 12

Enrollment Overview: Year 12 (7/1/21 - 6/30/22)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 11 (6/30/21)	12	62	19	87	**180**
Enrolled: Board Referral*	3	13	2	9	**27**
Enrolled: Self-Referral*	0	0	0	2	**2**
Successfully Completed	2	16	8	22	**48**
Terminations	0	9	0	4	**13**
Total Enrolled End of Year 12 (6/30/22)	**13**	**50**	**13**	**72**	**148**
Referred but Not Enrolled/Inquiry Only	*0*	*3*	*0*	*8*	*11*

**Referral Type at the time of enrollment*

Table 1 provides a summary of year twelve 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 twelve 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 eleven enrollment (see next page).

At the end of year twelve, the program had 148 participants, a 17.8% decrease from the 180 participants at the beginning of the year. Total enrollment decreased because the number of completions (48) and terminations (13) when combined (61), was greater than the 29 new enrollees (27 board referrals plus 2 self-referrals). The total completions and terminations this year (61) is comparable to those last year (62 completions and terminations in year eleven), however the new referrals continued to decline in year twelve (36 versus 29 in year eleven).

Decreasing enrollment has been a trend over the past several years, however, due to the ongoing COVID-19 pandemic, we expected to see an increase in enrollment (whether board or self-referred) in year twelve. We know that symptoms of mental health and substance use disorders have continued to increase over the past year, both in the general population and among healthcare professionals specifically. We also know that healthcare professionals, especially those who have

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worked on the “front lines” of providing care for COVID patients, are experiencing burnout at a significant rate, which can lead to new or worsening symptoms of mental health and substance use disorders. We are concerned that the continued decline in enrollment may indicate that there are more healthcare professionals suffering in secret and not being identified or getting help.

Another contributing factor to the ongoing decrease in enrollment may also be that more healthcare licensees are being referred for public discipline (i.e., license suspension or revocation) rather than the alternative to discipline. This may be due to infractions being more egregious than in years past, or the fact that licensing boards are by nature dynamic bodies, whose discipline-related decisions may be more or less conservative at any given time depending on the makeup of the board.

The number of people who inquired about HPSP as self-referrals, but did not enroll, was much greater in year twelve than in year eleven (11 versus four). About half of these were calls from people who were ineligible for HPSP due to license status, and they were referred to Uprise Health’s Extended Monitoring Program. The other five inquiries were from physicians who were interested more in peer support and counseling than monitoring services (none of these endorsed any patient safety concerns or on the job impairment) and were connected with other community resources.

Finally, we continued our trend of successful completions far outweighing terminations in year twelve. Participants were more than 3.5 times more likely to successfully complete the program versus being dismissed without successful completion. This continues to underline the overall success of the program in demonstrating that the majority of participants will complete successfully.

Table 2: 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 (6/30/21)	**12**	**62**	**19**	**87**	**180**
Referred but Not Enrolled/Inquiry Only	*0*	*1*	*0*	*3*	*4*

**Referral Type at the time of enrollment*

Report continued next page

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Table 3: Case Disposition (7/1/10 – 6/30/22)

Case Disposition as of 6/30/22	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled	**52**	**611**	**67**	**343**	**1073**
Number Successfully Completed	27	309	38	205	579
Number Active	13	50	13	72	148
Total Successful (Active + Completions)	40	359	51	277	727
Percentage Successful	**77.0%**	**58.8%**	**76.1%**	**80.8%**	**67.8%**
Number Termed	12	252	16	66	346
Percentage Unsuccessful	**23.0%**	**41.2%**	**23.9%**	**19.2%**	**32.2%**

Table 3 displays the cumulative data on the disposition of cases since the program's inception. To date, 1,073 licensees have enrolled, and 579 of these have completed; an additional 148 are on track to complete for a total of just under 68% (similar to year eleven). The percentage of successful completion ranges across the Boards from 58.8% (Board of Nursing), to 76% (Board of Pharmacy), 77% (Board of Dentistry) and 81% (Medical Board.)

Unfortunately, 346 licensees have been terminated. These cases include situations where HPSP and the Boards acted to protect public safety. The Board of Nursing has consistently had the highest number of program terminations, which is likely because they are the only board running their own, separate, probation program. One-third of Board of Nursing licensees whose participation was terminated were moved instead to public discipline (probation).

Uprise Health continues to recommend introducing discussions around adding peer support elements to the monitoring requirements or recommendations for Board of Nursing participants. This is empirically proven to increase success in monitoring programs nationwide and is used with HPSP participants licensed by the Oregon Medical Board.

Table 4: Video/In-Person Contacts

Video/In-Person Contacts: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Video/In-Person Contacts (including Intakes)	1	9	1	11	**22**
Number of Video/In-Person Intakes	1	3	0	4	**8**
Total Enrolled During Year 11	3	13	2	11	**29**
Percent with Video/In-Person Intakes	33.3%	23.0%	0.0%	36.4%	**27.6%**

During year twelve, HPSP Agreement Monitors met via video conference with a total of 22 licensees, eight for intakes and the other 29 for annual reviews. The Medical Board had 11 licensees meet with their agreement monitor via video conference and the Board of Nursing had nine. The Boards of Pharmacy and Dentistry each had one licensee participate in a video conference. The video conference intakes account for 27.6% of the intakes completed during year twelve; up from 14% last year.

All participants are offered the opportunity to complete their intake via video conference, and Agreement Monitors universally report a better intake experience when completed via video versus over the phone. We will continue to strive to increase the number of video conferences conducted for intakes and annual reviews in the next year.

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Table 5: Program Termination Reasons

Termination Reasons: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Deceased	0	0	0	0	**0**
Inappropriate Referral (Determined after Enrollment)	0	0	0	0	**0**
License Inactivated	0	0	0	0	**0**
License Retired	0	2	0	0	**2**
License Revoked	0	2	0	0	**2**
License Surrendered	0	2	0	3	**5**
License Suspended	0	0	0	1	**1**
Probation	0	3	0	0	**3**
TOTAL	**0**	**9**	**0**	**4**	**13**

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 13 licensees were terminated from the program in year twelve, a significant decrease from 21 last year. A total of four Medical Board licensees were terminated, three due to surrendered licenses and one due to suspended license. The Board of Nursing had nine terminations: two due to surrendered licenses, three due to transfer to probation, two due to a revoked license and two due to a retired license. No Board of Pharmacy or Board of Dentistry participants were termed from the program this year. 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 12)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Formally Not Participating (But Not Suspended)	0	3	0	0	**3**
Suspended: Board Request	0	0	0	0	**0**
Suspended: Expired License	0	2	0	0	**2**
Suspended: Health - Severe Issues	0	1	0	1	**2**
Suspended: Incarcerated	0	0	0	1	**1**
Suspended: Non-Compliance - Financial	0	0	0	0	**0**
Suspended: Per Board, Open HPSP But Not Participating	0	0	0	0	**0**
TOTAL	**0**	**6**	**0**	**2**	**8**

Table 6 details the eight licensees who were "formally not participating" at any time during year twelve. 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, two were suspended due to expired licenses, and three were formally not participating (but not suspended). The Medical Board

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had one licensee suspended due to severe health issues 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, as in year eleven.

No licensees were suspended or formally not participating at the end of year twelve.

Table 7: Licensees Formally Not Participating at the End of the Year

Licensees Formally Not Participating (At End of Year 12)	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					
Suspended: Non-Compliance - Financial					0
Suspended: Per Board, Open HPSP But Not Participating					0
TOTAL	0	0	0	0	0

Table 8: Non-Compliance Reports by Licensee

Non-Compliance Reports by Licensee: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Non-Compliance Reports	14	95	0	30	139
Total Non-Compliance Reports as a Percentage of Average # of Licensees Enrolled in Year 12	107.7%	161.0%	0.0%	38.5%	83.2%
# of Licensees with NC Reports	6	19	0	12	37
# of Licensees with NC Reports as a Percentage of Average # of Licensees Enrolled in Year 12	46.2%	32.2%	0.0%	15.4%	22.2%
# of Licensees with >1 NC report	2	4	0	2	8
# of Licensees with >3 NC report	1	7	0	2	10

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 breakdown 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 22.2% for year twelve, meaning that less than a quarter of licensees had a non-compliance report at some point during the year. This figure is down from 28.5% the prior year. This figure ranged from 46.2% (Board of Dentistry) to 0.0% (Board of Pharmacy).

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A total of 37 licensees had one or more non-compliance reports this year, a decrease from 55 last year. A total of 139 non-compliance reports were submitted this year, also a decrease from the 167 last year. The Board of Nursing licensees had 95 reports this year; 31 of these, though, were for just one licensee (one-third of all OSBN reports). The Medical Board had 30 non-compliant reports this year, the Board of Dentistry had six, and the Board of Pharmacy had zero. Ten licensees across all four boards had more than three non-compliant reports submitted, ranging from no (0) Board of Pharmacy licensees to seven Board of Nursing licensees.

The total number of non-compliance reports submitted as a percentage of the average number of enrolled licensees was 83.2%, a decrease from last year's 86.5%.

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**
Year 12 (7/1/21 – 6/30/22)	0	0	0	3	**3**
TOTAL	**1**	**11**	**0**	**58**	**70**

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, only the Medical Board had any licensees (three) in this category.

Report continued next page

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Table 10: Non-Compliance Reasons

Non-Compliance Reasons*: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Failure to Enroll	1	0	0	0	**1**
Failure to Participate: Missed AM Check-in	0	3	0	0	**3**
Failure to Participate: Missed IVR Call**	2	33	0	7	**42**
Failure to Participate: Missed Test (includes failure to provide specimen)	4	51	0	9	**64**
Failure to Participate: Non-Payment	0	0	0	0	**0**
Failure to Participate: Other	2	8	0	5	**15**
Hospitalization	0	0	0	0	**0**
Violated Restriction on Practice	0	0	0	0	**0**
Positive Non-Uprise Health Test	0	2	0	1	**3**
Positive Toxicology Test	7	39	0	13	**59**
Impaired in a Health Care Setting in the Course of Employment (including admitted substance use & diversion of medications)	0	0	0	0	**0**
Impaired Outside of Employment (including admitted substance use & diversion of medications)	0	4	0	4	**8**
Public Endangerment	0	0	0	0	**0**
Criminal Behavior (including DUI)	0	0	0	0	**0**
Unapproved Use of Prescription Medication	0	0	0	0	**0**
TOTAL	**16**	**142**	**0**	**39**	**197**
Unique Licensees with 1 or More Non-Compliance Reports	***6***	***19***	***0***	***12***	***37***

** There may be more than 1 reason per report*

*** "IVR Call" refers to all forms of daily testing check-in, including the IVR, mobile app, and web portal*

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 64 reports, down from 92 last year. Failure to test has been the most frequent reason for a non-compliance report for the past nine years. Positive toxicology tests, missed IVR calls, 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. It is important to note that of the Board of Nursing's 39 positive toxicology reports, 15 of those were for one licensee testing positive for THC.

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Table 11: Non-Negative Toxicology Tests

Non-Negative Toxicology Tests: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Invalid Tests	0	1	0	2	**3**
Positive Tests (non-negative results)	6	42	0	13	**61**
Total Non-Negative Tests (Positive + Invalid)	**6**	**43**	**0**	**15**	**64**
Positive Tests as a Percentage of Average # of Licensees Enrolled in Year 12	46.2%	72.9%	0.0%	19.2%	**38.3%**
Number of Licensees with a Positive Test	3	11	0	4	**18**
Number of Licensees with a Positive Test as a Percentage of Average # of Licensees Enrolled in Year 12	23.0%	18.7%	0.0%	5.1%	**10.8%**

Table 11 shows the number of invalid and positive toxicology tests per board. These include urinalysis (UA), hair, and blood tests. We are very pleased to report that there were only three invalid tests in year twelve, down substantially from 38 in the previous year. This is due to the fix that Medtox/Labcorp implemented in June 2022 to reduce the number of invalid results.

There were a total of 61 positive toxicology tests during year twelve, up slightly from 54 last year. Forty-three of these were from the Board of Nursing, 13 from the Medical Board, and six from the Board of Dentistry. The Board of Pharmacy licensees did not have any positive tests this year. 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 38.3% of the average number of enrolled licensees, an increase from last year's 28%. The boards ranged from a low of 19.2% (Medical Board) to a high of 72.9% (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 10.8%, nearly identical to last year's 10.9%. The Board of Nursing's percentage is 18.7% based on 11 licensees with positive tests. This is followed by the Board of Dentistry with 23.0% (three licensees), then Medical Board with 5.1% (four licensees) and finally the Board of Pharmacy with no positive tests.

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Table 12: Drugs Resulting in Positive Tests

Drugs Resulting in Positive Tests: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
amphetamines / methamphetamines	0	1	0	3	**4**
cocaine metabolite	0	1	0	0	**1**
ethyl glucuronide (ETG)	2	14	0	4	**20**
ethyl glucuronide (ETG) – PETH	4	9	0	6	**19**
marijuana metabolite (THC)	0	17	0	0	**17**
opioids (narcotics/opiates)	0	0	0	0	**0**
TOTAL	**6**	**42**	**0**	**13**	**61**
Number of Licensees with a Positive Test	***3***	***11***	***0***	***4***	***18***

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 Medical Review Officer (MRO) due to a valid prescription. As we have seen historically, the largest number of positive urine tests was for alcohol (ethyl glucuronide (ETG). This year positive ETG tests accounted for 32.8% of the positive tests (20 positives). Alcohol metabolites identified through a PEth (blood) test rather than a urine toxicology screen accounted for an additional 31.1% of the positive tests (19). Thus, nearly two-thirds (64% or 39) of the positive tests were due to alcohol consumption. This represents a significant increase from last year (50% or 27). This may be correlated with the overall nationwide increase in alcohol use due to the COVID pandemic. The next most frequently found substance this year was marijuana metabolite with 27.9% of the positives (17 tests), nearly identical to last year (27.8% or 15 tests).

Table 13: Missed Test Details – Breakdown by Reason

Missed Test Breakdown by Reason: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
No Call	1	58	0	6	**65**
No Show	3	23	0	2	**28**
Refused	0	0	0	1	**1**
TOTAL	**4**	**81**	**0**	**9**	**94**

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 was one "refusal" this year, from the Medical Board.

There were a total of 94 missed tests this year compared to 127 last year. The majority (65) of misses were due to No Call while 28 were due to No Show. This means that many 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, 81 of the missed tests were missed by Board of Nursing licensees, nine by Medical Board licensees, and four by the Board of Dentistry licensees. The Board of Pharmacy had no licensees who missed a test this year. Although there

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were 94 missed tests, note that there are only 64 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 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Number of Missed Tests	4	81	0	9	**94**
Number of Licensees with a Missed Test	4	11	0	8	**23**
Licensees with a Missed Test as a Percentage of Average # of Licensees Enrolled in Year 12	30.8%	18.6%	0.0%	10.3%	**13.8%**

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, 23 licensees were responsible for the 94 missed tests, an average of approximately four missed tests per licensee.

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 13.8%. The Board of Dentistry was highest with 30.8%, meaning that about a third of licensees missed at least one test. The Board of Nursing had 18.6% of licensees miss a test (less than 1 in 5 licensees missed a test), and the Medical Board had 10.3% (a tenth of licensees). The Board of Pharmacy did not have any licensees miss scheduled tests.

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Table 15: Workplace Safe Practice Reports

Workplace Safe Practice Reports: Year 12	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Licensees who had Reports Submitted	15	61	17	76	**169**
Number of Reports Received / Reviewed	142	493	132	770	**1,537**
Percentage of Required Reports Received	90.4%	92.0%	84.6%	93.8%	**92.0%**
Number of Reports Received with Concerns Noted	0	2	2	1	**5**
Percentage of Reports with Concerns Noted	0.0%	0.4%	1.5%	0.1%	**0.3%**
Percentage of Reports in which Noted Concerns were Addressed	N/A	100%	100%	100%	**100%**
Number of Licensees with a Report with Concerns Noted	0	1	1	1	**3**
Number of Licensees with Concerns Reported who also had a NC report	0	1	0	0	**1**

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, 92.0% of the required reports were received with a total of 1,537 reports received and carefully reviewed for 169 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 three such reports this year, with one each from licensees of the Board of Nursing, Board of Pharmacy, and the Medical Board. The Board of Dentistry 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. Only one of the three *did* have a non-compliance report on record. HPSP Agreement Monitors are in regular contact with workplace monitors and are nearly always alerted to possible workplace concerns prior to the monthly report being due.

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What's Next? Year Thirteen

We are pleased to demonstrate that HPSP remains a strong alternative to discipline option for Oregon health professionals. We saw decreases in positive toxicology, non-compliance reports, missed tests, and invalid tests. We also saw an increase in successful completions. We doubled the number of video conference intakes that were completed this year. We continue to experience an ongoing decrease in enrollment, and we want to affirm that HPSP remains ready to accommodate an increase in board and self-referrals.

Uprise Health did experience a correction in our workforce in March 2022; however, this did not lead to any disruptions in service delivery. Our team remains strong, knowledgeable, and committed to serving our licensees and stakeholders. COVID-19 continues to present unique challenges to monitoring, such as test sites with reduced hours and longer wait times. One area we would like to discuss this coming year is the possibility of adding at-home testing to our toxicology services. These tests are DNA-verified and/or video monitored and would likely increase overall adherence to testing schedules. This would also allow participants to test seven days a week, 365 days a year.

Finally, we are looking forward to a new partnership with RecoveryTrek for third-party administration of toxicology testing and billing. The RecoveryTrek participant portal will allow greater access to collection site information as well as provide the ability for new monitoring tools (including monthly monitoring forms, documented self-help meeting check ins, and ease of uploading required documentation). We anticipate that this new software will increase monitoring compliance and participant satisfaction in year thirteen.

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July 26, 2022

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Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction Report

Year 12 Annual Report: January and July 2022 Surveys

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Attachment #4

Executive Summary

Health Professionals' Services Program Satisfaction Survey: Year 12 Annual Report

Overview: This Health Professionals' Services Program report reviews the satisfaction survey results for the twelfth year of the program. Surveys were sent at the beginning of both January and July 2022 to the following groups of stakeholders: Licensees, Workplace Monitors, Providers (GMC/PMCs and third-party evaluators), and Professional 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 12	Licensees	Workplace Monitors	Providers (GMC/PMC/3rd Party Evaluators)	Health Associations
# Sent	296	264	48	36
# Of Responses	44	8	9	0
Response Rate	14.9%	3.0%	18.8%	0.0%

Response rates continued to remain low among all respondent pools, most significantly Workplace Monitors and licensees. We are acutely aware of the ongoing effects of the COVID-19 pandemic on stress levels, burnout, and workload, and we believe this may be a contributing factor. Uprise Health will continue to consider ways to increase response level from all respondent pools.

Highlights

- Licensee responses were received from all four boards:
    - Over 95% of respondents "agree" or "strongly agree" that they understand the program's statutory monitoring requirements
    - A majority feel that they are treated with dignity (77.3%) and respect (72.7%).
    - 81.8% feel that the program requirements are clearly explained.
    - 95.4% feel that HPSP provides a "significant amount" or between a "significant amount" and "some" structure. 100% of respondents feel this way about the program's accountability.
    - A minimum of 81% of respondents "agree" or "strongly agree" that:
        - 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 68% of respondents and, of those, 68% find it "useful" or "extremely useful."
    - 86.4% rated HPSP as "excellent," "above average," or "average."
- 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.
    - 89% 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, 55% provided an excellent rating.
- Responses were received from Workplace Monitors for licensees from each board:
    - 100% of workplace monitor respondents indicated that they are satisfied with Uprise Health's support in their role as a workplace monitor.
    - Uprise Health's ability to monitor licensees to ensure safety in the workplace is also endorsed by 100% of monitors.
    - "Excellent" was the most frequent response to the items rating Uprise Health'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.
    - 100% rated their overall experience working with Uprise Health as "excellent," "above average," or "average."

- While 18 members of professional healthcare associations were surveyed twice this year, no responses were received. Uprise Health will continue to foster relationships with these important stakeholders in the coming year.

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

Uprise Health Monitoring
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, Uprise Health 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 Uprise Health 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, Uprise Health 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 Uprise Health 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 12	Year 11	Year 10	Year 9	Year 8
# Sent	140	296	354	387	383	403
# Of Responses	19	44	55	65	80	99
Response Rate	13.6%	14.9%	15.5%	16.8%	20.1%	24.6%

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

The survey was emailed to 129 licensees and mailed to 11 this period, for a total of 140 surveys distributed. A total of 19 responses were received, representing a response rate of 13.6%. This continues the years-long trend of decreasing responses.

For the year, a total of 296 surveys were distributed with 44 responses received, bringing the response rate to 14.9%, approximately half a percentage point lower than in year eleven. 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. The next highest percentage of responses is from the Board of Nursing, followed by the Board of Dentistry, and finally the Board of Pharmacy. It is encouraging to see representation from all four boards.

Data Table 2:

Table 2: Respondents by Board	This Period (n=19)		Year 12 (n=44)		Year 11 (n=55)	
	#	%	#	%	#	%
Medical Board	10	52.6%	24	54.5%	30	54.5%
Board of Nursing	4	21.1%	12	27.3%	13	23.6%
Board of Dentistry	4	21.1%	7	15.9%	6	10.9%
Board of Pharmacy	1	5.2%	1	2.3%	5	9.1%
No Response	0	0.0%	0	0.0%	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 13.6% so that any skew in the data can be identified. In this case, responses are skewed toward the Board of Dentistry and away from the Boards of Nursing and Pharmacy. Medical Board response rates are in line with overall response rates.

Data Table 3:

Table 3: Response Rate by Board This Period	Number Surveyed	Number of Respondents	Response Rate
Medical Board	67	10	14.9%
Board of Nursing	47	4	8.5%
Board of Dentistry	13	4	30.8%
Board of Pharmacy	13	1	7.7%

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 approximately 95% 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 (after six tests in the first six months). (See Data Table 4).

Data Table 4:

Table 4: Participating in Toxicology Program?	This Period (n=19)		Year 12 (n=44)		Year 11 (n=55)	
	#	%	#	%	#	%
Yes	18	94.7%	42	95.5%	49	89.1%
No	1	5.3%	2	4.6%	4	7.3%
No Response	0	0.0%	0	0.0%	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).	95.5%	4.5%
The program treats me with dignity.	77.3%	22.7%
The program treats me with respect.	72.7%	27.3%
The program requirements are clearly explained.	81.8%	18.2%

Importantly, over 95% 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 (77.3%) and respect (72.7%). Finally, more than 80% of respondents 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 understanding of requirements and being treated with respect, and "agree" for being treated with dignity and feeling that requirements are clearly explained.

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%	**10**	**52.6%**	1	5.3%	0	0.0%	0	
The program treats me with dignity.	5	26.3%	**10**	**52.6%**	4	21.1%	0	0.0%	0	
The program treats me with respect.	**8**	**42.1%**	7	36.8%	4	21.1%	0	0.0%	0	
The program requirements are clearly explained.	7	36.8%	**10**	**52.6%**	1	5.3%	1	5.3%	0	

Table 5b: Year 12 (n=44)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	**23**	**52.3%**	19	43.2%	2	4.5%	0	0.0%	0	
The program treats me with dignity.	14	31.8%	**20**	**45.5%**	10	22.7%	0	0.0%	0	
The program treats me with respect.	**17**	**38.6%**	15	34.1%	12	27.2%	0	0.0%	0	
The program requirements are clearly explained.	15	34.1%	**21**	**47.7%**	5	11.7%	5	6.8%	0	

Table 5c: 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%	0	0.0%	0	
The program treats me with dignity.	**23**	**41.8%**	19	34.6%	9	16.4%	4	7.3%	0	
The program treats me with respect.	22	40.0%	22	40.0%	7	12.7%	4	7.3%	0	
The program requirements are clearly explained.	20	36.4%	**23**	**41.8%**	10	18.2%	2	3.6%	0	

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 84.1% for structure and 90.9% for accountability.

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	**11**	**57.9%**	6	31.6%	1	5.3%	1	5.3%	0	0.0%		
The amount of accountability the program provides	**15**	**79.0%**	3	15.8%	1	5.3%	0	0.0%	0	0.0%		

Table 6b: Year 12 (n=44)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**25**	**56.8%**	12	27.3%	5	11.4%	2	4.5%	0	0.0%		
The amount of accountability the program provides	**32**	**72.7%**	8	18.2%	4	9.1%	0	0.0%	0	0.0%		

Table 6c: 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%		

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	72.7%	27.3%
My questions and/or concerns are addressed fully within the structure of the program	81.8%	18.2%
Information is communicated clearly and professionally	88.6%	11.4%
My Agreement Monitor is knowledgeable about my case.	93.2%	6.8%

The clear majority of respondents positively endorsed each item, indicating overall satisfaction with all areas of communication. We experienced a concerning decrease in satisfaction regarding the first item, indicating that while the majority of respondents are continuing to experience their questions and/or concerns being addressed within one business day, over a quarter of respondents experienced a longer response time. This is not acceptable to Uprise Health and immediate steps have already been taken to remedy this. We expect a significant increase in this rating at the time of the next satisfaction survey, in January, 2023.

However, we did experience an increase in the percentage of repondents who "strongly agreed" or "agreed" that their Agreement Monitor is knowledgable about their case (93.2% this year compared with 87.3% last year). 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 split evenly among "strongly agree" and "agree," and was "strongly agree" for the second two 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	7	36.8%	7	36.8%	4	21.1%	1	5.3%		
My questions and/or concerns are addressed fully within the structure of the program	8	42.1%	8	42.1%	3	15.8%	0	0.0%		
Information is communicated clearly and professionally	**9**	**47.4%**	8	42.1%	2	10.5%	0	0.0%		
My Agreement Monitor is knowledgeable about my case	**13**	**68.4%**	4	21.1%	1	5.3%	1	5.3%		

Table 7b: Year 12 (n=44)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	13	29.5%	**19**	**43.2%**	11	25.0%	1	2.3%		
My questions and/or concerns are addressed fully within the structure of the program	17	38.6%	**19**	**43.2%**	8	18.2%	0	0.0%		
Information is communicated clearly and professionally	19	43.2%	**20**	**45.4%**	4	9.1%	1	2.3%		
My Agreement Monitor is knowledgeable about my case	**27**	**61.4%**	14	31.8%	2	4.5%	1	2.3%		

Table 7c: 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%

HPSP Portal

Question #6: This question asks respondents to rate the usefulness of the portal ***if*** they have used it. This year, 68.2% of respondents (30) indicated that they had used the portal, which is a decrease from 80% who did so last year. Of those who used the portal, approximately 60% find it "useful" or "extremely useful."

As of July 15, 2022, HPSP began partnering with RecoveryTrek as our third-party administrator for toxicology. This change means that the previous HPSP web portal has been replaced by RecoveryTrek's portal, which has a significant number of features that the previous portal did not. This question will be reworded in future surveys to ask about the RecoveryTrek portal, and we fully anticipate greatly increased licensee satisfaction with the new portal.

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=12)		Year 12 (n=30)		Year 10 (n=44)	
	#	%	#	%	#	%
Extremely Useful	2	10.5%	7	23.3%	10	22.7%
Useful	5	26.3%	**11**	**36.7%**	**22**	**50.0%**
Somewhat Useful	5	26.3%	10	33.3%	11	25.0%
Not Useful	0	0.0%	2	6.7%	1	2.3%

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 is barely useful now. if it updated in real time (to show that I had checked in for the day) rather than once every 24 hours in the middle of the night, it would be more useful.

Overall Rating of Services

Question #7: Respondents are asked to rate the overall services. The mode response was "average" for both the period and the year, although it is important to note that the difference between "excellent" and "average" was just one response for both the period and the year. Further, ratings of "excellent" or "above average" are higher both for the period (57.9%) and the year (54.5%) than in the previous year (52.7%). Finally, there were no "poor" ratings for either the period or the year, which cannot be said for the past several years. Overall, this can certainly be interpreted as an increase in overall satisfaction with the program.

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

Table 9: Overall Rating	This Period (n=19)		Year 12 (n=44)		Year 11 (n=55)		Year 10 (n=65)		Year 9 (n=80)		Year 8 (n=99)		Year 7 (n=149)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Excellent	6	31.6%	13	29.5%	**19**	**34.5%**	18	27.7%	**27**	**33.8%**	34	34.3%	35	23.5%
Above Average	5	26.3%	11	25.0%	10	18.2%	**19**	**29.2%**	24	30.0%	**37**	**37.4%**	**57**	**38.3%**
Average	**7**	**36.8%**	**14**	**31.8%**	17	30.9%	14	21.5%	21	26.3%	18	18.2%	35	23.5%
Below Average	1	5.3%	6	13.6%	5	9.1%	7	10.8%	5	6.3%	6	6.1%	10	6.7%
Poor					3	5.5%	7	10.8%	3	3.8%	4	4.0%	7	4.7%
No Response					1	1.8%							5	3.4%

Additional Comments

At the conclusion of the survey, respondents are asked for any additional comments. In addition to the nine comments received earlier in the survey, eight concluding comments were received this period. All seventeen 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. [Agreement Monitor name] has been so incredibly kind, respectful, responsive, helpful, and just all around wonderful. I am so incredibly grateful to be working with her.
2. It is difficult to get ahold of someone that understands the program when calling either the after hours number or talking to anyone that isn't the actual monitor. This feels very unstructured. There is the additional concern that if there is a testing problem/concern and we can't get ahold of our monitor, it is ultimately on us if something goes wrong.
3. It would be useful if we could check in after midnight rather than 3 AM. It would help me to plan my day knowing if I had to test.
4. It would be excellent for an option for early completion for self referrals with no compliance issues. Thanks [licensee name]
5. HPSP/Uprise has supported me in my practice of medicine for 16 years and allowed me to work unrestricted in my practice of Emergency Medicine and I am forever grateful!
6. Even though initially I didn't want to be monitored, I am now very grateful to have this program. It has helped me through my recovery. My monitor is awesome and treats me with a lot of respect, I have nothing but good

things to say about her and the program. I easily could have had everything taken from me, but this program has given me a second chance to continue my career and better my life. For that I am very grateful

7. I think this program is self-preserving and not supportive of any real applicable evidence-based practices. I think the questions being asked are too narrow out of fear of raising any debate about the real benefit or effectiveness of this program. End of the day I think it's beneficial for some people, overkill for most everyone else, just so the respective licensing boards can wash their hands of this and claim they're protecting the public. At the very least there should be an annual or bi-annual review of everyone's individual case to assess whether they need to continue or not. Putting a blanket and arbitrary term on everyone is just a complacent, disruptive and irresponsible policy.
8. I got 4 years in the HPSP for self reporting that I stole a vial of regular insulin from my workplace for a suicide attempt. I did not ever divert any narcotics or benzos. The HPSP program has made it extremely hard for me to find work as a RN. Not many managers are open to having me as an employee because I am in the HPSP program. I have experienced an extreme amount of workplace discrimination because my primary and secondary monitors believe I am a drug abuser because I am in the HPSP program. I also can not apply for any RN jobs that don't have "direct supervision". I have 20 years experience working full time as a nurse and would be very employable if not for the HPSP program. The only RN job that I found work with is an on-call employee for Mt.Hood hospital. I have no employer provided health benefits for my 8 year old son and I as an on call employee. The HPSP program has caused extreme financial hardship in my life. The program is not fair to its participants because I have treated like a "bad nurse" from employers ever since it begun for me 2 years ago. Uprise Health has been administering a unjust HPSP program correctly and with compassion. My monitoring liason [Agreement Monitor name] is a wonderfully compassionate person and she has encouraged me many times to get back out there. I appreciate her help more than she will ever know. However the HPSP program itself has caused me to lose my health benefits and lose respect among my colleagues. I also now only make $60k a year instead of the $95k I was making.

Summary Analysis

The response rate for this survey this year is 14.9%, 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-fifth each by the Board of Nursing and Board of Dentistry, and 5% from the Board of Pharmacy. This is representative of the Medical Board licensee pool, but less so among the other three boards.

Importantly, over 95% 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 (77.3%) and respect (72.7%). Finally, 81.8% of respondents 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 81% and 93% of all respondents "agree" or "strongly agree" 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. Overall, 86.4% of respondents rated the program as "excellent," "above average" or "average" this year, an increase from the previous year.

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

Uprise Health Monitoring
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. Uprise Health 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 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 Uprise Health'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 Uprise Health 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 12	Year 11	Year 10	Year 9	Year 8
# Sent	124	264	327	331	340	322
# Responses	3	8	20	60	42	46
Response Rate	2.4%	3.0%	6.1%	18.1%	12.4%	14.3%

This period the Workplace Monitors' satisfaction survey had a response rate of only 2.4%, with three responses out of 124 surveys sent. This brings the response rate for the year down to 3.0% with 8 responses out of 264 sent. This represents a continued decrease in the response rate among Workplace Monitors. Given the low response rate, results should not be considered representative of the population of workplace monitors.

Report continues next page

Professional Licensing Board

Question 1: Respondents are first asked which professional board licenses the employee they monitor. This period, one was licensed by the Medical Board and two by the Board of Nursing. For the year, there were again only responses from Workplace Monitors of Medical Board and Nursing Board licensees (50% or four each). Workplace Monitors of Board of Pharmacy and Board of Dentistry licensees are not represented in this year's responses.

Data Table 2: The mode (most frequent) response is highlighted in red.

Table 2: Type of Services Provided	This Period (n=3)		Year 12 (n=8)		Year 11 (n=20)	
	#	%	#	%	#	%
Medical Board	1	33.3%	4	50.0%	7	35%
Board of Nursing	**2**	**66.7%**	4	50.0%	**8**	**40%**
Board of Pharmacy					1	5%
Board of Dentistry					1	5%
Other / Not Identified					3	15%
No Response						

Supervision Support

Question 2: The next item reads: "Uprise Health supports you in your role as workplace monitor. How satisfied are you with our support?" This year, all respondents were either "very satisfied" (50%) or "satisfied" (50%) with Uprise Health's support. The same is true for this period, although the mode response was "satisfied" with 66.7% of responses, and the other response being "very satisfied." Overall, this is slightly more positive than last year, as there were no responses that indicated dissatisfaction.

Data Table 3: The mode (most frequent) response is in red:

Table 3: Supervision Support	This Period (n=3)		Year 12 (n=8)		Year 11 (n=20)	
	#	%	#	%	#	%
Very Satisfied	1	33.3%	4	50.0%	9	45%
Satisfied	**2**	**66.7%**	4	50.0%	**10**	**50%**
Unsatisfied					1	5%
Very Unsatisfied						
No Response						

Workplace Safety

Question 3: Uprise Health'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 continue to be primarily positive. This year, 62.5% of respondents indicated that Uprise Health does an "excellent" or "above average" job at monitoring licensees to ensure public safety. While the remaining three responses (37.5%) indicated that this was "average," we are pleased to report that no respondents indicated ratings of "below average" or "poor."

Data Table 4: The mode (most frequent) response is highlighted in red:

Table 4: Workplace Safety	This Period (n=3)		Year 12 (n=8)		Year 11 (n=20)	
	#	%	#	%	#	%
Excellent	1	33.3%	**4**	**50.0%**	**9**	**45%**
Above Average			1	12.5%	6	30%
Average	**2**	**66.7%**	3	37.5%	3	15%
Below Average					1	5%
Poor						
No Response					1	5%

A follow-up question requests any suggested changes or recommendations. No comments were provided for this period.

Services

Question 4: Respondents are asked to think about their recent contacts with Uprise Health 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 Uprise Health. Finally, an overall rating is requested.

The mode response to items one, three, four, and five was "excellent" this year, just like last year. The mode responses to item two were split evenly between "excellent" and "above average." Responses continue to be positive overall with no "below average" or "poor" ratings.

Data for this period, this year and the prior year follows on the next page.

Report continues next page

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

Table 5a This Period (n=3)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	1	33.3%			**2**	**66.7%**						
Staff knowledge of a licensee when there is concern in the workplace					**1**	**33.3%**					2	66.7%
Our ability to respond to questions regarding program administration	1	33.3%	1	33.3%	1	33.3%						
Frequency of feedback from Uprise Health regarding licensee's compliance					**2**	**66.7%**					1	33.3%
Overall rating of our services	1	33.3%			**2**	**66.7%**						

Table 5b Year 12 (n=8)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**4**	**50.0%**	2	25.0%	2	25.0%						
Staff knowledge of a licensee when there is concern in the workplace	2	25.0%	2	25.0%	1	12.5%					3	37.5%
Our ability to respond to questions regarding program administration	**4**	**50.0%**	2	25.0%	1	12.5%					1	12.5%
Frequency of feedback from Uprise Health regarding licensee's compliance	**3**	**37.5%**	2	25.0%	2	25.0%					1	12.5%
Overall rating of our services	**4**	**50.0%**	2	25.0%	2	25.0%						

Table 5c 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 Uprise Health 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%				

Overall Experience

Question 5: Respondents are asked to rate their overall experience working with Uprise Health. The mode response was "excellent" at 50% of respondents for the year and was evenly split with one response each of "excellent," "above average," and "average" for the period. This year, overall satisfaction increased over the previous year, with 87.5% of respondents rating their overall experience as "excellent" or "above average," which was 75% in year eleven.

Data Table 6: The mode (most frequent) response is highlighted in red:

Table 6: Overall Experience	This Period (n=3)		Year 12 (n=8)		Year 11 (n=20)	
	#	%	#	%	#	%
Excellent	1	33.3%	**4**	**50.0%**	**12**	**60%**
Above Average	1	33.3%	3	37.5%	3	15%
Average	1	33.3%	1	12.5%	4	20%
Below Average						
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. Reports "misplaced" during e-mail transition to new organization from IBH to Uprise. I am still sending duplicates for reports sent in January

Summary Analysis

The response rate for this survey was extremely low, both for the period (2.4%) and the year (3.0%.) As such, results should be interpreted carefully as they may not be representative of the entire population. That said, results are not dissimilar from what has been reported in past years.

For both this period and the year, there were no responses indicating dissatisfaction with Uprise Health's services, communication, or ability to ensure public safety. All responses were either "very satisfied," "satisfied," "excellent," "above average," or "average." This is a positive change from last year, where there was one respondent who expressed dissatisfaction with Uprise Health's services.

The PAC committee will review the survey data and the comment carefully.

Uprise Health Monitoring
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, Uprise Health 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 Uprise Health 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 Uprise Health 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 12	Year 11	Year 10	Year 9	Year 8
# Sent	18	36	16	10	10	8
# Responses	0	0	3	2	2	1
Response Rate	0.0%	0.0%	18.8%	20.0%	20.0%	12.5%

Eighteen surveys were sent out this period to various contacts at related professional associations, however, no responses were received in year twelve. Uprise Health staff has continued to foster relationships with representatives from these associations by holding quarterly or semi-annual conversations, and this will continue.

Report continues next page

Uprise Health Monitoring
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. Uprise Health 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 Uprise Health'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 Uprise Health 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 12	Year 11	Year 10	Year 9
# Sent	24	48	48	51	52
# Responses	3	9	12	10	14
Response Rate	12.5%	18.8%	25.0%	19.6%	26.9%

Surveys were sent to seven GMC/PMC providers and 17 third-party evaluators by email this period, for a total of 24 surveys distributed. Only three responses were received this period for a rate of 12.5%. For the year, the response rate is 18.8%, representing nine responses to the 48 surveys that were sent. These rates represent a decrease from year eleven.

Role of Respondent

The first question asks the respondents the capacity in which they provide services to HPSP licensees. This period, all three respondents indicated they serve as a "monitor" (GMC/PMC).

For the year, three respondents indicated they were "evaluators" with the remaining nine as "monitors" (GMC/PMC).

Report continues next page

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 "strongly agree" for the first statement and "agree" for the second. The third question was split evenly between "strongly agree," "agree," and "disagree." For the year as a whole, responses were more positive, with the mode response for all three questions being "strongly agree." Compared with the previous year, respondents generally reported greater satisfaction with communication in year twelve.

Data Tables 2a and b: The mode (most frequent) response is highlighted in red.

Table 2a: This Period (n=3)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	**2**	**66.7%**	1	33.3%								
Information was communicated clearly and professionally	1	33.3%	**2**	**66.7%**								
I had all the information I needed when I saw the licensee	1	33.3%	1	33.3%	1	33.3%						

Table 2b: This Year (n=9)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	**7**	**77.8%**	2	22.2%								
Information was communicated clearly and professionally	**6**	**66.7%**	3	33.3%								
I had all the information I needed when I saw the licensee	**5**	**55.6%**	3	33.3%	1	11.1%						

Table 2c: Year 11 (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%						

Overall Experience

Question 3: Respondents are next asked "Overall, how would you rate your experience working with Uprise Health staff of HPSP?" For the period, the three respondents were split between "excellent," "above average," and "average." For the year, the mode response was "excellent" with over half of the responses. There was one "average" response for the year as well as one "N/A" response, but the remainder were "above average."

Data Table 3: The mode (most frequent) response is highlighted in red where applicable.

Table 3: Overall Rating	This Period (n=3)		Year 12 (n=9)		Year 11 (n=12)	
	#	%	#	%	#	%
Excellent	1	33.3%	**5**	**55.6%**	**6**	**50%**
Above Average	1	33.3%	2	22.2%	5	41.7%
Average	1	33.3%	1	11.1%	1	8.3%
Below Average						
Poor						
N/A or No Response			1	11.1%		

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. Some communication issues since the sale to Uprise and staff turnover.
2. Greatful to [staff name] for allowing e-mailed (de-idenitifed) reports. Changing staff is not the best for the program, but I realize is problematic all over. Fees as a consultant are below my needs. An annual increase would help as my costs continue to go up. Please consider to retain continuity for the program.

Summary Analysis

The response rate was 12.5% for the period and 18.8% for the year. These rates represent a decrease from the last several years. Responses from this period were especially low and may not be indicative of the provider population as a whole.

Overall, responses for the year were positive and improved from year eleven. Nearly all respondents "strongly agreed" or "agreed" that all aspects of Uprise Health's communication with providers was clear, complete, and timely. Further, most respondents this year rated overall services as "excellent" or "above average."

Two comments were received for this period. The PAC will review all survey data and comments.

DENTAL ASSISTANT FUTURE WORKFORCE

STAKEHOLDER FORUM SUMMARY REPORT

14 JULY 2022 • CHICAGO

Attachment #5

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WORKSHOP AGENDA

- Welcome and Introductions
- Vision Activity: Dealing with Change
- Creating the Future Activities: Gallery Walk & Timeline
- SWOT Analysis Activity
- Dental Workforce Opportunities & Initiatives Activity
- Closing Conversation

INTRODUCTION TO THE SESSION

Workforce development is a critical issue for DANB and the DALE Foundation, and one we recognize that we cannot resolve alone.

This forum session was held on July 14 in Chicago to bring together leaders in dentistry and health care to share perspectives and identify ways we can collectively work toward solutions to assure a robust, effective, and adequately staffed dental assistant workforce.

During the session we explored key issues, identified opportunities, created initiatives, and defined actions.

This document is a concise summary of the work we did during a very full day of discovery and creative thinking.

We are grateful for the dedicated engagement of all participants, and are hopeful that the work done during the session will lead to significant progress in addressing key issues regarding the dental workforce.

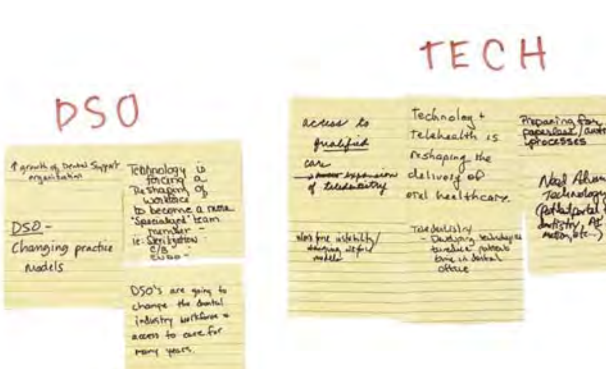
VISION ACTIVITY

In this initial activity, the participants described the three most pressing challenges that their own organization is presently dealing with, the three most pressing changes occurring now across the dental profession, and the top three ways they expect the practice of dentistry in the future will be different from today. They then discussed their individual reflections in small groups, and brought key ideas back to share with the large group.

SEVEN KEY THEMES

The key ideas were then clustered, and we discovered that we had identified seven key themes for the future of dentistry and the dental assistant role:

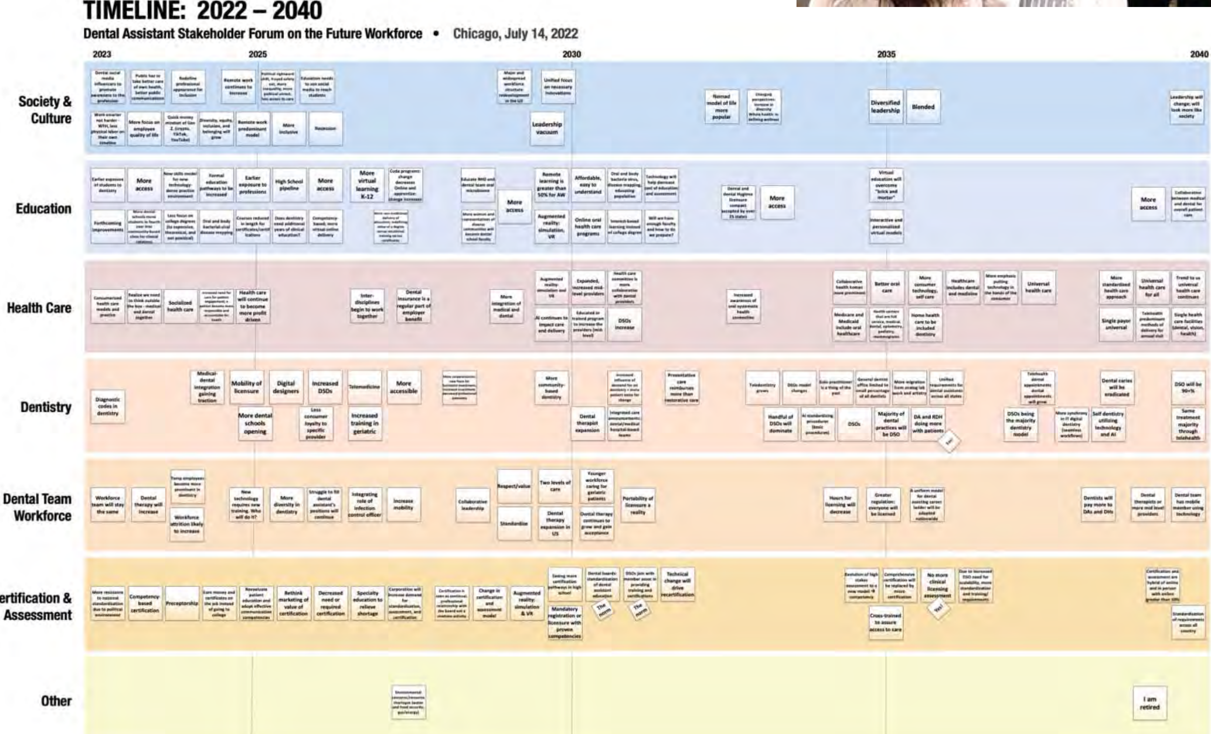
- **Certification Value / Awareness**
- **DSO Growth**
- **Technology**
- **Generational Shifts and the Workforce**
- **Business Model of Dentistry**
- **Workforce Development / Education**
- **Leadership Pipeline**



GALLERY & TIMELINE ACTIVITY

In the next activity, participants studied a gallery of information about the future of dentistry, society, and health care, and then used Post-it notes to create a detailed timeline of the period from 2022 to 2040 in order to consider how the future may be evolving.

The full timeline has been re-created as a poster, which is available as a separate document.



SWOT ANALYSIS

The third activity of the Forum was a SWOT analysis of the future of dentistry in 2028. By looking at the Strengths, Weaknesses, Opportunities, and Threats that the dental profession as a whole faces we gain a deeper understanding of the forces and factors we must deal with in order to achieve our desired goals by 2028.

Participants worked in 6 teams, and then identified the most important elements in each of the four categories.

Strengths.

- Effective organizational structure
- High frequency of in-patient visits
- Patient care & communication (comfort/trust)
- Passion for profession and patient care/patient care
- Purpose-driven job satisfaction
- Leveraging technology

Weaknesses

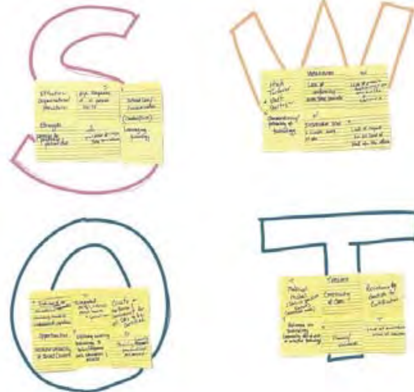
- High turnover and staff shortage
- Standardizing/portability of technology
- Variability of dental assistant requirements in dental practice acts across states
- High variability of the dental assistant's job and scope of functions across states
- Lack of public awareness concerning oral health careers
- Insufficient understanding and appreciation of the contributions of dental team members

Opportunities

- Incentivize increasing reach to underserved populations (take care of our own communities)
- Increase visibility of dental careers
- Integrated dental, medical, mental health, and social care
- Utilizing evolving technology to tailor/improve care, education, and access
- Create a uniform model for dental assistants
- Training levels, stacked credentials, and microcredentials

Threats

- Medical model (dentist perceive threat; insurance model)
- Reliance on technology (especially out-of-date or untested technology)
- Continuity of care
- Finances/insurance
- Lack of awareness and appreciation for dental assistant credentialing and education



12 KEY INITIATIVES

The final activity of the day focused on identifying cross-organizational initiatives that could be undertaken across the dental profession to assure that our future workforce needs are met. These were the 12 key ideas that emerged. As this work was done by teams working independently, there is some overlap among these ideas which we will address as we go forward.

1. **DEVELOP STANDARD DENTAL ASSISTANT MODEL** to create a uniform initial and continuing education curriculum, assessment program (exams and certifications) and state regulation. This will enable measurable outcomes for the profession and career portability across state lines.

2. **DEFINE DA & RDH NATIONAL STANDARD** which will provide a roadmap for states and lead to improved patient care, increased access to care, and growing workforce numbers. It will also provide data required to make the case for certification, establish standardization around skillset, raise awareness, and establish minimum requirements.

3. **STANDARDIZE EDUCATION REQUIREMENTS** New partnerships and collaborations will be formed; training, education, and certification requirements will be established to ensure DAs can effectively perform their scope of duties.

4. **CREATE UNIFORM REGULATORY FRAMEWORK** in order to establish a minimum base of knowledge across states and to encourage recognition of DANB credentials.

5. **ENHANCE STATE LICENSING** to establish training and competency standards and demand for formal training, which will result in increased patient and provider safety, increased public awareness, and DA job mobility across state lines.

6. **ESTABLISH MINIMUM REQUIREMENTS FOR ORAL HEALTHCARE SETTING STAFF** with the primary objective of improving patient safety.

7. **FORM A WORKFORCE COALITION** to address DA low pay and benefits, to educate and encourage employers to increase pay and benefits for DAs, and to define and promote uniformity for the DA profession.

8. **PARTNER TO RECRUIT A MORE DIVERSE WORKFORCE** that reflects a diverse patient population and increases the size of the workforce.

9. **IMPROVE WORKFORCE DEVELOPMENT** through marketing campaigns, partnering with new groups (e.g., Junior Achievement) and outreach to underserved populations to grow interest in the profession, to increase DA workforce numbers; maintaining or improving quality levels is a challenge but critically important.

10. **CONDUCT FOUNDATIONAL & CROSS-FUNCTIONAL EDUCATION & RECRUITMENT** aimed at increasing diversity in dental assistant education and recruitment and in state dental associations, by standardizing requirements across states, looking for microcredential opportunities, and leveraging new technologies alongside existing dental education facilities to expand access and accelerate the timeframe for students to earn income.

11. **FOCUS ON RECRUITMENT AND EDUCATION PATHWAYS** including stakeholder engagement, "train the trainer" and speaker programs, and development of workforce models, training standards and micro-credentialing that will lead to early and diverse recruitment, an articulated career ladder, career awareness, and standardization across the profession.

12. **REVAMP OUTREACH AND EDUCATION** to ensure training is readily available to meet new minimum standards, to help a diverse public understand why they should value oral health career opportunities, to promote diversity, and to instill a sense of professionalism and pride within the DA workforce.

THANK YOU!

“Thank you to all of you, the DANB and DALE Foundation board members, and our staff. The energy in the room today was really high all day, and there was a lot of laughter.

We are going to be stronger and go further if we do this work on the Dental Workforce together. Hopefully you are connecting with people you can collaborate with, and let’s think about who else should be in the conversation.

Let’s also think about how we can keep this conversation going.”

Laura Skarnulis, DANB and DALE Foundation CEO

Attachment #5

Attachment #5

Staff:
Brian Nieubuurt, LPRO Analyst
Oliver Droppers, LPRO Analyst
Erica Schroeder, Committee Assistant

Members:
Rep. Rob Nosse, Chair
Rep. Cedric Hayden, Vice-Chair
Rep. Rachel Prusak, Vice-Chair
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Rep. Maxine Dexter
Rep. Christine Goodwin
Rep. Raquel Moore-Green
Rep. Travis Nelson
Rep. Ron Noble
Rep. Andrea Salinas
Rep. Sheri Schouten
Rep. Suzanne Weber

HOUSE INTERIM COMMITTEE ON HEALTH CARE

Oregon State Capitol
900 Court Street NE, Room 453, Salem, Oregon 97301
Phone: 503-986-1509

AGENDA

Revision 2 Posted: SEP 19 11:27 AM

WEDNESDAY

Date: September 21, 2022
Time: 2:30 P.M.
Room: Remote C

Informational Meeting

Invited Speakers Only

(2:30 pm) **Sustainable Health Care Cost Growth Target Program Update**
Patrick Allen, Director, Oregon Health Authority

(3:00 pm) **HB 4035 (2022) Redeterminations and Bridge Program Updates**
Patrick Allen, Director, Oregon Health Authority
Fariborz Pakseresht, Director, Oregon Department of Human Services

(3:30 pm) **1115 Waiver Update**
Patrick Allen, Director, Oregon Health Authority
Lori Coyner, Senior Medicaid Policy Advisor, Oregon Health Authority

(4:00 pm) **Health Care Workforce - Board Perspectives**
Nicole Krishnaswami, Executive Director, Oregon Medical Board
Kathleen Harder, Immediate Past Chair, Oregon Medical Board
Ruby Jason, Executive Director, Oregon State Board of Nursing
Stephen Prisby, Executive Director, Oregon Board of Dentistry
Joe Schnabel, Executive Director, State Board of Pharmacy
Ian Doyle, Vice President, State Board of Pharmacy
Charles Hill, Executive Director, Oregon Mental Health Regulatory Agency
Celeste Jones, Chair, Oregon Board of Psychology
Matthew Hatch, Chair, Oregon Board of Licensed Professional Counselors and Therapists
Michelle Sigmund-Gaines, Executive Director, Oregon Physical Therapy Board
Philip Haworth, Chair, Oregon Board of Physical Therapy

For ADA accommodation requests, please email employee.services@oregonlegislature.gov or call 1-800-332-2313.
Attachment #6

Stacy Katler, Executive Director, Oregon Board of Medical Imaging
Melissa Downer-Valdez, Chair, Oregon Board of Medical Imaging

Note change: Kathleen Harder was added as a presenter for Health Care Workforce - Board Perspectives.

Please note:
- This meeting is being held remotely.
- To view a live stream of the meeting go to: https://olis.oregonlegislature.gov/liz/2021I1/Committees/HHC/Overview
- A viewing station is available at the Capitol Building.
- Times above are tentative start times for each agenda item.

Language Access Services (interpreter, translation, CART):
- Go to: https://www.oregonlegislature.gov/citizen_engagement/Pages/language-access.aspx
- Request services at least 2 days prior to the scheduled meeting date.
- Closed captioning is available for live and recorded meetings.

OREGON BOARD OF DENTISTRY

Presentation to the House Interim Committee On Health Care 9/21/2022 provided by Stephen Prisby, OBD Executive Director

The Board of Dentistry was created by an act of the Legislature in 1887.

The oldest health licensing Board in Oregon.

The mission of the Oregon Board of Dentistry is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

Attachment #6

OREGON BOARD OF DENTISTRY

Ten members serve on the Board:

- Six Dentists
- Two Dental Hygienists
- Two Public members

All are appointed by the Governor and confirmed by the Senate. A term is four years in length and they may serve two terms. The Board convenes every other month for regular meetings.

The OBD has 8 full time employees carrying out the day to day activities and work of the OBD.

Attachment #6

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS

As of July 1, 2022:

All Dentists Licensed = 3826

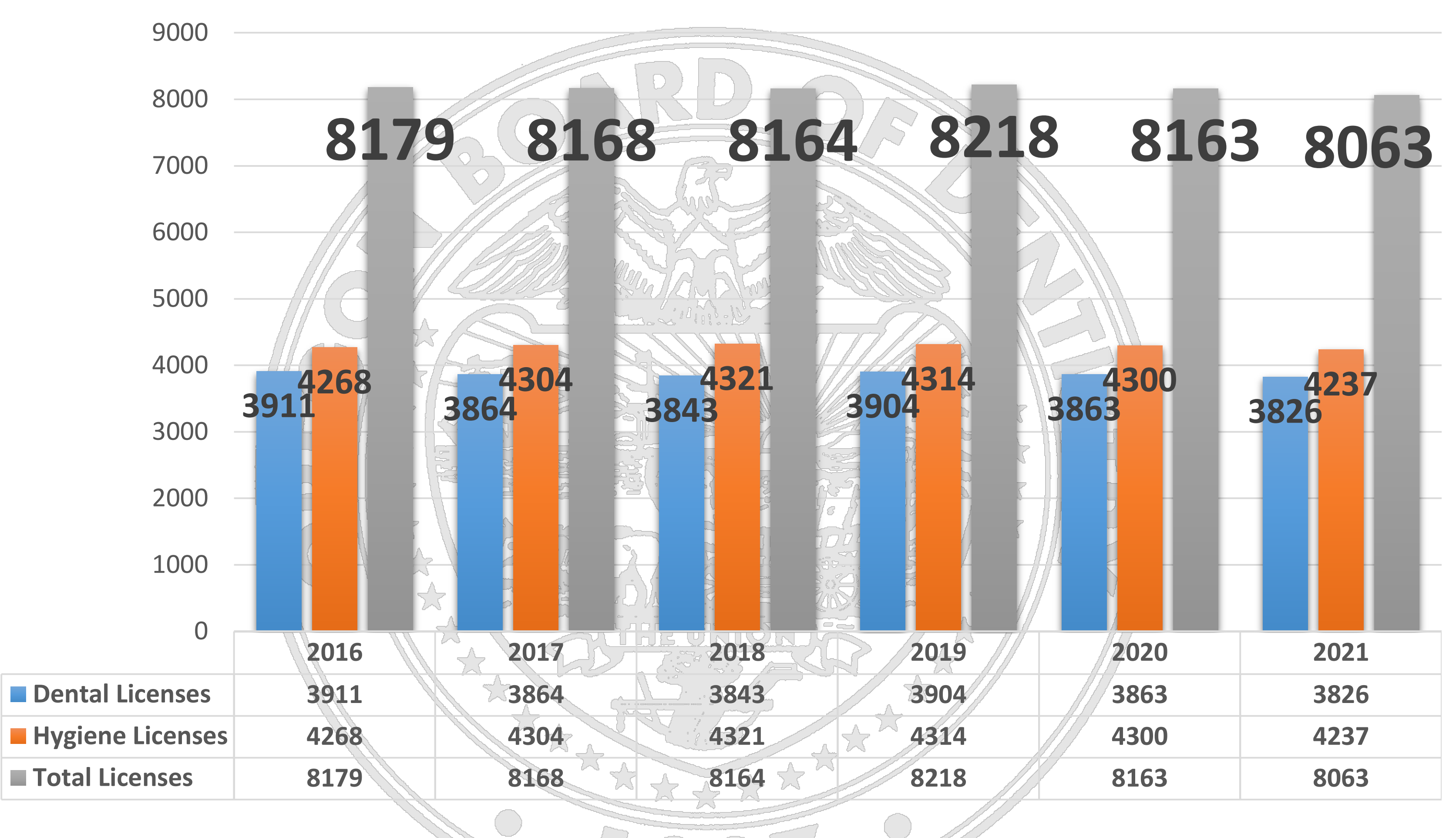
(3,089 In State)
(21 Faculty)
(15 Volunteer)

All Hygienists Licensed = 4237

(3,609 In State)
(972 Expanded Practice)
(0 Faculty)
(3 Volunteer)

Attachment #6

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



	2016	2017	2018	2019	2020	2021
Dental Licenses	3911	3864	3843	3904	3863	3826
Hygiene Licenses	4268	4304	4321	4314	4300	4237
Total Licenses	8179	8168	8164	8218	8163	8063

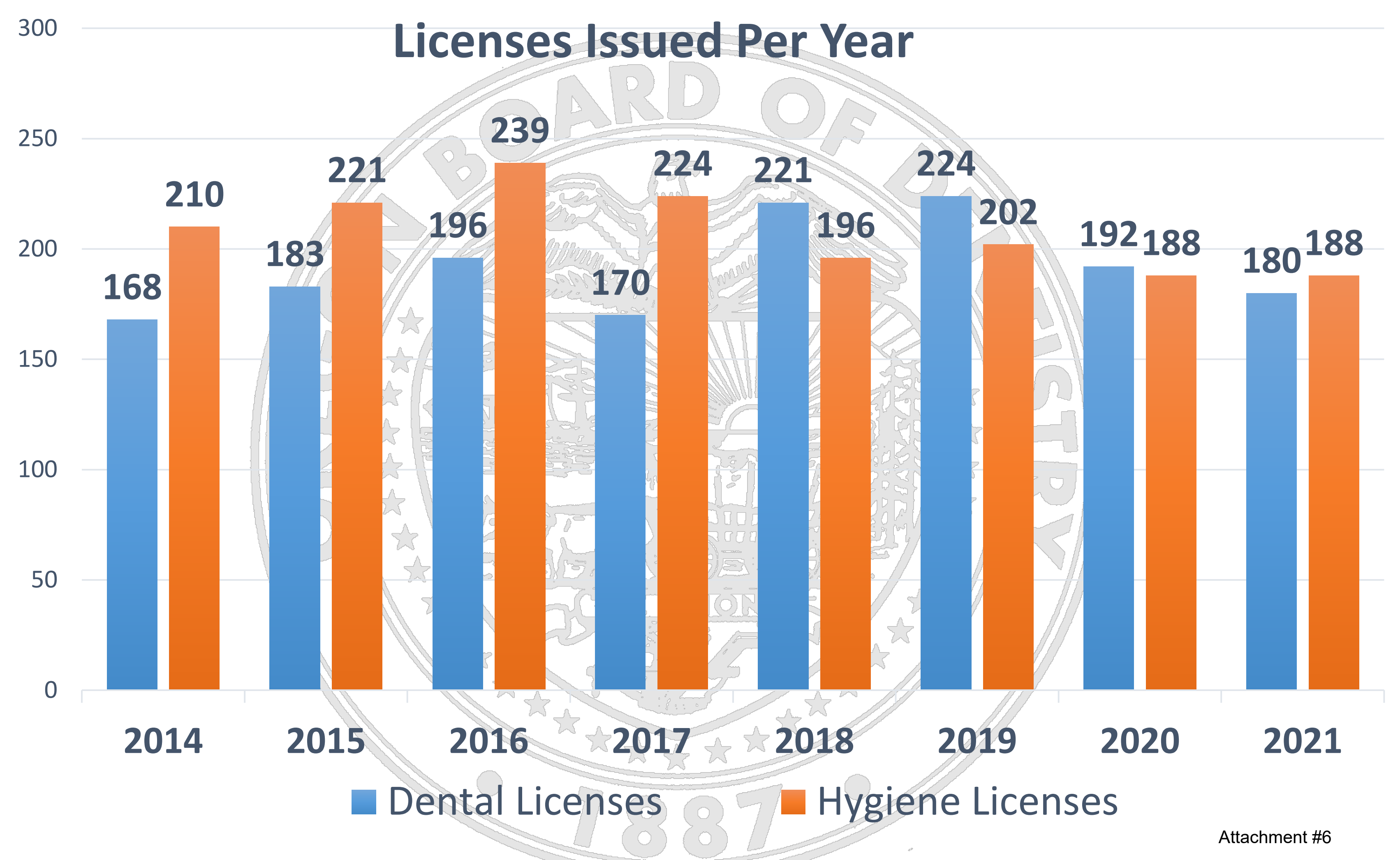
Attachment #6

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS

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

Attachment #6

OREGON BOARD OF DENTISTRY
LICENSE STATISTICS



Attachment #6

OREGON BOARD OF DENTISTRY

Dental Assistants

There are an estimated 5500 – 5800 Dental Assistants in Oregon. Since they are not licensed, there is not an exact way to count them.

- They are integral to a successful oral healthcare team
- The OBD does not license them. They work under the supervision of dentists. The OBD ensures proper certification for specific functions and activities:
    - Certification - Exposing of Radiographs
    - Expanded Functions – Orthodontics
    - Expanded Functions – Preventative
    - Expanded Functions – Anesthesia
    - Expanded Functions – Restorative Functions

OREGON BOARD OF DENTISTRY

Dental Assisting National Board (DANB)

About DANB

Our Mission and History

Our mission is to promote the public good by providing credentialing services to the dental community. We accomplish and measure the success of this mission through the creation of valid dental assisting exams; recertification requirement integrity; and valuable, visible and accessible DANB exams, certificates and certifications.

We have a long and interesting history that traces back to 1948, when the American Dental Assistants Association (ADAA) identified the need for dental assistant certification and founded the Certifying Board of the American Dental Assistants Association. In 1978, the Certifying Board became a separately incorporated organization and, in 1980, changed its name to the Dental Assisting National Board.

Today, DANB is recognized by the American Dental Association as the national certification board for dental assistants. More than 36,000 dental assistants hold DANB certification, and each year, DANB issues nearly 50,000 certificates to those who pass its national and state exams.

BOARD OF DENTISTRY OREGON 1887 THE UNION

Attachment #6

OREGON BOARD OF DENTISTRY

DANB held a stakeholder Forum in July to address workforce shortage issues

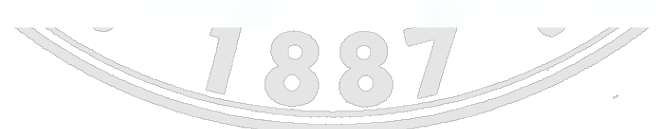
Forum held in July - Mr. Prisby was a participant

FORUM OBJECTIVES

Workforce development is a **critical issue** for **DANB** and **the DALE Foundation**, as well, and one we believe we cannot resolve alone.

The forum is an invitation-only event designed to bring together leaders in dentistry and health care to share their perspectives and identify ways we can collectively work toward **solutions to assure a robust, effective, and adequately staffed dental assistant workforce.**

We will **explore key issues, identify opportunities, create initiatives, and define actions.**



Attachment #6

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WORKSHOP

INTRODUCTION TO THE SESSION

Workforce development is a critical issue for DANB and the DALE Foundation, and one we recognize that we cannot resolve alone.

This forum session was held on July 14 in Chicago to bring together leaders in dentistry and health care to share perspectives and identify ways we can collectively work toward solutions to assure a robust, effective, and adequately staffed dental assistant workforce.

Attachment #6

OREGON BOARD OF DENTISTRY

SEVEN KEY THEMES

The key ideas were then clustered, and we discovered that we had identified seven key themes for the future of dentistry and the dental assistant role:

- **Certification Value / Awareness**
- **DSO Growth**
- **Technology**
- **Generational Shifts and the Workforce**
- **Business Model of Dentistry**
- **Workforce Development / Education**
- **Leadership Pipeline**

Attachment #6

OREGON BOARD OF DENTISTRY

The full report and summary recommendations is uploaded into OLIS and available to all.

REVAMP OUTREACH AND EDUCATION to ensure training is readily available to meet new minimum standards, to help a diverse public understand why they should value oral health career opportunities, to promote diversity, and to instill a sense of professionalism and pride within the DA workforce.

FOCUS ON RECRUITMENT AND EDUCATION PATHWAYS including stakeholder engagement, "train the trainer" and speaker programs, and development of workforce models, training standards and micro-credentialing that will lead to early and diverse recruitment, an articulated career ladder, career awareness, and standardization across the profession.

DEVELOP STANDARD DENTAL ASSISTANT MODEL to create a uniform initial and continuing education curriculum, assessment program (exams and certifications) and state regulation. This will enable measurable outcomes for the profession and career portability across state lines.

IMPROVE WORKFORCE DEVELOPMENT through marketing campaigns, partnering with new groups (e.g., Junior Achievement) and outreach to underserved populations to grow interest in the profession, to increase DA workforce numbers;

CREATE UNIFORM REGULATORY FRAMEWORK in order to establish a minimum base of knowledge across states and to encourage recognition of DANB credentials.

Attachment #6

OREGON BOARD OF DENTISTRY

Work Force Shortage is only one part of the problem in ensuring all Oregonians can be healthy.

Important to retain current workforce and compensate and educate accordingly as well.

- The OBD supports the Oregon Health Plan reimbursing at higher rates and working with organizations and dentists that express this as well. Dentists and others choose not to participate mainly due to low reimbursement rates and reporting requirements.
- The OBD supports parental guidance, education and personal responsibility as integral components to one's oral health.
- The OBD supports a focus on oral health services and education, plus nutrition programs for underserved and uninsured residents of all ages. Support dental disease prevention, oral health education, dental treatment, and medical-dental integration.

Attachment #6

OREGON BOARD OF DENTISTRY

Oregon Wellness Program

- Currently available to dentists and plans to expand to dental hygienists and dental therapists in the future.
- A program to help with life issues focusing on mitigating "professional burnout"
- Confidential, unless participants consent
- Up to eight free sessions in 12 month intervals
- No insurance is billed
- Not to replace or to be used for those that are in an immediate crisis
- Go to https://oregonwellnessprogram.org for more information

Almost all organizations/systems are aware that retention is key to having adequate staff in the current work environment.

Attachment #6

OREGON BOARD OF DENTISTRY

The five priorities identified in the OBD's 2022-2025 Strategic Plan include:

1. Licensure Evolution

Develop and implement rules based on legislative changes

Successfully implement Dental Therapy Rules

2. Dental Practice Accountability

Ensure Licensee dictates clinical care provided to patients

Assert OBD jurisdiction over dental practices regardless of ownership model

3. Community Interaction and Equity

Increase ease of access to OBD services and information

Ensure equity exists in investigation outcomes

4. Workplace Environment

Increase workplace flexibility through hybrid work models

Increase workplace satisfaction

5. Technology & Processes

Improve investigation management and archived files

Improve resource efficiencies

Attachment #6

OREGON BOARD OF DENTISTRY

Thanks for the invitation today. Since you asked…

- The OBD is one of the most liberal state boards' in accepting applicants for licensure. We accept all regional and national clinical licensure examinations, whether conducted on patients, models or a computer based objective structured clinical examination.
- Staffing levels in administration & licensing have not been impacted during the pandemic. The application materials and presentations to OHSU School of Dentistry and the six Oregon dental hygiene programs is consistent: it takes 6 - 8 weeks to process an application and approve a license. Delays typically occur due to US mail delays, applicant error, criminal histories and verifications from other states.
- The OBD is monitoring the preparation and formation of the dental & dental hygiene licensure compact by the Council of State Governments. The OBD does not have a formal position on it yet.
- Dental Therapy rules are in place and applications are being accepted for dental therapists - the first new licensee since dental hygienists in the 1940s.
- The OBD is always a resource for the Legislature on anything related to Dental Practice Act statutes, rules or proposed changes anytime requested of it.

Attachment #6

OREGON BOARD OF DENTISTRY

Progress is impossible without change; and those who cannot change their minds cannot change anything.

-George Bernard Shaw

Please contact me if you have any questions or need any additional information.

Stephen Prisby

OBD Executive Director

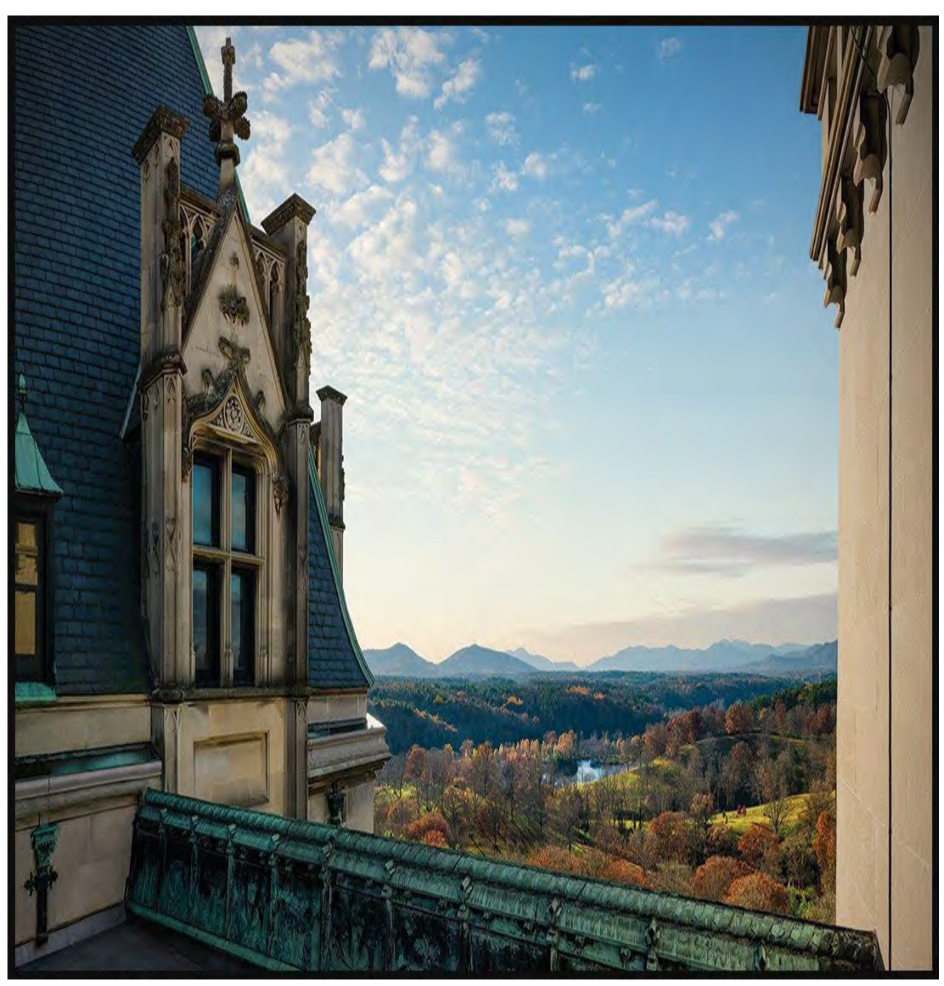
Stephen.Prisby@obd.oregon.gov

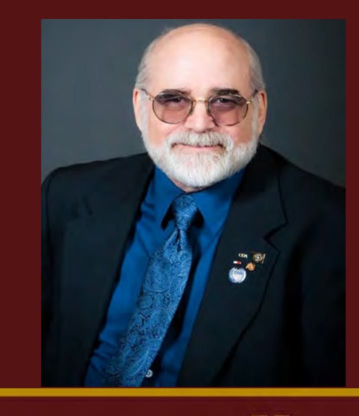
OREGON BOARD OF DENTISTRY
THE UNION
1887

AADB 139th Annual Meeting

Renaissance Asheville Hotel
31 Woodfin Street
Asheville, North Carolina 28801

October 7th – 9th, 2022





President James A. Sparks, DDS

AADB Thanks Our Program Committee

Chair:
James A. Sparks, DDS (OK)

Vice Chair:
Dale Chamberlain, DDS (MT)

Yvonne Bach (KY)

Brian Barnett (MO)

Sherry Campbell, RDH, CDHC (AL)

Bobby Carmen, DDS (OK)

Cliff Feingold, DDS (NC)

Arthur Chen-Shu Jee, DMD (MD)

Frank Maggio, DDS (IL)

D. Kevin Moore, DDS (NV)

Laura Richoux, RDH (MS)

Tonia Socha-Mower, MBA, EdD (AADB)

Robert Zena, DMD (KY)

American Association of Dental Boards

1701 Pennsylvania Ave NW, Suite 200
Washington, DC 20006

200 East Randolph Street, Suite 5100
Chicago, IL 60601

Attachment #7

Updated 09-09-2022

Return to Asheville

AADB held its national meeting in Asheville, North Carolina in 1903.

Illustration from *Dental Cosmos* (1903).

After 119 years, we return to beautiful Asheville in the fall, a color-filled time to experience the wonderful autumn and attend an exciting meeting. The presentations will address issues that concern our state and territory boards.

Interestingly, some of the topics of the 1903 meeting were practice standards, educational requirements for dental schools, and the licensing of new graduates. Seems we still have these same issues in 2022. We, as board members, certainly understand that change is constant, and we must deal with these same issues as they evolve over time.

Our annual meeting in Asheville is the ideal venue for our members to network and collaborate. We look forward to seeing you in October when the AADB presents great speakers as well as in-person networking opportunities.

Attachment #7

WELCOME TO ASHEVILLE

Dear AADB Members,

I have lived in Asheville for seven decades now – and the natives are starting to accept me. October is the prime time to visit here because the mountain leaves are changing colors and the "leaf lookers" abound.

I will endeavor to recommend a few of my favorite places here. One of the most famous attractions in the area is the Biltmore Estate – America's largest privately owned home. A tour of the House, the gardens, the winery with wine tastings, and several excellent restaurants are times well-spent. Please visit https://www.biltmore.com for more information. Asheville's most famous literary figure is Thomas Wolfe. His boyhood home and visitors' center are around the corner from the Renaissance Hotel. More information may be found at https://www.wolfememorial.com. If you would like to visit one of Asheville's premier resorts, the Grove Park Inn is a must. A few of their amenities include a golf course designed by Donald Ross in 1926, a world-class spa, excellent dining, or just enjoying the view with a cocktail on the Sunset Terrace. More information can be found at https://www.omnihotels.com/hotels/asheville-grove-park.

A few restaurants within walking distance (less than a half mile) of the Renaissance Hotel are some of my favorites. An excellent casual French restaurant is Bouchon https://www.ashevillebouchon.com. A casual historic restaurant is Pack's Tavern https://www.packstavern.com. An eclectic casual restaurant is Sovereign Remedies https://www.sovereignremedies.com. A famous Spanish Catalan restaurant downtown is Curate https://curatetapasbar.com. Also, near Curate is Posana whose website is https://www.posanarestaurant.com.

In Biltmore Village (a cab or Uber ride) is The Red Stag Grill in the Grand Bohemian Hotel https://www.kesslercollection.com/bohemian-asheville/dining/. Also in Biltmore, we have Ruth's Chris Steak House https://www.ruthschris.com/restaurant-locations/asheville. Another interesting restaurant in Biltmore is Fig Bistro https://figbistro.com.

Asheville is an art destination because we have many art galleries https://www.riverartsdistrict.com. We are also known as Beer City USA, because there are more breweries per capita than any other city. Sierra Nevada has their East Coast headquarters near the airport here. Some people describe it as "Disneyland for adults". https://sierranevada.com.

Another don't miss in Asheville is The French Broad Chocolate Lounge. It is less than a half-mile walk from the hotel, and your sweet tooth will thank you for the visit. For nightlife there are a variety of rooftop bars, a favorite of mine is Antidote (#9 on the following list), but there are many others: https://www.therooftopguide.com/rooftop-bars-in-asheville.html. An excellent casual Southern restaurant downtown Tupelo Honey, and an authentic Middle Eastern restaurant Jerusalem Garden are both less than a mile walk from the hotel. In that same area on Friday night, there might be the Asheville Drum Circle happening. Interesting local shops, art galleries, taverns, coffee shops, and restaurants abound in downtown. Street performers, or as we call

them, buskers, are usually plentiful: https://avltoday.6amcity.com/busking-asheville-guide/. The Asheville City Farmers Market is around the corner from the hotel on Saturday for some local homegrown food, arts, and goods. A very interesting old-time general store is The Mast General Store. It is walkable from the hotel and there are many art galleries and eclectic shops and restaurants on Biltmore Avenue nearby. A fun bus tour of the city can be found at LaZoom City/Comedy/Beer/Ghost tour buses (take your choice) — a great recommendation.

As I mentioned earlier, this is a busy time in Asheville, so you might be well-advised to make reservations for wherever you wish to visit well in advance of your arrival in Asheville and maybe plan to stay an extra day or two. If you partake of some of the attractions that Asheville has to offer, I think that you will be very satisfied. Of course, this time of the year, a car ride on the Blue Ridge Parkway can be magnificent. The AADB Annual Meeting is reason enough to be in Asheville, but the amenities are oh so wonderful.

I look forward to seeing all y'all in October here in Asheville.

Clifford Feingold, DDS
Treasurer
American Association of Dental Boards

About AADB

The American Association of Dental Boards is a national association that encourages the highest standards of dental education. The AADB promotes higher and uniform standards of qualification for dental practitioners. Membership is composed of boards of dentistry, advanced education boards, present and past members of those boards, board administrators, board attorneys, educators, and oral health stakeholders.

Our Mission

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

About AADB's Annual Meeting

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

Preliminary Meeting Agenda

Friday, October 7

Please note the times listed below are in Eastern Time

4:00 p.m. - 7:00 p.m.	**Registration**
6:00 p.m. - 8:00 p.m.	**AADB Board of Directors' Dinner** *By invitation only*

Saturday, October 8

Please note the times listed below are in Eastern Time

6:45 a.m. - 6:00 p.m.	**Registration**
7:00 a.m. - 9:00 a.m.	**The Urban Trail Tour** (Optional) A casual 2-hour walking tour of the city's history **https://www.exploreasheville.com/urban-trail/**
9:00 a.m. - 10:00 a.m.	**AADB Board of Directors Meeting**
10:15 a.m. - 10:45 a.m.	**New Member Orientation** Robert B. Zena, DMD, AADB Immediate Past-President
11:00 a.m. - 12:00 p.m.	**Hygienist Caucus Meeting** Laura Richoux, RDH, AADB Caucus Chair *This is a closed session for hygienists who serve or have served on a board of dentistry.*
11:00 a.m. - 12:00 p.m.	**AADB Attorney Round Table Meeting** Lori Lindley, Senior Assistant Attorney General Oregon Board of Dentistry Susan Rogers, Executive Director and General Counsel Oklahoma State Board of Dentistry *This closed session is for Attorneys who represent State/Territory Dental Boards.*

Attachment #7

12:00 p.m. - 12:10 p.m.	**President's Opening Remarks** James A. Sparks, DDS, AADB President
12:10 p.m. - 12:15 p.m.	**Chief Executive Officer's Welcome & Report** Tonia Socha-Mower, MBA, EdD, AADB Chief Executive Officer
12:15 p.m. - 12:25 p.m.	**Opioid Regulatory Collaboration, Teledentistry Coalition & Other AADB Initiatives** Tonia Socha-Mower, MBA, EdD, AADB Chief Executive Officer
12:25 p.m. - 12:30 p.m.	**Treasurer's Report** Clifford Feingold, DDS, AADB Treasurer
12:30 p.m. - 1:30 p.m.	**Teledentistry** Michael Monopoli DMD, MPH, MS, FICD, Vice President CareQuest Institute for Oral Health
1:30 p.m. - 2:00 p.m.	**Exhibits & Networking Break**
2:00 p.m. - 3:00 p.m.	**Achieving Oral Health Equity through Workforce Improvements** Tim Ricks, DMD, MPH, FICD, FACD, FPFA
3:00 p.m. - 3:15 p.m.	**AADB Representative Reports:** **CDEL:** Barbara Mousel, DDS (NORTH) Donald P. Bennett, DDS (SOUTH) Maurice Miles, DDS (EAST) David Nielson, DDS (WEST) **CODA:** Frank Recker, DDS, JD (NORTH) Carolyn Brown, DMD (SOUTH) Maxine Feinberg, DDS (EAST) Burrell Tucker, DDS (WEST) **JCNDE:** Julie W. McKee, DMD (SOUTH) Jeetendra Patel, DDS (SOUTH) Mark Zajkowski, DDS, MD (EAST) Dr. Michael Sanders, DMD (WEST) **DANB:** Frank A. Maggio, DDS (NORTH)
3:15 p.m. - 3:30 p.m.	**American Dental Education Association (ADEA) Report** Karen West, DMD, MPH, President and CEO ADEA
3:30 p.m. - 4:30 p.m.	**Medical and Dental Integration of Care** Lisa Bozzetti, DDS, Dental Director Virginia Garcia Memorial Health Center
4:30 p.m. - 5:00 p.m.	**Exhibits & Networking Break**

5:00 p.m. - 5:30 p.m. **Insights Garnered from Twelve Months with AADB's Remediate+ Program**
Richard S. Callan, DMD, EdS, EdD, Co-founder and Co-Owner
Promethean Dental Systems

Jeril R. Cooper III, DMD, Co-founder and Co-Owner
Promethean Dental Systems

5:30 p.m. - 6:00 p.m. **Sponsorship Recognition**

6:00 p.m. - 7:30 p.m. **Presidential Reception**

Registered attendees are invited to join President James A. Sparks, DDS, the AADB Board of Directors, AADB team, and invited speakers for light hors d'oeuvres and drinks. Guests of AADB meeting attendees are welcome to participate once registered at: ***https://aadb.memberclicks.net/aadb-139th-annual-meeting***.

Sunday, October 9

*****Please note the times listed below are in Eastern Time*****

8:00 a.m. - 11:00 a.m. **Registration**

8:00 a.m. - 9:00 a.m. **Regional Caucus Meetings**

9:00 a.m. - 9:15 a.m. **Exhibits & Networking Break**

9:15 a.m. - 9:30 a.m. **Caucus Reports**

South: Yvonne Maldonado, DDS, AADB Caucus Chair

North: Frank Maggio, DDS, AADB Caucus Co-Chair and/or Susan Rogers, Esq., AADB Caucus Co-chair

East: Jim Goldsmith, DMD, AADB Caucus Chair

West: Stephen Prisby, AADB Caucus Chair

9:30 a.m. - 10:30 a.m. **Attorney Round Table**
Lori Lindley, Senior Assistant Attorney General
Oregon Board of Dentistry

Susan Rogers, Executive Director and General Counsel
Oklahoma State Board of Dentistry

10:30 a.m. - 10:50 a.m. **AADB Accredited Continuing Education (ACE) Program**
Robert B. Zena, DMD, AADB Immediate Past-President

10:50 a.m. - 11:15 a.m.	**Exhibits & Networking Break**
11:15 a.m. - 12:30 p.m.	**Advances in Technology and Challenges for Regulators** Eric Thorn, Esq., Chief Staff Executive National Association of Dental Laboratories
12:30 p.m. - 1:30 p.m.	**Members' Luncheon** *Registered attendees are invited to join President James A. Sparks, DDS, the AADB Board of Directors, AADB staff, and for a farewell celebration to honor our Citizen of the Year awardee and our members. Guests of AADB meeting attendees are welcome to participate once registered at:* ***https://aadb.memberclicks.net/aadb-139th-annual-meeting.***
1:30 p.m. - 2:30 p.m.	**AADB Forum: State/Territory Board Issues** Frank Maggio, DDS, AADB Member and Moderator *This closed session is for individual voting members who have seats (or had seats) on their Board of Dentistry.*
2:30 p.m.	**Adjournment**

The registration fee for the AADB 139th Annual Meeting is **$695** for AADB members; **$895** for non-members and can be processed online at:

Prices increase on Thursday, September 1, 2022.

https://aadb.memberclicks.net/aadb-139th-annual-meeting

Refund Policy:

Notification of cancellation must be submitted in writing to srojas@dentalboards.org. Cancellations are subject to a $75 cancellation charge. No refunds will be given after August 15, 2022. Substitutions are allowed at any time but must be submitted in writing and must be of the same membership status.

Continuing Education:

The ACE Program is a service of the AADB to assist dental boards in identifying quality continuing education courses to help protect the public. ACE accreditation may not be accepted by particular boards of dentistry. Questions or comments can be directed to the AADB at info@dentalboards.org.

The American Association of Dental Boards is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. The American Association of Dental Boards designates this activity for 8.25 continuing education credits. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www.ada.org/cerp.

Attachment #7

Updated 09-09-2022

Covid Precautions:

Health and Safety

The health and safety of meeting attendees is our top priority. Attendees are encouraged to familiarize themselves with COVID-19 guidelines provided by the CDC and the appropriate state and local public health authorities in areas they are traveling. Please note that the AADB is following all state and local public health requirements related to COVID-19. **At this time, the AADB is encouraging vaccinations, social distancing, and the use of masks; and will continue to evaluate the circumstances as we get closer to the event.**

Please monitor your health when you reach Asheville and while attending the meeting. If you develop symptoms of sickness, please do not attend the sessions and email srojas@dentalboards.org or text: 312-718-0843. **If state and local health orders change prior to the meeting, we will communicate with all meeting attendees through email.**

Unauthorized recording policy

The American Association of Dental Boards is committed to providing a professional environment that is open to the free expression of views and ideas and cultivating a learning community. Recording conversations, phone calls, images, or organizational meetings with any recording device (including but not limited to a cellular telephone, PDA, digital recording device, digital camera, etc.) unless all parties to the conversation give their consent in advance is hereby prohibited. A violation of this policy will result in corrective action which can include being removed from the conference.

Caucuses by State

East	West	North	South
Connecticut	Alaska	Illinois	Alabama
Delaware	Arizona	Indiana	Arkansas
District of Columbia	California	Iowa	Florida
Maine	Colorado	Kansas	Georgia
Maryland	Hawaii	Michigan	Kentucky
Massachusetts	Idaho	Minnesota	Louisiana
New Hampshire	Montana	Missouri	Mississippi
New Jersey	Nevada	Nebraska	North Carolina
New York	New Mexico	North Dakota	Puerto Rico
Pennsylvania	Oregon	Ohio	South Carolina
Rhode Island	Utah	Oklahoma	Tennessee
Vermont	Washington	South Dakota	Texas
West Virginia	Wyoming	Wisconsin	Virginia
			Virgin Island

Attachment #7

AADB Board of Directors

James A. Sparks, DDS, President
5804 Northwest Expressway Street
Warr Acres, OK 73132

Dale Chamberlain, DDS, President-Elect
1240 Lariat Road
Helena, MT 59602

Arthur Chen-Shu Jee, DMD, Vice President
13934 Baltimore Avenue
Laurel, Maryland 20707

Clifford Feingold, DDS, Treasurer
4 Stuart Circle
Asheville, NC 2880

Bobby J. Carmen, DDS, MAGD, Secretary
1141 Sonoma Park Drive
Norman, OK 73072

Yvonne Bach, Public Member
312 Whittington Pkwy, Suite 101
Louisville, KY 40222

Brian Barnett, Administrator Member
3605 MO Blvd
Jefferson City, MO 65102

Laura Richoux, RDH, Dental Hygiene Member
600 East Amite Street, Suite 100
Jackson, MS 39201

Frank Recker, DDS, JD, Board Attorney
The Queens Tower
810 Matson Place Suite 1101
Cincinnati, Ohio 45204

Tonia Socha-Mower, MBA, EdD,
Chief Executive Officer
AADB
200 East Randolph Street, Suite 5100
Chicago, IL 60601

Attachment #7

Updated 09-09-2022

Thursday 10/6:

8:30 – 9:00	Breakfast
9:00 – 9:15	Welcome & Introductions – AADA President Mr. Stephen Prisby
9:15 – 11:00	Presentations: (Short Break around 10 am) ➢ Prescription Monitoring Programs and Drug Diversion ➢ ADA - Wellness Program ➢ Scope of Practice Expansion - Brief Updates on Dental Therapy ➢ Legislative Discussion on Criminal Justice Reforms
11:00 – 12:00	Update from Testing Agencies and other parties
12:00 – 1:10	Lunch
1:10 – 1:30	DANB Update
1:30 – 2:30	State Roundtable Discussion
2:30 – 2:45	Break
2:45 – 3:45	State Roundtable Discussion (*continued*)
3:45 – 4:30	AADA Committee Updates ➢ Strategic Planning Advisory Committee Report ➢ Other Committees
6:00 – 8:00	DANB Network Reception

Friday 10/7:

8:30 – 9:00	Breakfast
9:00 – 10:30	Business Session: ➢ Bylaw Update to consider ➢ Treasurer Report ➢ Election of Officers
10:30 – 10:45	Break
10:45 – 12:00	Dental Licensure Compact - *Matthew Shafer, Council of State Governments*
12:00	Executive Committee Final Words & Thank You
1:00	Networking

Regional Caucus Agenda

2022 AADB Annual Meeting

Time has been allocated for caucus meetings on Sunday, October 9th from 8:00 a.m. - 9:00 a.m. ET. Oral caucus reports are scheduled to be given to the General Assembly at 9:15 a.m. ET on Sunday, October 9th. Written reports from caucus leaders are due on October 21st.

1. Elect a regional caucus chair for the Mid-Year 2023 and Annual 2023 AADB meetings.

2. The AADB Board of Directors is always looking for effective and inspiring leaders.

A. Please elect a member from your caucus to serve on the AADB Nominating Committee.

B. Other leadership opportunities exist on the following committees by Presidential appointment and confirmation by the AADB Board of Directors:

- Program Committee
- Bylaws Committee
- Finance Committee
- Award Selection
- Membership Committee
- Sponsor Committee
- Administrators' Committee

Please have interested members email their CVs and cover letters to info@dentalboards.org by October 14th to be considered for a committee appointment.

3. North and West Caucuses should elect candidates for appointment to external organizations as outlined below.

The AADB Bylaws stipulate appointees shall attend at least one AADB meeting each year and attend at least one AADB Annual Meeting every two years. Reports are given to the General Assembly.

A. Council on Dental Education and Licensure (CDEL) - *West* Caucus.

Requirements from the ADA:

- Appointee agrees to continue to be an active, life, or retired member of the ADA while serving as a member of CDEL.
- Appointee must be an active member of the AADB.
- Appointee cannot be dental school faculty at the time of appointment or while serving in this role.
- To be eligible to serve, the appointee cannot have previously served in this AADB role.
- Appointee cannot have served on any other ADA councils or commissions.

B. Joint Commission on National Dental Examinations (JCNDE) - *North* Caucus

Requirements from the ADA:

- Appointee is in good standing as an active, life, or retired member of the ADA and will continue to be while serving as a member of the JCNDE.
- Appointee is an active member of the AADB.
- Candidate is not dental school faculty at the time of appointment or while serving in this role.
- Appointee cannot be a principal officer of an organization such as AADB, ADA, ADEA, ADHA, and/or ASDA which has a role in appointing a member of the JCNDE while serving as a member of JCNDE.
- Appointee has not served as a principal officer or active examiner of an external testing agency such as ADEX, CRDTS, CDCA, CITA, SRTA, or WREB within the last 3 years.
- Appointee will not serve as a principal officer or active examiner of an external testing agency such as ADEX, CRDTS, CDCA, CITA, SRTA, or WREB while serving as a member of the JCNDE.
- Appointee cannot have previously served as a member of the JCNDE.
- Appointee cannot have served on any other previous ADA councils or commissions.

4. At the AADB 2021 Annual Meeting, the Council of State Governments (CSG) representatives presented their vision for the dental compact. **Since dental boards can be influential in these types of decisions, is your regulatory board interested in joining the compact? Does your board have concerns?**

5. Dr. Tim Ricks, Retired Chief Dental Officer of the U.S. Public Health Service, spoke at a recent AADB meeting about bi-directional integration of oral health and overall health. This concept could allow dental teams to be able to do things like hypertension screenings, diabetes screenings, HPV education/vaccine administration, influenza and pneumococcal education/vaccine administration, childhood immunization screening vaccine/administration, obstructive sleep apnea screenings, and HIV screenings. Some states have a very narrow definition of dentistry in their state practice acts, and dental teams in those states may not be able to do some of the above screenings, while other states have a broader definition, which would potentially allow them to do screenings for chronic diseases. **How does your board interpret the definition of dentistry? Is there interest in your area to broaden the scope of practice for dental professionals?**

6. **Identify other discussion topics important to your region to be explored in 2023.**

UNFINISHED BUSINESS & RULES

Changes to Oregon Pain Education Requirements

Q: How are the requirements related to pain education for Oregon licensed providers changing?

A: The Oregon Legislature passed, and the Governor signed, House Bill 2078. The bill changes the requirement from six hours of one-time pain management education training upon initial licensure to one hour of training completed at a frequency of at least once every 36 months, as determined by the practitioner's licensing board.

Q: Which licensure types are affected by HB 2078?

A: ORS 413.590 lists the practitioners who either must complete a pain management education program described in ORS 413.572 (1)(c) or an equivalent pain management education program[1] at initial licensure and every 36 months thereafter:

1. Physician Assistant licensed under ORS chapter 677;
2. Nurse licensed under ORS chapter 678;
3. Psychologists licensed under ORS 675.010 to 675.150
4. Chiropractic Physician licensed under ORS chapter 684;
5. Naturopath licensed under ORS chapter 685
6. Acupuncturist licensed under ORS 677.759
7. Pharmacist licensed under ORS chapter 689;
8. Dentist licensed under ORS chapter 679
9. Occupational Therapist licensed under ORS 675.210 to 675.340;
10. Physical Therapist licensed under ORS 688.010 to 688.201
11. Optometric Physicians licensed under ORS 683

The Oregon Medical Board, in consultation with the Oregon Pain Management Commission (OPMC), 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 a pain management education program described in ORS 413.572. The board may identify by rule circumstances under which the requirement under this section may be waived.

Q: When does HB 2078 go into effect?

A: It will affect licenses issued or renewed on or after January 1, 2022.

Q: What is the reasoning behind requiring licensees to complete a pain management education program at least once every 36 months?

A: The intent is to ensure that licensed practitioners have up-to-date knowledge and the information needed to appropriately manage their patients' pain.

Because different licensing boards have different license renewal schedules, the language in HB 2078 provides flexibility so that the required training hour is completed at least once every 36 months. For boards with 1- or 2-year renewal-cycles, the boards can elect to require the training more frequently, or to count completion of the training towards future renewals as long as the requirement has been met in the 36 months prior to each renewal.

Q: Will the OPMC training continue to be updated biennially?

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[1] as described in ORS 675.110, 677.228, 677.510, 678.101, 684.092, 685.102 or 689.285.

A: Yes, the OPMC is required to provide biennial updates to its continuing education content. This may be done as an update to the current online continuing education module or via an alternative continuing education format. OHA will advise each licensure board on the updates as they become available. A new version of the pain module was released 07/01/2021, so professionals who completed the previous module will see fresh content.

Q: Will the pain management education program produced by the OPMC continue to be free and offered online?

A: Yes, the online pain management module produced by OHA and the OPMC will continue to be offered free and online at https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/module.aspx.

Q: Are there other courses licensees can take in pain management that meet the one-hour requirement, besides the free module offered by OHA and the Oregon Pain Management Commission?

A: Yes, this legislation allows for flexibility in course selection. Licensees should refer to the specific stipulations set forth by their licensure board to make sure the courses they select for continuing education comply with the board's requirements.

Q: How can licensing boards obtain verification of which providers have completed the OPMC's free online pain management module?

A: OHA staff can provide a list of licensees who have completed the module to each board and commission at an interval that meets the needs of each board. To make arrangements, contact Mark Altenhofen, OPMC Coordinator at: mark.g.altenhofen@dhsoha.state.or.us.

Q: Who can I contact if I have further questions regarding HB 2078?

A: Please contact Mark Altenhofen, OPMC Coordinator at: mark.g.altenhofen@dhsoha.state.or.us

CORRESPONDENCE

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

TO: Governor Kate Brown

FROM: Stephen Prisby, OBD Executive Director

DATE: September 30, 2022

SUBJECT: Request Regarding ORS 679.546

The Oregon Board of Dentistry (OBD) was involved in litigation regarding specialty advertising statute and rules. The American Academy of Implant Dentistry (AAID) sued the Board and myself in our official capacities regarding perceived restrictions on advertising as a specialist. The DOJ settled the matter on behalf of the OBD. As part of the settlement agreement: the OBD is recommending you add repealing ORS 679.546 to your 2023 Legislative Agenda.

ORS 679.546 is provided as reference for you.

679.546 Advertising as specialist; requirements; rules. (1) A dentist licensed by the Oregon Board of Dentistry may advertise that the dentist is a specialist in one or more areas of dentistry if the dentist:
(a) Has completed a post-doctoral residency program that is at least two years in length and is accredited by the Commission on Dental Accreditation, or its successor organization, and approved by the board by rule;
(b) Is a specialist as defined by the National Commission on Recognition of Dental Specialties and Certifying Boards, or its successor organization, and adopted by the board by rule; or
(c) Has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education, and approved by the board by rule.
(2) The board may adopt rules as necessary to carry out this section. [2019 c.379 §2]

<u>The Terms of the settlement agreement related to you include this provision</u>:
Defendants will recommend to the Governor including the repeal of the specialty advertising restrictions in ORS 679.546 in the Governor's 2023 legislative agenda, and, should the Governor agree, Defendants will support the repeal in the 2023 legislative session. Nothing in this Agreement purports to bind any future Governor of Oregon.

I can provide any additional information at your request.

Sincerely,
Stephen Prisby
OBD Executive Director

Attachments – AAID V. OBD Complaint, Amended Complaint & Settlement

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**pro hac vice admission applications pending*

Attorneys for Plaintiffs

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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

AMERICAN ACADEMY OF IMPLANT DENTISTRY,
211 East Chicago Ave., Suite 1100
Chicago, IL 50511

JAMES MILLER, D.M.D.,
518 S.E. Oak, Suite 100
Hillsboro, OR 97123

and

NATHAN DOYEL, D.M.D.,
17680 S.W. Handley, Suite 101
Sherwood, OR 97140

Plaintiffs,

v.

In their official capacities:

STEPHEN PRISBY,
Executive Director
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

YADIRA MARTINEZ, R.D.H.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

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Case No. ______________________

COMPLAINT FOR PRELIMINARY INJUNCTION, DECLARATORY JUDGMENT, AND DAMAGES

DEMAND FOR JURY TRIAL

ALICIA RIEDMAN, R.D.H.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

AMY B. FINE, D.M.D.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
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GARY UNDERHILL, D.M.D.,
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REZA J. SHARIFI, D.M.D.,
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CHARLES "CHIP" DUNN,
Member
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JOSE JAVIER, D.D.S.,
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Portland, OR 97201

AARATI KALLURI, D.D.S.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

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SHEENA KANSAL, D.D.S.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

and

JENNIFER BRIXEY,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

Defendants.

Through counsel, Plaintiffs—the American Academy of Implant Dentistry ("AAID") and dentists Dr. James Miller and Dr. Nathan Doyel—allege as follows for their complaint against the Defendants, the executive director, and the individual members of the Oregon Board of Dentistry (the "Oregon Board"), in their official capacities:

PRELIMINARY STATEMENT

1. AAID is a national dental organization. Dentists, upon satisfying certain experiential, educational, and testing requirements, may earn credentials issued by AAID and its certifying board, the American Board of Oral Implantology/Implant Dentistry ("Implant-Dentistry Board"), in the field of implant dentistry. The highest certification a dentist can earn through the Implant-Dentistry Board is "Diplomate." The Diplomate credential issued by the Implant-Dentistry Board is the most rigorous, objectively verifiable credential that a dentist can earn in the field of implant dentistry.

2. Drs. Miller and Doyel are each Oregon dentists and Implant-Dentistry Board Diplomates. In other words, they are each board-certified in implantology. This objectively verifiable

credential provides consumers with important information concerning their confirmed competence in the field of implant dentistry.

3. Because they are board-certified in implantology, Drs. Miller and Doyel—and other similarly situated board-certified members of AAID in Oregon—seek to hold themselves out as specialists in implant dentistry, also known as implantology. Advertising a specialty in this sub-field of dentistry under these circumstances is truthful, is not misleading, and conveys more precise information to the public and promotes their practice. A specialty statement would be truthful and non-misleading, and it therefore constitutes commercial speech protected by the First Amendment to the United States Constitution and Article I, section 8, of the Oregon Constitution.

4. Unfortunately, Oregon law and regulations as adopted and applied by the Defendants unconstitutionally bar the Plaintiffs from conveying this truthful information.

5. The Defendants wrongfully limit the practice areas in which a dentist can advertise a specialty to practice areas recognized as specialties by the Oregon Board.

6. The State of Oregon has a substantial interest in prohibiting false and misleading advertising. But the Defendants' purported prohibition on truthfully advertising specialization in implantology when a dentist has achieved board certification by a bona fide dental organization like AAID and the Implant-Dentistry Board does not directly and materially advance the State's substantial interest. Indeed, it does not advance it at all, but instead denies the public important and accurate information. Moreover, the State of Oregon's regulatory structure, as enacted and applied by Defendants, is not narrowly tailored as required by a litany of cases on this issue.

7. The Oregon regulatory regime is a discriminatory and irrational classification system that arbitrarily distinguishes between licensed dentists who can hold themselves out to be specialists or board-certified, and those like Drs. Miller and Doyel, and other Implant-Dentistry-

Board-certified dentists, who cannot so advertise. Defendants confer rights on dentists who have obtained designations as recognized specialists, while impinging on the fundamental rights of dentists who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty. This irrational, unequal treatment is prohibited by the United States and Oregon constitutions.

8. Defendants have also denied Drs. Miller and Doyel, and other AAID member-dentists in Oregon a mechanism for evaluating or acknowledging the professional dental credentials earned by them in areas of dentistry not recognized by the State of Oregon or the American Dental Association ("ADA") as specialties. The regulatory scheme likewise deprives AAID itself of any mechanism for appealing the Board's denial of recognition of any credentialing organization or any areas of dental practice not recognized as specialty areas of practice by the State of Oregon.

9. The at-issue portions of Oregon law and regulations, both on their face and as applied by Defendants, violate the Free Speech Clause of the First Amendment to the United States Constitution and Article I, section 8, of the Oregon Constitution, the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, and likewise violate the procedural and substantive due-process rights guaranteed to Drs. Miller and Doyel by the Fourteenth Amendment.

10. Along similar lines, Oregon law and regulations, as enacted and applied by Defendants, violate the rights of AAID individually as well as the rights of the numerous Oregon-based member-dentists that it represents.

11. For these reasons, as explained more fully below, Plaintiffs AAID and Drs. Miller and Doyel seek a declaratory judgment from this Court finding that the at-issue Oregon laws and

regulations are unconstitutional both facially and as-applied. Plaintiffs likewise seek injunctive relief to safeguard them from further injury by Defendants.

JURISDICTION AND VENUE

12. This Court has original jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343(a). Plaintiffs seek declaratory, injunctive, and other relief pursuant to 28 U.S.C. §§ 2201 and 2202, as well as 42 U.S.C. §§ 1983 and 1988. This matter arises under the First and Fourteenth Amendments to the United States Constitution and is asserted via 42 U.S.C. § 1983.

13. This Court has jurisdiction over Plaintiffs' state-law claim under the doctrine of pendent jurisdiction.

14. Venue is proper in this Court pursuant to 28 U.S.C. §§ 117 and 1391(b). Defendants' official place of business is in Portland, Multnomah County, Oregon, which lies within this District. Upon information and belief, all Defendants are residents of the State of Oregon and work in this District. Additionally, a substantial part of the events or omissions giving rise to these claims occurred in this District.

BACKGROUND AND INTRODUCTION TO THE PLAINTIFFS

15. Implantology, or implant dentistry, is a field of dentistry that involves the surgical placement of artificial posts in the jawbone, which anchor replacement teeth or bridges. Implants offer certain advantages over other alternatives (like dentures), but not all patients are candidates for implants, and implant surgery can lead to serious complications. Implant dentistry is a multidisciplinary field, which includes dental surgery, prosthetics, periodontics, occlusion, pain management, anatomy, physiology, pathology, and dental-facial aesthetics.

16. Plaintiff AAID is a national dental organization whose primary mission is educating dentists in the field of implant dentistry and enhancing its members' knowledge, skills, and expertise in the field.

17. The Implant-Dentistry Board is AAID's certifying board. It is accredited as a certifying board by the American Board of Dental Specialties ("ABDS"). ABDS is an independent specialty-certifying entity not controlled by the ADA or by any other professional dental organization representing any specific area of dentistry.

18. AAID's member-dentists, upon satisfying certain experiential, educational, and testing requirements, may earn credentials issued by AAID and the Implant-Dentistry Board in the field of implant dentistry.

19. Specifically, members of AAID may earn various credentials in the field of implant dentistry: the "Associate Fellow—AAID," "Fellow—AAID," and "Diplomate— Implant-Dentistry Board" designations. The requirements that any dentist must meet before earning any of these designations are both objective and verifiable.

20. To become an "Associate Fellow–AAID," a dentist must: (a) complete 300 hours of continuing education in implant dentistry, including 150 hours of clinical implant education; (b) pass a written examination; and (c) successfully complete an oral/clinical treatment case examination.

21. To become a "Fellow–AAID," a dentist must: (a) have five years of experience in implant dentistry; (b) complete an additional 100 hours of continuing education in implant dentistry (beyond the 300 hours required for the associate fellow credentials); (c) provide dental implant treatment in at least fifty cases; (d) pass an oral examination; and (e) satisfactorily present ten cases to the AAID's admissions and credential board.

22. Nationally, the AAID currently has approximately 3,947 members. Of those 3,947 members, approximately 1,045 have earned Associate Fellow or Fellow status.

23. The Implant-Dentistry Board, for its part, issues the "Diplomate" (aka "Board Certified") credential. The Diplomate credential is the highest certification a dentist can earn through the Implant-Dentistry Board, and it is the most rigorous, objectively verifiable credential that a dentist can earn in the field of implant dentistry.

24. Dentists may earn this credential by passing the Implant-Dentistry Board's certification examination and by fulfilling certain rigorous educational, experiential, and examination requirements. To be eligible to become a Diplomate, a dentist first must (a) be a graduate of a full-time, two-year post-doctoral program in oral implantology, (b) be a board-certified graduate of a full-time advanced education program, and (c) complete a full-time advanced education program and pass a written exam. All applicants must also have seven or more years of experience in the practice of implant dentistry and have completed at least 75 implant cases. Once a practitioner meets these initial qualifications, the practitioner must then take and pass a comprehensive oral examination covering both standardized implant cases developed by the Implant-Dentistry Board as well as four of eight cases the candidate submits to the Implant-Dentistry Board as part of the application process in specific areas of implant dentistry.

25. Since the Implant-Dentistry Board began issuing these credentials in 1989, approximately 633 dentists have successfully completed the requirements and received this designation.

26. AAID has promoted the field of implant dentistry through education, training, and research for over 70 years. AAID and the Implant-Dentistry Board have both issued credentials to dentists for over 30 years. Under Oregon law, as enacted and applied by Defendants, these dentists are unable to advertise as specialists or board-certified in implantology. Moreover, Defendants

defer exclusively to the specialty-recognition process of the ADA, whether through the ADA's Commission on the Recognition of Dental Specialties and Certifying Boards (the "ADA Recognition Commission") or through the United States Department of Education ("DOE"), which itself relies on the ADA. That is, while Oregon does not yet recognize every specialty recognized by the ADA, Defendants only recognize as specialties—and therefore permit factually accurate advertising concerning—specialty areas that are recognized by the ADA. Notably, the ADA is a private organization comprised of dentist–members who are, in many instances, in competition with Plaintiffs, and who therefore have a direct financial stake in restricting who may represent themselves as a "specialist" or as board-certified in implantology to the consuming public.

27. Education specific to implant dentistry is not required in dental-school curriculum as promulgated by the ADA's Commission on Dental Accreditation ("CODA").

28. Plaintiff AAID brings this action as the associational representative of its Oregon members who wish to advertise as specialists in implant dentistry and as board-certified in implantology.

29. Dentists are less likely to seek membership in AAID and certification by the Implant-Dentistry Board if they cannot truthfully advertise a specialization in implant dentistry once they achieve that certification.

30. Plaintiff James Miller ("Dr. Miller") is an Oregon dentist. He resides in Hillsboro, Oregon. Dr. Miller has been licensed to practice dentistry in Oregon since 1979. He practices dentistry in Washington County, Oregon. Dr. Miller has been providing implants as a dental service since 1987. He has been a member of AAID since 2007 and a credentialed AAID Fellow

since 2015. He also received recognition in 2014 as a Diplomate of the Implant-Dentistry Board. His practice is almost exclusively centered on comprehensive reconstructive implant dentistry.

31. Plaintiff Nathan Doyel ("Dr. Doyel") is an Oregon dentist. He resides in Sherwood, Oregon. Dr. Doyel has been licensed to practice dentistry in Oregon since 1997. He practices dentistry in Sherwood, Oregon. Dr. Doyel has been providing implants as a dental service since 1997. He has been a member of AAID since 2013 and a credentialed AAID Fellow since 2020. He also received recognition in 2019 as a Diplomate of the Implant-Dentistry Board. A large percentage of his practice is comprised of implant dentistry.

32. Drs. Miller and Doyel are Implant-Dentistry Board Diplomates—board-certified in implantology. This objectively verifiable credential provides consumers with important information concerning Drs. Miller and Doyel's confirmed competence in the field of implant dentistry.

33. Drs. Miller and Doyel wish to be recognized as specialists and to advertise as specialists in implant dentistry. They wish to use terms like "specialist" and "specialize" in their advertisements and communications with the public, as well as related descriptions that may imply specialization like "board-certified in implantology by the American Academy of Implant Dentistry." They bring this action to protect their constitutional rights, to increase the provision of truthful, non-misleading information to consumers about their own specialization in the area of implant dentistry, and to improve the financial well-being of their dental practices. They and similarly situated AAID member–dentists face an imminent risk of irreparable injury unless the Court declares Oregon's specialty-regulation scheme unconstitutional and grants Plaintiffs the injunctive relief sought.

34. Under Oregon law, as interpreted and applied by Defendants, Drs. Miller and Doyel, and other credentialed AAID members who are engaged in the practice of dentistry in

Oregon are unable to achieve recognition of their status as specialists in implant dentistry because Defendants have chosen not to recognize implant dentistry as a specialty area.

35. Defendants defer exclusively to the ADA, directly or indirectly, as to which practice areas will be recognized as specialty areas and which areas are denied specialty recognition. Defendants only recognize a specialty area—and therefore permit factually accurate advertising concerning that area— if that area is recognized by the ADA Recognition Commission. Oregon allows the Defendants to recognize a dentist as a specialist if the dentist has met certain standards established by the ADA Commission on Dental Accreditation or the ADA Recognition Commission. Oregon also allows the Defendants to recognize a dentist as a specialist if the dentist "has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education," but the DOE—in turn—relies on these same two ADA commissions to decide which programs to recognize.

36. In practice, the Defendants have relied exclusively on the ADA to decide which practice areas to recognize as specialties.

37. For example, the ADA for the first time chose to recognize Oral Medicine and Orofacial Pain as specialty areas in September 2020. Those two areas were not yet recognized by the Oregon Board, but immediately and predictably, in October 2020, the Oregon Board unanimously passed a proposed rule amendment to recognize those areas of specialty in Oregon.

38. The ADA is a private organization comprised, in large measure, of dentist–members who are in competition with Plaintiffs, and who therefore have a direct financial stake in restricting who may represent themselves as a "specialist" or as board-certified in implantology to the consuming public.

39. Defendants' deferral to the ADA gives Plaintiffs' competitors a *de facto* veto over Plaintiffs' ability to be recognized as specialists and deprives Plaintiffs of their rights without due process.

40. In this matter, AAID sues on its own behalf and also in a representative capacity on behalf of its dentist–members who are engaged in the practice of dentistry in Oregon and who have been certified in implant dentistry by the AAID and the Implant-Dentistry Board, and who are thus adversely affected by O.A.R. 818-015-000, Or. Rev. Stat. ("ORS") 679.546(1), and O.A.R. 818-021-0015 (the "Regulatory Scheme").

The Defendants

41. The Oregon Board of Dentistry is the state professional board charged with regulating the practice of dentistry and dental hygiene in ORS Chapters 679, 680.010–680.205.

42. Among other things, the Board is empowered to license dentists, make, and enforce rules to regulate the practice of dentistry, and investigate and discipline licensees. ORS 679.250. In adopting rules, the Board is required to "take into account all relevant factors germane to an orderly and fair administration of this chapter . . . , 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." ORS 679.250(7).

43. Defendant Stephen Prisby is the Executive Director of the Oregon Board of Dentistry (the "Board"). Defendant Prisby is sued only in his official capacity.

44. Oregon law requires that the Board be composed of ten members appointed by the Governor and subject to confirmation by the Senate, six of whom must be licensed dentists. ORS 679.230(1), ORS 679.230(1)(a). One of these dentist-members "must be a dentist practicing in a dental specialty recognized by the American Dental Association." *Id.* § 679.230(1)(a). Under ORS 679.230, Board members are appointed and confirmed to four-year terms, though they can be removed by the Governor of Oregon prior to the expiration of their terms.

45. Defendants Yadira Martinez, Alicia Riedman, Amy B. Fine, Gary Underhill, Reza J. Sharifi, Charles "Chip" Dunn, Hai Pham, José Javier, and Jennifer Brixey are the current members of the Oregon Board of Dentistry.

46. The individual members of the Board are sued only in their official capacities.

47. Collectively, the Defendants are responsible for implementing, administering, and enforcing the Oregon Dental Practice Act, ORS 679. This authority includes the power to discipline licensed dentists in Oregon, ORS 679.140, 679.250(8), including the power to discipline such dentists for "unprofessional conduct," ORS 679.140(1)(c). Under the Oregon Dental Practice Act, "unprofessional conduct" includes using statements in advertising "tending" to deceive or mislead the public or that are untruthful. ORS 679.140(2)(d). The members of the Oregon Board also are authorized to adopt regulations consistent with the Oregon Dental Practice Act, ORS 679.250(7), specifically including such rules as are necessary to carry out ORS 679.546, which is the statute that allows licensed Oregon dentists to advertise as specialists in "one or more areas of dentistry" if certain conditions are met. It is ostensibly under this authority that the Oregon Board has promulgated, and the Oregon Board and its Executive Director enforce, the specialty advertising rule, O.A.R. 818-015-0007.

48. All of the Defendants may be served with process at the official office of the Oregon Board of Dentistry, which is located at 1500 S.W. 1st Avenue, Suite 770, Portland, Oregon 97201.

THE REGULATORY SCHEME

49. Oregon law permits all licensed dentists to practice in any and all areas of dentistry (including the placement of dental implants) regardless of whether those areas are recognized by the ADA as specialties and regardless of the individual dentist's actual education, experience, or expertise in performing dental services in those areas. All Oregon dentists may therefore place dental implants, whether or not they have had any formal training, education, or experience in placing implants.

50. Oregon law also allows any Oregon dentist to advertise that the dentist performs services in any area of dentistry. If a dentist is not recognized by the Regulatory Scheme as a specialist in a given subfield of dentistry yet advertises that he performs services in, or limits his practice to, a recognized specialty area, he must disclaim that he is a specialist in that subfield by disclosing in the advertisement that he is a general dentist or a specialist in a different specialty. O.A.R. 818-015-007(3).

51. As implant dentistry is not a recognized specialty area, any Oregon-licensed dentist—regardless of their actual education, experience, or expertise in performing dental-implant services—can perform those services on patients and can advertise that they do so.

52. But Oregon law does regulate who may be classified as a specialist in a subfield of dentistry.

53. Oregon law, specifically ORS 679.546, only allows a dentist to advertise as a specialist in a given subfield of dentistry if the dentist:

(a) has completed a post-doctoral residency program that is at least two years in length and is accredited by the ADA's Commission on Dental Accreditation, or its successor organization, and approved by the board by rule;

(b) is a specialist as defined by the ADA Recognition Commission, or its successor organization, and adopted by the board by rule; or

(c) has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education, and approved by the board by rule.

54. The Board has promulgated rules, including O.A.R. 818-015-0007, to implement the statute.

55. Oregon regulations, specifically O.A.R. 818-015-0007, authorize advertising of a specialty in only ten specific subfields of dentistry. Implant dentistry is not among them. The regulation provides:

> (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.

56. The list of dental specialties recognized by the Oregon Board exactly mirrors the list of specialties recognized by the ADA. A temporary deviation last year only proves the rule: In September 2020, the ADA chose to recognize Oral Medicine and Orofacial Pain as specialties, thus rendering the ADA and Oregon Board temporarily out of sync, given that the latter had not yet recognized these specialties. But predictably, in October 2020, the Oregon Board unanimously passed a proposed rule amendment adding these two specialty areas of practice to O.A.R. 818-015-0007 and 818-021-0012.

57. The listed "specialties" are defined in more detail in O.A.R. 818-001-0002(12).

58. Under O.A.R. 818-015-0005(1), "to advertise" means "to publicly communicate information about a licensee's professional services or qualifications for the purpose of soliciting business."

59. Under ORS 679.140(1)(c)–(d) and ORS 679.250(8), the Oregon Board may punish licensed Oregon dentists, including the individual Plaintiffs in this case, for violations of the specialty advertising rule, including the suspension or revocation of their licenses and the imposition of civil monetary penalties, ORS 679.140(5).

60. Each of the individual Plaintiffs is a member of the AAID and has earned credentials from the AAID and the Implant-Dentistry Board. The individual Plaintiffs have expended many thousands of dollars in expenses and professional time to earn these credentials and acquire expertise in their respective areas of practice. But because the ADA and the Oregon Board have

not recognized implant dentistry as a specialty area of practice, Plaintiffs are prohibited under O.A.R. 818-015-0007 from advertising their specialty. The Oregon Board's specialty advertising rule has therefore deprived them of any opportunity to recoup their investments and to be rewarded for their industry in earning these credentials and declaring themselves to be specialists in their respective areas of expertise. The restrictive rule further deprives the public of knowledge of those dental professionals who are more highly educated, trained, and tested in their respective fields in dental implants, dental anesthesia, oral medicine, and orofacial pain.

61. Despite the objectively verifiable education, training, and experience required to obtain credentials from the AAID and the Implant-Dentistry Board, as the individual Plaintiffs have done, neither these Plaintiffs nor any AAID members in Oregon who have satisfied the same criteria can declare themselves specialists or advertise that their respective areas of expertise are specialty areas of dental practice. Both the Oregon Board and the ADA refuse to recognize implant dentistry as a specialty area of practice. Through the Defendants' enforcement of the Regulatory Scheme, these refusals by the Oregon Board and by the private ADA constitute a legal prohibition, barring many licensed Oregon dentists, including the individual Plaintiffs, from rightfully holding themselves out as specialists in their fields.

62. The Oregon Board has effectively used the Regulatory Scheme to delegate governmental authority to the ADA to determine which areas of dental practice should receive specialty designation and, hence, which areas may be advertised by Oregon dentists as specialties. The regulations provide no mechanism for evaluating the accrediting organization or its credentials or for contesting the decisions of the ADA denying specialty recognition.

63. The ADA is neither a neutral nor an impartial factfinder concerning dental accrediting organizations in the specialty area of dentistry represented by the Plaintiffs. On the contrary,

credentialed AAID members compete with ADA members who are either board-certified in ADA-recognized specialties or are dentists who engage in implant dentistry, but who have not earned any bona fide credentials in those fields. Advertising of credentials or specialization in the area of implant dentistry, as Plaintiffs seek to establish the right to do, presents a direct economic threat to ADA members who decide specialty areas of practice, thereby precluding an impartial determination of specialties and specialty areas of practice.

64. The determination of whether or not an area of dentistry will be deemed a specialty area of dentistry recognized by the ADA is made by the ADA Recognition Commission.
The ADA Recognition Commission states on its website that dental specialties are recognized "to protect the public, nurture the art and science of dentistry and improve the quality of care."

65. Under the Regulatory Scheme—the State of Oregon has no active, continuing, or meaningful supervision over the ADA, to which is has effectively delegated unfettered regulatory power to determine which subfields of dentistry may be advertised as specialties and what specific credentials entitle a dentist to so-advertise. The Federal constitution does not allow the Oregon Board to delegate unguided and uncontrolled authority to a private organization to establish rules determining the lawfulness or unlawfulness of commercial speech. Yet, this is precisely what Defendants have done in promulgating the Oregon Board's specialty advertising rule and continuing to enforce it.

66. The Regulatory Scheme has effectively granted the ADA the power to regulate the right to free speech of the individual Plaintiffs by not allowing credentialed members in the AAID to advertise as specialists even though they are highly qualified to do so. The specialty regulation has a chilling effect on Plaintiffs' lawful exercise of their right to engage in truthful, non-misleading commercial speech because, if they were to advertise to the public as specialists, their licenses

would be at risk, and they would be subject to civil monetary penalties imposed by the Oregon Board.

67. The Regulatory Scheme imposes arbitrary conditions precedent to advertising without regard to the nature, validity, or truthfulness of the information provided to the public, all in direct violation of Plaintiffs' rights. Pursuant to the Regulatory Scheme, the Oregon Board engages in no substantive analysis, fact-finding, or rulemaking concerning how a dental organization (such as the ADA or AAID) becomes bona fide, how credentialing is obtained, and whether advertising as a specialist in the field would be deceptive or misleading to the public.

68. The regulation also violates procedural due process. The ADA is given the authority, final and unchecked, to determine the limits of lawful dental advertising and is free from procedures consistent with due process. There is no established procedure by which an Oregon-licensed dentist may request recognition of his field as a specialty. The ADA does not have to give any Oregon dentist notice or an opportunity to be heard, despite the fact that it is, *de facto*, the sole arbiter as to what specialties can and cannot be advertised in Oregon. By outsourcing this decision-making, the Regulatory Scheme denies interested persons the pre- and post-deprivation remedies which due process commands. The challenged regulation deprives interested parties of an opportunity to be heard, and while the failure to provide pre-deprivation notice and hearing may be cured by post-deprivation remedies, the challenged regulation offers no such remedy. A refusal by the ADA to recognize specific organizations or areas of dentistry as specialty areas of practice, such as those represented by the individual Plaintiffs, is final and not reviewable. This violates the due process guarantees of the Fourteenth Amendment to the Constitution of the United States.

69. Furthermore, the regulation also violates substantive due process, which protects fundamental rights from arbitrary and unwarranted encroachment by the government. When a

regulation encroaches on fundamental constitutional rights, it must be narrowly tailored to achieve a state's purpose. The specialty regulation in question encroaches on the fundamental rights of Plaintiffs. Their rights to be rewarded for their industry and truthful communication regarding their credentials and expertise, and to declare themselves specialists in implant dentistry, have been denied. The Regulatory Scheme does not satisfy basic constitutional standards and is not narrowly tailored. It creates false impressions regarding the eminently legitimate credentialing organizations the individual Plaintiffs belong to and imputes a State-sanctioned stamp of illegitimacy to their specializations. The specialty advertising regulation implies that the ADA has evaluated the authenticity of the organizational Plaintiff and determined that it is unfit for inclusion as a specialty board and its field of implant dentistry is unworthy of advertising as a specialty area of practice. As such, the Regulatory Scheme violates constitutional guarantees of due process.

CAUSES OF ACTION

COUNT I: FREEDOM OF SPEECH
(42 U.S.C. § 1983)

70. Paragraphs 1–69 are incorporated as if fully set forth herein.

71. The right of AAID member-dentists—including Drs. Miller and Doyel—to advertise truthfully is protected by the First Amendment to the U.S. Constitution, which applies to the State of Oregon through the Due Process Clause of the Fourteenth Amendment.

72. Drs. Miller and Doyel have invested a significant amount of time and money into obtaining certified credentials in implant dentistry and advertising their practice in Oregon, including by maintaining business websites.

73. Other Oregon dentists certified by AAID and the Implant-Dentistry Board similarly have a constitutional right to advertise truthfully. Many of these dentists, too, have invested in advertising regarding their education and credentials in implant dentistry.

74. The individual Plaintiffs wish to advertise as specialists in implant dentistry, and it would not be false or misleading to do so.

75. Notwithstanding the fact that the individual Plaintiffs have obtained bona fide credentials in implant dentistry and do in fact specialize in the subfield of dentistry, Defendants—through their use of Oregon's specialty advertising rule, O.A.R. 818-015-0007—seek to prohibit the individual Plaintiffs and other similarly situated dentists certified by AAID and the Implant-Dentistry Board from exercising their right to truthful, non-misleading commercial speech. Specifically, the Rule bars the individual Plaintiffs and others similarly situated from advertising their specialization—and AAID- and/or Implant-Dentistry Board-conferred certification—in Oregon. This violates the First Amendment rights of both the individual Plaintiffs and Plaintiff AAID, thus rendering the rule unconstitutional both on its face and as applied.

76. Oregon's unconstitutional regulatory structure, on its face and as applied to the Plaintiffs, also injures Oregon dental patients who may be seeking dental implants and other specialized implant procedures. These patients lack access to truthful information about legitimate accreditations that could distinguish more experienced and trained dentists like Implant-Dentistry-Board Diplomates from general dentists who lack that experience and training.

77. Further, if Oregon continues to enforce the regulatory scheme, fewer Oregon dentists will seek membership in AAID or the education and certification of AAID and the Implant-Dentistry Board. Not only will this negatively affect dental-implant patients in Oregon, who will not benefit from the added specialized training that AAID and the Implant-Dentistry Board provide, but it will continue to financially harm AAID because its membership will continue to be artificially reduced.

78. The Oregon's Regulatory Scheme, on its face and as applied to the Plaintiffs, violates Plaintiffs' constitutional rights. This violation is actionable under 42 U.S.C. § 1983.

COUNT II: FREEDOM OF SPEECH
(OREGON CONSTITUTION, ART. I § 8)

79. Paragraphs 1–78 are incorporated as if fully set forth herein.

80. AAID member-dentists in Oregon—including Drs. Miller and Doyel—are protected by the Oregon Constitution, including Article I, section 8, which prohibits Defendants from "restraining the free expression of opinion, or restricting the right to speak, write, or print freely on any subject whatever." Or. Const., Art. I, § 8.

81. The Regulatory Scheme violates Plaintiffs' free-expression guarantees under Article I, section 8, of the Oregon Constitution. On its face, the Regulatory Scheme prohibits truthful speech, and the prohibition is not permitted by any historical exception. Further, the Regulatory Scheme is unconstitutionally overbroad. It prohibits speech that would not cause any of the effects the Defendants seek to avoid.

82. Defendants' actions in promulgating and enforcing the Regulatory Scheme unreasonably discriminates against Plaintiffs based on the content of their speech, in violation of Article I, section 8, of the Oregon Constitution.

COUNT III: EQUAL PROTECTION
(42 U.S.C. § 1983)

83. Paragraphs 1–82 are incorporated as if fully set forth herein.

84. The Regulatory Scheme creates discriminatory classifications between dentists who have obtained designations as Board-recognized specialists and those who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty.

85. The specialty regulation creates irrational and discriminatory classifications between licensed dentists who can hold themselves out to be specialists or board-certified, and those such as Drs. Miller and Doyel, and other Implant-Dentistry-Board-certified dentists who cannot so advertise.

86. The Regulatory Scheme confers rights on dentists who have obtained designations as recognized specialists, while impinging on the fundamental rights of dentists who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty. This irrational, unequal treatment is prohibited by the United States Constitution.

87. The Regulatory Scheme is suspect and subject to heightened judicial scrutiny because it directly impinges upon fundamental rights.

88. Both facially and as applied, the Regulatory Scheme denies equal protection of the laws to Plaintiffs. This violation of Plaintiffs' constitutional rights by Defendants is actionable under 42 U.S.C. § 1983.

COUNT IV: SUBSTANTIVE AND PROCEDURAL DUE PROCESS
(42 U.S.C. § 1983)

89. Paragraphs 1–88 are incorporated as if fully set forth herein.

90. Drs. Miller and Doyel—as well as AAID's other Oregon member-dentists—have protected property and liberty interests in their licenses to practice dentistry and have a right to engage in truthful commercial speech.

91. The Regulatory Scheme deprives Drs. Miller and Doyel, and other Implant-Dentistry-Board-certified dentists of a state mechanism for evaluating or acknowledging the professional dental credentials earned by them in areas of dentistry not recognized by the State of Oregon or the ADA as specialties. The Regulatory Scheme likewise deprives AAID itself of any mechanism

for appealing the Board's denial of recognition of any credentialing organization or any areas of dental practice not recognized as specialty areas of practice by the State of Oregon.

92. Both facially and as applied, the Regulatory Scheme deprives Plaintiffs of the right to a neutral and impartial factfinder, resulting in arbitrary and capricious decisions, in violation of Plaintiffs' due process rights guaranteed by the Fifth and Fourteenth Amendments to the U.S. Constitution. This violation of Plaintiffs' constitutional rights is actionable under 42 U.S.C. § 1983.

PRAYER FOR RELIEF

93. Plaintiffs ask the Court to:

a. declare Oregon's specialty-advertising rule, O.A.R. 818-015-0007, unconstitutional on its face and as applied to Plaintiffs;

b. declare ORS 679.546(1) and O.A.R. 818-021-0015 each unconstitutional on its face and as applied to Plaintiffs;

c. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with them from further maintenance, implementation, or enforcement of the provisions of Oregon's specialty-advertising rule, O.A.R. 818-015-0007;

d. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with them from further maintenance, implementation, or enforcement of the provisions of ORS 679.546(1) and O.A.R. 818-021-0015;

e. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with

them from instituting or from further maintenance of any disciplinary actions against dentists who have achieved Implant-Dentistry Board Diplomate status for advertising as specialists;

f. award Plaintiffs their reasonable attorney fees, litigation expenses, and costs incurred in bringing and prosecuting this action, pursuant to 28 U.S.C. § 1920, 42 U.S.C. § 1988(b), and Fed. R. Civ. P. 54(d); and

g. grant Plaintiffs any other relief as may be necessary, appropriate, and equitable.

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Respectfully submitted,

Dated: August 11, 2021.

s/ *Kendra Matthews*
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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

Case No. 3:21-CV-01182-SB

AMERICAN ACADEMY OF IMPLANT DENTISTRY,
211 East Chicago Ave., Suite 1100
Chicago, IL 50511

JAMES MILLER, D.M.D.,
518 S.E. Oak, Suite 100
Hillsboro, OR 97123

and

NATHAN DOYEL, D.M.D.,
17680 S.W. Handley, Suite 101
Sherwood, OR 97140

Plaintiffs,

v.

In their official capacities:

STEPHEN PRISBY,
Executive Director
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

YADIRA MARTINEZ, R.D.H.,
Member
Oregon Board of Dentistry
1500 S.W. 1st Ave., Suite 770
Portland, OR 97201

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AMENDED COMPLAINT FOR PRELIMINARY INJUNCTION, DECLARATORY JUDGMENT, AND DAMAGES

DEMAND FOR JURY TRIAL

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Defendants.

Through counsel, Plaintiffs—the American Academy of Implant Dentistry ("AAID") and dentists Dr. James Miller and Dr. Nathan Doyel—allege as follows for their complaint against the Defendants, the executive director, and the individual members of the Oregon Board of Dentistry (the "Oregon Board"), in their official capacities:

PRELIMINARY STATEMENT

1. AAID is a national dental organization. Dentists, upon satisfying certain experiential, educational, and testing requirements, may earn credentials issued by AAID and its certifying board, the American Board of Oral Implantology/Implant Dentistry ("Implant-Dentistry Board"), in the field of implant dentistry. The highest certification a dentist can earn through the Implant-Dentistry Board is "Diplomate." The Diplomate credential issued by the Implant-Dentistry Board is the most rigorous, objectively verifiable credential that a dentist can earn in the field of implant dentistry.

2. Drs. Miller and Doyel are each Oregon dentists and Implant-Dentistry Board Diplomates. In other words, they are each board-certified in implantology. This objectively verifiable

credential provides consumers with important information concerning their confirmed competence in the field of implant dentistry.

3. Because they are board-certified in implantology, Drs. Miller and Doyel—and other similarly situated board-certified members of AAID in Oregon—seek to hold themselves out as specialists in implant dentistry, also known as implantology. Advertising a specialty in this sub-field of dentistry under these circumstances is truthful, is not misleading, and conveys more precise information to the public and promotes their practice. A specialty statement would be truthful and non-misleading, and it therefore constitutes commercial speech protected by the First Amendment to the United States Constitution and Article I, section 8, of the Oregon Constitution.

4. Unfortunately, Oregon law and regulations as adopted and applied by the Defendants unconstitutionally bar the Plaintiffs from conveying this truthful information.

5. The Defendants wrongfully limit the practice areas in which a dentist can advertise a specialty to practice areas recognized as specialties by the Oregon Board.

6. The State of Oregon has a substantial interest in prohibiting false and misleading advertising. But the Defendants' purported prohibition on truthfully advertising specialization in implantology when a dentist has achieved board certification by a bona fide dental organization like AAID and the Implant-Dentistry Board does not directly and materially advance the State's substantial interest. Indeed, it does not advance it at all, but instead denies the public important and accurate information. Moreover, the State of Oregon's regulatory structure, as enacted and applied by Defendants, is not narrowly tailored as required by a litany of cases on this issue.

7. The Oregon regulatory regime is a discriminatory and irrational classification system that arbitrarily distinguishes between licensed dentists who can hold themselves out to be specialists or board-certified, and those like Drs. Miller and Doyel, and other Implant-Dentistry-

Board-certified dentists, who cannot so advertise. Defendants confer rights on dentists who have obtained designations as recognized specialists, while impinging on the fundamental rights of dentists who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty. This irrational, unequal treatment is prohibited by the United States and Oregon constitutions.

8. Defendants have also denied Drs. Miller and Doyel, and other AAID member-dentists in Oregon a mechanism for evaluating or acknowledging the professional dental credentials earned by them in areas of dentistry not recognized by the State of Oregon or the American Dental Association ("ADA") as specialties. The regulatory scheme likewise deprives AAID itself of any mechanism for appealing the Board's denial of recognition of any credentialing organization or any areas of dental practice not recognized as specialty areas of practice by the State of Oregon.

9. The at-issue portions of Oregon law and regulations, both on their face and as applied by Defendants, violate the Free Speech Clause of the First Amendment to the United States Constitution and Article I, section 8, of the Oregon Constitution, the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, and likewise violate the procedural and substantive due-process rights guaranteed to Drs. Miller and Doyel by the Fourteenth Amendment.

10. Along similar lines, Oregon law and regulations, as enacted and applied by Defendants, violate the rights of AAID individually as well as the rights of the numerous Oregon-based member-dentists that it represents.

11. For these reasons, as explained more fully below, Plaintiffs AAID and Drs. Miller and Doyel seek a declaratory judgment from this Court finding that the at-issue Oregon laws and

regulations are unconstitutional both facially and as-applied. Plaintiffs likewise seek injunctive relief to safeguard them from further injury by Defendants.

JURISDICTION AND VENUE

12. This Court has original jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343(a). Plaintiffs seek declaratory, injunctive, and other relief pursuant to 28 U.S.C. §§ 2201 and 2202, as well as 42 U.S.C. §§ 1983 and 1988. This matter arises under the First and Fourteenth Amendments to the United States Constitution and is asserted via 42 U.S.C. § 1983.

13. This Court has jurisdiction over Plaintiffs' state-law claim under the doctrine of pendent jurisdiction.

14. Venue is proper in this Court pursuant to 28 U.S.C. §§ 117 and 1391(b). Defendants' official place of business is in Portland, Multnomah County, Oregon, which lies within this District. Upon information and belief, all Defendants are residents of the State of Oregon and work in this District. Additionally, a substantial part of the events or omissions giving rise to these claims occurred in this District.

BACKGROUND AND INTRODUCTION TO THE PLAINTIFFS

15. Implantology, or implant dentistry, is a field of dentistry that involves the surgical placement of artificial posts in the jawbone, which anchor replacement teeth or bridges. Implants offer certain advantages over other alternatives (like dentures), but not all patients are candidates for implants, and implant surgery can lead to serious complications. Implant dentistry is a multi-disciplinary field, which includes dental surgery, prosthetics, periodontics, occlusion, pain management, anatomy, physiology, pathology, and dental-facial aesthetics.

16. Plaintiff AAID is a national dental organization whose primary mission is educating dentists in the field of implant dentistry and enhancing its members' knowledge, skills, and expertise in the field.

17. The Implant-Dentistry Board is AAID's certifying board. It is accredited as a certifying board by the American Board of Dental Specialties ("ABDS"). ABDS is an independent specialty-certifying entity not controlled by the ADA or by any other professional dental organization representing any specific area of dentistry.

18. AAID's member-dentists, upon satisfying certain experiential, educational, and testing requirements, may earn credentials issued by AAID and the Implant-Dentistry Board in the field of implant dentistry.

19. Specifically, members of AAID may earn various credentials in the field of implant dentistry: the "Associate Fellow—AAID," "Fellow—AAID," and "Diplomate— Implant-Dentistry Board" designations. The requirements that any dentist must meet before earning any of these designations are both objective and verifiable.

20. To become an "Associate Fellow–AAID," a dentist must: (a) complete 300 hours of continuing education in implant dentistry, including 150 hours of clinical implant education; (b) pass a written examination; and (c) successfully complete an oral/clinical treatment case examination.

21. To become a "Fellow–AAID," a dentist must: (a) have five years of experience in implant dentistry; (b) complete an additional 100 hours of continuing education in implant dentistry (beyond the 300 hours required for the associate fellow credentials); (c) provide dental implant treatment in at least fifty cases; (d) pass an oral examination; and (e) satisfactorily present ten cases to the AAID's admissions and credential board.

22. Nationally, the AAID currently has approximately 3,947 members. Of those 3,947 members, approximately 1,045 have earned Associate Fellow or Fellow status.

23. The Implant-Dentistry Board, for its part, issues the "Diplomate" (aka "Board Certified") credential. The Diplomate credential is the highest certification a dentist can earn through the Implant-Dentistry Board, and it is the most rigorous, objectively verifiable credential that a dentist can earn in the field of implant dentistry.

24. Dentists may earn this credential by passing the Implant-Dentistry Board's certification examination and by fulfilling certain rigorous educational, experiential, and examination requirements. To be eligible to become a Diplomate, a dentist first must (a) be a graduate of a full-time, two-year post-doctoral program in oral implantology, (b) be a board-certified graduate of a full-time advanced education program, and (c) complete a full-time advanced education program and pass a written exam. All applicants must also have seven or more years of experience in the practice of implant dentistry and have completed at least 75 implant cases. Once a practitioner meets these initial qualifications, the practitioner must then take and pass a comprehensive oral examination covering both standardized implant cases developed by the Implant-Dentistry Board as well as four of eight cases the candidate submits to the Implant-Dentistry Board as part of the application process in specific areas of implant dentistry.

25. Since the Implant-Dentistry Board began issuing these credentials in 1989, approximately 633 dentists have successfully completed the requirements and received this designation.

26. AAID has promoted the field of implant dentistry through education, training, and research for over 70 years. AAID and the Implant-Dentistry Board have both issued credentials to dentists for over 30 years. Under Oregon law, as enacted and applied by Defendants, these dentists are unable to advertise as specialists or board-certified in implantology. Moreover, Defendants

defer exclusively to the specialty-recognition process of the ADA, whether through the ADA's Commission on the Recognition of Dental Specialties and Certifying Boards (the "ADA Recognition Commission") or through the United States Department of Education ("DOE"), which itself relies on the ADA. That is, while Oregon does not yet recognize every specialty recognized by the ADA, Defendants only recognize as specialties—and therefore permit factually accurate advertising concerning—specialty areas that are recognized by the ADA. Notably, the ADA is a private organization comprised of dentist–members who are, in many instances, in competition with Plaintiffs, and who therefore have a direct financial stake in restricting who may represent themselves as a "specialist" or as board-certified in implantology to the consuming public.

27. Education specific to implant dentistry is not required in dental-school curriculum as promulgated by the ADA's Commission on Dental Accreditation ("CODA").

28. Plaintiff AAID brings this action as the associational representative of its Oregon members who wish to advertise as specialists in implant dentistry and as board-certified in implantology.

29. Dentists are less likely to seek membership in AAID and certification by the Implant-Dentistry Board if they cannot truthfully advertise a specialization in implant dentistry once they achieve that certification.

30. Plaintiff James Miller ("Dr. Miller") is an Oregon dentist. He resides in Hillsboro, Oregon. Dr. Miller has been licensed to practice dentistry in Oregon since 1979. He practices dentistry in Washington County, Oregon. Dr. Miller has been providing implants as a dental service since 1987. He has been a member of AAID since 2007 and a credentialed AAID Fellow

since 2015. He also received recognition in 2014 as a Diplomate of the Implant-Dentistry Board. His practice is almost exclusively centered on comprehensive reconstructive implant dentistry.

31. Plaintiff Nathan Doyel ("Dr. Doyel") is an Oregon dentist. He resides in Sherwood, Oregon. Dr. Doyel has been licensed to practice dentistry in Oregon since 1997. He practices dentistry in Sherwood, Oregon. Dr. Doyel has been providing implants as a dental service since 1997. He has been a member of AAID since 2013 and a credentialed AAID Fellow since 2020. He also received recognition in 2019 as a Diplomate of the Implant-Dentistry Board. A large percentage of his practice is comprised of implant dentistry.

32. Drs. Miller and Doyel are Implant-Dentistry Board Diplomates—board-certified in implantology. This objectively verifiable credential provides consumers with important information concerning Drs. Miller and Doyel's confirmed competence in the field of implant dentistry.

33. Drs. Miller and Doyel wish to be recognized as specialists and to advertise as specialists in implant dentistry. They wish to use terms like "specialist" and "specialize" in their advertisements and communications with the public, as well as related descriptions that may imply specialization like "board-certified in implantology by the American Academy of Implant Dentistry." They bring this action to protect their constitutional rights, to increase the provision of truthful, non-misleading information to consumers about their own specialization in the area of implant dentistry, and to improve the financial well-being of their dental practices. They and similarly situated AAID member–dentists face an imminent risk of irreparable injury unless the Court declares Oregon's specialty-regulation scheme unconstitutional and grants Plaintiffs the injunctive relief sought.

34. Under Oregon law, as interpreted and applied by Defendants, Drs. Miller and Doyel, and other credentialed AAID members who are engaged in the practice of dentistry in

Oregon are unable to achieve recognition of their status as specialists in implant dentistry because Defendants have chosen not to recognize implant dentistry as a specialty area.

35. Defendants defer exclusively to the ADA, directly or indirectly, as to which practice areas will be recognized as specialty areas and which areas are denied specialty recognition. Defendants only recognize a specialty area—and therefore permit factually accurate advertising concerning that area— if that area is recognized by the ADA Recognition Commission. Oregon allows the Defendants to recognize a dentist as a specialist if the dentist has met certain standards established by the ADA Commission on Dental Accreditation or the ADA Recognition Commission. Oregon also allows the Defendants to recognize a dentist as a specialist if the dentist "has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education," but the DOE—in turn—relies on these same two ADA commissions to decide which programs to recognize.

36. In practice, the Defendants have relied exclusively on the ADA to decide which practice areas to recognize as specialties.

37. For example, the ADA for the first time chose to recognize Oral Medicine and Orofacial Pain as specialty areas in September 2020. Those two areas were not yet recognized by the Oregon Board, but immediately and predictably, in October 2020, the Oregon Board unanimously passed a proposed rule amendment to recognize those areas of specialty in Oregon.

38. The ADA is a private organization comprised, in large measure, of dentist–members who are in competition with Plaintiffs, and who therefore have a direct financial stake in restricting who may represent themselves as a "specialist" or as board-certified in implantology to the consuming public.

39. Defendants' deferral to the ADA gives Plaintiffs' competitors a *de facto* veto over Plaintiffs' ability to be recognized as specialists and deprives Plaintiffs of their rights without due process.

40. In this matter, AAID sues on its own behalf and also in a representative capacity on behalf of its dentist–members who are engaged in the practice of dentistry in Oregon and who have been certified in implant dentistry by the AAID and the Implant-Dentistry Board, and who are thus adversely affected by O.A.R. 818-015-000, Or. Rev. Stat. ("ORS") 679.546(1), and O.A.R. 818-021-0015 (the "Regulatory Scheme").

THE DEFENDANTS

41. The Oregon Board of Dentistry is the state professional board charged with regulating the practice of dentistry and dental hygiene in ORS Chapters 679, 680.010–680.205.

42. Among other things, the Board is empowered to license dentists, make, and enforce rules to regulate the practice of dentistry, and investigate and discipline licensees. ORS 679.250. In adopting rules, the Board is required to "take into account all relevant factors germane to an orderly and fair administration of this chapter . . . , 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." ORS 679.250(7).

43. Defendant Stephen Prisby is the Executive Director of the Oregon Board of Dentistry (the "Board"). Defendant Prisby is sued only in his official capacity.

44. Oregon law requires that the Board be composed of ten members appointed by the Governor and subject to confirmation by the Senate, six of whom must be licensed dentists. ORS 679.230(1), ORS 679.230(1)(a). One of these dentist-members "must be a dentist practicing in a dental specialty recognized by the American Dental Association." *Id.* § 679.230(1)(a). Under ORS 679.230, Board members are appointed and confirmed to four-year terms, though they can be removed by the Governor of Oregon prior to the expiration of their terms.

45. Defendants Yadira Martinez, Alicia Riedman, Amy B. Fine, Gary Underhill, Reza J. Sharifi, Charles "Chip" Dunn, Hai Pham, José Javier, and Jennifer Brixey are the current members of the Oregon Board of Dentistry.

46. The individual members of the Board are sued only in their official capacities.

47. Collectively, the Defendants are responsible for implementing, administering, and enforcing the Oregon Dental Practice Act, ORS 679. This authority includes the power to discipline licensed dentists in Oregon, ORS 679.140, 679.250(8), including the power to discipline such dentists for "unprofessional conduct," ORS 679.140(1)(c). Under the Oregon Dental Practice Act, "unprofessional conduct" includes using statements in advertising "tending" to deceive or mislead the public or that are untruthful. ORS 679.140(2)(d). The members of the Oregon Board also are authorized to adopt regulations consistent with the Oregon Dental Practice Act, ORS 679.250(7), specifically including such rules as are necessary to carry out ORS 679.546, which is the statute that allows licensed Oregon dentists to advertise as specialists in "one or more areas of dentistry" if certain conditions are met. It is ostensibly under this authority that the Oregon Board has promulgated, and the Oregon Board and its Executive Director enforce, the specialty advertising rule, O.A.R. 818-015-0007.

48. All of the Defendants may be served with process at the official office of the Oregon Board of Dentistry, which is located at 1500 S.W. 1st Avenue, Suite 770, Portland, Oregon 97201.

THE REGULATORY SCHEME

49. Oregon law permits all licensed dentists to practice in any and all areas of dentistry (including the placement of dental implants) regardless of whether those areas are recognized by the ADA as specialties and regardless of the individual dentist's actual education, experience, or expertise in performing dental services in those areas. All Oregon dentists may therefore place dental implants, whether or not they have had any formal training, education, or experience in placing implants.

50. Oregon law also allows any Oregon dentist to advertise that the dentist performs services in any area of dentistry. If a dentist is not recognized by the Regulatory Scheme as a specialist in a given subfield of dentistry yet advertises that he performs services in, or limits his practice to, a recognized specialty area, he must disclaim that he is a specialist in that subfield by disclosing in the advertisement that he is a general dentist or a specialist in a different specialty. O.A.R. 818-015-007(3).

51. As implant dentistry is not a recognized specialty area, any Oregon-licensed dentist—regardless of their actual education, experience, or expertise in performing dental-implant services—can perform those services on patients and can advertise that they do so.

52. But Oregon law does regulate who may be classified as a specialist in a subfield of dentistry.

53. Oregon law, specifically ORS 679.546, only allows a dentist to advertise as a specialist in a given subfield of dentistry if the dentist:

(a) has completed a post-doctoral residency program that is at least two years in length and is accredited by the ADA's Commission on Dental Accreditation, or its successor organization, and approved by the board by rule;

(b) is a specialist as defined by the ADA Recognition Commission, or its successor organization, and adopted by the board by rule; or

(c) has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education, and approved by the board by rule.

54. The Board has promulgated rules, including O.A.R. 818-015-0007, to implement the statute.

55. Oregon regulations, specifically O.A.R. 818-015-0007, authorize advertising of a specialty in only ten specific subfields of dentistry. Implant dentistry is not among them. The regulation provides:

> (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:
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> (a) Endodontics;
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> (b) Oral and Maxillofacial Surgery;
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> (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.

56. The list of dental specialties recognized by the Oregon Board exactly mirrors the list of specialties recognized by the ADA. A temporary deviation last year only proves the rule: In September 2020, the ADA chose to recognize Oral Medicine and Orofacial Pain as specialties, thus rendering the ADA and Oregon Board temporarily out of sync, given that the latter had not yet recognized these specialties. But predictably, in October 2020, the Oregon Board unanimously passed a proposed rule amendment adding these two specialty areas of practice to O.A.R. 818-015-0007 and 818-021-0012.

57. The listed "specialties" are defined in more detail in O.A.R. 818-001-0002(12).

58. Under O.A.R. 818-015-0005(1), "to advertise" means "to publicly communicate information about a licensee's professional services or qualifications for the purpose of soliciting business."

59. Under ORS 679.140(1)(c)–(d) and ORS 679.250(8), the Oregon Board may punish licensed Oregon dentists, including the individual Plaintiffs in this case, for violations of the specialty advertising rule, including the suspension or revocation of their licenses and the imposition of civil monetary penalties, ORS 679.140(5).

60. Each of the individual Plaintiffs is a member of the AAID and has earned credentials from the AAID and the Implant-Dentistry Board. The individual Plaintiffs have expended many thousands of dollars in expenses and professional time to earn these credentials and acquire expertise in their respective areas of practice. But because the ADA and the Oregon Board have

not recognized implant dentistry as a specialty area of practice, Plaintiffs are prohibited under O.A.R. 818-015-0007 from advertising their specialty. The Oregon Board's specialty advertising rule has therefore deprived them of any opportunity to recoup their investments and to be rewarded for their industry in earning these credentials and declaring themselves to be specialists in their respective areas of expertise. The restrictive rule further deprives the public of knowledge of those dental professionals who are more highly educated, trained, and tested in their respective fields in dental implants, dental anesthesia, oral medicine, and orofacial pain.

61. Despite the objectively verifiable education, training, and experience required to obtain credentials from the AAID and the Implant-Dentistry Board, as the individual Plaintiffs have done, neither these Plaintiffs nor any AAID members in Oregon who have satisfied the same criteria can declare themselves specialists or advertise that their respective areas of expertise are specialty areas of dental practice. Both the Oregon Board and the ADA refuse to recognize implant dentistry as a specialty area of practice. Through the Defendants' enforcement of the Regulatory Scheme, these refusals by the Oregon Board and by the private ADA constitute a legal prohibition, barring many licensed Oregon dentists, including the individual Plaintiffs, from rightfully holding themselves out as specialists in their fields.

62. The Oregon Board has effectively used the Regulatory Scheme to delegate governmental authority to the ADA to determine which areas of dental practice should receive specialty designation and, hence, which areas may be advertised by Oregon dentists as specialties. The regulations provide no mechanism for evaluating the accrediting organization or its credentials or for contesting the decisions of the ADA denying specialty recognition.

63. The ADA is neither a neutral nor an impartial factfinder concerning dental accrediting organizations in the specialty area of dentistry represented by the Plaintiffs. On the contrary,

credentialed AAID members compete with ADA members who are either board-certified in ADA-recognized specialties or are dentists who engage in implant dentistry, but who have not earned any bona fide credentials in those fields. Advertising of credentials or specialization in the area of implant dentistry, as Plaintiffs seek to establish the right to do, presents a direct economic threat to ADA members who decide specialty areas of practice, thereby precluding an impartial determination of specialties and specialty areas of practice.

64. The determination of whether or not an area of dentistry will be deemed a specialty area of dentistry recognized by the ADA is made by the ADA Recognition Commission.
The ADA Recognition Commission states on its website that dental specialties are recognized "to protect the public, nurture the art and science of dentistry and improve the quality of care."

65. Under the Regulatory Scheme—the State of Oregon has no active, continuing, or meaningful supervision over the ADA, to which is has effectively delegated unfettered regulatory power to determine which subfields of dentistry may be advertised as specialties and what specific credentials entitle a dentist to so-advertise. The Federal constitution does not allow the Oregon Board to delegate unguided and uncontrolled authority to a private organization to establish rules determining the lawfulness or unlawfulness of commercial speech. Yet, this is precisely what Defendants have done in promulgating the Oregon Board's specialty advertising rule and continuing to enforce it.

66. The Regulatory Scheme has effectively granted the ADA the power to regulate the right to free speech of the individual Plaintiffs by not allowing credentialed members in the AAID to advertise as specialists even though they are highly qualified to do so. The specialty regulation has a chilling effect on Plaintiffs' lawful exercise of their right to engage in truthful, non-misleading commercial speech because, if they were to advertise to the public as specialists, their licenses

would be at risk, and they would be subject to civil monetary penalties imposed by the Oregon Board.

67. The Regulatory Scheme imposes arbitrary conditions precedent to advertising without regard to the nature, validity, or truthfulness of the information provided to the public, all in direct violation of Plaintiffs' rights. Pursuant to the Regulatory Scheme, the Oregon Board engages in no substantive analysis, fact-finding, or rulemaking concerning how a dental organization (such as the ADA or AAID) becomes bona fide, how credentialing is obtained, and whether advertising as a specialist in the field would be deceptive or misleading to the public.

68. The regulation also violates procedural due process. The ADA is given the authority, final and unchecked, to determine the limits of lawful dental advertising and is free from procedures consistent with due process. There is no established procedure by which an Oregon-licensed dentist may request recognition of his field as a specialty. The ADA does not have to give any Oregon dentist notice or an opportunity to be heard, despite the fact that it is, *de facto*, the sole arbiter as to what specialties can and cannot be advertised in Oregon. By outsourcing this decision-making, the Regulatory Scheme denies interested persons the pre- and post-deprivation remedies which due process commands. The challenged regulation deprives interested parties of an opportunity to be heard, and while the failure to provide pre-deprivation notice and hearing may be cured by post-deprivation remedies, the challenged regulation offers no such remedy. A refusal by the ADA to recognize specific organizations or areas of dentistry as specialty areas of practice, such as those represented by the individual Plaintiffs, is final and not reviewable. This violates the due process guarantees of the Fourteenth Amendment to the Constitution of the United States.

69. Furthermore, the regulation also violates substantive due process, which protects fundamental rights from arbitrary and unwarranted encroachment by the government. When a

regulation encroaches on fundamental constitutional rights, it must be narrowly tailored to achieve a state's purpose. The specialty regulation in question encroaches on the fundamental rights of Plaintiffs. Their rights to be rewarded for their industry and truthful communication regarding their credentials and expertise, and to declare themselves specialists in implant dentistry, have been denied. The Regulatory Scheme does not satisfy basic constitutional standards and is not narrowly tailored. It creates false impressions regarding the eminently legitimate credentialing organizations the individual Plaintiffs belong to and imputes a State-sanctioned stamp of illegitimacy to their specializations. The specialty advertising regulation implies that the ADA has evaluated the authenticity of the organizational Plaintiff and determined that it is unfit for inclusion as a specialty board and its field of implant dentistry is unworthy of advertising as a specialty area of practice. As such, the Regulatory Scheme violates constitutional guarantees of due process.

CAUSES OF ACTION

COUNT I: FREEDOM OF SPEECH
(42 U.S.C. § 1983)

70. Paragraphs 1–69 are incorporated as if fully set forth herein.

71. The right of AAID member-dentists—including Drs. Miller and Doyel—to advertise truthfully is protected by the First Amendment to the U.S. Constitution, which applies to the State of Oregon through the Due Process Clause of the Fourteenth Amendment.

72. Drs. Miller and Doyel have invested a significant amount of time and money into obtaining certified credentials in implant dentistry and advertising their practice in Oregon, including by maintaining business websites.

73. Other Oregon dentists certified by AAID and the Implant-Dentistry Board similarly have a constitutional right to advertise truthfully. Many of these dentists, too, have invested in advertising regarding their education and credentials in implant dentistry.

74. The individual Plaintiffs wish to advertise as specialists in implant dentistry, and it would not be false or misleading to do so.

75. Notwithstanding the fact that the individual Plaintiffs have obtained bona fide credentials in implant dentistry and do in fact specialize in the subfield of dentistry, Defendants—through their use of Oregon's specialty advertising rule, O.A.R. 818-015-0007—seek to prohibit the individual Plaintiffs and other similarly situated dentists certified by AAID and the Implant-Dentistry Board from exercising their right to truthful, non-misleading commercial speech. Specifically, the Rule bars the individual Plaintiffs and others similarly situated from advertising their specialization—and AAID- and/or Implant-Dentistry Board-conferred certification—in Oregon. This violates the First Amendment rights of both the individual Plaintiffs and Plaintiff AAID, thus rendering the rule unconstitutional both on its face and as applied.

76. Oregon's unconstitutional regulatory structure, on its face and as applied to the Plaintiffs, also injures Oregon dental patients who may be seeking dental implants and other specialized implant procedures. These patients lack access to truthful information about legitimate accreditations that could distinguish more experienced and trained dentists like Implant-Dentistry-Board Diplomates from general dentists who lack that experience and training.

77. Further, if Oregon continues to enforce the regulatory scheme, fewer Oregon dentists will seek membership in AAID or the education and certification of AAID and the Implant-Dentistry Board. Not only will this negatively affect dental-implant patients in Oregon, who will not benefit from the added specialized training that AAID and the Implant-Dentistry Board provide, but it will continue to financially harm AAID because its membership will continue to be artificially reduced.

78. The Oregon's Regulatory Scheme, on its face and as applied to the Plaintiffs, violates Plaintiffs' constitutional rights. This violation is actionable under 42 U.S.C. § 1983.

COUNT II: FREEDOM OF SPEECH (OREGON CONSTITUTION, ART. I § 8)

79. Paragraphs 79 through 82 of the initial complaint are voluntarily dismissed.

COUNT III: EQUAL PROTECTION (42 U.S.C. § 1983)

83. Paragraphs 1–78 are incorporated as if fully set forth herein.

84. The Regulatory Scheme creates discriminatory classifications between dentists who have obtained designations as Board-recognized specialists and those who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty.

85. The specialty regulation creates irrational and discriminatory classifications between licensed dentists who can hold themselves out to be specialists or board-certified, and those such as Drs. Miller and Doyel, and other Implant-Dentistry-Board-certified dentists who cannot so advertise.

86. The Regulatory Scheme confers rights on dentists who have obtained designations as recognized specialists, while impinging on the fundamental rights of dentists who have obtained professional dental credentials in an area of dentistry not recognized by the State as a specialty. This irrational, unequal treatment is prohibited by the United States Constitution.

87. The Regulatory Scheme is suspect and subject to heightened judicial scrutiny because it directly impinges upon fundamental rights.

88. Both facially and as applied, the Regulatory Scheme denies equal protection of the laws to Plaintiffs. This violation of Plaintiffs' constitutional rights by Defendants is actionable under 42 U.S.C. § 1983.

COUNT IV: SUBSTANTIVE AND PROCEDURAL DUE PROCESS (42 U.S.C. § 1983)

89. Paragraphs 1–88 are incorporated as if fully set forth herein.

90. Drs. Miller and Doyel—as well as AAID's other Oregon member-dentists—have protected property and liberty interests in their licenses to practice dentistry and have a right to engage in truthful commercial speech.

91. The Regulatory Scheme deprives Drs. Miller and Doyel, and other Implant-Dentistry-Board-certified dentists of a state mechanism for evaluating or acknowledging the professional dental credentials earned by them in areas of dentistry not recognized by the State of Oregon or the ADA as specialties. The Regulatory Scheme likewise deprives AAID itself of any mechanism for appealing the Board's denial of recognition of any credentialing organization or any areas of dental practice not recognized as specialty areas of practice by the State of Oregon.

92. Both facially and as applied, the Regulatory Scheme deprives Plaintiffs of the right to a neutral and impartial factfinder, resulting in arbitrary and capricious decisions, in violation of Plaintiffs' due process rights guaranteed by the Fifth and Fourteenth Amendments to the U.S. Constitution. This violation of Plaintiffs' constitutional rights is actionable under 42 U.S.C. § 1983.

PRAYER FOR RELIEF

93. Plaintiffs ask the Court to:

a. declare Oregon's specialty-advertising rule, O.A.R. 818-015-0007, unconstitutional on its face and as applied to Plaintiffs;

b. declare ORS 679.546(1) and O.A.R. 818-021-0015 each unconstitutional on its face and as applied to Plaintiffs;

c. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with them from further maintenance, implementation, or enforcement of the provisions of Oregon's specialty-advertising rule, O.A.R. 818-015-0007;

d. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with them from further maintenance, implementation, or enforcement of the provisions of ORS 679.546(1) and O.A.R. 818-021-0015;

e. issue a permanent injunction prohibiting Defendants, their officers, agents, employees, attorneys, successors in office, and all persons in active concert or participation with them from instituting or from further maintenance of any disciplinary actions against dentists who have achieved Implant-Dentistry Board Diplomate status for advertising as specialists;

f. award Plaintiffs their reasonable attorney fees, litigation expenses, and costs incurred in bringing and prosecuting this action, pursuant to 28 U.S.C. § 1920, 42 U.S.C. § 1988(b), and Fed. R. Civ. P. 54(d); and

g. grant Plaintiffs any other relief as may be necessary, appropriate, and equitable.

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Respectfully submitted,

Dated: December 17, 2021

s/ *Kendra Matthews*
KENDRA M. MATTHEWS, OSB No. 965672
kendra@boisematthews.com

BOISE MATTHEWS LLP
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— and —

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Attorneys for Plaintiffs

Ballard Jackie

From: info@ord.uscourts.gov
Sent: Friday, December 17, 2021 4:21 PM
To: nobody@ord.uscourts.gov
Subject: Activity in Case 3:21-cv-01182-SB American Academy Of Implant Dentistry et al v. Prisby et al Amended Complaint

Follow Up Flag: Follow up
Flag Status: Flagged

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U.S. District Court

District of Oregon

Notice of Electronic Filing

The following transaction was entered by Matthews, Kendra on 12/17/2021 at 4:20 PM PST and filed on 12/17/2021

Case Name: American Academy Of Implant Dentistry et al v. Prisby et al
Case Number: 3:21-cv-01182-SB
Filer: James Miller
American Academy Of Implant Dentistry
Nathan Doyel
Document Number: 28

Docket Text:
Amended Complaint *For Preliminary Injunction, Declaratory Judgment, and Damages*. Filed by James Miller, American Academy Of Implant Dentistry, Nathan Doyel against All Defendants. (Matthews, Kendra)

3:21-cv-01182-SB Notice has been electronically mailed to:

Christina L. Beatty-Walters tina.beattywalters@doj.state.or.us, jackie.ballard@doj.state.or.us, marianna.almasi@doj.state.or.us

Colin Callahan ccallahan@flannerygeorgalis.com, ressig@flannerygeorgalis.com

Frank Recker recker@ddslaw.com

Justin Withrow jwithrow@flannerygeorgalis.com, ressig@flannerygeorgalis.com

Kendra M. Matthews kendra@boisematthews.com, pat@boisematthews.com

3:21-cv-01182-SB Notice will not be electronically mailed to:

The following document(s) are associated with this transaction:

Document description: Main Document
Original filename: Not Available
Electronic document Stamp:
[STAMP ordStamp_ID=875559790 [Date=12/17/2021] [FileNumber=7677105-0]
[53845839ce4c71bf99e15603bb9804632aff57639448f3012b1fae22704adc75e33b0
ba3769fbe148010818e7c54779e27143f313ac8c35d59a373f327c9c335]]

SETTLEMENT AGREEMENT

The parties to this agreement ("Agreement") are the American Academy of Implant Dentistry, James Miller, DMD, Nathan Doyel, DMD, Stephen Prisby, in his official capacity as Executive Director of the Oregon Board of Dentistry, and each of the members of the Oregon Board of Dentistry in their official capacities, namely, Yadira Martinez, RDH, Alicia Riedman, RDH, Amy B. Fine, DMD, Gary Underhill, DMD, Reza J. Sharifi, DMD, Charles "Chip" Dunn, Jose Javier, DDS, Aarati Kalluri, DDS, Sheena Kansal, DDS, and Jennifer Brixey (collectively, the "Parties").

RECITALS

A. On August 11, 2021, the American Academy of Implant Dentistry ("AAID"), James Miller, DMD, and Nathan Doyel, DMD ("Plaintiffs") filed a lawsuit in the United States District Court for the District of Oregon, Case No. 3:21-cv-01182-SB ("Lawsuit"), asserting claims against Stephen Prisby, in his official capacity as Executive Director of the Oregon Board of Dentistry, and Yadira Martinez, RDH, Alicia Riedman, RDH, Amy B. Fine, DMD, Gary Underhill, DMD, Reza J. Sharifi, DMD, Charles "Chip" Dunn, Jose Javier, DDS, Aarati Kalluri, DDS, Sheena Kansal, DDS, and Jennifer Brixey, in their official capacities as members of the Oregon Board of Dentistry ("Defendants").

B. In the Lawsuit, Plaintiffs assert claims under 42 U.S.C. § 1983 alleging their rights under the First Amendment's Freedom of Speech Clause, the Fourteenth Amendment's Equal Protection Clause, and the Fourteenth Amendment's Due Process Clause have been violated. Plaintiffs originally asserted a claim under the Oregon Constitution, but they voluntarily dismissed that claim in their Amended Complaint. Plaintiffs contend the dental specialty advertising statute, ORS 679.546, and the Board of Dentistry's ("Board's") specialty advertising administrative rules are unconstitutional facially and as applied to them.

C. The Parties now wish to resolve all claims asserted by Plaintiffs against Defendants in the Lawsuit.

TERMS OF AGREEMENT

A. The Plaintiffs will file a notice of dismissal of the Lawsuit within seven days of the date this Agreement is fully executed. The notice will state that the dismissal will be without an award of fees or costs to any Party.

B. Defendants will not enforce OAR 818-015-0007(1), OAR 818-015-0007(3), or the specialty advertising restrictions in ORS 679.546 against Plaintiffs or members of AAID.

C. Defendants will repeal OAR 818-015-0007(1) and (3).

D. Defendants will recommend to the Governor including the repeal of the specialty advertising restrictions in ORS 679.546 in the Governor's 2023 legislative agenda, and, should the Governor agree, Defendants will support the repeal in the 2023 legislative session. Nothing in this Agreement purports to bind any future Governor of Oregon.

ENFORCEMENT AND MISCELLANEOUS PROVISIONS

A. Defendants do not admit liability on any claims.

B. Should any member of the Oregon Board of Dentistry or its executive director change prior to the satisfaction of Terms of Agreement detailed herein, all future Board members and future executive directors shall be bound by the agreement not to enforce OAR 818-015-0007(1), OAR 818-015-0007(3), or the specialty advertising restrictions in ORS 679.546 against Plaintiffs or members of AAID.

C. If any Party believes that another Party is not in compliance with the terms of this Agreement, the Party alleging noncompliance will provide notice as follows:_If to Defendants, then by U.S. mail to the Executive Director of the Oregon Board of Dentistry and to the Chair of the Oregon Board of Dentistry at 1500 SW 1st Avenue, Suite 770, Portland, OR 97201; and if to Plaintiffs, then by U.S. mail to Justin Withrow, Esq. and/or Colin Callahan, Esq., Flannery | Georgalis, 1375 E. 9th Street, 30th Floor, Cleveland, Ohio 44114.

D. No sooner than seven calendar days after providing notice under paragraph B above, a party alleging noncompliance with the terms of this Agreement may seek enforcement in the Multnomah County Circuit Court. Should such legal action be deemed necessary, the Parties agree to jurisdiction and venue in the Multnomah County Circuit Court. Oregon law applies.

E. This Agreement constitutes the entire agreement among the Parties relating to the Lawsuit and no other statement, promise, or agreement, written or oral, made by any Party or any agent of any Party that is not contained in this Agreement shall be enforceable.

F. The persons executing this Agreement on behalf of the respective Parties warrant that they are duly authorized to accomplish the same and possess all requisite authority to bind the represented Parties to all the provisions of this Agreement.

G. The Parties agree that they have jointly participated in the preparation of this Agreement and that, accordingly, any rule of interpretation construing terms and conditions against the party preparing this Agreement is inapplicable.

H. This Agreement may be executed in counterparts, each of which shall be deemed to be an original but all of which taken together shall constitute one and the same agreement. The Agreement shall become effective on the date that the last counterpart is executed.

BY OUR SIGNATURES BELOW, WE AGREE TO THE FOREGOING:

For American Academy of Implant Dentistry:

_______________________________________ Date: ___________________

By Carolina Hernandez, Executive Director
American Academy of Implant Dentistry

_______________________________________ Date: ___________________

James Miller, DMD

_______________________________________ Date: ___________________

Nathan Doyel, DMD

/ / /

/ / /

/ / /

For Stephen Prisby, Yadira Martinez, RDH, Amy B. Fine, DMD, Gary Underhill, DMD, Reza Sharifi, DMD, Charles Dunn, Jose Javier, DDS, Aarati Kalluri, DDS, Sheena Kansal, DDS, and Jennifer Brixey:

_______________________________________ Date: ___________________

By Stephen Prisby, Executive Director
Oregon Board of Dentistry

AS TO FORM:

_______________________________________ Date: ___________________

Colin Callahan
Justin Withrow
Flannery | Georgalis, LLC

_______________________________________ Date: ___________________

Christina Beatty-Walters
Assistant Attorney General
Oregon Department of Justice

OTHER ISSUES

From: UMPHLETT Amy M <Amy.M.UMPHLETT@dhsoha.state.or.us>
Sent: Thursday, September 15, 2022 9:26 AM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc: Branger Munoz Cynthia <Cynthia.Branger-Munoz@dhsoha.state.or.us>; Wilcox Cate S <Cate.S.WILCOX@dhsoha.state.or.us>; Aragon Catalina <Catalina.Aragon@dhsoha.state.or.us>
Subject: LC 438 Removes Sunset for OHA Dental Pilot Project Program

Hi Stephen,

The Oregon Health Authority (OHA) has released a list of legislative concepts (LC) that OHA has requested be considered in the 2023 legislative session. We wanted to make sure the Board of Dentistry was aware of LC 438 that would remove the sunset date for the OHA Dental Pilot Project Program. To view the specific LC language, please visit https://www.oregon.gov/oha/ERD/Pages/Government-Relations.aspx.

The OHA Dental Pilot Project Program, which is scheduled to sunset on January 2, 2025, is a unique program that provides a mechanism whereby innovative methods in the delivery of oral health care and expansion of scope of practice can be tested before changes in licensing laws are made in Oregon. OHA needs the Dental Pilot Project Program sunset date removed to continue operating the Program well into the future, allowing a limitless number of dental pilot projects to test various oral health workforce models and methodology while monitoring projects for patient safety.

Oral health disparities exist for children, adolescents and adults based on race, ethnicity, geographic residence, household income, etc. These disparities persist because there is inequitable access to oral health services, and the workforce shortage of dental providers that Oregon is currently experiencing only worsens the problem. The OHA Dental Pilot Project Program is designed to improve the oral health workforce in Oregon and drive workforce innovation to reduce oral health disparities and increase access to oral health care.

OHA has overseen three dental pilot projects so far, two of which led to legislation in 2021:

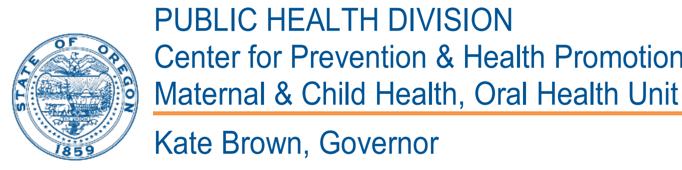
- Expanding the scope of practice for an expanded practice dental hygienist to place an interim therapeutic restoration (HB 2627); and
- Creating a new category of dental practitioner called dental therapist (HB 2528).

For more details about the OHA Dental Pilot Project Program, please see the attached handout or visit the website at www.healthoregon.org/dpp.

We are looking forward to having more conversations with you around this LC. If you would like to see this Program continue or have any questions, please contact Cynthia Branger Muñoz, OHA Government Relations at Cynthia.Branger-Munoz@dhsoha.state.or.us or (971) 372-0768.

Thank you,
Amy

Amy Umphlett, MPH *(she/her)*
Oral Health Operations & Policy Analyst
OREGON HEALTH AUTHORITY
Public Health Division
Work Cell Phone: 971-666-8815
amy.m.umphlett@dhsoha.state.or.us



800 NE Oregon Street, Suite 825
Portland, Oregon 97232
Voice: (971) 372-0768
TTY-TDD: 711
www.healthoregon.org/dpp

FACT SHEET
OHA Dental Pilot Project Program

Establishment of OHA Dental Pilot Project Program

Senate Bill 738 was passed by the Oregon State Legislature in 2011. This bill allows the Oregon Health Authority (OHA) to administer and evaluate a dental pilot project once an application has been approved.

The OHA Dental Pilot Project Program is a unique program that provides a mechanism whereby innovative methods in the delivery of oral health care and expansion of scope of practice can be tested before changes in licensing laws are made in Oregon. Dental pilot projects test emerging and expanding workforce models that aim to improve health equity and increase oral health access for underserved populations.

The Program is designed after California's Health Workforce Pilot Projects Program, which has been in existence since 1972 and has led to 33 projects so far specifically related to dental care.

The OHA Dental Pilot Project Program is scheduled to sunset on January 2, 2025, but OHA has requested legislative concept 438 be considered in the 2023 legislative session that would remove the sunset date.

What are Dental Pilot Projects?

Dental pilot projects are community driven and designed to increase access to dental care for communities of color and other populations that face oral health disparities by doing one of the following:

- Teaching new skills to existing dental providers;
- Developing new categories of dental providers;
- Accelerating the training of existing dental providers; or
- Teaching new oral health care roles to untrained people.

Pilot projects are allowed to operate 3-5 years or a sufficient amount of time to evaluate the validity of the project. Projects are required to evaluate the quality of care provided, monitor for patient safety and adverse events, and determine the impact to

access to care, the costs of the workforce model, the impact on the oral healthcare workforce, and the efficacy of the project concept.

OHA Dental Pilot Project Program Responsibilities

OHA accepts applications from project sponsors to operate dental pilot projects. OHA does not fund projects, as project sponsors are responsible for developing and operating projects.

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

OHA may convene an Advisory Committee for each of the dental pilot projects. Committees are comprised of oral health subject matter experts tasked with attending quarterly meetings, site visits and conducting chart reviews to assist OHA with the monitoring of patient safety and quality of care provided under the pilot.

History of Dental Pilot Projects

OHA has overseen three dental pilot projects so far, two of which led to successful legislation in 2021:

- Expanding the scope of practice for an expanded practice dental hygienist to place an interim therapeutic restoration (HB 2627).
- Creating a new category of dental practitioner called dental therapist (HB 2528).

Current Dental Pilot Projects

- Dental Pilot Project #100 – Dental Therapy Workforce Model, sponsored by the Northwest Portland Area Indian Health Board. Project concludes May 2023.
- Dental Pilot Project #300 – Dental Therapy Workforce Model, sponsored by Willamette Dental, co-sponsored by Pacific University. Project concludes December 2024.

Former Dental Pilot Projects

- Dental Pilot Project #200 – Expanded Practice Dental Hygienist Workforce Model (scope expansion), sponsored by Oregon Health & Sciences School of Dentistry. Project concluded July 2022.

Potential Future Projects

- Future projects may include testing the expansion of the scope of practice of dental assistants and other allied oral health providers.

Focusing on the Needs of a Changing World

2021 Annual Report

Mission Fulfilling Moments

Feedback from our Participants

Assessment and Education

- Entire CPEP staff and physicians were more than excellent…… EVERY encounter with staff was friendly, soothing, and interactive, making me feel at ease during the entire assessment
- Overall impression of the Assessment was a great experience
- I enjoyed all the staff. I felt heard and not judged

PROBE

- The faculty's capacity to be warm, engaging, and non-judgmental allowed for a deeper and more meaningful experience
- I knew what I did was wrong – the program gave me tools to do better going forward
- The platform worked extremely well…Many of us have been quite isolated in our situations and I felt a comforting sense of belonging

Prescribing Controlled Drugs

- The seminar is uplifting and empowering, not blaming or belittling
- Thank you for all your effort and energy. It did not go unnoticed …
- Should be mandated prior to getting DEA number

Mission Fulfilling Moments

Feedback from our Participants

Improving Inter-Professional Communication

- Top of the line speakers who have walked the walk
- Really great discussion on introspection and how to cultivate a positive culture
- Loved the intimacy of Zoom format
- Will fundamentally change my approach to people at work and outside of work

Enhanced Patient Communication

- Faculty were disarming from the beginning. We are all in this class for a reason. No shaming but the delivery of the information was on point and with empathy towards the students and patients we care for
- I was well aware that the people in my group shared similar challenges and traits and it helped with my own development watching them work through the role plays
- Makes you realize that you are not alone. This class will help the Type A stream-line their care with more focused and individual communication strategies

Medical Record Keeping

- I am extremely impressed with the kindness and human warmth Dr. Grace brings to a complicated and often frustrating topic. Combined with her expertise this makes for an engaging seminar and allows for much of the openness she asks for in the beginning
- I love the advent of zoom and using breakout rooms to engage participants
- Very concise and informative

LETTER FROM THE CEO

Welcome to a snapshot of 2021 – CPEP's first full year as a largely "virtual" organization. As with the rest of the world, CPEP was forced to make an organization-wide pivot in 2020 so we could continue to offer our services in the midst of a global pandemic. We transitioned all of our services to *CPEP LIVE*, our live, interactive video education approach using the Zoom platform.

In 2021 we absolutely hit our stride in this new world. Participation in CPEP's remote assessments and seminars grew by 47% over 2020 and overall enrollment grew by 17%. This builds on our exponential growth over the last decade. Since our founding in 1990, we have worked with almost 8,000 participants from across North America. The majority of participants enrolled in just the past 10 years and one-third of all participants enrolled in the past three years alone.

While CPEP has changed over these two years, so too has the rest of the world. Public health conditions, technology, and comfort with technology have all changed along with expectations of accessibility and convenience enabled by that technology. Our remote services have been embraced by our participants as well as the licensing authorities, hospitals and other organizations that rely on our services, and these approaches remove barriers to participation and make our services more accessible to our participants in the U.S. and Canada.

Approximately 95% of our seminar participants rate their satisfaction with our remote seminars as very good/excellent and participant outcomes are essentially unchanged compared to in-person programming.

In 2022, we continue to listen carefully to our stakeholders – referring organizations, participants and donors – as we work to optimize our processes to meet their evolving needs and expectations.

Of course, without our donors we could do none of these things. Last year we received generous donations from 49 organizations and 60 individuals (a record high number). This support came in through our annual Physicians Excellence Campaign as well as through the online 30th Anniversary Celebration, and I would like to express my personal thanks to each and every one of our donors.

Wishing you all the best!

Elizabeth J. Korinek, M.P.H.
Chief Executive Officer

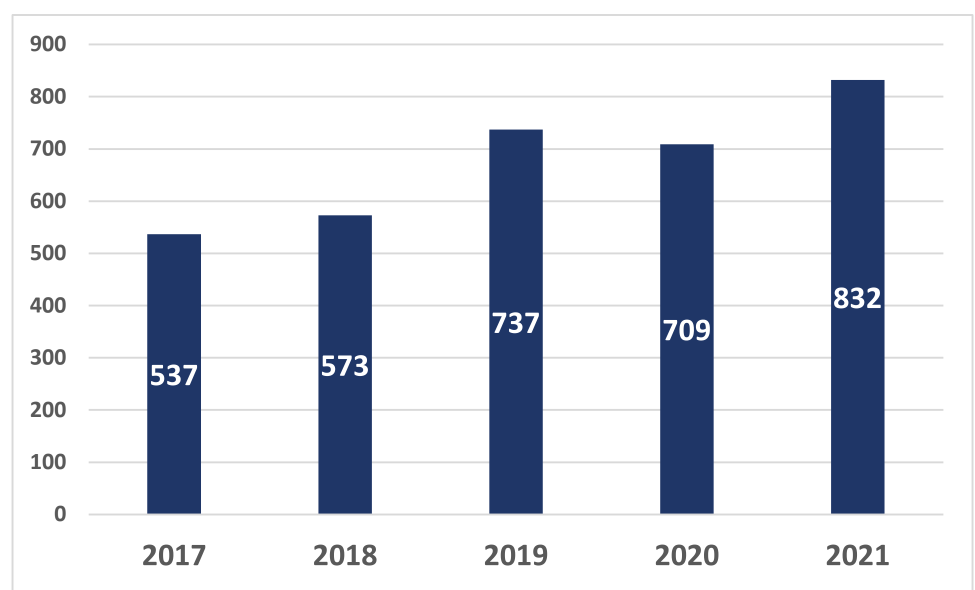
2021 PROGRAM UPDATE

Another Record-Breaking Year

After encountering headwinds in 2020 due to the pandemic, CPEP resumed its strong growth trajectory. Total participation in CPEP programs increased 17% in 2021 with 832 participants referred by 284 organizations across the United States and Canada.

Looking back further, CPEP participation was 55% higher than it was in 2017, without a commensurate grown in staffing. Why? Because at CPEP, we are working harder *and* smarter to serve the needs of our particippnts and the organizations that refer them.

Growth in CPEP Participation: 2017 - 2021



2021 ASSESSMENT UPDATE

Remote Assessments, Evaluations and Screens

CPEP's experience with remote Competence/Skills Assessments, Reentry Evaluations, Screens and other evaluations has been very successful and has been very well-received by participants and referring organizations alike. While we are happy to discuss in-person assessments on a case-by-case basis, what was the remote option is now our standard process.

Embracing Technology

With the exception of technical skills simulations, advances in technology enable CPEP staff to conduct in-depth, customized assessments, screens, and evaluations without the need for expensive travel and excessive time away from practice.

Technical simulation of procedural skills still requires an in-person visit.

Assessment Components Done Remotely

Structured Clinical Interviews

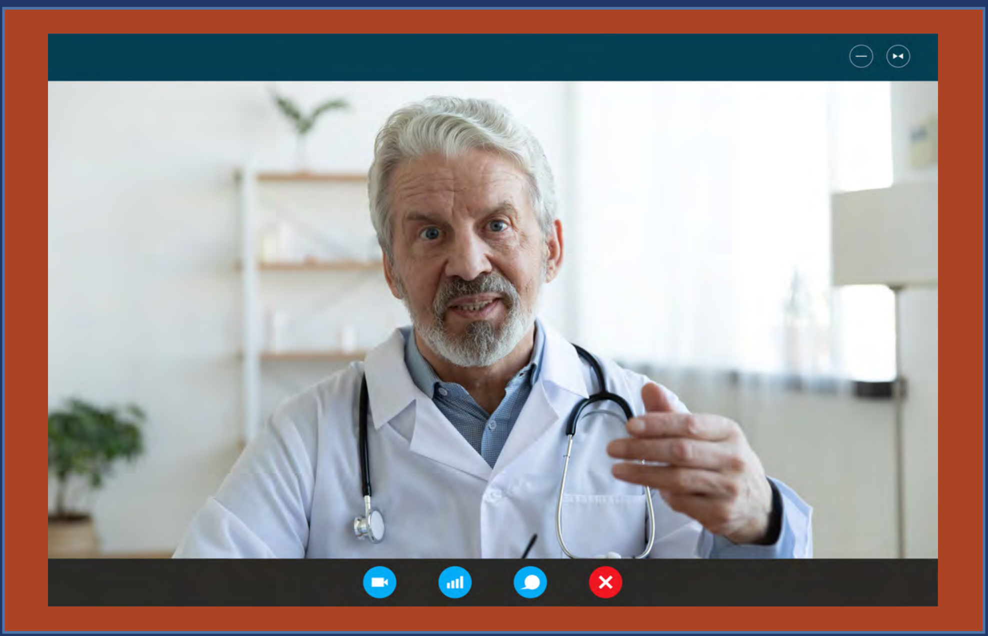
Cognitive Screens

Fetal Monitoring Strip Interpretations

Simulated Patient Encounters

EKG Interpretations

Radiologic Image Interpretations

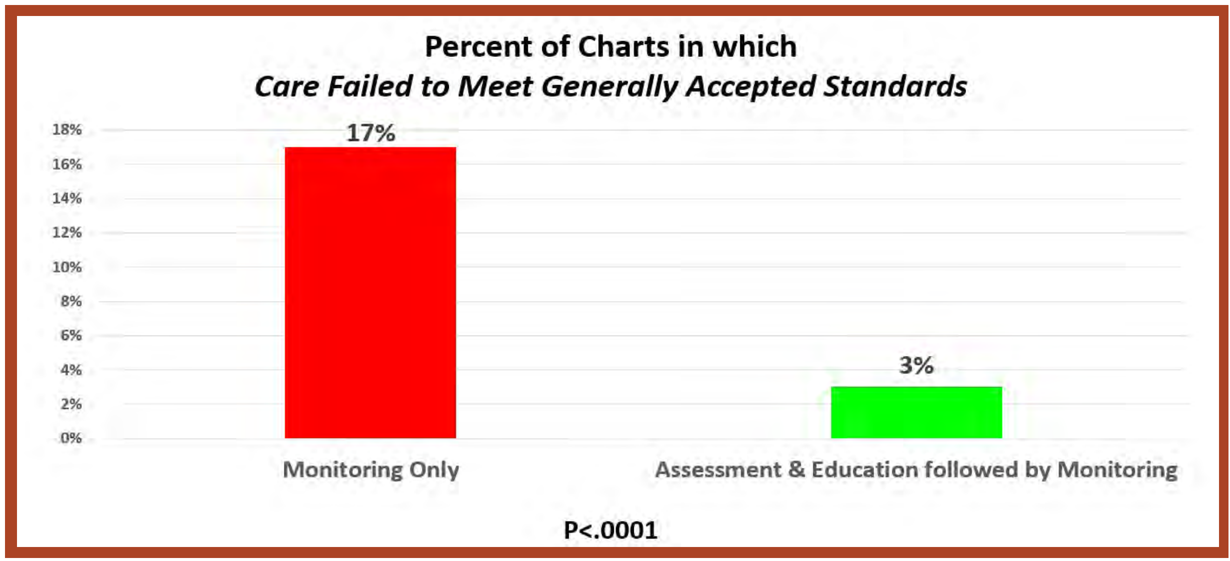


- In 2021, CPEP assessed clinicians from 30 specialties ranging from addiction medicine to vascular surgery.
- In an anonymous survey, assessment participants rated their experience with CPEP staff as 4.9 out of 5!

CPEP ASSESSMENT / EDUCATION OUTCOMES STUDY

In 2021, CPEP staff completed a study that sought to measure the impact of our assessment and educational intervention programs on the quality of care delivered by our participants. This retrospective study examined patient charts submitted by two groups of physicians enrolled in our Practice Monitoring Program (PMP). The first group of charts (N = 1,215) was submitted by participants who had already completed the CPEP Educational Intervention Program prior to PMP. The second group of charts (N = 858) was submitted by PMP particpants who had not engaged in the Education Intervention.

Charts submitted by Assessment and Education "alumni" were *5.49 times less likely* to indicate care that failed to meet generally accepted standards than those submitted by physicians in monitoring only.



Competence Assessment and Structured Educational Remediation: Long-Term Impact on the Quality of Care Provided by Disciplined Physicians; Korinek et. al.; Journal of Medical Regulation (2022) 108 (1): 7–15

This study suggests that completion of a CPEP competence assessment, followed by an education intervention program, is an effective means of achieving acceptable quality of care that is sustained over time (average 18 months) after completion of the intervention.

ABMS Re-Eligibility Programs

CPEP's collaborations with the *American Boards of Emergency Medicine, Family Medicine and Urology* really took flight in 2021. These programs, which are the first of their kind, are intended to help physicians whose board eligibility has expired to regain their eligibility and pursue certification. These "alternative pathways" to eligibility are intended to balance academic and clinical rigor with a process that is logistically accessible to physicians. To date, over 40 CPEP participants have regained their eligibility through these approaches.

2021 SEMINARS UPDATE

CPEP faculty and staff conducted 50 seminars in 2021, all delivered via *CPEP LIVE™* - Live, Interactive Video Education. These included:

- *PROBE* - Professional Ethics & Boundaries: 28 sessions (13 Canadian, 15 U.S.)
- Medical Record Keeping: 8 sessions
- Improving Inter-Professional Communication: 7 sessions
- Enhanced Patient Communication: 4 sessions
- Prescribing Controlled Drugs: 3 sessions

Participant feedback on the remote approach has been overwhelmingly postive, with participants commenting on the comfort and convenience of engaging in the programs from their own homes or offices as well as the reduced expense once travel costs are removed.

At the same time, referring organizations have been pleased to know that the rigor of these programs remains unchanged, with identical content, time committment, and requirements for interactivity when compared to in-person sessions.

Bringing Connection to Remote Experiences

CPEP is committed to providing the best possible educational experience for our particpants. To achieve that, we limited class sizes to maximize individual attention to each individual's needs. In addition, each and every participant is taken through a one-on-one Zoom-based "tech-check" prior to their activity to make sure they have the tools, knowledge and comfort they need to engage effectively. In 2021, this totaled well over 1,000 personalized meetings between CPEP staff and individual seminar and assessment participants.

"He knew he had many fences to mend and burned bridges to repair and he has worked diligently to do so since the seminar"
Feedback from a Referring Organization regarding an Improving Inter-Professional Communication seminar participant

PROFESSIONAL SOCIETY PRESENTATIONS

The Impact of the Pandemic on Remedial Education Programs: Turning Lemons into Lemonade
Federation of State Physician Health Programs Annual Meeting (Poster Presentation) – Bill O'Neill, M.B.A.

Terror, Anxiety and Excitement: The Pandemic Pivot of one Assessment/Education Program
Federation of State Medical Boards Annual Meeting (Poster Presentation) – Bill O'Neill, M.B.A.

The Impact of the Pandemic on Remedial Education Programs: Turning Lemons into Lemonade
Montana Association of Medical Staff Services Meeting – Elizabeth J. Korinek, M.P.H.

Regaining Focus: Addressing Clinical Performance Concerns in a Distracted World
Colorado Association of Medical Staff Services Meeting – Elizabeth J. Korinek, M.P.H.

Managing Disruptive Communication
National Association of Medical Staff Services Webinar – Bill O'Neill, M.B.A.

Inappropriate and Unprofessional Conduct: Why It Happens and How to Address It from the Peer Review and Clinical Perspective
American Health Lawyers Association Annual Meeting – Alexis Angel, J.D. (Shareholder, Polsinelli, CPEP Board Member) and Elizabeth Grace, M.D.

Regaining Focus: Addressing Clinical Performance Concerns in a Distracted World
Michigan Association of Medical Staff Services/Hardenbergh Group – Elizabeth J. Korinek, M.P.H.

Physicians Reentering Practice: Know When to Hold em… Know When to Fold em… Know When to Walk Away…Know When to Run
Louisiana State Association of Medical Staff Services Conference – Elizabeth J. Korinek, M.P.H.

Tips from the Trenches: Managing Disruptive Communication from the MSP Perspective
Louisiana State Association of Medical Staff Services Conference – Alexis Angel, J.D. (Shareholder, Polsinelli, CPEP Board Member) and Bill O'Neill, M.B.A.

Tips from the Trenches: Managing Disruptive Communication from the MSP Perspective
Georgia Association of Medical Staff Services – Alexis Angel, J.D. (Shareholder, Polsinelli, CPEP Board Member) and Bill O'Neill, M.B.A.

Focus in a Fog: Addressing Clinical Performance Concerns in a Distracted World
National Association of Medical Staff Services Annual Conference – Elizabeth J. Korinek, M.P.H.

Physicians Reentering Practice: Know When to Hold em… Know When to Fold em… Know When to Walk Away…Know When to Run
National Association of Medical Staff Services Annual Conference – Elizabeth J. Korinek, M.P.H. and Sally Pelletier, Advisory Consultant, Greeley Company

Pushed to the Limit: The Impact of a Pandemic on the Prevalence and Management of Disruptive Communication
National Association of Medical Staff Services Annual Conference – Alexis Angel, J.D. (Shareholder, Polsinelli, CPEP Board Member) and Bill O'Neill, M.B.A.

GRATITUDE

RESULTS OF THE 2021 PHYSICIAN EXCELLENCE CAMPAIGN

Premier Donors: $10,000 and Above

COPIC Insurance Company	St. Mary's Medical Center, *Administration & Medical Staff*
Centura Health	UCHealth, *Medical Staff*
St. Joseph Hospital, *Administration & Medical Staff*	

$5,000 - $9,999

Children's Hospital, *Medical Staff*	Longmont United Hospital, *Medical Staff*
Colorado Medical Society	Lutheran Medical Center, *Medical Staff*
Good Samaritan Medical Center, *Medical Staff*	Medical Center of Aurora, *Administration & Medical Staff*
HealthONE	

$5,000 - $9,999 continued

North Suburban Medical Center, *Medical Staff* Parker Adventist, *Medical Staff* Rose Medical Center, *Administration & Medical Staff*	St. Anthony Hospital North, *Medical Staff* Sky Ridge Medical Center, *Medical Staff*

$2,500 - $4,999

CU Medicine	Wake Forest Baptist, *Medical Staff*

$1,000 - $2,499

Arkansas Valley Regional Medical Center, *Administration & Medical Staff* Avista Adventist Hospital, *Medical Staff* Banner Health, Ft. Collins, *Medical Staff* Banner Health, McKee Medical Center, *Medical Staff* Banner Health, Northern Colorado Medical Center, *Medical Staff* Boulder Community Health, *Medical Staff* Denver Health Medical Center, *Medical Staff* Montrose Memorial Health, *Administration & Medical Staff*	Penrose St. Francis Health Services, *Medical Staff* Platte Valley Medical Center, *Administration & Medical Staff* Presbyterian/St. Luke's Medical Center, *Administration & Medical Staff* St. Mary-Corwin Medical Center, *Medical Staff* San Luis Vallley Health, *Administration & Medical Staff* Valley View Hospital, *Medical Staff*

<$1,000

Conejos County Hospital, *Medical Staff* Estes Park Health, *Medical Staff* Georgia Association of Medical Staff Services	St. Anthony Summit Medical Center, *Medical Staff* Sterling Regional Medical Center, *Medical Staff*

Individual Donors

Alexis Angell, J.D.	Michael Johnson
Josh Blum, M.D.	Jennifer Linhorst
Diana Breyer, M.D.	Lisa Kettering, M.D.
William Brown, M.D.	Katie Lozano, M.D.
Greg D'Argonne	Randall Meacham, M.D.
Susan Diaz, C.P.C.S., C.P.M.S.M.	Michael Otte, M.D.
Shawn Dufford, M.D., M.B.A.	Katie Richardson, M.D.
Sean Gelsey, M.B.A.	Rick Roman, M.D., M.B.A.
Shauna Gulley, M.D.	Philip Stehel, M.D.
Russell Howerton, M.D.	Andrew Weinfeld, M.D.
Bruce Johnson, J.D.	

CPEP THANKS ALL OF THE SPONSORS OF OUR 30TH ANNIVERARY CELEBRATION!

Aspen Valley Hospital - Caplan & Earnest - Childs McCune Attorneys
Greeley Company - Polsinelli - SingerLewak
Strategic Operations, Inc. - Zim Consulting

ANNIVERARY REFLECTIONS FROM CPEP STAKEHOLDERS

CPEP IS:

"...competency, education, and professional safe practice of medicine"
Sarah Early, Psy.D.,Executive Director, Colorado Physician Health Program

"...career saving"
Gerald Zarlengo, M.D., Chairman & Chief Executive Officer, COPIC

"...trusted"
Jamie Smith, M.B.A., President, St. Joseph Hospital

"...a remarkably unique organization"
Alan Synn, M.D., Founding Member, Vascular Institute of the Rockies

"...innovation and integrity"
Nancy Kirsch, D.P.T., Professor of Rehabilitation and Movement Sciences, Rutgers University

While 2020 was the 30th Anniversary of CPEP's founding, celebrating that occasion had to be put off due to the pandemic. On April 28, 2021 the CPEP community came together for a virtual event that celebrated 30 years of advancing healthcare professional development and patient safety; celebrating our past and present while looking hopefully to the future.

SPECIAL THANKS TO THE INDIVIDUALS AND ORGANIZATIONS WHO DONATED TO OUR ANNIVERARY CELEBRATION

Jenny Aalborg
Irene Aguilar
Grace Alfonsi
Jandel Allen-Davis
Abby Anderson
Alexis Angell
Sheila Balzer
Diana Breyer
William Brown
Karen Burke-Haynes
Carol Cairns
Holly Church
Colleen Conry
Greg D'Argonne
Edward Dauer
Anthony Davis
Courtney Davis
Shawn Dufford
Sean Gelsey

Marshall and Joyce Gottesfeld
Elizabeth Grace
Sally Hallingstad
Michelle Harden
Cindy Huggett
Bruce Johnson
Victoria Kaprielian
Lisa Kettering
Elizabeth Korinek
Heather Korinek
Anthony LaPorta
Keith Lapuyade
Jeremy Long
Lucy Loomis
Katie Lozano
Allegra Manigione
Peter McNally
Cindy Mestan
Garrett Mitchell

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Robert Nieder
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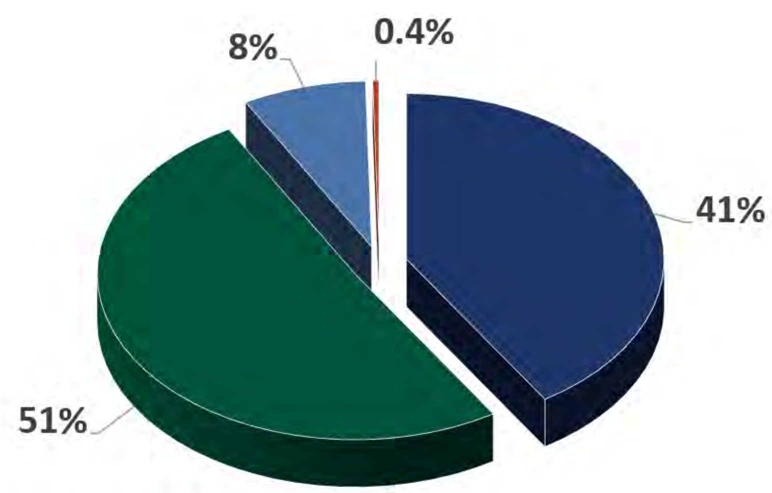
Mimi Sabo
Judy Scott
Philip Stahel
Matthew Steinkamp
Michael Victoroff
Christie Ward
Andrew Weinfeld
Dennis Wentz
Heather Wickman
Shandra Wilson
Frank Xavier
Gerald Zarlengo
Claire Zilber

FINANCIAL OVERVIEW

With robust enrollment in our programs and generous support from our donors, CPEP remained financially healthy throughout 2021.

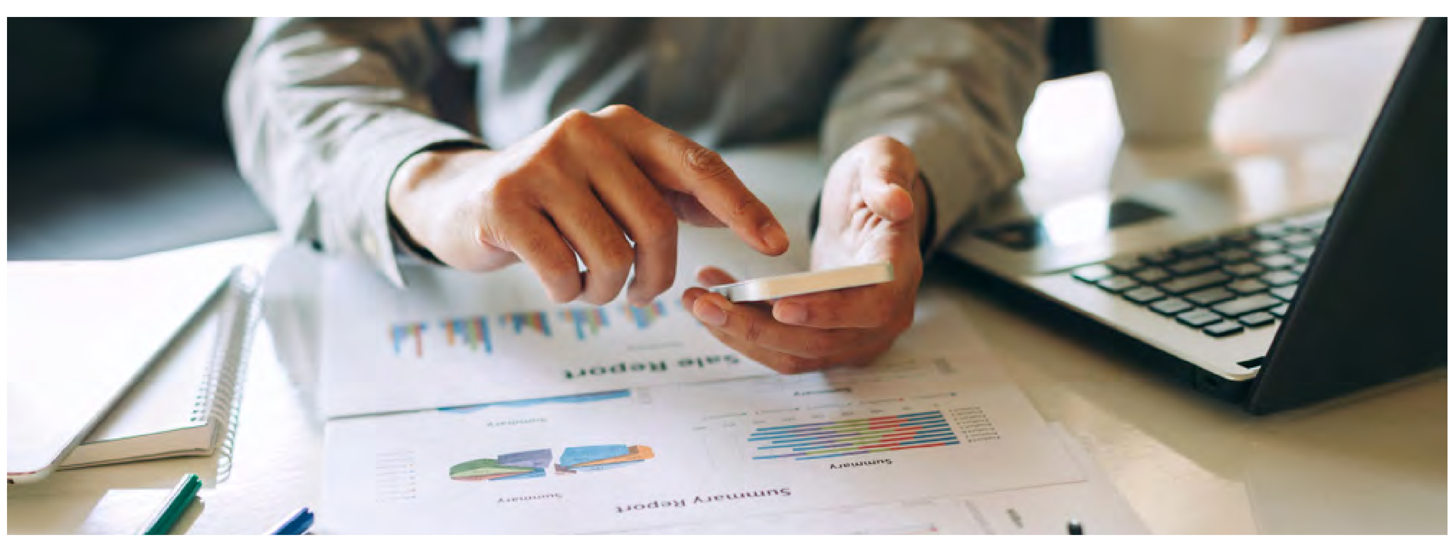


■ Assessments (41%) ■ Education (51%) ■ Fundraising (8%) ■ Other Income (.4%)

Balance Sheet Summary

Assets	$2,439,623
Liabilities	$649,379
Equity	$1,790,245

Only 15% of CPEP's budget is spent on non-program expenses



ALL HANDS ON DECK...

CPEP'S 2021 BOARD OF DIRECTORS AND CURRENT STAFF

2021 BOARD OF DIRECTORS

2021 Board Officers

Katie Richardson, M.D.
Pediatrician & Healthcare Consultant
President

Shawn Dufford, M.D., M.B.A.
Senior Vice President/Chief Medical Officer
SCL Health
President-Elect

Bruce A. Johnson, J.D.
Attorney
Dispatch Health
Immediate Past-President

Greg D'Argonne
Chief Financial Officer
HealthONE/HCA Continental Division
Treasurer

Elizabeth J. Korinek, M.P.H.
Chief Executive Officer/Secretary

2021 Board Members

Alexis Angell, J.D.
Shareholder
Polsinelli

Diana Breyer, M.D.
Chief Quality Officer Northern Region
UCHealth

Susan Diaz, C.P.C.S., C.P.S.M.
Corporate Director, Medical Staff
New York Presbyterian Hospital System

Sean Gelsey, M.B.A.
SVP of Claims & Strategic Partnerships
COPIC Insurance Company

Shauna Gulley, M.D.
Chief Medical Officer
Centura Health

Russell Howerton, M.D.
President
Wake Forest Health Network

2021 Board Members continued

Lisa Kettering, M.D.
Executive Director & Hospitalist
LINC MD, PLLC

Katie Lozano, M.D.
Radiologist
Virtual Radiologic (vRad)

Randall Meacham, M.D.
Professor and Chief, Division of Urology
University of Colorado School of Medicine

Philip Stahel, M.D.
Chief Medical Officer
The Medical Center of Aurora

Andrew Weinfeld, M.D., M.B.A.
Chief Medical Officer
Rose Medical Center

2020 Emeritus Board Member

Richard M. Roman, M.D., M.B.A.
Gastroenterologist
South Denver Gastroenterology

CURRENT STAFF

Executive Leadership

Elizabeth J. Korinek, M.P.H.
Chief Executive Officer

Elizabeth S. Grace, M.D.
Medical Director

Program Services

Alisa Johnson, M.S.H.S.A.
Director of Program Services

Assessment Services

Amanda Bessmanoff
Recruitment/Outreach Specialist

Linda Kottman, D.N.P.
Associate Nursing Director

Barclay Taylor
Assistant Manager, Assessment Services

Kacie Torrens
Administrative Assistant

CURRENT STAFF

Education Plan Services

Toni Leonard
Manager, Education Plan Services

Abigail Anderson, M.D.
Associate Medical Director

Dan Shamburek, M.D.
Associate Medical Director

Summer West, M.P.H.
Program Coordinator

Seminars

Britt Johnson-Schenk, Ph.D., J.D.
PROBE Program Manager

Kelley Blaine
Seminars Coordinator

Mary Minobe
Program Services Liaison

Operations & Finance

Frank Xavier
Director

Nancy Melear
Operations Coordinator

Outreach and Communications/East Coast Operations

Bill O'Neill, M.B.A.
Director

CPEP

PROBE
Remediate
Rehabilitate
Rededicate
A CPEP Program

CPEP Denver

720 South Colorado Boulevard
Suite 1100N
Denver, CO 80246
Phone: 303-577-3232

CPEP Raleigh

222 North Person Street
Raleigh, NC 27601
Phone: 919-238-6436

Web: cpepdoc.org
E-mail: info@cpepdoc.org

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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, Executive Director

DATE: October 11, 2022

SUBJECT: Strategic Plan Priorities & Work

I will update the Board on work that is fulfilling our strategic objectives and hope to discuss the priorities and direction for OBD Staff over the next few months on our strategic plan initiatives. At this board meeting you will be taking positive and meaningful steps toward Strategic Priorities A, C, D & E.

- STRATEGIC PRIORITY A Licensure Evolution
  - Dental Therapy License Applications
  - Communications to Interested Parties
- STRATEGIC PRIORITY C Community Interaction and Equity
  - OBD Affirmative Action Plan submitted for review
- STRATEGIC PRIORITY D Workplace Environment
  - Support professional Development opportunities with Investigators' attending CLEAR Training
  - Support all staff and encourage them all to attend the PERS Expo and maximize their retirement accounts
- STRATEGIC PRIORITY E Technology & Processes
  - Board members have state issued laptops and emails are set up for Teams connectivity for board meeting materials

OBD 2022-2025 Strategic Plan Attached

Oregon Board of Dentistry

Strategic Plan
2022-2025

Adopted February 25, 2022

Table of Contents

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Oregon Board of Dentistry

2022-2025 Strategic Plan

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

Alicia Riedman, RDH - President
Jose Javier, DDS - Vice President
Amy B. Fine, DMD
Gary Underhill, DMD
Reza J. Sharifi, DMD
Charles "Chip" Dunn
Yadira Martinez, RDH
Jennifer Brixey
Aarati Kalluri, DDS
Sheena Kansal, DDS

Stephen Prisby - Executive Director
Haley Robinson - Office Manager
Winthrop "Bernie" Carter, DDS - Dental Director/Chief Investigator
Angela M. Smorra, DMD - Dental Investigator
Ingrid Nye - Investigator
Lori Lindley - Sr. Assistant Attorney General

<u>Facilitators:</u>
Jennifer Coyne - CEO, The PEAK Fleet
Theresa Trelstad - Contractor Consultant, The PEAK Fleet

Oregon Board of Dentistry
Strategic Plan Overview

The Oregon Board of Dentistry's (OBD) responsibilities and oversight authority is bestowed from the Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.10 to 680.205 (Dental Hygienists), Oregon Administrative Rules Chapter 818. In addition, direction for Dental Therapists is guided by HB 2528 (2021) and the addition of Interim Therapeutic Restorations, HB 2627 (2021) for Expanded Practice Dental Hygienists. These new statutes task the OBD with regulation and oversight of the practice of dentistry and dental hygiene by enforcing standards of practice established in the Oregon Legislature statutes and rule.

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

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

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

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

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

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

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

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

Oregon Board of Dentistry
Mission Statement & Core Values

Mission of the Oregon Board of Dentistry:

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

Oregon Board of Dentistry Core Values:

- Integrity
- Fairness
- Responsibility
- Community

Oregon Board of Dentistry

Organizational & External Influences Analysis

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

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

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

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

STRATEGIC PRIORITY A

Licensure Evolution

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

Goals

⟹ Develop and implement rules based on legislation changes

⟹ Successfully implement Dental Therapy license

Action Items

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

STRATEGIC PRIORITY B

Dental Practice Accountability

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

Goals

- ⟹ Ensure Licensees dictate clinical care provided to patients (in contrast to corporate non-Licensees driving care decisions)
- ⟹ Increase OBD visibility into practice ownership models
- ⟹ OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model
- ⟹ Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice

Action Items

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

STRATEGIC PRIORITY C

Community Interaction and Equity

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

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

Goals

⟹ Communicate and market to reach the diverse communities within Oregon

⟹ Increase ease of access to OBD services

⟹ Ensure equity exists in Investigation outcomes

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

Action Items

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

STRATEGIC PRIORITY D

Workplace Environment

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

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

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

Goals

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

⟹ Increase workplace flexibility through a hybrid workplace guideline

⟹ Increase workplace satisfaction and career development conversations

Action Items

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

STRATEGIC PRIORITY E

Technology & Processes

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

Goals

⟹ Improve efficiency and resource utilization through online record keeping

⟹ Increase ability to complete analytics related to licensees and investigations

⟹ Improve investigation case management with archived files

Action Items

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

Oregon Board of Dentistry Strategic Plan 2022-2025

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

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

Oregon Board of Dentistry 2022-2025 Strategic Plan

Roadmap and Goals

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

Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. NE, Room 410
P.O. Box 14480
Salem, OR 97309-0405

September 9, 2022

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Ste. # 770
Portland OR 97201

Delivered by E-mail to: stephen.prisby@obd.oregon.gov

Dear Mr. Prisby:

I am writing to report to the Oregon Board of Dentistry on services provided by Expanded Practice Dental Hygienists between July 1st, 2020 and June 30th, 2022.

ORS 680.210(2) requires that the Division of Financial Regulation provide information collected on the reimbursement of services provided by expanded practice dental hygienists to the Board of Dentistry. This information has been collected and aggregated and is being forwarded electronically with this letter.

For this reporting period, we proactively sent reminder notices to insurance companies and third-party administrators that may have had information to report. Any company that did not report had to submit an attestation stating that they had no information to report.

We received a response from Companion Life Insurance Company where they indicated that, as of now, they cannot specifically identify expanded practice dental hygienist business. We are actively working with the company and the expectation is that they will provide this information for the next reporting period.

We identified a significant increase in what was reported by Advantage Dental from prior years reporting. We followed up to confirm accuracy of information reported and received the following explanation: “To provide some additional context, we had previously been submitting reports only for Advantage Dental Plan, Inc., which did commercial dental business before it wound down its operations last year. Earlier this year, we realized that OAR 836-11-0600 applies not only to commercial insurance companies, but also to Medicaid plans run by CCOs and DCOs. Accordingly, we are now submitting this report for Advantage Dental Services, LLC, which is an Oregon Dental Care Organization contracted with OHA and numerous Oregon CCOs. These numbers represent EPDH services provided to OHP members by Advantage Dental Services, LLC.”

We also contacted PacificSource Community Health Plans as they were a new entity reporting and the amount reported is larger than we have traditionally seen. They confirmed that the values they reported are accurate.

Thirteen (13) entities reported paying for services provided by expanded practice dental hygienists between July 1st, 2020 and June 30, 2022.

The next reporting period for reimbursement of services provided by expanded practice dental hygienists will extend from July 1, 2022 through June 30, 2024. After receipt, data will again be forwarded to the Board of Dentistry.

A spreadsheet aggregating submissions by the thirteen insurers reporting payment of these services has been forwarded electronically to you along with this letter. If you have questions about this information, please contact me.

Sincerely,

Marc Rivers
Data Analyst
(971) 375-7065
marc.rivers@dcbs.oregon.gov

Company	Amount billed by the EPDH to the insurer for the service provided.
Advantage Dental Services, LLC	8,427,893.53
Aetna Life Insurance Company	7,193.98
Cigna Health and Life Insurance Company	9,218.00
Independence American Insurance Company	104.00
LifeMap Assurance Company	5,227.00
Loyal American Life Insurance Company	-
Metropolitan Life Insurance Company	159,979.27
Mutual of Omaha Insurance Company	150.00
Oregon Dental Service	124,036.69
PacificSource Community Health Plans	1,379,402.30
PacificSource Health Plans	35,656.28
Regence Blue Cross Blue Shield of Oregon	37,190.21
Standard Life & Accident Insurance Company	4,571.23
Total	**$ 10,190,622.49**

Amount allowed for the service under the insurance plan.	Amount of benefit paid by the insurer for the dental service.	Amount owed by the insured for the service.
5,284,438.43	147,136.68	73,163.73
4,568.68	3,925.39	517.80
2,803.00	2,228.70	1,050.30
68.00	48.00	56.00
4,525.00	3,498.00	1,027.00
-	-	-
117,211.27	74,119.07	43,092.20
109.00	109.00	11.00
51,669.77	41,767.93	9,901.84
736,763.97	226,401.19	-
20,850.62	19,217.81	1,101.65
31,913.64	30,301.24	2,472.97
3,047.67	2,560.35	1,798.46
$ 6,257,969.05	**$ 551,313.36**	**$ 134,192.95**

Amount of excluded charges owed by the insured.	Amount of excluded charges, if any, that the provider is not allowed to collect from the insured due to their provider agreement with the insurer.
4,180,982.27	4,180,982.27
517.80	2,625.30
3,185.00	-
36.00	-
-	702.00
-	-
32,512.00	-
30.00	-
70,113.90	2,253.02
642,392.57	
14,805.66	
860.57	5,276.57
-	
$ 4,945,435.77	**$ 4,191,839.16**

Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. NE, Room 410
P.O. Box 14480
Salem, OR 97309-0405

August 14, 2020

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Ste. # 770
Portland OR 97201

Delivered by E-mail to: Stephen.Prisby@state.or.us

Dear Mr. Prisby:

I am writing to report to the Oregon Board of Dentistry on services provided by Expanded Practice Dental Hygienists between July 1st, 2018 and June 30th, 2020.

ORS 680.210 (2) requires that the Division of Financial Regulation (formerly known as the Oregon Insurance Division) provide information collected on the reimbursement of services provided by expanded practice dental hygienists to the Board of Dentistry. This information has been collected and aggregated and is being forwarded electronically with this letter.

Nine entities reported paying for services provided by expanded practice dental hygienists between July 1st, 2018 and June 30, 2020. Oregon Dental Service was the largest provider of these services that made payment, with a total billed amount of $171,734 and total payments of $52,477. In total, $132,367 was paid by insurers on billings totaling $299,071.

The next reporting period for reimbursement of services provided by expanded practice dental hygienists will extend from July 1, 2020 through June 30, 2022. After receipt, data will again be forwarded to the Board of Dentistry .

A spreadsheet aggregating submissions by the nine insurers reporting payment of these services has been forwarded electronically to you along with this letter. If you have questions about this information, please contact me.

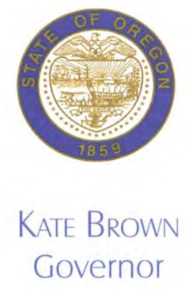
Sincerely,

Spencer Peacock
Data Analyst
(503) 947-7201
spencer.c.peacock@oregon.gov

Company	Amount billed by the EPDH to the insurer for the service provided.	Amount allowed for the service under the insurance plan.
Advantage Dental	3,912.00	285.26
Aetna Life	18,492.22	14,021.71
Cigna Life and Health	410.00	293.00
Dentegra Insurance Company	26,403.59	24,682.34
Independence American	1,349.00	459.00
LifeMap Assurance Company	1,121.97	1,121.97
Oregon Dental Service	171,734.76	69,311.93
PacificSource	37,145.44	27,821.55
Regence	38,502.51	33,019.22
Total	**$ 299,071.49**	**$ 171,015.98**

Amount of benefit paid by the insurer for the dental service.	Amount owed by the insured for the service.	Amount of excluded charges owed by the insured.
251.80	1,329.18	0.00
10,780.02	2,126.90	2,126.90
221.50	188.50	0.00
14,728.70	8,702.89	12.73
459.00	890.00	890.00
217.01	1.30	724.26
52,476.81	16,835.12	102,025.33
24,979.55	2,619.44	9,323.89
28,252.45	7,243.57	2,523.68
$ 132,366.84	**$ 39,936.90**	**$ 117,626.79**

Amount of excluded charges, if any, that the provider is not allowed to collect from the insured due to their provider agreement with the insurer.
39.98
4,470.51
0.00
0.00
0.00
0.00
397.50
0.00
0.00
$ 4,907.99



KATE BROWN
Governor

September 12, 2022

Dear Agency Director,

It is with great pleasure that I invite you to participate in this year's Tribal-State Government-to-Government Annual Summit. This year's Summit will be held in-person on October 4, 2022, at Three Rivers Resort & Casino in Florence, Oregon. There also will be an informal reception held at Three Rivers on the evening before the Summit, on October 3 from 7:00 p.m. – 8:30 p.m. for those who would like to attend. The Summit will be generously co-hosted by the Confederated Tribes of Coos, Lower Umpqua & Siuslaw.

The theme of this year's Summit is: ***Celebrating our accomplishments, and preparing for the challenges ahead.*** Since we last met, several tribal governments have transitioned to new leadership; during the coming months, our state government will transition to a new administration as well. With change comes opportunity—for our governments, for our relationships, and for our people. At the Summit this year, I look forward to celebrating the successes we have achieved together during my time as Governor, and I encourage us to identify key issues for our governments to collaborate on during the coming years.

As the director of your agency, you set the tone for the relationship with the tribes and your personal participation in this Summit is encouraged and appreciated. In addition to agency leadership, please extend the invitation to attend to your agency's tribal liaison or key contact. These individuals serve a valuable role in building and maintaining the government-to-government relationship.

My tribal liaisons, General Counsel Dustin Buehler and Deputy General Counsel Sarah Weston, will be available to answer any questions you may have. I know this is an important occasion for everyone involved, and I look forward to seeing you at the Summit.

Sincerely,

Kate Brown

Governor Kate Brown

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

2022 Annual Tribal-State Government-to-Government Summit

"Celebrating our accomplishments, and preparing for the challenges ahead"

Monday, October 3, 2022: **Informal Reception**
7:00 – 8:30 PM

Tuesday, October 4, 2022: **Summit Program – Three Rivers Event Center, Three Rivers Resort and Casino**

8:00 – 9:00 AM	**Registration and Continental Breakfast**
9:00 – 9:30 AM	**Opening Ceremony** (Processional, Flag Ceremony, Honor Guard, National Anthem, Invocation & Welcome from Tribal Chairman Brad Kneaper, Governor's General Counsel, and LCIS Director)
9:30 – 10:30 AM	**Tribal Chairs and Governor Opening Remarks**
10:30-10:45 AM	Break
10:45 – 11:45 AM	**Our Journey Together: Celebrating Tribal/State Accomplishments during Gov. Brown's Administration, and Identifying Challenges Ahead**
11:45 - 1:00 PM	**Lunch** (Networking, No formal program)
1:00 – 2:00 PM	**Tribal/State Accomplishments and Challenges – Workforce, Housing, and Economic Development**
2:00-2:15 PM	**Break**
2:15 – 3:15 PM	**Tribal/State Accomplishments and Challenges – Water, Climate, and Natural Resources**
3:15 – 4:15 PM	**Closing Remarks of Tribal Chairs and Governor**
4:15 – 4:30 PM	**Flags Retired and Adjourn**

*Our special thanks to the Confederated Tribes of Coos, Lower Umpqua & Siuslaw

Please Join Us

For an Evening Reception with Tribal/State Leaders

Monday, October 3, 2022

7:00—8:30pm

Three Rivers Resort

5647 Highway 126

Florence, OR 97439

- Meet and socialize with friends and colleagues, both old and new
- Light appetizers and sweet treats will be served
- Please RSVP by September 27th if you will be attending the Tuesday Evening Reception to adriennelfischer@oregonlegislature.gov

Graciously Co-hosted by The Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians

NEWSLETTERS & ARTICLES OF INTEREST

Dental Workforce Shortages: Data to Navigate Today's Labor Market

October 3, 2022

HPI Health Policy Institute

ADA American Dental Association®

Dental Workforce Shortages: Data to Navigate Today's Labor Market

Presenter | Moderator | Panelists

Chelsea Fosse
Senior Health Policy Analyst
ADA Health Policy Institute

Marko Vujicic
Chief Economist/VP
ADA Health Policy Institute

Hana Alberti
Senior Director
ADA Center for Dental Practice Policy

Hanna Aronovich
Chief Marketing & Communications Officer
Dental Assisting National Board

JoAnn Gurenlian
Director, Education
American Dental Hygienists' Association

Research Partners

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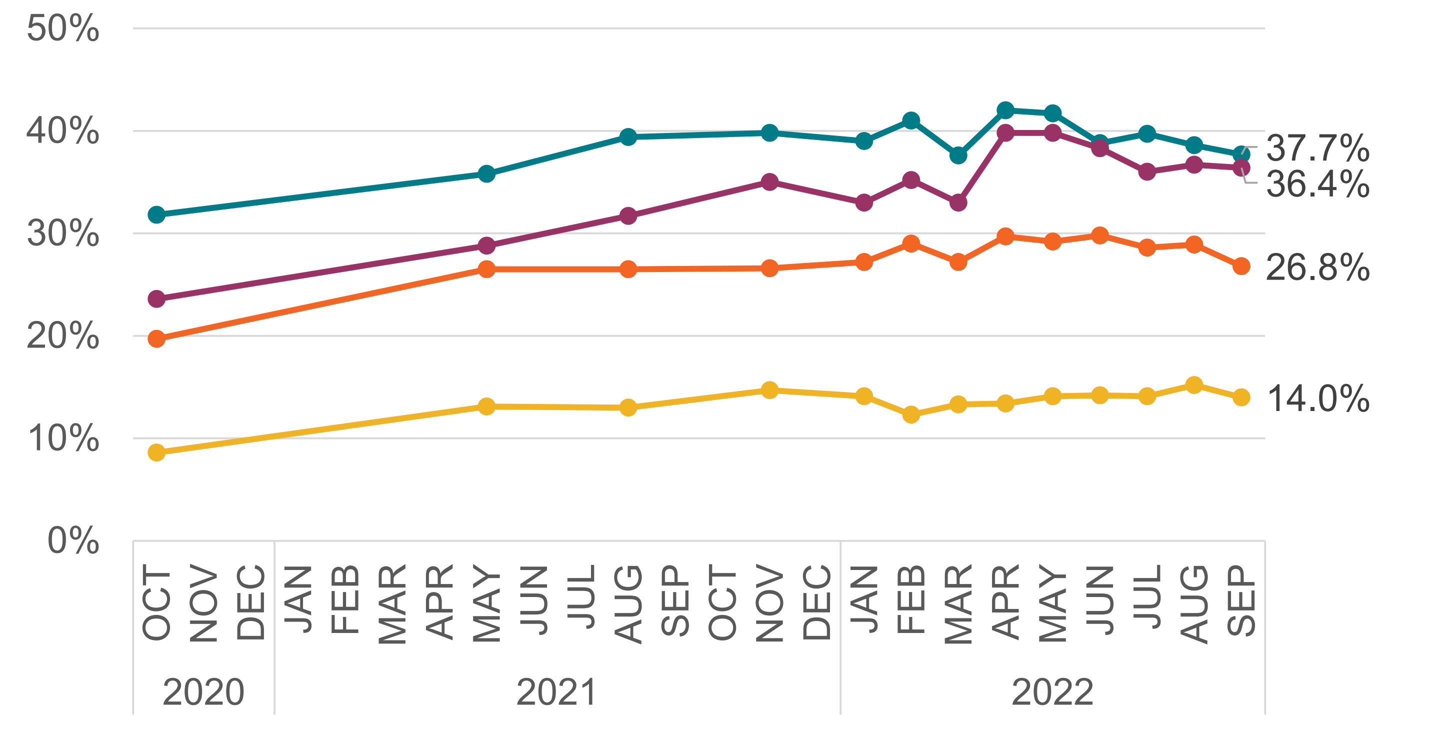
Why This Matters

Have you recently or are you currently recruiting any of the following positions in your dental practice? (Percentages indicating "yes.")



In any given month, roughly 4 out of 10 dental practices are hiring dental assistants or dental hygienists.

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Report Now Available

Dental Workforce Shortages: Data to Navigate Today's Labor Market

What keeps dental assistants and dental hygienists satisfied in their roles?

What workplace conditions are to blame for dental assistants and dental hygienists leaving their positions?

What levers are available to recruit and retain a high quality dental workforce?

ADA.org/HPI

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What the New Report Tells Us

- Approximately one-third of the dental assistant (33.7%) and dental hygienist (31.4%) workforce indicate they expect to **retire in five years or less**.
- The majority of dental assistants and dental hygienists are **satisfied** in their current job.
- Roughly half of dental assistants and dental hygienists indicate they have **received a raise within the past year**. The majority of wage increases are in the **1-3%** range.
- The majority of dental assistants and dental hygienists indicated that they receive **dental benefits, paid holidays, paid vacation, and retirement savings** from their employers. **Health insurance, paid sick time, paid leave, and continuing education or professional development funds** are rare overall. These benefits matter for recruitment and retention.
- Factors associated with retention include **work-life balance, positive workplace culture, and ability to help patients**.
- Factors associated with attrition include **negative workplace culture, insufficient pay, lack of growth opportunity, inadequate benefits, and feeling overworked**.

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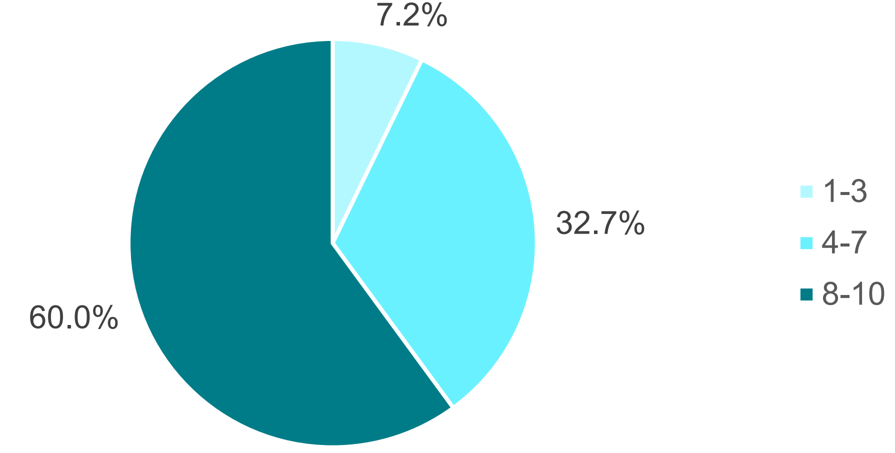
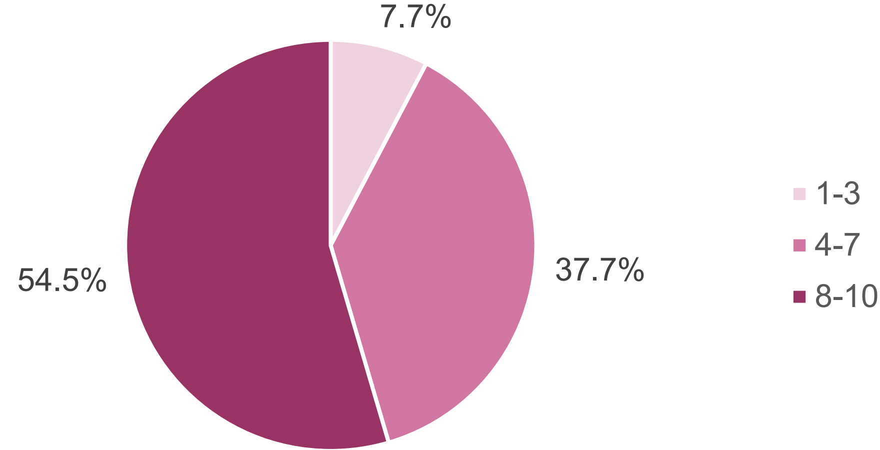
Job Satisfaction





The majority of currently employed dental assistants and dental hygienists indicate they are satisfied in their role.

Fewer than 1 in 10 indicate a low level of satisfaction.

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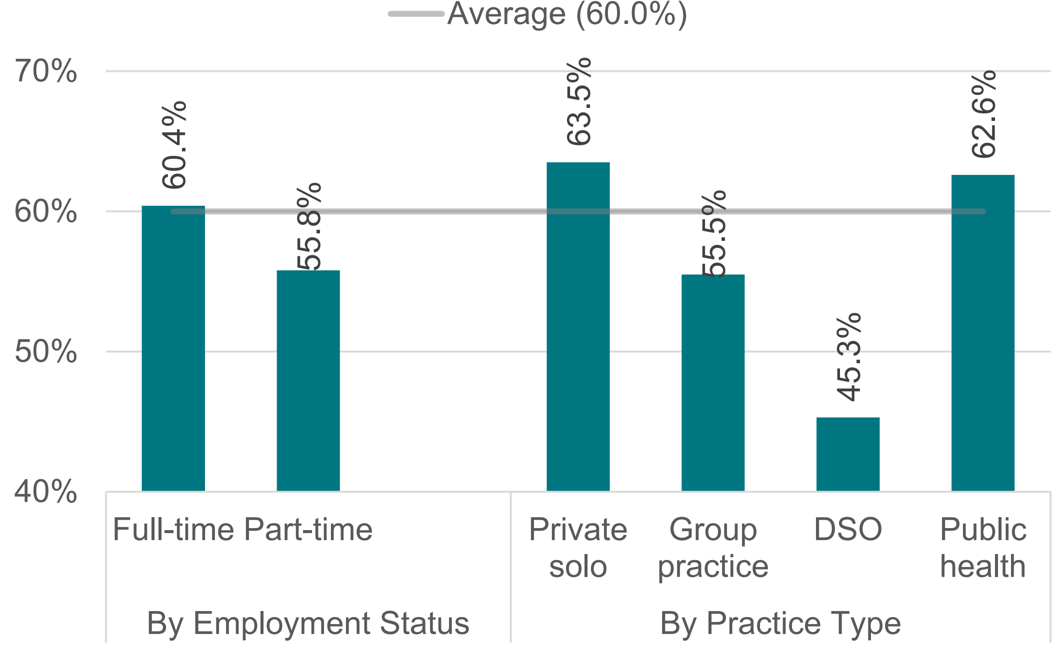
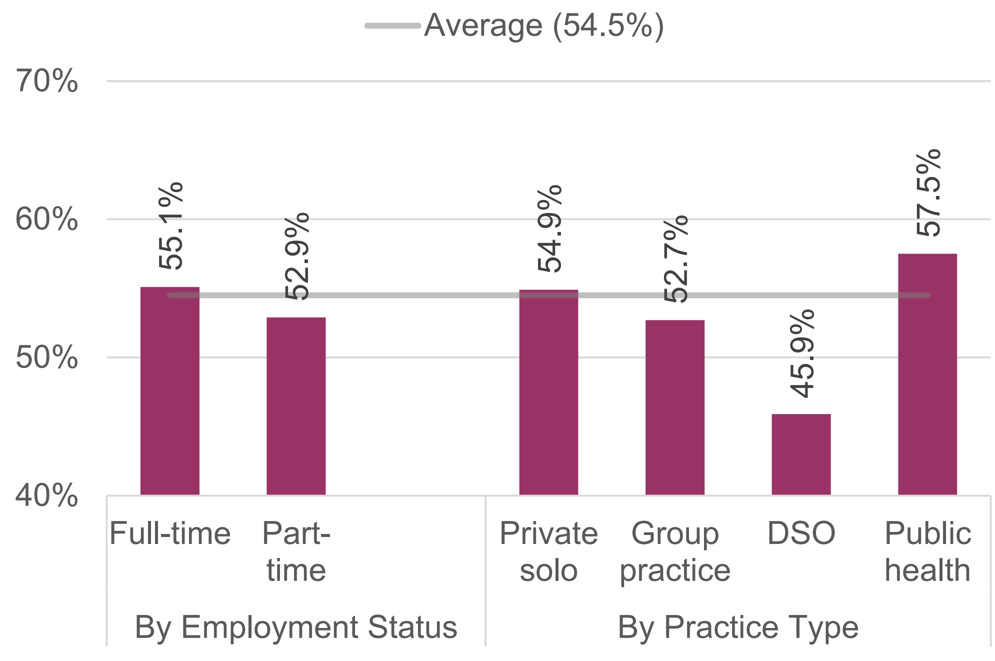
Job Satisfaction





A lesser share of dental service organization (DSO) employees and part-time employees indicate high job satisfaction.

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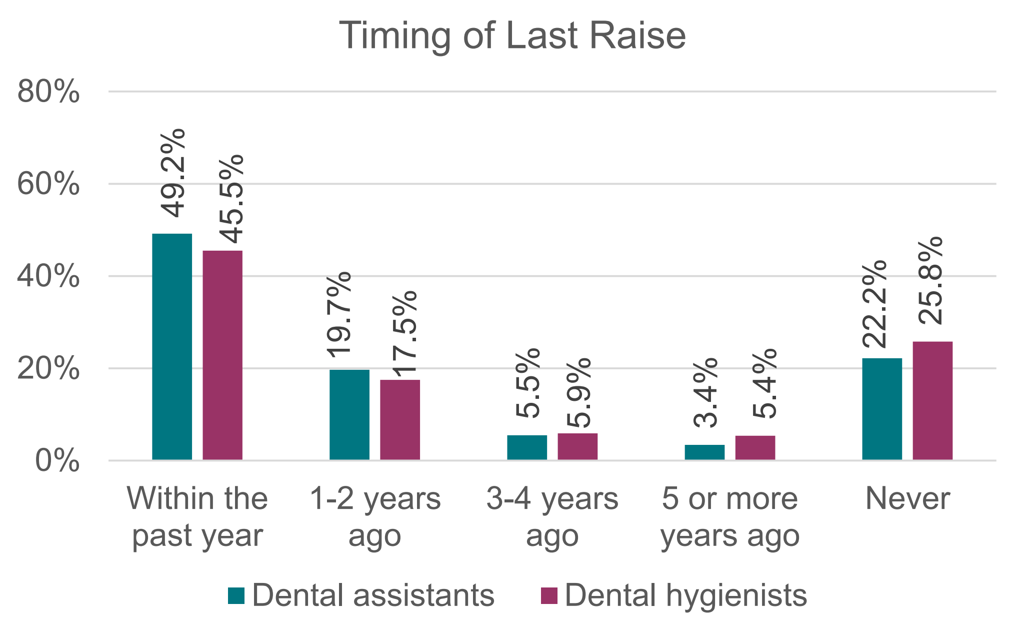
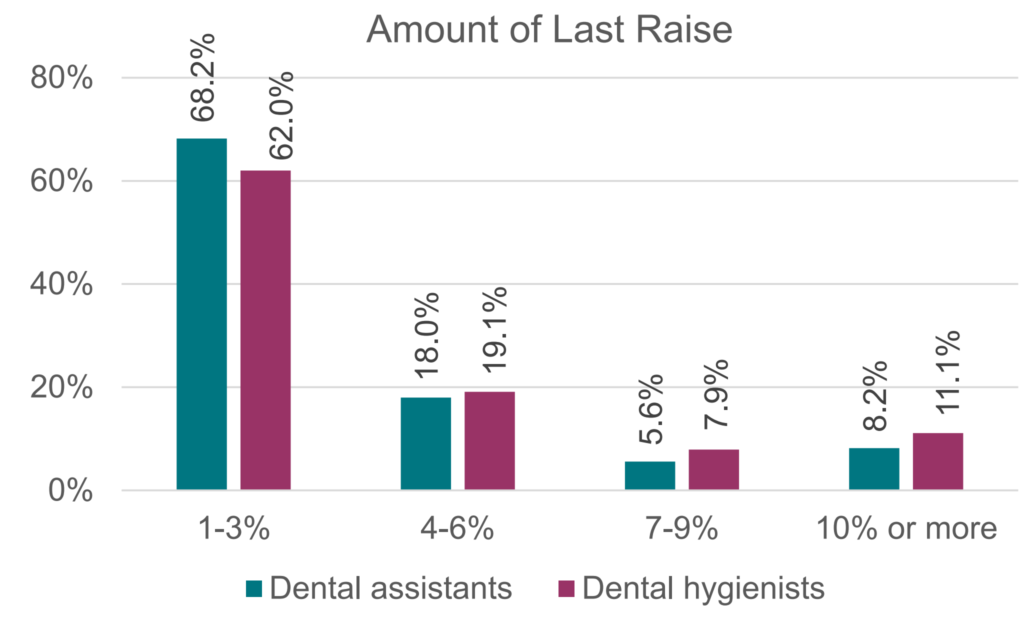
Pay Raises





Most dental assistants and dental hygienists indicate that they received wage increases within the past year or 1-2 years ago.

Among those who indicated they have received a raise, it was most commonly an increase in the 1-3% range.

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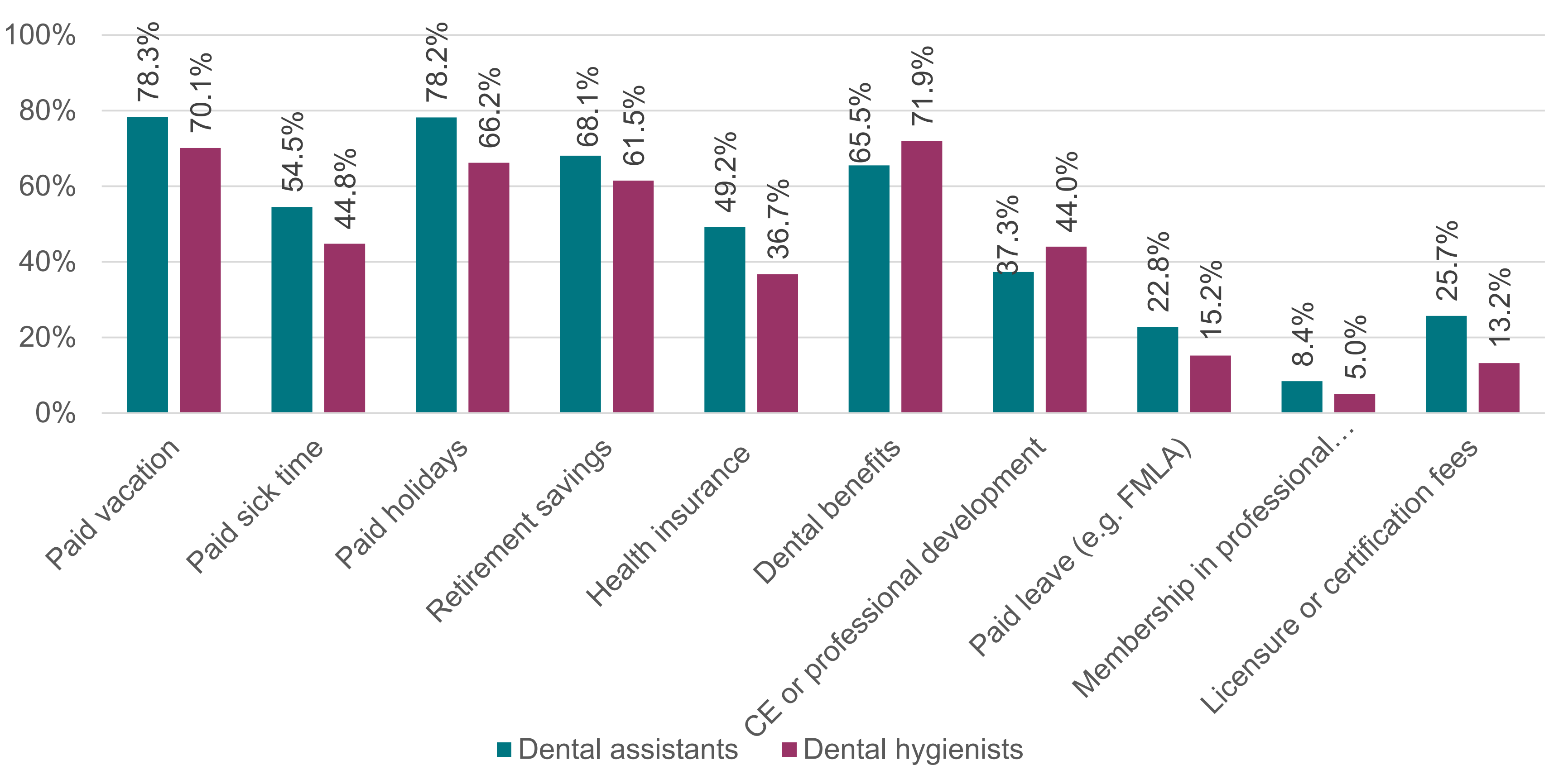
Benefits



The majority of dental assistants and dental hygienists receive dental benefits, paid holidays, paid vacation, and retirement savings.

Health insurance, paid sick time, paid leave, and continuing education or professional development funds are much less common.

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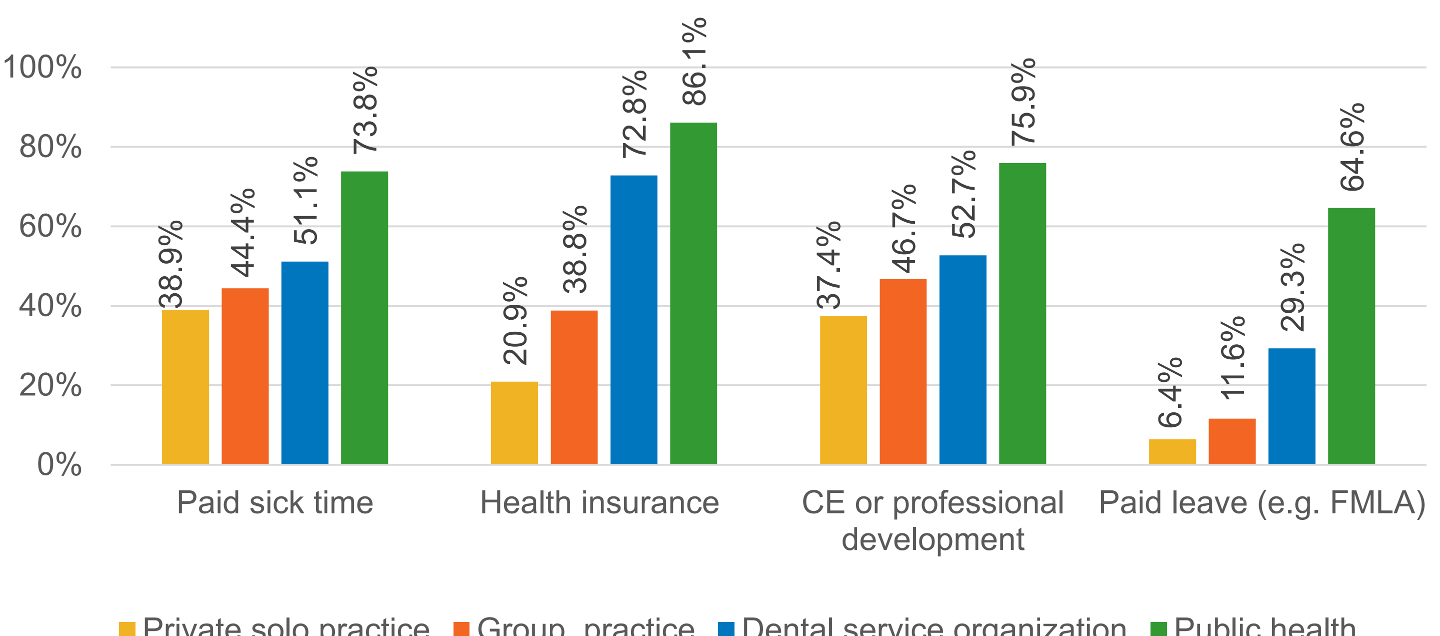
Group Settings Offer More Benefits



Health insurance, paid sick time, paid leave, and continuing education or professional development funds – while rare overall – are available to the majority of dental hygienists working in public health settings.

These benefits are also more common in DSOs and group practices than in private solo practices.

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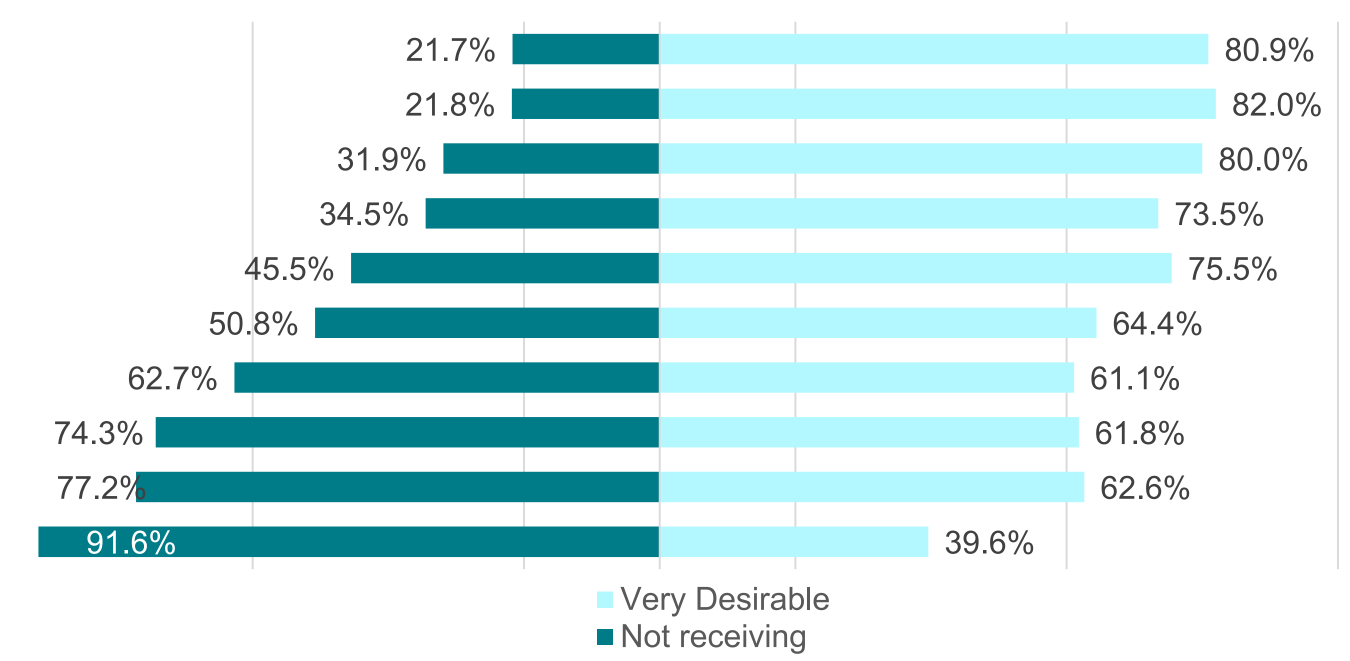
Missing Benefits are Highly Desirable



Among dental assistants and dental hygienists not receiving these workplace benefits, the majority indicate that almost all of these benefits are "very desirable."

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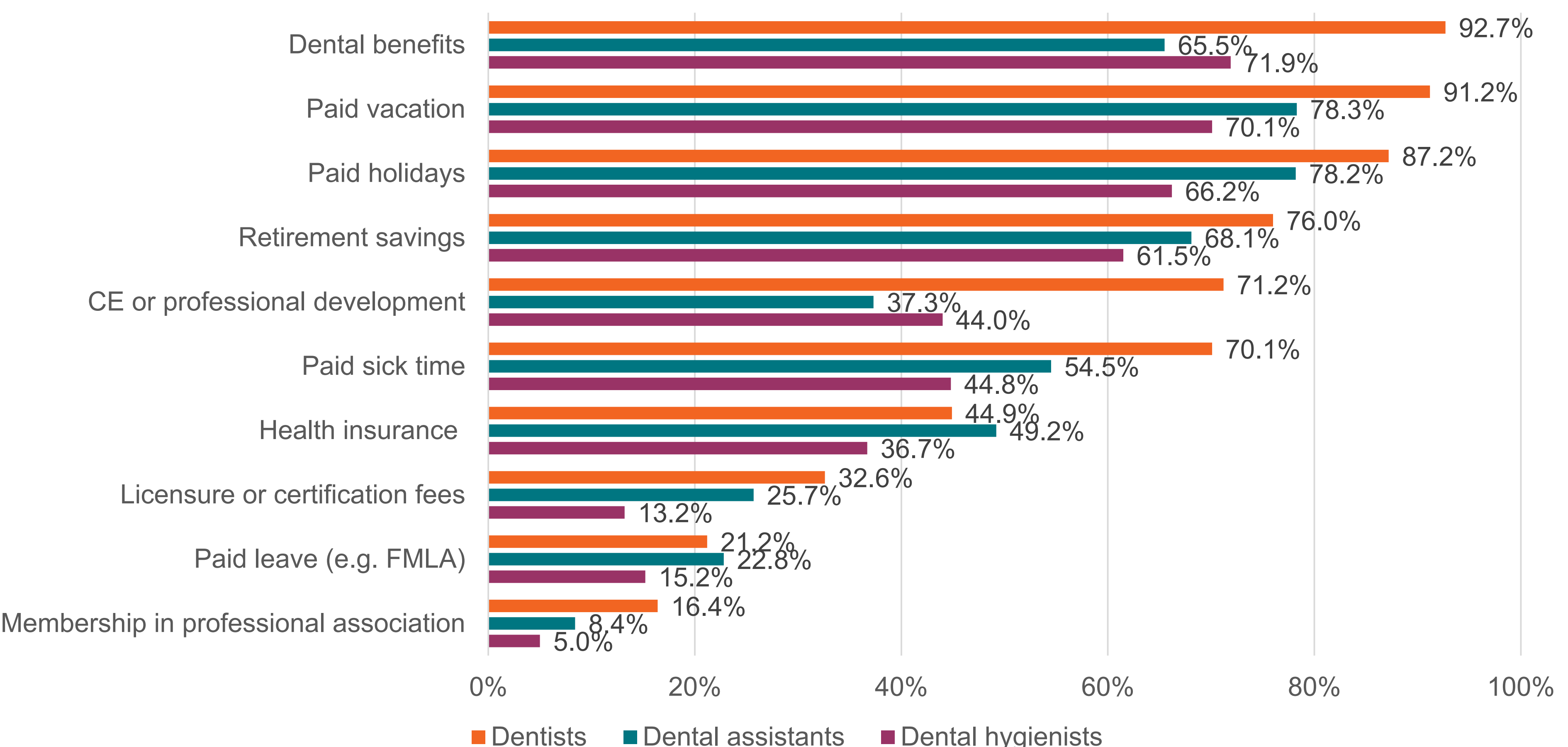
Perceptions on Benefits Generosity



In general, dentist employers indicated greater generosity in terms of their benefits packages than reported by dental assistant and dental hygienist employees.

Better communication and more transparency surrounding workplace benefits might be helpful.

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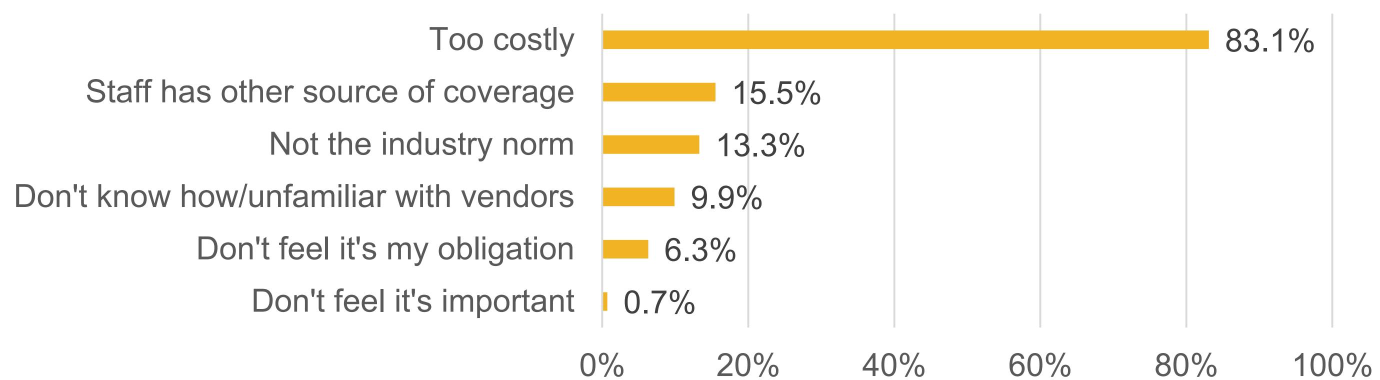
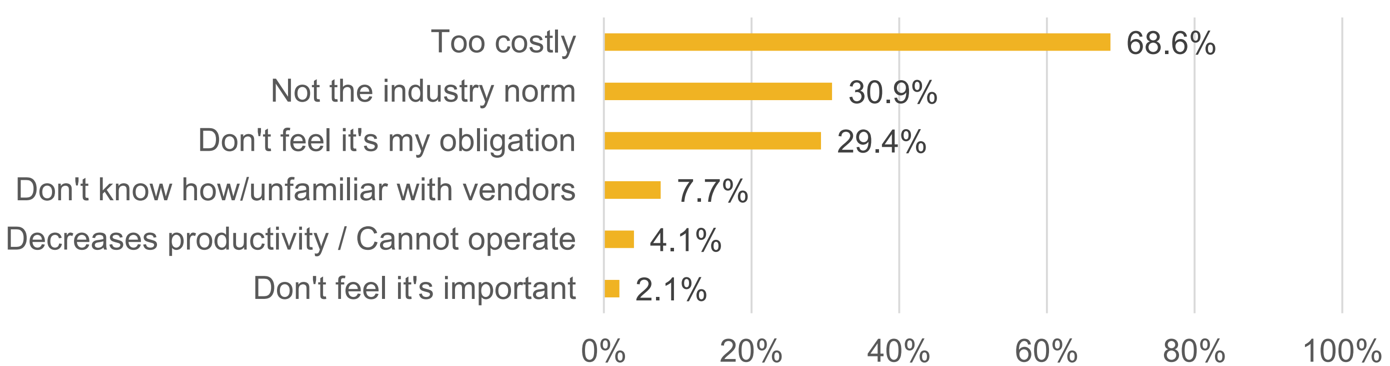
Why Health Insurance Isn't More Common





Dentists who do not offer their employees health insurance were asked why, and the overwhelming majority indicated cost as a reason.

While cost was also the predominant reason among dentists not offering paid leave, nearly 1 in 3 also indicated that they do not offer the benefit because it is not the industry norm and/or not their obligation.

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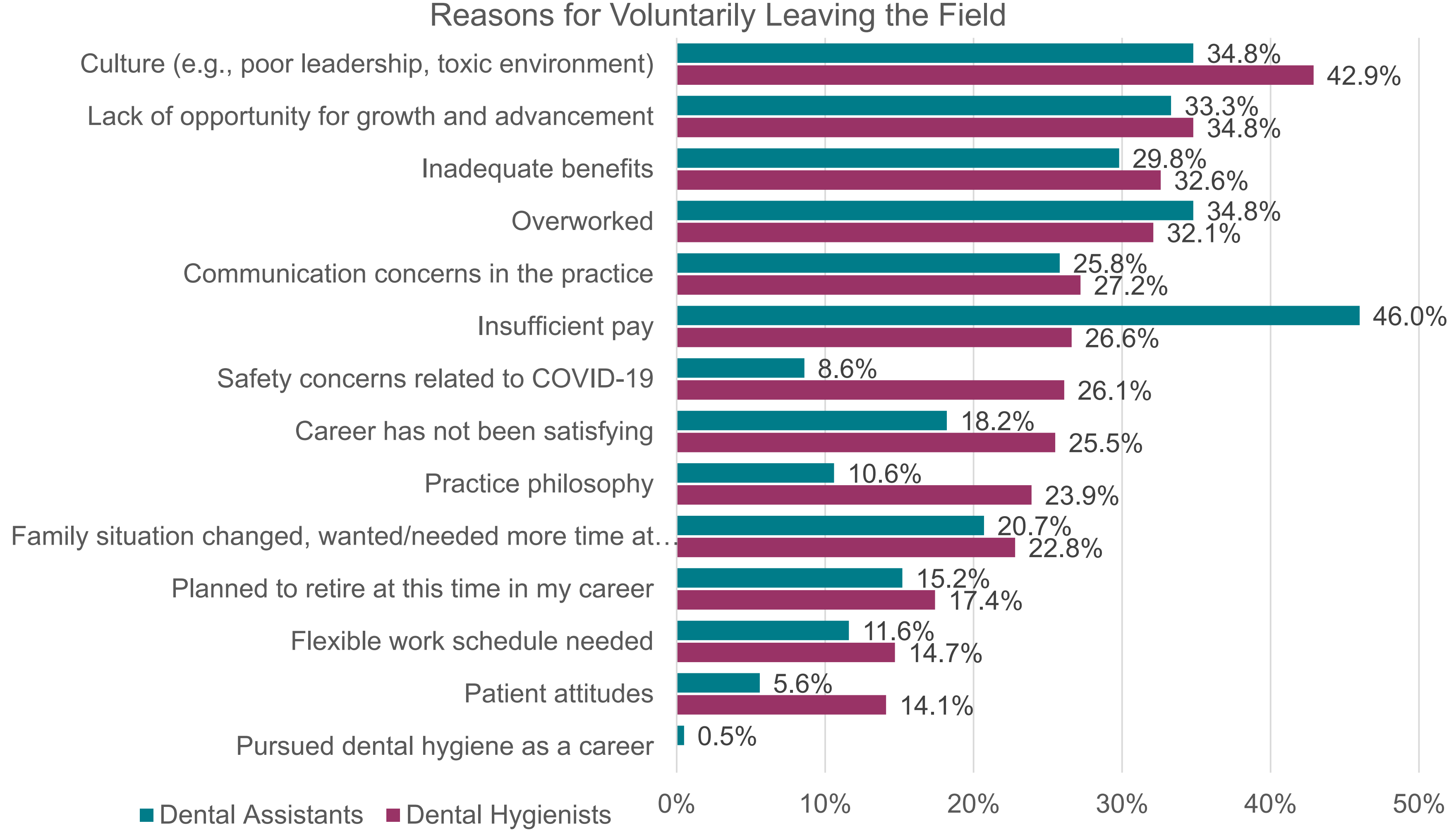
Leaving the Field Voluntarily



The most common reasons dental hygienists opt to leave the field include negative workplace culture, lack of growth opportunity, and inadequate benefits.

The most common reasons among dental assistants were insufficient pay, negative workplace culture, and feeling overworked.

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Considerations for Dental Employers

Dental practices need to remain competitive as employers when it comes to employee benefits.

Responsive compensation is a must.

Workplace culture cannot be overlooked.

Consolidated dental practices have an edge when it comes to employee benefits.

Shoring up the workforce pipeline will require long-term changes.

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Thank You!

ADA.org/HPI

ADHA.org

DANB.org

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Dental Workforce Shortages: Data to Navigate Today's Labor Market

Presenter | Moderator | Panelists

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Senior Health Policy Analyst
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Chief Economist/VP
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Hana Alberti
Senior Director
ADA Center for Dental Practice Policy

Hanna Aronovich
Chief Marketing & Communications Officer
Dental Assisting National Board

JoAnn Gurenlian
Director, Education
American Dental Hygienists' Association

HPI Health Policy Institute
ADA American Dental Association®

From: PRISBY Stephen * OBD
To: OBD_DL_OBD Staff
Cc: Lindley Lori
Subject: Fw: CODA - Dental therapy Skagit Valley College
Date: Tuesday, August 16, 2022 3:18:27 PM

FYI

From: Kowalski Sarah E <SARAH.E.KOWALSKI@dhsoha.state.or.us>
Sent: Tuesday, August 16, 2022 3:11 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Subject: CODA - Dental therapy Skagit Valley College

Just wanted to pass along that the Dental Therapy (DHAT) program at Skagit Valley College in Washington was granted initial accreditation by the Commission on Dental Accreditation (CODA) yesterday. They are a tribal college and they are the second program in the United States to achieve this outside of the Alaska program at Illasgvik College.

Thanks!
Sarah

Sarah Kowalski, MS, RDH
Dental Pilot Projects: Oral Health Program
Operations and Policy Analyst 3
Oregon Health Authority: Public Health Division
800 NE Oregon Street, #825
Portland, Oregon 97203

dəxʷx̌ayəbus-Dental Therapy Program

Associate of Applied Sciences in Dental Therapy

The Skagit Valley College (SVC), in partnership with Swinomish Indian Tribal Community (SITC), developed the first ***Dental Therapy*** (DT***) Education Program*** in the State of Washington to address the on-going oral health workforce disparities among underrepresented minorities specifically, the American Indian/Alaska Native (AI/AN) communities**.** The name of the DT program is ***dəxʷx̌ayəbus***, which is a Lushootseed phrase pronounced as dahf-hi-ya-buus and translates to a ***Place of Smiles***. Lushootseed is a common language of coastal Salish tribes, made up of many local dialects of Native

Americans throughout the Puget Sound region. This new dental professional education program is co-located at Skagit Valley College's Mt. Vernon Campus and Swinomish Indian Tribal Community's Dental Clinic. The program aims in delivering "smiles" because smiles are strong indicators of personal confidence as well as physical and mental health. When a person smiles with confidence, they exude a positive reaction to those around them and more importantly, within themselves.

dəxʷx̌ayəbus-Dental Therapy is a rigorous three (3) year curriculum focused on cultivating the learner in the scope of Dental Therapy and understanding the broader functions within a dental team. The program focuses on student-centered teaching and learning with a commitment to equitable student outcomes in areas of access, achievement, and community. The synergy between dəxʷx̌ayəbus-Dental Therapy and its partners is evident with the common focus on quality programming and equitable student success.

The mission of dəxʷx̌ayəbus-Dental Therapy at Skagit Valley College is to grow primary oral health providers who enhance a dental team through excellence in education, research, patient care, and community service. Its vision is to apply evidence-based practices for clinical excellence, rich in cultural humility, public health and community awareness, provider integrity, and a holistic health team approach.

Catalog Program Information and Program Map – Associate

of Applied Science in Dental Therapy

View Program Information

Program Learning Outcomes

Graduates of the Dental Therapy program will be able to:

- Develop clinical care through a holistic health team approach that is grounded in evidence-based practices, rich in cultural humility, public health, and community awareness.
- Recognize the complexity of patient care and partner with patients to collaborate with other dental specialists and healthcare providers in managing patients' comprehensive oral health.
- Comprehend the oral health needs of underserved communities, specifically native communities, and become oral health advocates when leading community service-related activities.
- Apply scientific knowledge when learning, researching, and delivering oral health care by utilizing critical thinking and evidence-based decision-making.

Dental Therapy Curriculum

The Dental Therapy program is designed to develop students into people who have the knowledge, values, and skills to practice of dental therapy. The objective for Quarters 1-2 is Preparation. The courses in these quarters focus on general education instruction, and fundamental concepts of biomedical and dental sciences. The objective for Quarters 3-4 is Processing. The emphasis is on the use of simulators where students apply preclinical skills in a lab setting. The objective for Quarter 5 is Application where students transition from preclinical to a clinic setting. The transition consists of skill consolidation activities and competency assessments to prepare students to provide patient care. The objective for Quarters 6-8 is Integration where students function as novice dental therapists in supervised clinical and community settings. Students work toward completing competency assessments to be able to progress to the Quarter 9 preceptorship. The

objective for the final quarter is Reflective Practice. Students provide care within the scope of dental therapy, and reflect on what they are doing to synthesize, internalize and embody dental therapy skills.

Specialized Program Information

CERTIFICATION/LICENSURE

Upon successful completion of the AAS degree in Dental Therapy, graduates are eligible to be certified/licensed by regional certification/licensure boards.

DENTAL THERAPY PROGRAM LOCATIONS

The Dental Therapy program at SVC is offered at the Mount Vernon Campus and Swinomish Indian Tribal Community (SITC) Dental Clinic.

- Mount Vernon Campus – 2405 E College Way, Mount Vernon, WA 98273
- SITC Dental Clinic – 17395 Reservation Rd., PO Box 332, La Conner, WA 98257

Program Notes

For additional information about the Dental Therapy program, visit the **Catalog Program Information page**.

Inquiries can be sent to **dentaltherapy@skagit.edu**.

Dr. Rachael Hogan
dəxʷx̌ayəbus Program Director
Swinomish Dental Director
Rachael.Hogan@skagit.edu

Cardinal Athletics

CONTACT US

Mount Vernon Campus
2405 East College Way
Mount Vernon, WA
98273-5899

English **360.416.7600**
Español **360.416.7740**
(TTY) **360.416.7718**
Whidbey Island Campus
1900 SE Pioneer Way
Oak Harbor, WA 98277
360.675.6656

View additional SVC Locations

NEED TO KNOW

- Accreditation
- Annual Security Report
- Career Opportunities
- Consumer and Disclosure Information
- Emergency Response Plan
- Non-Discrimination Statement - Annual Notice
- Sign Up for Emergency Alerts
- Submit Campus Incident Report
- Title IX

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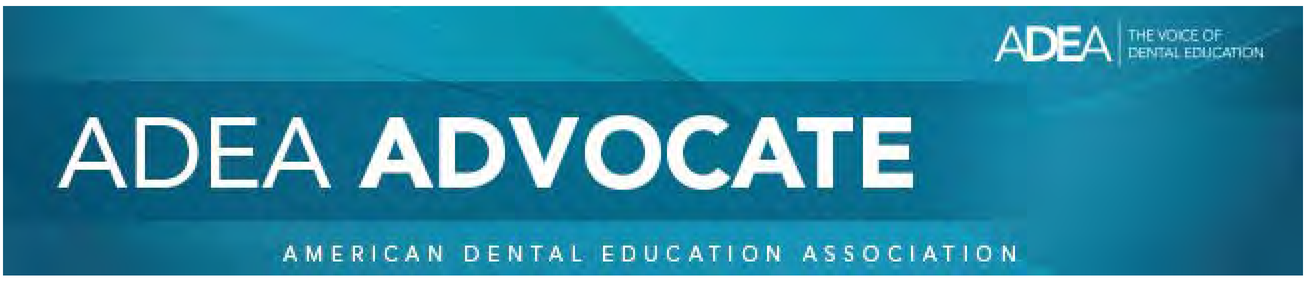

Volume 2, No. 69, September 27, 2022

CSG Releases Draft of Dentist and Dental Hygiene Licensure Compact

Licensure compacts have become a popular method for increasing licensure portability among health professions. Recently, the Council for State Governments (CSG) released a draft of the Dentist and Dental Hygienist Compact, that if enacted by states, could lead to greater licensure portability for individuals licensed in those professions.

Licensure compacts serve as a means for creating licensure reciprocity among states that join the compact. When states join, the compact license holders in compact states are granted the opportunity to apply for a "compact privilege" that will allow them to practice in another member state. Under the current draft of the compact, license holders will be granted the opportunity to apply for compact privilege if they:

- Hold a license as a dentist or dental hygienist;
- Graduate from a Commission on Dental Accreditation-accredited program;
- Successfully complete a clinical assessment for licensure, with "clinical assessment" currently defined as an examination or process required for licensure as a dentist or dental hygienist as applicable, that provides evidence of clinical competence in dentistry or dental hygiene;
- Have passed a National Board Examination of the Joint Commission on National Dental Examinations or another examination accepted by rule as a requirement for licensure;
- Meet any jurisprudence requirements;
- Complete a criminal background check;
- Submit an application and pay applicable fees; and
- Comply with requirements to submit specified information for administrative purposes.

Compacts are overseen by commissions that consist of representation from each compact state. Commissions are granted the authority to grant "compact privilege" and create commission rules to which member states agree to comply. Under the current draft, a commission will be created to oversee the dentist and dental hygiene licensure compact after 10 states have joined the compact.

States can join a compact by passing substantially similar legislation. The final compact language will serve as model legislation that state legislatures can pass in order to join the compact.

CSG has requested feedback from stakeholders by Sept. 30.

The Council of State Governments (CSG) is partnering with the Department of Defense (DoD), the American Dental Association (ADA), and the American Dental Hygienists' Association (ADHA) to support the mobility of licensed dentists and dental hygienists through the development of a new interstate compact. This compact will create reciprocity among participant states, and reduce the barriers to license portability.

Contributing Stakeholders

Along with the American Dental Association and American Dental Hygienists' Association, the following organizations contributed to the compact development process.

- American Student Dental Association
- Alaska Board of Dental Examiners
- Arizona State Board of Dental Examiners
- Idaho Board of Dentistry
- Iowa Dental Board
- Louisiana State Board of Dentistry
- Minnesota Board of Dentistry
- North Carolina Dental Board of Dental Examiners
- Ohio State Dental Board
- University of Colorado School of Dental Medicine
- University of Connecticut School of Dental Medicine
- Washington Dental Quality Assurance Commission
- Washington Department of Health

Dentist and Dental Hygienist Compact Fact Sheet

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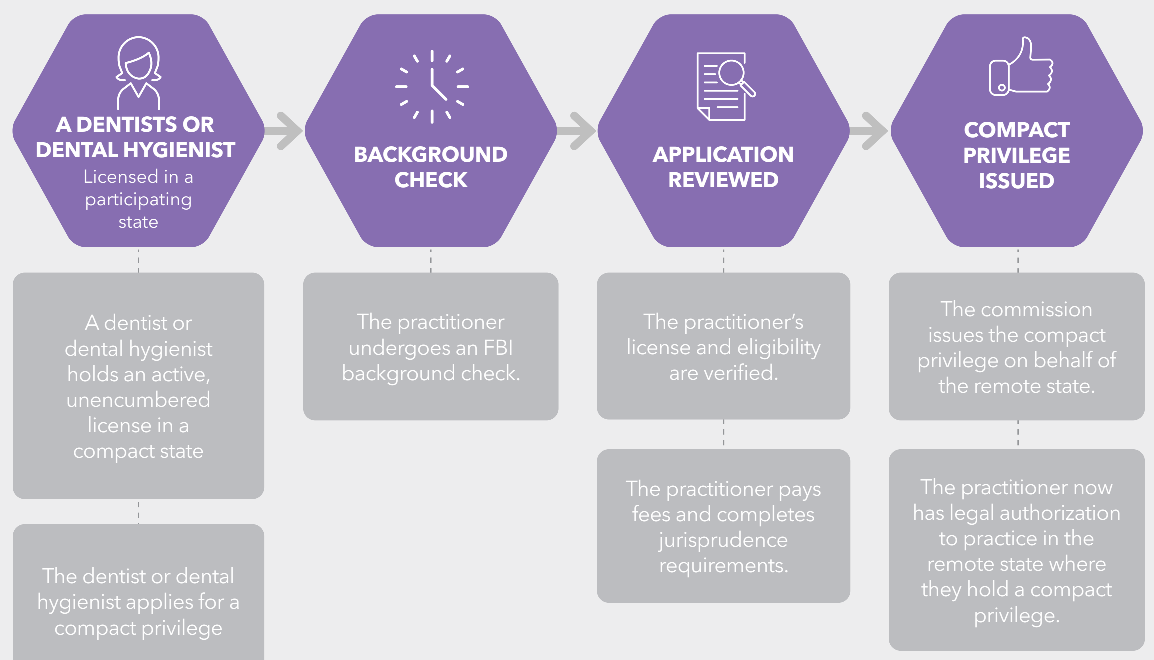
What is the **Dentist and Dental Hygienist Compact?**

The Dentist and Dental Hygienist Compact is an interstate occupational licensure compact. Interstate compacts are constitutionally authorized, legally binding, legislatively enacted contracts among states. This compact will enable licensed dentists and dental hygienists to practice in all states participating in the compact, rather than get an individual license in every state in which they want to practice. Like the compact for a driver's license, each compact state agrees to mutually recognize the licenses issued by the other participating states.



What other professions have an interstate compact?

- Interstate Medical Licensure Compact (IMLC)
- Nurse Licensure Compact (NLC) and Advanced Practice Nurse Compact (APRN Compact)
- Emergency Medical Service Officials Licensure Compact (EMS Compact)
- Physical Therapists Licensure Compact (PT Compact)
- Psychology Interjurisdictional Compact (PSYPACT)
- Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC)
- Occupational Therapy Interstate Licensure Compact (OT Compact)
- Counseling Interstate Licensure Compact

Who can use the **Dentist and Dental Hygienist Compact?**

A dentist or dental hygienist is eligible to participate in the compact if they have:

- An active, unencumbered license in any state participating in the compact.
- Passed the National Board Examination or other exam accepted by the compact commission.
- Completed a clinical assessment.
- Graduated from an education program accredited by the Commission on Dental Accreditation.
- No disqualifying criminal history.

BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR LICENSEES:

Facilitates multistate practice.

Enhances license portability when changing state of residence.

Expands employment opportunities into new markets.

Improves continuity of care when patients or providers relocate.

Supports relocating military spouses.

Reduces burden of maintaining multiple licenses.

BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR REGULATORS:

Reduces administrative burden.

Facilitates practitioner mobility during public health emergencies.

Ensures retention of jurisdiction over practitioners working in their state.

Expands state licensure board cooperation on investigations and disputes.

Enhances public safety through shared data system.

BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR STATES:

Promotes workforce development and strengthens labor markets.

Expands consumer access to highly qualified practitioners.

Preserves state sovereignty.

Increases collaboration among states.

What's Next?

Interstate compacts take time to develop and implement because of the necessary coordination among state legislatures, state regulatory boards and the compact commission.

The Council of State Governments (CSG) will facilitate a stakeholder review process to receive input and feedback on the draft of the model legislation. The goal is for this legislation to be ready for introduction during state 2023 legislative sessions. Legislatures must enact the Dentist and Dental Hygienist Compact model legislation in order for their state to be a participant.

To get involved in the stakeholder review process or learn more about advocating for the compact, please visit **https://compacts.csg.org/compact-updates/dentistry-and-dental-hygiene/**.

DENTIST AND DENTAL HYGIENIST COMPACT

SECTION 1. TITLE AND PURPOSE

This statute shall be known and cited as the Dentist and Dental Hygienist Compact. The purpose of this Compact is to facilitate the interstate practice of dentistry and dental hygiene with the goal of improving public access to services and supporting the ability of Dentists and Dental Hygienists to provide dentistry and dental hygiene services when relocating in Participating States. The Compact preserves the regulatory authority of Participating States to protect public health and safety through their authority to regulate the practice of dentistry and dental hygiene in their State by Dentists and Dental Hygienists who practice in their State pursuant to a Compact Privilege.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

A. **"Active-Duty Military"** means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active-duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

B. **"Adverse Action"** means disciplinary action or encumbrance imposed on a license or Compact Privilege by a State Licensing Authority.

C. **"Alternative Program"** means a non-disciplinary monitoring or practice remediation process applicable to a Dentist or Dental Hygienist approved by the State Licensing Authority of a Participating State in which the Dentist or Dental Hygienist is licensed. This includes, but is not limited to, programs to which Licensees with substance abuse or addiction issues are referred in lieu of Adverse Action.

D. **"Clinical Assessment"** means examination or process, required for licensure as a Dentist or Dental Hygienist as applicable, that provides evidence of clinical competence in dentistry or dental hygiene.

E. **"Commissioner"** means the individual appointed by a Participating State to serve as the member of the Commission for that Participating State.

F. **"Compact"** means this Dentist and Dental Hygienist Licensing Compact.

G. **"Compact Privilege"** means the authorization granted by the Commission to allow a Licensee from a Participating State to practice as a Dentist or Dental Hygienist in a Remote State.

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32 H. **"Continuing Professional Development"** means a requirement, as a condition of license
33 renewal or the renewal of a license registration, to provide evidence of successful
34 participation in, educational or professional activities relevant to practice or area of work.

35 I. **"Criminal Background Check"** means the submission of fingerprints or other
36 biometric-based information for a license applicant for the purpose of obtaining that
37 applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d) from
38 the Federal Bureau of Investigation and the agency responsible for retaining State
39 criminal records in the State.

40 J. **"Data System"** means the Commission's repository of information about Licensees,
41 including but not limited to examination, licensure, investigative, Compact Privilege,
42 Adverse Action, and Alternative Program.

43 K. **"Dental Hygienist"** means an individual who is licensed by a State Licensing Authority
44 to practice dental hygiene.

45 L. **"Dentist"** means an individual who is licensed by a State Licensing Authority to practice
46 dentistry.

47 M. **"Dentist and Dental Hygienist Compact Commission" or "Commission"** means a
48 government agency established by this Compact comprised of each State that has enacted
49 the Compact and a national administrative body comprised of a Commissioner from each
50 State that has enacted the Compact.

51 N. **"Encumbered License"** means a license that a State Licensing Authority has limited in
52 any way other than through an Alternative Program.

53 O. **"Executive Board"** means the Chair, Vice Chair, Secretary and Treasurer and any other
54 Commissioners as may be determined by Commission Rule or bylaw.

55 P. **"Jurisprudence Requirement"** means the assessment of an individual's knowledge of
56 the laws and Rules governing the practice of dentistry or dental hygiene, as applicable, in
57 a State.

58 Q. **"Licensee"** means an individual who currently holds an authorization from a
59 Participating State, other than a Compact Privilege, or other privilege, to practice as a
60 Dentist or Dental Hygienist in that State.

61 R. **"Model Compact"** the model for the Interstate Dentist and Dental Hygienist Compact on
62 file with the Council of State Governments or other entity as designated by the
63 Commission.

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S. **“Participating State”** means a State that has enacted the Compact and been admitted to the Commission in accordance with the provisions herein and Commission Rules.

T. “**Qualifying License”** means a license that is not an Encumbered License issued by a Participating State to practice dentistry or dental hygiene.

U. **“Remote State”** means a Participating State where a Licensee who is not licensed as a Dentist or Dental Hygienist is exercising or seeking to exercise the Compact Privilege.

V. **“Rule”** means a regulation promulgated by an entity that has the force of law.

W. **“Scope of Practice”** means the procedures, actions, and processes a Dentist or Dental Hygienist licensed in a State is permitted to undertake in that State and the circumstances under which the Licensee is permitted to undertake those procedures, actions and processes. Such procedures, actions and processes and the circumstances under which they may be undertaken may be established through means, including, but not limited to, statute, Rules and regulations, case law, and other processes available to the State Licensing Authority or other government agency.

X. **“Significant Investigative Information”** means information, records, and documents received or generated by a State Licensing Authority pursuant to an investigation for which a determination has been made that there is probable cause to believe that the Licensee has violated a statute or regulation that is considered more than a minor infraction for which the State Licensing Authority could pursue adverse action against the Licensee.

Y. **“State”** means any state, commonwealth, district, or territory of the United States of America that regulates the practices of dentistry and dental hygiene.

Z. **“State Licensing Authority”** means the agency or other entity of a State that is responsible for the licensing and regulation of Dentists and Dental Hygienists.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. In order to join the Compact and thereafter continue as a Participating State, a State must:

1. Enact a compact that is not materially different from the Model Compact as determined in accordance with Commission Rules;
2. Participate fully in the Commission’s Data System;
3. Have a mechanism in place for receiving and investigating complaints about its Licensees;

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95 4. Notify the Commission, in compliance with the terms of the Compact and Commission
96 Rules, of any Adverse Action or the availability of Significant Investigative Information
97 regarding a Licensee;

98 5. Fully implement a Criminal Background Check requirement, within a time frame
99 established by Commission Rule, by receiving the results of a qualifying Criminal
100 Background Check;

101 6. Comply with the Commission Rules applicable to a Participating State;

102 7. Utilize the National Board Examinations of the Joint Commission on National Dental
103 Examinations or another examination accepted by Commission Rule as a requirement for
104 licensure;

105 8. Require for licensure that applicants graduate from a predoctoral dental education
106 program, leading to the D.D.S. or D.M.D. degree, or a dental hygiene education program
107 accredited by the Commission on Dental Accreditation or another agency permitted by
108 Commission Rule;

109 9. Require for licensure that applicants successfully complete a Clinical Assessment;

110 10. Have Continuing Professional Development requirements as a condition for license
111 renewal or renewal of license; and

112 11. Pay a participation fee to the Commission as established by Commission Rule.

113 B. When conducting a Criminal Background Check the State Licensing Authority shall:

114 1. Consider that information in making a licensure decision;

115 2. Maintain documentation of completion of the Criminal Background Check and
116 background check information to the extent allowed by State and federal law; and

117 3. Report to the Commission whether it has completed the Criminal Background Check and
118 whether the individual was denied a license.

119 C. The Commission shall grant a Licensee of a Participating State who does not hold an
120 Encumbered License in any other Participating State, the Compact Privilege in a Remote
121 State in accordance with the terms of the Compact and Commission Rules. If a Remote State
122 has a Jurisprudence Requirement, the Commission shall not grant the Licensee the Compact
123 Privilege for that Remote State unless and until the Commission is informed by the Remote
124 State or Licensee that the Licensee has satisfied the Jurisprudence Requirement.

125 **SECTION 4. COMPACT PRIVILEGE**

126 A. To exercise the Compact Privilege under the terms and provisions of the Compact, the
127 Licensee shall:

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128 1. Have a Qualifying License as a Dentist or Dental Hygienist in a Participating State.

129 2. Be eligible for a Compact Privilege in any Remote State in accordance with D, G and H
130 of this section;

131 3. Apply to the Commission whenever the Licensee is seeking a Compact Privilege within
132 one or more Remote States;

133 4. Pay any applicable Commission and Remote State fees for a Compact Privilege in the
134 Remote State;

135 5. Meet any Jurisprudence Requirements established by a Remote State in which the
136 Licensee is seeking a Compact Privilege;

137 6. Have passed a National Board Examination of the Joint Commission on National Dental
138 Examinations or another examination accepted by Commission Rule as a requirement for
139 licensure;

140 7. Have graduated from a predoctoral dental education program, leading to the D.D.S. or
141 D.M.D. degree, or a dental hygiene education program accredited by the Commission on
142 Dental Accreditation or another agency permitted by Commission Rule;

143 8. Have successfully completed a Clinical Assessment for licensure;

144 9. Report to the Commission Adverse Action taken by any non-Participating State when
145 applying for a Compact Privilege and, otherwise, within thirty (30) days from the date the
146 Adverse Action is taken;

147 10. Report to the Commission when applying for a Compact Privilege the address of the
148 Licensee's primary residence and thereafter immediately report to the Commission any
149 change in the address of the Licensee's primary residence; and

150 11. Consent to accept service of process by mail at the Licensee's primary residence on
151 record with the Commission with respect to any action brought against the Licensee by
152 the Commission or a Participating State, and consent to accept service of a subpoena by
153 mail at the Licensee's primary residence on record with the Commission with respect to
154 any action brought or investigation conducted by the Commission or a Participating
155 State.

156 B. The Licensee must comply with the requirements of subsection A of this section to maintain
157 the Compact Privilege in the Remote State. If those requirements are met, the Compact
158 Privilege will continue as long as the Licensee maintains a Qualifying License and pays any
159 applicable renewal fees.

160 C. A Licensee providing dentistry or dental hygiene in a Remote State under the Compact
161 Privilege shall function within the Scope of Practice authorized by the Remote State for a
162 Dentist or Dental Hygienist licensed in that State.

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D. A Licensee providing dentistry or dental hygiene pursuant to Compact Privilege in a Remote State is subject to that State's regulatory authority. A Remote State may, in accordance with due process and that State's laws, remove by Adverse Action a Licensee's Compact Privilege in the Remote State for a specific period of time, and impose fines or take any other necessary actions to protect the health and safety of its citizens. If a Remote State imposes an Adverse Action against a Compact Privilege that limits the Compact Privilege, that Adverse Action applies to all Compact Privileges in all Remote States. A Licensee whose Compact Privilege in a Remote State is removed for a specified period of time is not eligible for a Compact Privilege in any other Remote State until the specific time for removal of the Compact Privilege has passed and all encumbrance requirements are satisfied.

E. If a license in a Participating State is an Encumbered License, the Licensee shall lose the Compact Privilege in a Remote State and shall not be eligible for a Compact Privilege in any Remote State until the license is no longer encumbered.

F. Once an Encumbered License in a Participating State is restored to good standing, the Licensee must meet the requirements of subsection A of this section to obtain a Compact Privilege in a Remote State.

G. If a Licensee's Compact Privilege in a Remote State is removed by the Remote State, the individual shall lose or be ineligible for the Compact Privilege in any Remote State until the following occur:

1. The specific period of time for which the Compact Privilege was removed has ended; and

2. All conditions for removal of the Compact Privilege have been satisfied.

H. Once the requirements of subsection G of this section have been met, the Licensee must meet the requirements in subsection A of this section to obtain a Compact Privilege in a Remote State.

SECTION 5. ACTIVE-DUTY MILITARY PERSONNEL OR THEIR SPOUSES

An Active-Duty Military individual and their spouse shall not be required to pay to the Commission for a Compact Privilege the fee otherwise charged by the Commission. If a Remote State chooses to charge a fee for a Compact Privilege, it may choose to charge a reduced fee or no fee to an Active-Duty Military individual and their spouse for a Compact Privilege.

SECTION 6. ADVERSE ACTIONS

A. A Participating State in which a Licensee is licensed shall have exclusive authority to impose Adverse Action against the Qualifying License issued by that Participating State.

B. A Participating State may take Adverse Action based on the Significant Investigative Information of a Remote State, so long as the Participating State follows its own procedures for imposing Adverse Action.

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198 C. Nothing in this Compact shall override a Participating State's decision that participation in an
199 Alternative Program may be used in lieu of Adverse Action and that such participation shall
200 remain non-public if required by the Participating State's laws. Participating States must
201 require Licensees who enter any Alternative Program in lieu of discipline to agree not to
202 practice in any other Participating State during the term of the Alternative Program without
203 prior authorization from such other Participating State.

204 D. Any Participating State in which a Licensee is applying to practice or is practicing pursuant
205 to a Compact Privilege may investigate actual or alleged violations of the statutes and
206 regulations authorizing the practice of dentistry or dental hygiene in any other Participating
207 State in which the Dentist or Dental Hygienist holds a license or Compact Privilege.

208 E. A Remote State shall have the authority to:

209 1. Take Adverse Actions as set forth in Section 4.D against a Licensee's Compact Privilege
210 in the State;

211 2. Issue subpoenas for both hearings and investigations that require the attendance and
212 testimony of witnesses, and the production of evidence. Subpoenas issued by a State
213 Licensing Authority in a Participating State for the attendance and testimony of
214 witnesses, or the production of evidence from another Participating State, shall be
215 enforced in the latter State by any court of competent jurisdiction, according to the
216 practice and procedure of that court applicable to subpoenas issued in proceedings
217 pending before it. The issuing authority shall pay any witness fees, travel expenses,
218 mileage, and other fees required by the service statutes of the State where the witnesses
219 or evidence are located; and

220 3. If otherwise permitted by State law, recover from the Licensee the costs of investigations
221 and disposition of cases resulting from any Adverse Action taken against that Licensee.

222 F. Joint Investigations

223 1. In addition to the authority granted to a Participating State by its respective dentist or
224 dental hygienist licensure act or other applicable State law, a Participating State may
225 jointly investigate Licensees with other Participating States.

226 2. Participating States shall share any Investigative Information, litigation, or compliance
227 materials in furtherance of any joint or individual investigation initiated under the
228 Compact.

229 G. Authority to Continue Investigation.

230 1. After a Licensee's Compact Privilege in a Remote State is terminated, the Remote State
231 may continue an investigation of the Licensee that began when the Licensee had a
232 Compact Privilege in that Remote State.

233 2. If the investigation yields what would be Significant Investigative Information had the
234 Licensee continued to have a Compact Privilege in that Remote State, the Remote State

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235 shall report the presence of such Information to the Data System as required by Section
236 8.B.6 as if it was Significant Investigative Information.

237 **SECTION 7. ESTABLISHMENT OF THE COMMISSION.**

238 A. The Compact Participating States hereby create and establish a joint government agency and
239 national administrative body known as the Dentist and Dental Hygienist Compact
240 Commission. The Commission is an instrumentality of the Compact States acting jointly and
241 not an instrumentality of any one state. The Commission shall come into existence on or
242 after the effective date of the Compact as set forth in Section 11.A.

243 B. Participation, Voting, and Meetings

244 1. Each Participating State shall have and be limited to one (1) Commissioner. The
245 Commission may by Rule or bylaw establish a term of office of a Commissioner or term
246 limits.

247 2. The Commissioner shall be a member or designee of the State Licensing Authority.

248 3. Any Commissioner may be removed or suspended from serving as a Commissioner as
249 provided by the law of the State from which the Commissioner is appointed or the
250 Commission's Rules or bylaws.

251 4. The Participating State shall fill a vacancy of its Commissioner in the Commission within
252 sixty (60) days of the vacancy.

253 5. Each Commissioner shall be entitled to one (1) vote with regard to all matters that are
254 voted upon by the Commissioners.

255 6. A Commissioner shall vote in person or by such other means as provided in the
256 Commission's bylaws. The bylaws may provide for Commissioner participation in
257 meetings by telephone or other means of communication.

258 7. The Commission shall meet at least once during each calendar year. Additional meetings
259 shall be held as set forth in the Commission's bylaws.

260 C. The Commission shall have the following powers and duties:

261 1. Establish code of conduct and conflict of interest policies;

262 2. Establish the fiscal year of the Commission;

263 3. Establish bylaws;

264 4. Maintain its financial records in accordance with the bylaws;

265 5. Meet and take such actions as are consistent with the provisions of this Compact and the
266 bylaws;

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6. Promulgate Commission Rules to facilitate and coordinate implementation and administration of this Compact. The Rules shall have the force and effect of law and shall be binding on all Participating States;

7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Authority to sue or be sued under applicable law shall not be affected;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Participating State;

10. Hire employees and engage contractors, elect officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

11. Accept and dispose of equipment, supplies, materials and services, and provide for financing of the Commission and payments of its debts and expenses, provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

14. Establish a budget and make expenditures;

15. Borrow money;

16. Appoint committees, including standing committees composed of Commissioners, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Commission's bylaws;

17. Provide and receive information from, and cooperate with, law enforcement agencies;

18. Elect a Chair, Vice Chair, Secretary and Treasurer and such other officers of the Commission as provided in the Commission's bylaws;

19. Reserve for itself, in addition to those reserved exclusively to the Commission under the Compact, powers that the Executive Board may not exercise;

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300 20. Approve or disapprove a State's participation in the Compact based upon its
301 determination as to whether the State's Compact legislation departs in a material manner
302 from the model Compact language;

303 21. In its discretion, establish a period of time a Compact Privilege shall be in effect without
304 renewal.

305 22. As set forth in the Commission Rules, charge a fee to a Licensee for the grant of a
306 Compact Privilege in a Remote State and thereafter, as may be established by
307 Commission Rule, charge the Licensee a Compact Privilege renewal fee for each renewal
308 period in which the Licensee exercises or intends to exercise the Compact Privilege in
309 that Remote State. Nothing herein shall be construed to prevent a Remote State from
310 charging a Licensee a fee for a Compact Privilege or renewals of a Compact Privilege, or
311 a fee for the Jurisprudence Requirement if the Remote State imposes such a requirement
312 for the grant of a Compact Privilege;

313 23. Maintain and certify records and information provided to a Participating State as the
314 authenticated business records of the Commission, and designate a person to do so on the
315 Commission's behalf; and

316 24. Perform such other functions as may be necessary or appropriate to achieve the purposes
317 of this Compact.

318 D. Meetings of the Commission

319 1. All meetings of the Commission that are not closed pursuant to this subsection shall be
320 open to the public. Notice of public meetings shall be posted on the Commission's
321 website at least thirty (30) days prior to the public meeting.

322 2. Notwithstanding subsection D.1 of this section, the Commission may convene a public
323 meeting by providing at least twenty-four (24) hours prior notice on the Commission's
324 website, and any other means as provided in the Commission's Rules, for any of the
325 reasons it may dispense with notice of proposed rulemaking under Section 9.L.

326 3. The Commission may convene in a closed, non-public meeting or non-public part of a
327 public meeting to receive legal advice or to discuss:

328 a. Non-compliance of a Participating State with its obligations under the Compact;

329 b. The employment, compensation, discipline or other matters, practices or procedures
330 related to specific employees or other matters related to the Commission's internal
331 personnel practices and procedures;

332 c. Current, threatened, or reasonably anticipated litigation;

333 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real
334 estate;

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335 e. Accusing any person of a crime or formally censuring any person;

336 f. Disclosure of trade secrets or commercial or financial information that is privileged or
337 confidential;

338 g. Disclosure of information of a personal nature where disclosure would constitute a
339 clearly unwarranted invasion of personal privacy;

340 h. Disclosure of investigative records compiled for law enforcement purposes;

341 i. Disclosure of information related to any investigative reports prepared by or on behalf
342 of or for use of the Commission or committee charged with the responsibility of
343 investigation or determination of compliance issues pursuant to the Compact;

344 j. Legal advice;

345 k. Matters specifically exempted from disclosure by federal or Participating State law;
346 or

347 l. Other matters as provided by Commission Rule.

348 4. If a meeting, or portion of a meeting, is closed pursuant to subsection D.3 of this section,
349 the presiding officer shall make an announcement that the meeting or portion of the
350 meeting shall be closed and shall reference each relevant exempting provision.

351 5. The Commission shall keep minutes that fully and clearly describe all matters discussed
352 in a meeting and shall provide a full and accurate summary of actions taken. All
353 documents considered in connection with an action shall be identified in such minutes.
354 All minutes and documents of a closed meeting shall remain under seal, subject to release
355 by a majority vote of the Commission or order of a court of competent jurisdiction.

356 E. The Commission shall prepare and provide to the Participating States an annual report of its
357 activities.

358 F. Financing of the Commission

359 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
360 establishment, organization, and ongoing activities.

361 2. The Commission may accept any and all appropriate sources of revenue, donations, and
362 grants of money, equipment, supplies, materials, and services.

363 3. The Participating States' annual assessment fees and the Licensees' Compact Privilege
364 fees and any applicable renewal fees shall be used to cover the cost of the operations and
365 activities of the Commission and its staff and must be in a total amount sufficient to cover
366 its annual budget as approved each year for which revenue is not provided by other
367 sources. The aggregate annual assessment amount for Participating States shall be
368 allocated based upon a formula to be determined by Commission Rule.

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4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any Participating State, except by and with the authority of the Participating State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

G. The Executive Board

1. The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact and Commission Rules.

2. The Commission may remove any member of the Executive Board as provided in the Commission's bylaws.

3. The Executive Board shall meet at least annually.

4. The Executive Board shall have the following duties and responsibilities:

    a. Recommend to the Commission changes to the Commission's Rules or bylaws, changes to this Compact legislation, fees to be paid by Compact Participating States such as annual dues, and any Commission Compact fee charged to Licensees for the Compact Privilege;

    b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

    c. Prepare and recommend the budget;

    d. Maintain financial records on behalf of the Commission;

    e. Monitor Compact compliance of Participating States and provide compliance reports to the Commission;

    f. Establish additional committees as necessary;

    g. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for issuing proposed rulemaking or adopting Commission Rules or bylaws, or exercising any other powers and duties exclusively reserved to the Commission by the Commission's Rules; and

    h. Other duties as provided in the Commission's Rules or bylaws.

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5. All meeting of the Executive Board at which it votes or plans to vote on matters in exercising the powers and duties of the Commission shall be open to the public and public notice of such meetings shall be given as public meetings of the Commission are given.

6. The Executive Board may convene in a closed, non-public meeting for the same reasons that the Commission may convene in a non-public meeting as set forth in Section 7.D 3 and shall announce the closed meeting as the Commission is required to under Section 7.D.4 and keep minutes of the closed meeting as the Commission is required to under Section 7.D.5.

H. Qualified Immunity, Defense, and Indemnification

1. The Commissioners, officers, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any Commissioner, officer, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or, as determined by the Commission, that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any Commissioner, officer, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses in any proceedings as authorized by Commission Rules.

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5. Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

6. Nothing herein shall be construed to designate the venue or jurisdiction to bring actions for alleged acts of malpractice, professional misconduct, negligence, or other such civil action pertaining to the practice of dentistry or dental hygiene. All such matters shall be determined exclusively by State law other than this Compact.

7. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Participating State's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other state or federal antitrust or anticompetitive law or regulation.

8. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Participating States or by the Commission.

SECTION 8. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system containing licensure, Adverse Action, Alternative Program and the reporting of the existence of Significant Investigative Information, on all Licensees in Participating States.

B. Notwithstanding any other provision of State law to the contrary, a Participating State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a license or Compact Privilege and information related thereto;

4. Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation not made confidential under Participating State law;

5. Any denial of an application for licensure, and the reason(s) for such denial (excluding the reporting of any Criminal history record information where prohibited by law); and

6. The presence of Significant Investigative Information; and

7. Other information that may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. Significant Investigative Information pertaining to a Licensee in any Participating State will only be available to other Participating States.

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D. It is the responsibility of each Participating State to report any Adverse Action it takes against a license or Compact Privilege, including upon an applicant for a license, and to monitor the database to determine whether Adverse Action has been taken against a Licensee or license applicant. Adverse Action information pertaining to a Licensee in any Participating State will be available to any other Participating State. Participating States may obtain from the Data System information of any Adverse Action taken against a Licensee or an individual applying for a license.

E. Participating States contributing information to the Data System may, in accordance with a State or federal law so requiring, designate information that may not be shared with the public without the express permission of the contributing State. Notwithstanding any such designation, such information shall be reported to the Commission through the Data System.

F. Any information submitted to the Data System that is subsequently expunged Pursuant to federal law or the laws of the Participating State contributing the information shall be removed from the Data System upon reporting of such by the Participating State to the Commission.

G. The records and information provided to a Participating State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Participating State.

SECTION 9. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Commission Rules shall become binding as of the date specified in its adoption of each Rule.

B. No Rule of the Commission shall conflict with the laws of a Participating State that establishes the Scope of Practice of a Licensee in that Participating State.

C. The Commission shall promulgate reasonable Rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review, as determined by a court of competent jurisdiction, the Rules to which the judicial determination applies shall be invalid and have no force and effect.

D. If a majority of the legislatures of the Participating States rejects a Commission Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Participating State or to any State applying to participate in the Compact.

E. Commission Rules shall be adopted at a regular or special meeting of the Commission.

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F. Prior to promulgation and adoption of a final Rule or Rules by the Commission, and at least thirty (30) days in advance of the meeting at which the Rule will be considered and voted upon, the Commission shall place a Notice of Proposed Rulemaking on the website of the Commission or other publicly accessible platform and provide written Notice of Proposed Rulemaking to the State Licensing Authority of each Participating State;

G. The Notice of Proposed Rulemaking shall include:

1. The time, date and location of a public hearing on the proposed rule and the proposed time, date, and location of the meeting in which the proposed Rule will be considered and voted upon;

2. The text of the proposed Rule and the reason for the proposed Rule;

3. A request for comments on the proposed Rule from any interested person and the date by which written comments must be received; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing or provide any written comments.

H. Prior to adoption of a proposed Rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

I. If the hearing is to be held via electronic means, the Commission shall publish in the Notice of Proposed Rulemaking the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall as directed in the notice of the public hearing, not less than five (5) business days before the scheduled date of the hearing, notify the Commission of their desire to appear and testify at the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording and the written Comments, data, facts, opinions, and arguments received in response to the proposed rulemaking will be made available to a person upon request.

4. Nothing in this section shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

J. Following the public hearing the Commission shall consider all written and oral comments received.

K. The Commission shall, by majority vote of all Commissioners, take final action on the proposed Commission Rule and shall determine the effective date of the Rule, if adopted, based on the rulemaking record and the full text of the Rule.

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547 1. If adopted, the Rule shall be posted on the Commission's website.

548 2. The Commission may adopt changes to the proposed Rule provided the changes do not
549 enlarge the original purpose of the proposed Rule.

550 3. The Commission shall provide on its website an explanation of the reasons for
551 substantive changes made to the proposed Rule as well as reasons for substantive changes
552 not made that were recommended by commenters.

553 4. The Commission shall determine a reasonable effective date for the Rule. Except for an
554 emergency as provided in subsection L, the effective date of the Rule shall be no sooner
555 than thirty (30) days after issuing the notice that it adopted the Rule.

556 L. Upon a determination that an emergency exists, the Commission may consider and adopt an
557 emergency Rule with twenty-four (24) hours prior notice, without the opportunity for
558 comment, or hearing, provided that the usual rulemaking procedures provided in the
559 Compact and in this section shall be retroactively applied to the Rule as soon as reasonably
560 possible, in no event later than ninety (90) days after the effective date of the Rule. For the
561 purposes of this provision, an emergency Rule is one that must be adopted immediately in
562 order to:

563 1. Meet an imminent threat to public health, safety, or welfare;

564 2. Prevent a loss of Commission or Participating State funds;

565 3. Meet a deadline for the promulgation of a Rule that is established by federal law or Rule;
566 or

567 4. Protect public health and safety.

568 M. The Commission or an authorized committee of the Commission may direct revisions to a
569 previously adopted Rule for purposes of correcting typographical
570 errors, errors in format, errors in consistency, or grammatical errors. Public notice of any
571 revisions shall be posted on the website of the Commission. The revision shall be subject to
572 challenge by any person for a period of thirty (30) days after posting. The revision may be
573 challenged only on grounds that the revision results in a material change to a Rule. A
574 challenge shall be made to the Commission as set forth in the notice of revisions and
575 delivered to the Commission prior to the end of the notice period. If no challenge is made,
576 the revision will take effect without further action. If the revision is challenged, the revision
577 may not take effect without the approval of the Commission.

578 **SECTION 10. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT**

579 A. Oversight

580 1. The executive and judicial branches of State government in each Participating State shall
581 enforce this Compact and take all actions necessary and appropriate to implement the
582 Compact.

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583 2. The Commission shall be entitled to receive service of process in any such proceeding
584 regarding the enforcement or interpretation of the Compact or the Commission's Rules
585 and shall have standing to intervene in such a proceeding for all purposes. Failure to
586 provide the Commission with service of process shall render a judgment or order in such
587 proceeding void as to the Commission, this Compact, or promulgated Rules.

588 B. Default, Technical Assistance, and Termination

589 1. If the Commission determines that a Participating State has defaulted in the performance
590 of its obligations or responsibilities under this Compact or the promulgated Rules, the
591 Commission shall provide written notice to the defaulting State and other Participating
592 States. The notice shall describe the default, the proposed means of curing the default
593 and any other action that the Commission may take, and shall offer remedial training and
594 specific technical assistance regarding the default.

595 2. If a State in default fails to cure the default, the defaulting State may be terminated from
596 the Compact upon an affirmative vote of a majority of the Commissioners of the
597 Participating States, and all rights, privileges and benefits conferred by this Compact
598 upon such State may be terminated on the effective date of termination. A cure of the
599 default does not relieve the offending State of obligations or liabilities incurred during the
600 period of default.

601 3. Termination of participation in the Compact shall be imposed only after all other means
602 of securing compliance have been exhausted. Notice of intent to suspend or terminate
603 shall be given by the Commission to the governor and the majority and minority leaders
604 of the defaulting State's legislature, and to the State Licensing Authority of each of the
605 Participating States.

606 4. A State that has been terminated is responsible for all assessments, obligations, and
607 liabilities incurred through the effective date of termination, including obligations that
608 extend beyond the effective date of termination.

609 5. The Commission shall not bear any costs related to a State that is found to be in default or
610 that has been terminated from the Compact, unless agreed upon in writing between the
611 Commission and the defaulting State.

612 6. The defaulting State may appeal its termination from the Compact by the Commission by
613 petitioning the U.S. District Court for the District of Columbia or the federal district
614 where the Commission has its principal offices. The prevailing party shall be awarded all
615 costs of such litigation, including reasonable attorney's fees.

616 7. If a State has been terminated from participation in the Compact, the State shall
617 immediately provide notice to all Licensees within that State of such termination:

618 a. Licensees who have been granted a Compact Privilege in that State shall retain the
619 Compact Privilege for one hundred eighty (180) days following the effective date of
620 such termination.

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b. Licensees who are licensed in that State who have been granted a Compact Privilege in a Participating State shall retain the Compact Privilege for one hundred eighty (180) days unless the Licensee also has a license in a Participating State or obtains a license in a Participating State before the one hundred eighty (180)-day period ends, in which case the Compact Privilege shall continue.

C. Dispute Resolution

1. Upon request by a Participating State, the Commission shall attempt to resolve disputes related to the Compact that arise among Participating States and between Participating and non-Participating States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

2. If compliance is not secured after all means to secure compliance have been exhausted, by majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia, or the federal district where the Commission has its principal offices, against a Participating State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under applicable federal or State law.

E. Legal Action Against the Commission

1. A Participating State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

2. No person other than a Participating State shall enforce this compact against the Commission.

SECTION 11.EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

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656 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
657 law in the tenth Participating State.

658 1. On or after the effective date of the Compact, the Commission shall convene and review
659 the enactment of each of the first ten Participating States (“Charter Participating States”)
660 to determine if the statute enacted by each such Charter Participating State is materially
661 different than the Model Compact.

662 a. A Charter Participating State whose enactment is found to be materially different
663 from the Model Compact shall be entitled to the default process set forth in Section
664 10.B.

665 b. If any Participating State later withdraws from the Compact or its participation is
666 terminated, the Commission shall remain in existence and the Compact shall remain
667 in effect even if the number of Participating States should be less than ten.
668 Participating States enacting the Compact subsequent to the ten initial Charter
669 Participating States shall be subject to the process set forth in Section 7.C.20 to
670 determine if their enactments are materially different from the Model Compact and
671 whether they qualify for participation in the Compact.

672 2. Participating States enacting the Compact subsequent to the ten initial Charter
673 Participating States shall be subject to the process set forth in Section 7.C.20 to determine
674 if their enactments are materially different from the Model Compact and whether they
675 qualify for participation in the Compact.

676 3. All actions taken for the benefit of the Commission or in furtherance of the purposes of
677 the administration of the Compact prior to the effective date of the Compact or the
678 Commission coming into existence shall be considered to be actions of the Commission
679 unless specifically repudiated by the Commission.

680 B. Any State that joins the Compact subsequent to the Commission’s shall be subject to the
681 Commission’s Rules and bylaws as they exist on the date on which the Compact becomes
682 law in that State. Any Rule or bylaw that has been previously adopted by the Commission
683 shall have the full force and effect of law on the day the Compact becomes law in that State.

684 C. Any Participating State may withdraw from this Compact by enacting a statute repealing the
685 same.

686 1. A Participating State’s withdrawal shall not take effect until one hundred eighty (180)
687 days after enactment of the repealing statute. During this one hundred eighty (180) day-
688 period, all Compact Privileges that were in effect in the withdrawing State and were
689 granted to Licensees licensed in the withdrawing State shall remain in effect. If any
690 Licensee licensed in the withdrawing State is also licensed in another Participating State
691 or obtains a license in another Participating State within the one hundred eighty (180)
692 days, the Licensee’s Compact Privileges in other Participating States shall not be affected
693 by the passage of the 180 days.

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694 2. Withdrawal shall not affect the continuing requirement of the State Licensing Authority
695 of the withdrawing State to comply with the investigative, Alternative Program and
696 Adverse Action reporting requirements of the Compact prior to the effective date of
697 withdrawal.

698 3. Upon the enactment of a statute withdrawing from this compact, a State shall
699 immediately provide notice of such withdrawal to all Licensees within that State. Such
700 withdrawing State shall continue to recognize all licenses granted pursuant to this
701 compact for a minimum of one hundred eighty (180) days after the date of such notice of
702 withdrawal.

703 D. Nothing contained in this Compact shall be construed to invalidate or prevent any State
704 licensure agreement or other cooperative arrangement between Participating States and
705 between a Participating and non-Participating State that does not conflict with the provisions
706 of this Compact.

707 E. This Compact may be amended by the Participating States. No amendment to this Compact
708 shall become effective and binding upon any Participating State until it is enacted materially
709 in the same manner into the laws of all Participating States as determined by the
710 Commission.

711 **SECTION 12. CONSTRUCTION AND SEVERABILITY**

712 A. This Compact and the Commission's rulemaking authority shall be liberally construed so as
713 to effectuate the purposes, and the implementation and administration of the Compact.
714 Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall
715 not be construed to limit the Commission's rulemaking authority solely for those purposes.

716 B. The provisions of this Compact shall be severable and if any phrase, clause, sentence or
717 provision of this Compact is held by a court of competent jurisdiction to be contrary to the
718 constitution of any Participating State, a State seeking participation in the Compact, or of the
719 United States, or the applicability thereof to any government, agency, person or circumstance
720 is held to be unconstitutional by a court of competent jurisdiction, the validity of the
721 remainder of this Compact and the applicability thereof to any other government, agency,
722 person or circumstance shall not be affected thereby.

723 C. Notwithstanding subsection B or this section, the Commission may deny a State's
724 participation in the Compact or, in accordance with the requirements of Section10.B,
725 terminate a Participating State's participation in the Compact, if it determines that a
726 constitutional requirement of a Participating State is, or would be with respect to a State
727 seeking to participate in the Compact, a material departure from the Compact. Otherwise, if
728 this Compact shall be held to be contrary to the constitution of any Participating State, the
729 Compact shall remain in full force and effect as to the remaining Participating States and in
730 full force and effect as to the Participating State affected as to all severable matters.

731 **SECTION 13. BINDING EFFECT OF COMPACT AND OTHER LAWS**

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732 A. Nothing herein shall prevent the enforcement of any other law of a Participating State that is
733 not inconsistent with the Compact.

734 B. Any laws of a Participating State in conflict with the Compact are superseded to the extent of
735 the conflict.

736 C. All agreements between the Commission and the Participating States are binding in
737 accordance with their terms.

Navigating the various state licensing requirements, rules, regulations and fee structures can present significant challenges for workers. To address these challenges, states and professions have turned to occupational licensure interstate compacts. These compacts create reciprocal professional licensing practices between states, while ensuring the quality and safety of services and safeguarding state sovereignty. To date, over 40 states and territories have adopted occupational licensure compacts for nurses, physicians, physical therapists, emergency medical technicians and psychologists.

The National Center for Interstate Compacts (NCIC)

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

The compacts center is a program borne from CSG's more than 85 year history of promoting multi-state problem solving and advocating the role of the states in determining their respective futures. During that time, CSG began tracking the progress of more than 200 active interstate compacts, researching innovative solutions for the states and bringing the states together to build consensus on national issues.

OCCUPATIONAL LICENSURE COMPACT MEMBERSHIP

- None
- 1 compact
- 2 compacts
- 3 compacts
- 4 compacts
- 5 compacts
- 6 compacts

Advanced Practice Nursing (APRN) Compact
Physical Therapy (PT) Compact
Psychology Interjurisdictional Compact (PsyPact)
Nurse Licensure Compact (NLC)
Interstate Medical Licensure Compact (IMLC)
Emergency Medical Technician Compact (REPLICA)

PHYSICAL THERAPY COMPACT

Arizona
Arkansas
Colorado
Georgia
Iowa
Kentucky
Louisiana
Maryland
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Jersey
North Carolina
North Dakota
Oklahoma
Oregon
South Carolina
Tennessee
Texas
Utah
Virginia
Washington
West Virginia

INTERSTATE MEDICAL LICENSURE COMPACT

Alabama
Arizona
Colorado
Georgia
Idaho
Illinois
Iowa
Kansas
Kentucky
Maine
Maryland
Michigan
Minnesota
Mississippi
Montana
Nebraska
Nevada
New Hampshire
North Dakota
Oklahoma
Pennsylvania
South Dakota
Tennessee
Utah
Vermont
Washington
West Virginia
Wisconsin
Wyoming
District of Columbia
Guam

ADVANCED PRACTICE NURSING COMPACT (APRN)

Idaho
North Dakota
Wyoming

NURSE LICENSURE COMPACT

Alabama
Arizona
Arkansas
Colorado
Delaware
Florida
Georgia
Idaho
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Mexico
North Carolina
North Dakota
Oklahoma
South Carolina
South Dakota
Tennessee
Texas
Utah
Virginia
West Virginia
Wisconsin
Wyoming

EMERGENCY MEDICAL TECHNICIAN COMPACT

Alabama
Colorado
Delaware
Georgia
Idaho
Kansas
Mississippi
Missouri
Nebraska
New Hampshire
North Dakota
South Carolina
South Dakota
Tennessee
Texas
Utah
Virginia
Wyoming

PSYCHOLOGY INTERJURISDICTIONAL COMPACT

Arizona
Colorado
Georgia
Illinois
Missouri
Nebraska
Nevada
New Hampshire
Oklahoma
Texas
Utah

SUMMARY REPORT

ADEA Education Research Series
Issue 4, September 2022

Dentists of Tomorrow 2022:

An Analysis of the Results of the ADEA 2022 Survey of U.S. Dental School Seniors

ADEA THE VOICE OF DENTAL EDUCATION

Emilia C. Istrate, Ph.D., M.A.I.S.
Betsy Cooper, Ph.D., M.A.
Karen P. West, D.M.D., M.P.H.

This report summarizes the key findings of the analysis of the results of the American Dental Education Association (ADEA) Survey of Dental School Seniors, Class of 2022 (henceforth called "the ADEA 2022 survey" and the overall survey is called "the ADEA Senior Survey"). The study examines the journey of U.S. dental schools' predoctoral senior class of 2022, from its influences and motivations to pursue careers in dentistry and the students' perceptions of their dental school experience to their plans upon graduation and the investment in their careers. Whenever feasible, the analysis compares the answers of the 2022 survey respondents with their 2017 counterparts. Further, this research attempts to better understand the journey of predoctoral senior students of historically underrepresented race and ethnicity (HURE) groups by comparing the responses of the overall response sample with the responses of the HURE students. This research considers the following four race and ethnicity categories to be part of HURE: non-Hispanic African American, Hispanic or Latino of all races, non-Hispanic American Indian or Alaska Native and non-Hispanic Native Hawaiian or Other Pacific Islander.

For the first time, this annual analysis examines the preferences and decisions of the senior students by demographic generation, with a focus on Generation Z (henceforth called "Gen Z") relative to the rest of the graduating students. The members of this demographic cohort, born between 1997 and 2012, are starting to graduate from U.S. dental schools and enter into the job market.[1] Of the 2,801 students who responded to the ADEA 2022 survey and provided their birth year information, 85 individuals fit into the Gen Z demographic cohort. This is the generation that will increasingly fill the dental school classrooms in the years to come. These preliminary findings give the academic dentistry community a glimpse into the preferences of a new demographic cohort of students.

ADEA surveyed the 66 U.S. dental schools with a graduating class in 2022 between March 8 and June 17, 2022. A total of 6,754 students received the survey and 3,095 responded from all of the 66 U.S. dental schools with a graduating class in 2022. As a result, 46% of the senior students graduating in 2022 responded to the ADEA Senior Survey, compared with 79% for the 2017 graduating class. The response sample to the ADEA survey is representative of the overall senior student population at U.S. dental schools with graduating predoctoral classes in 2022 (see Table A1 in the Methodological Appendix).

1. Dimock M, Defining generations: Where Millennials end and Generation Z begins. Pew Research Center, Jan. 17, 2019. Accessed June 14, 2022 at pewresearch.org/fact-tank/2019/01/17/where-millennials-end-and-generation-z-begins.

65% OF THE GEN Z SENIOR STUDENTS RESPONDING TO THE ADEA 2022 SURVEY DECIDED TO BECOME A DENTIST BEFORE COLLEGE

1 THE SENIOR STUDENTS RESPONDING TO THE 2022 ADEA SURVEY INDICATED THEY DECIDED TO PURSUE A CAREER IN DENTISTRY BEFORE COLLEGE AT A HIGHER RATE THAN THEIR 2017 COUNTERPARTS.

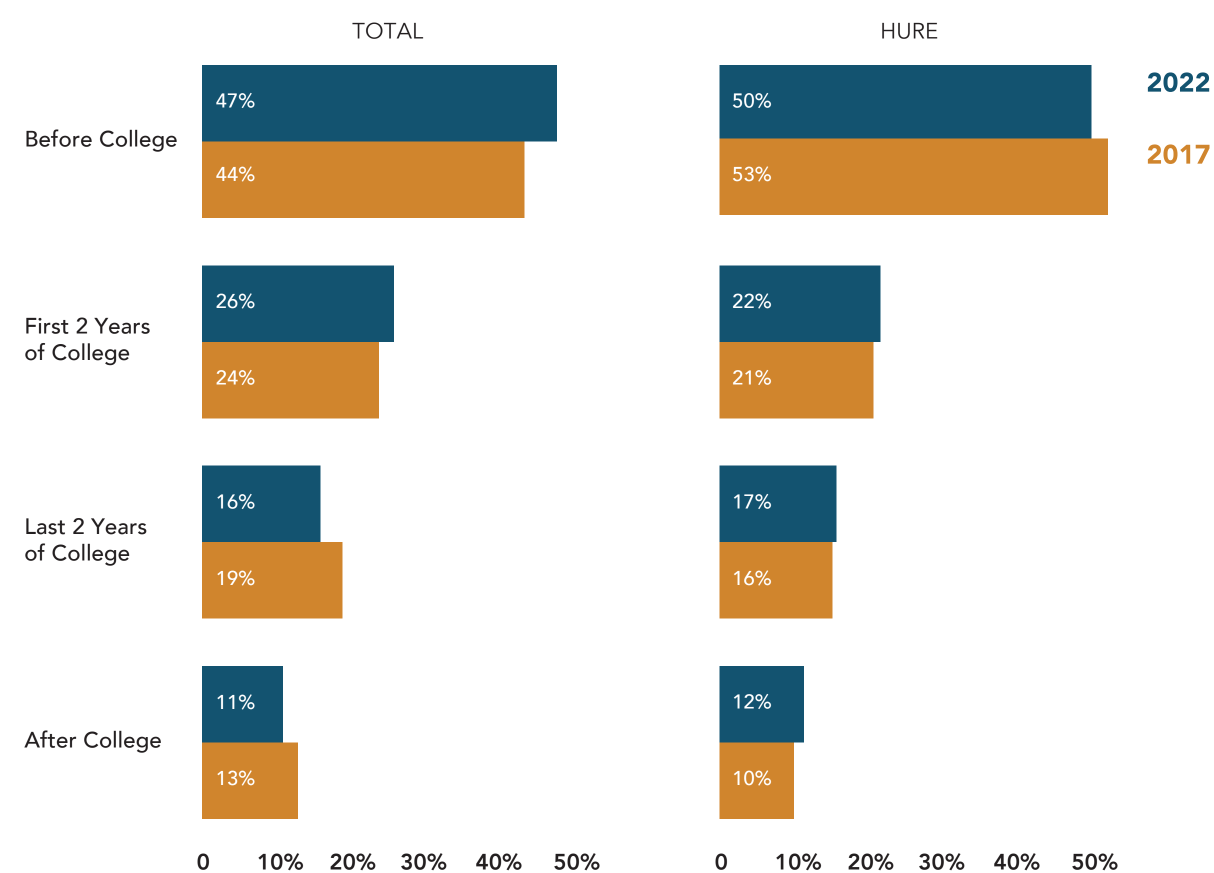
Close to half of all the 2022 respondents decided to become a dentist before college, slightly more than the share of their 2017 counterparts (see Figure 1). HURE students' responses in 2022 are relatively similar with their 2017 HURE colleagues: half of the HURE participants in 2022 decided for a career in dentistry before college, relative to 53% for their 2017 colleagues. Sixty-five percent of Gen Z respondents in 2022 selected a career in dentistry before college.

A lower cost of attendance was the most mentioned reason for 2022 respondents for selecting the dental school they attended. Academic reputation was tied with proximity to family and friends as the second most frequently cited reason for overall 2022 respondents for choosing the school they were graduating from in 2022. For Gen Z respondents, academic reputation and lower cost of attendance were the most frequently cited top selection criterion for selecting the dental school of their choice.

For access to the online storyboard and the data behind the charts, visit: **ADEA.org/Seniors2022**

FIGURE 1

Timing of Decision to Pursue a Career in Dentistry, Total and HURE, 2017 and 2022



Notes: The number of respondents to this question was 3,035 total and 432 for HURE students in 2022, and 4,772 total and 650 for HURE students in 2017.

Sources: American Dental Education Association (ADEA) Surveys of Dental School Seniors, Classes of 2017 and 2022.

97% OF RESPONDENTS AGREED AND STRONGLY AGREED WITH THE NEED OF CONTINUING EDUCATION REQUIREMENTS FOR PRACTITIONERS

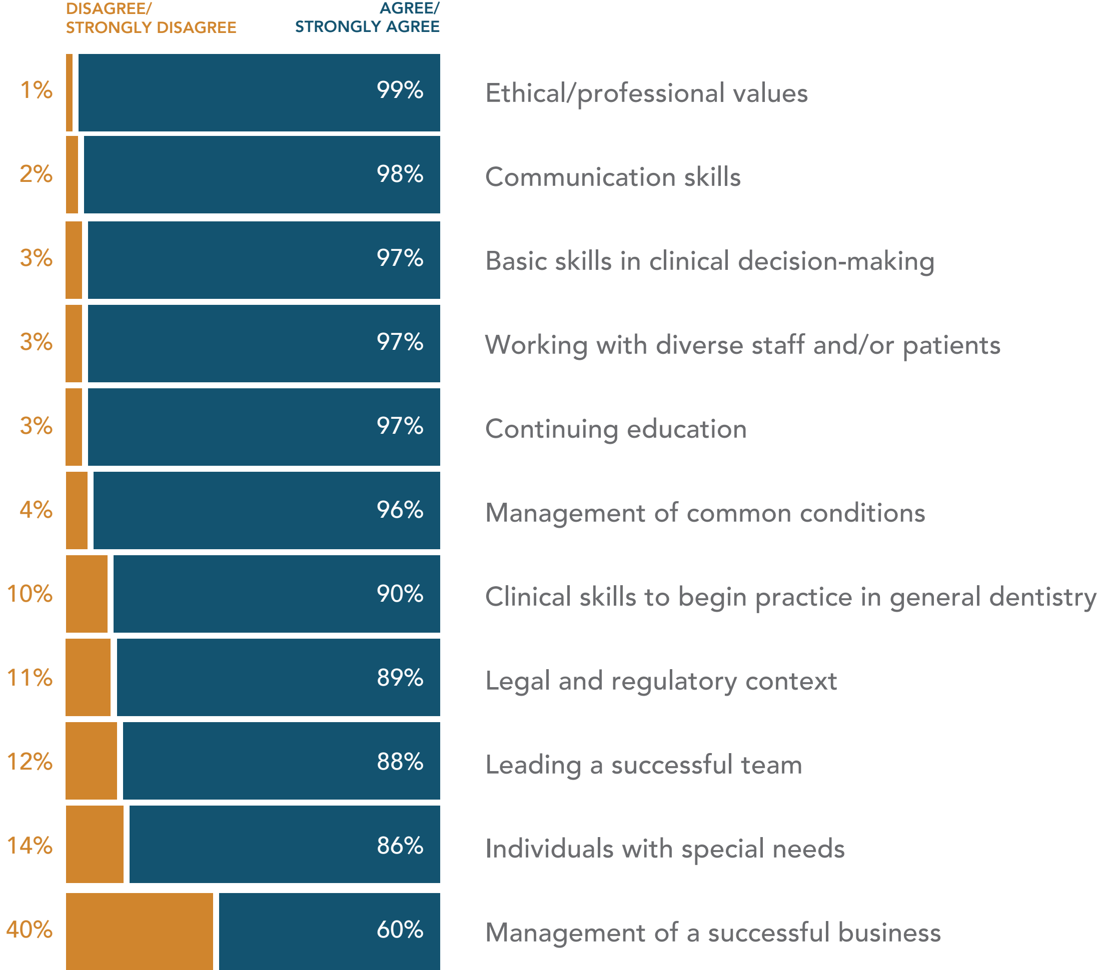
2 THE RESPONDENTS TO THE ADEA 2022 SURVEY INDICATED A HIGH LEVEL OF READINESS TO GO INTO THE PROFESSION.

The ADEA 2022 survey asked participants to estimate the adequacy of clinical experience gained across 14 different areas of education. For 12 of the 14 categories, the majority of respondents reported receiving appropriate or above appropriate levels of clinical experience during dental school. Preventive care, examination and diagnosis, and direct restorations were the top three clinical areas in terms of percentage of survey respondents indicating they had acquired an adequate or above adequate level of clinical experience. Gen Z respondents also expressed a high level of readiness, with the majority of respondents reported receiving appropriate or above appropriate levels of clinical experience during dental school in 13 of the 14 different areas of education.

Most of the senior students responding to the ADEA 2022 survey stated high levels of confidence in their skills across the 15 clinical areas mentioned in the survey. On average, 78% of survey respondents were moderately or highly confident in their abilities gained across the 15 clinical areas included in the survey. For Gen Z respondents, the percentage is in the same range (80%). In two clinical areas, confidence in skills exceeded 90% for overall respondents: the ability to perform health promotion and disease prevention, including caries management (94%) and restoration of teeth (93%). In addition to these two fields, more than 90% of Gen Z respondents felt moderately and highly confident in two different areas: patient assessment, diagnosis, comprehensive treatment planning, prognosis and informed consent (92%) and the ability to recognize the complexity of patient treatment and identifying when referral is indicated (91%). Overall, respondents felt the least confident in their skills to deal with malocclusion and space management (50% stated being moderately or highly confident in their abilities gained in this area), as well as hard and soft tissue surgery (53%). Gen Z participants had only a single area in which less than half of them felt less confident: malocclusion and space management (47%).

The overwhelming majority of ADEA 2022 survey respondents (97%) either agreed or strongly agreed with the need of continuing education

FIGURE 2 **Preparedness to Practice, Percent of Respondents, 2022**



Notes: For the full text of the statements, please check Table A2 in the Methodological Appendix. The number of respondents to this question varied between 3,001 and 3,006, depending on the statement.

Sources: American Dental Education Association (ADEA) Survey of Dental School Seniors, Class of 2022.

requirements for practitioners. The ADEA 2022 survey asked respondents' level of agreement to 11 different statements that reflected a variety of abilities needed to enter dental practice, such as continuing education (see Table A2 in the Methodological Appendix for the full text of the statements). On average, 91% of respondents agreed or strongly agreed with the preparedness to practice statements in the survey (see Figure 2). Survey respondents felt most ready about understanding the ethical and professional values that are expected of the profession and the needed communication skills. Clinical skills factored high for 2022 graduating senior students. The survey participants expressed confidence in their basic skills in clinical decision-making and clinical skills needed to practice. Only one area received less than 80% agreement: 60% felt prepared to manage a successful business. Overall, Gen Z responses mirrored the preferences of the 2022 respondent group.

35% OF THE 2022 GEN Z RESPONDENTS WHO PLANNED TO GO INTO PRIVATE PRACTICE IMMEDIATELY UPON GRADUATION INTENDED TO JOIN A DSO-AFFILIATED PRACTICE

3 THE SENIOR PREDOCTORAL STUDENTS RESPONDING TO THE ADEA 2022 SURVEY WERE MORE LIKELY TO JOIN A PRIVATE PRACTICE UPON GRADUATION THAN THEIR 2017 COUNTERPARTS.

Between 2017 and 2022, the share of ADEA survey respondents who expressed plans to work in a practice immediately after graduation increased to more than half (Figure 3). The proportion of survey respondents indicating plans to enroll in advanced education in 2022 was similar with five years earlier. The share of respondents planning to practice dentistry in a not-for-profit or government agency recorded the only significant decrease between the two annual student cohorts. Gen Z respondents follow the same pattern of plans as their colleagues. The majority of them (55%) planned to join a private practice immediately upon graduation, 40% were interested in attending advanced dental education and 4% intended to practice in a not-for-profit or government agency.

Entering private practice remained the favorite professional choice for senior predoctoral students responding to the ADEA 2022 survey. This choice increased in popularity among the 2022 respondents relative to the 2017 cohort, including for the HURE students (see Figure 3). Almost half of 2022 HURE survey participants stated they planned to join a private practice upon graduation, much more than the 2017 HURE respondents. Almost a third of the 2022 HURE respondents (31%) who planned to go into private practice immediately upon graduation intended to join a Dental Service Organization (DSO), similar with the overall response group (30%). More than a third (35%) of Gen Z respondents who planned to go into private practice immediately upon graduation intended to join a DSO.

The ADEA 2022 survey respondents planning to join a DSO-affiliated private practice upon graduation differed in some regards to their colleagues planning to join a non-DSO affiliated practice. Close to half of them (45%) were people of color (HURE, Asian and multiple races)—relative to a third (33%) of those planning to join non-DSOs. The difference stayed when examining only HURE respondents: 15% of those planning to join a DSO-affiliated practice were HURE students versus 11% planning to join non-DSOs. The respondents planning to work in a DSO-affiliated practice were more likely to have

attended schools in Northeast than those planning to join a non-DSO-affiliated practice.

HURE students planning to join a private practice upon graduation were much more unsure about their future employer than the overall response group. They were more likely to be unsure if they would join a DSO-affiliated or non-DSO-affiliated practice (31% of the HURE respondents who were planning to enter private practice versus 22% for overall response group who were planning to join a private practice) and were unsure if the practice would have single or multiple locations (21% of HURE respondents versus 16% overall response group).

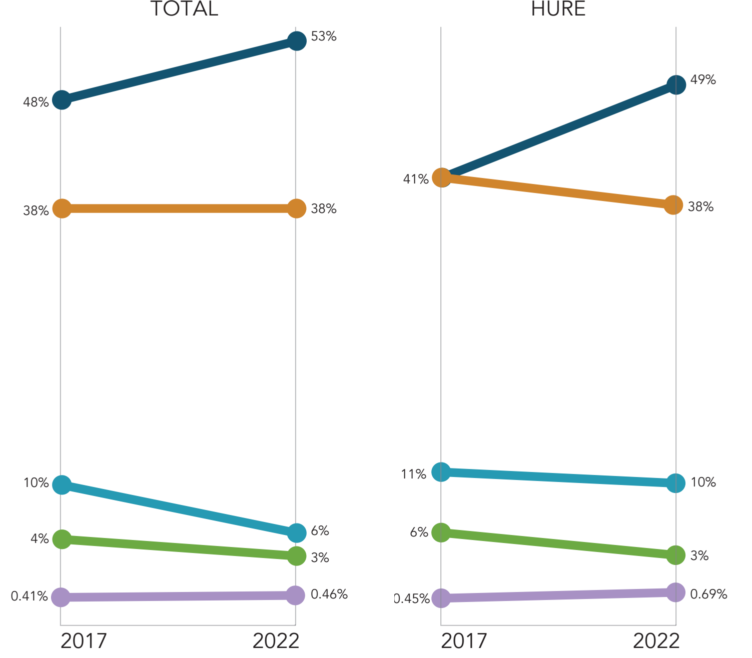
HURE respondents maintained their interest in attending further dental education in 2022 relative to the 2017 response cohorts (see Figure 3). The ADEA 2022 survey allowed respondents to select any or all the delineated types of advanced education they applied to, such as general dentistry programs, approved specialties and specialties not approved by the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSB). More than half (57%) of the students planning to pursue graduate dental programs applied to general dentistry programs, both general practice residency (GPR) and advanced education in general dentistry (AEGD). Approved specialties were the second most cited advanced education by students planning to further their education.

Practicing dentistry for a government agency or a nonprofit was selected less by the 2022 students than their 2017 counterparts (see Figure 3). The percentage of survey respondents intending to practice dentistry in government service or nonprofit almost halved from 2017 to 2022. Overall, HURE students were more likely to select it as a career path upon graduation than the 2022 response group and their interest stayed steady relative to their 2017 counterparts. Interest in practicing dentistry in the federal government service dropped by almost half for overall respondents, largely due to a steep decline in plans to serve as a uniformed services dentist. The proportion of HURE students planning to work for the federal government upon graduation also declined over the past five years, but not as much. HURE students responding to the ADEA 2022 survey had fewer plans to serve as a uniformed services dentist than their 2017 counterparts, similar to the overall 2022 response group.

A small percentage of respondents planned to teach in a dental program immediately upon graduation in 2022, similar to the 2017 graduating class (see Figure 3).

FIGURE 3

Immediate Professional Plans Upon Graduation, Percent of Respondents Total and HURE, 2017 and 2022

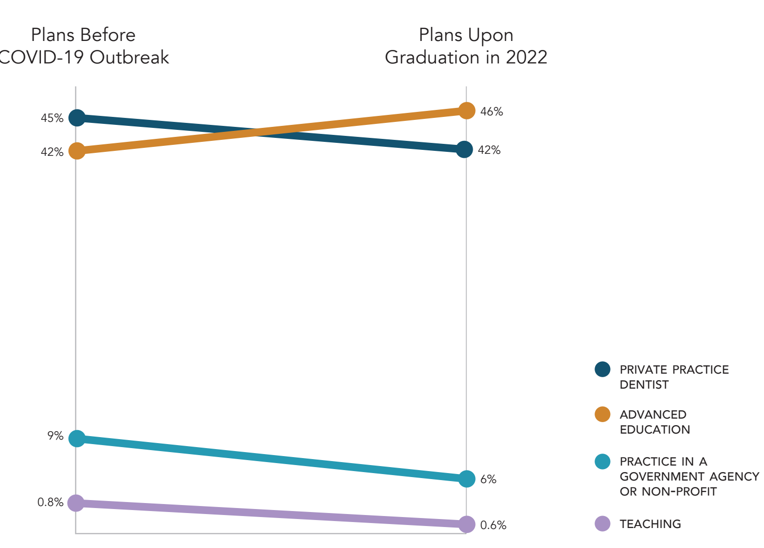


Note: The number of respondents to this question in 2022 was 2,853 total and 433 for HURE students, and in 2017 was 4,833 total and 660 for HURE students. The "Other" category includes working in another position related to dentistry, but not those mentioned in the chart; working in a position not related to dentistry; and being unsure about professional plans upon graduation. "Teaching" means working as a faculty/staff member at a dental school immediately upon graduation.

Source: American Dental Education Association (ADEA) Survey of Dental School Seniors, Classes of 2017 and 2022.

FIGURE 4

Changes of Immediate Professional Plans Upon Graduation Because of the COVID-19 Pandemic, Percent Responses of the 2022 Survey Participants Who Reported Changes Because of the COVID-19 Outbreak



Notes: The total number of respondents who reported changes to their professional plans immediately upon graduation and mentioned their plans before and after the COVID-19 pandemic is 523. Besides the categories presented in the chart, there is an "Other" category selected by 4% of respondents before the COVID-19 outbreak and 5% of respondents upon graduation in 2022. The "Other" category includes working in another position related to dentistry, but not those mentioned in the chart; working in a position not related to dentistry; and being unsure about professional plans upon graduation. "Teaching" means working as a faculty/staff member at a dental school immediately upon graduation.

Source: American Dental Education Association (ADEA) Survey of Dental School Seniors, Class of 2022.

19% OF THE ADEA 2022 SURVEY PARTICIPANTS REPORTED THAT THE COVID-19 PANDEMIC AFFECTED THEIR IMMEDIATE PROFESSIONAL PLANS AFTER GRADUATION

4 THE COVID-19 PANDEMIC CHANGED THE PROFESSIONAL PLANS OF CLOSE TO ONE IN FIVE OF THE ADEA 2022 SURVEY RESPONDENTS AND SKEWED THEM TOWARD ADVANCED EDUCATION.

Nineteen percent (19%) of the ADEA 2022 survey participants reported they changed their immediate professional plans upon graduation because of the COVID-19 pandemic. Of the respondents who reported changes, a higher proportion decided to continue education upon graduation and a smaller share decided to practice dentistry relative to plans before the COVID-19 outbreak (see Figure 4). A smaller share of participants who mentioned changes in professional plans because of the COVID-19 outbreak decided to practice in a nonprofit or government agency upon graduation.

The pandemic skewed the preferences of the respondents who mentioned that the COVID-19 outbreak affected their professional plans and, as a result, a smaller share planned to join private practice. Out of this group, 17% were thinking before the COVID outbreak that they would join a DSO-affiliated practice. Upon graduation in 2022, 34% mentioned planning to work in a DSO-affiliated practice. They were more likely to join a group practice (58% of the respondents who were planning to enter private practice upon graduation in 2022 versus 45% before the COVID-19 outbreak), an existing practice (88% in 2022 versus 74% before the COVID-19 outbreak) and a multiple locations practice (49% in 2022 vs. 23% before the COVID-19 outbreak).

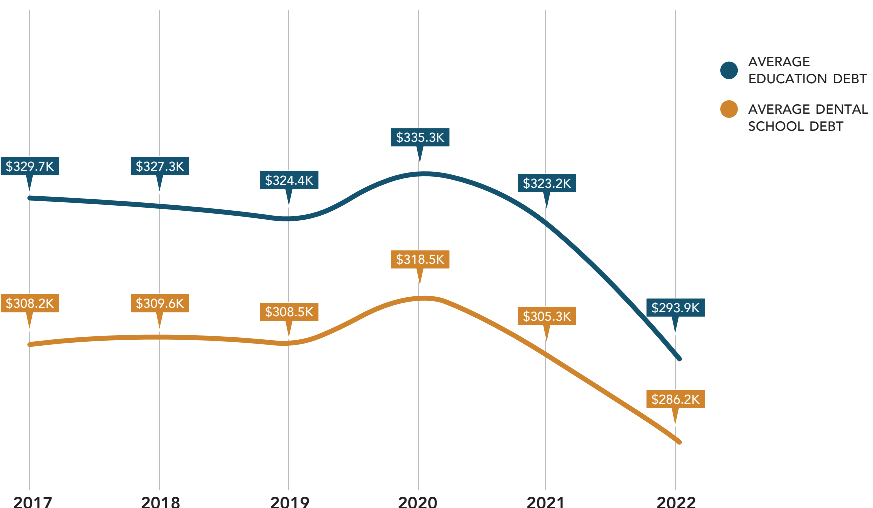
11% DECREASE OF THE AVERAGE EDUCATION DEBT FOR GRADUATING STUDENTS RESPONDING TO ADEA 2022 SURVEY RELATIVE TO THEIR 2017 COUNTERPARTS, WHEN ACCOUNTING FOR INFLATION

5 AVERAGE EDUCATION DEBT WAS $293.9 THOUSANDS FOR STUDENTS GRADUATING WITH DEBT AND RESPONDING TO THE ADEA 2022 SURVEY.

When accounting for inflation, this amount was 11% lower from what the 2017 respondents reported. Education debt is a combination of the dental school debt the senior students graduate with from dental school (the loans contracted to finance partially or al the cost of the predoctoral degree) and their predental education debt, which is the outstanding education debt the senior students had when they entered dental school. Annual average education debt amounts varied between 2017 and 2022 given different cohorts and various response rates to the debt question to the ADEA survey over the years (see Figure 5).

Most of the average education debt that predoctoral students reported in the ADEA 2022 survey was from dental school debt (97%). Only 3% of the 2022 average education debt was from predental education debt.

FIGURE 5 **Average Education Debt and Average Dental School Debt, as Stated by Respondents Graduating With Debt, 2017–2022, in 2022 dollars**



Notes: The response rates for this survey question vary between 35% in 2020 and 75% in 2017. A response rate reflects the number of respondents for the debt question relative to the senior student population in that academic year. Education debt is a combination of the dental school debt the senior students graduate with from dental school (the loans contracted to finance partially or all of the cost of the predoctoral degree) and their predental education debt, which is the outstanding education debt the senior students had when they entered dental school. Debt values are adjusted to 2022 dollars with the U.S. Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) for all urban consumers.

Source: American Dental Education Association (ADEA) Survey of Dental School Seniors, Classes of 2017 to 2022.

U.S. DENTAL SCHOOLS CONTINUED THEIR MISSION TO TRAIN AND EDUCATE ORAL HEALTH PROFESSIONALS AND PROVIDE ORAL HEALTH CARE THROUGH THEIR CLINICS TO LOCAL COMMUNITIES

The percentage of ADEA survey respondents graduating with debt decreased between 2017 and 2022. While in 2017, 85% of respondents reported graduating with education debt (dental school debt and/or outstanding predental debt), by 2022 the proportion declined to 83%. For students participating in the ADEA survey, the percent of those graduating with dental school debt recorded a decrease, between 82% in 2017 and 81% in 2022, but the change is not statistically significant at 90% confidence level. Fewer Gen Z respondents finished dental school with any education debt; only 73% of them reported graduating with education debt.

Federal loans persisted as the top source of funding for a doctoral education degree between 2017 and 2022. On average, ADEA 2022 survey respondents financed more than two-thirds of their dental education through loans (65%), the rest covered to a large degree by a combination of financial support from family and friends (20%) and grants and scholarships (10%). Savings (4%), part-time employment (1%) and other sources (0.5%) were small sources of funding for a doctoral degree for the 2022 respondents. Respondents to the ADEA 2017 survey had a similar pattern of funding sources.

Gen Z respondents funded their doctoral education much more through gifts and/or financial support from family and friends and less through debt than their other 2022 colleagues. A quarter of their funding for dental school came from support from family and friends and more than half (56%) from loans. They used less savings (3%) than the other 2022 respondents.

2022 was a year of progress, as dental schools were increasingly adapting to the COVID-19 pandemic on campus, in clinics and in communities. During uncertain economic times, a new generation of dentists graduated from 66 accredited U.S. dental schools in the 2021-22 academic year. U.S. dental schools stood steady in their mission to train and educate oral health professionals and provide oral health care through their clinics to local communities.

METHODOLOGICAL APPENDIX

TABLE A1

Senior Class Population at U.S. Dental Schools and 2022 ADEA Senior Survey Response Sample by Type of School, Census Region Where the School Is Located and Gender of the Students, 2021–22 Academic Year

	2021–22 SENIOR STUDENT POPULATION		2022 ADEA SENIOR STUDENT SURVEY RESPONSE SAMPLE	
BY TYPE OF SCHOOL	**COUNT**	**%**	**COUNT**	**%**
PRIVATE	3011	44%	1,008	33%
PRIVATE/ STATE-RELATED	332	5%	217	7%
PUBLIC	3,465	51%	1,870	60%
BY U.S. CENSUS REGION OF THE DENTAL SCHOOL	**COUNT**	**%**	**COUNT**	**%**
MIDWEST	1,490	22%	676	22%
NORTHEAST	1,848	27%	682	22%
SOUTH	1,992	29%	1,049	34%
WEST	1,478	22%	688	22%
BY GENDER OF SENIOR STUDENT	**COUNT**	**%**	**COUNT**	**%**
WOMEN	3,591	53%	1,542	50%
MEN	3,199	47%	1,179	38%
NOT LISTED	18	0.3%	374	12%
TOTAL NUMBER OF U.S. DENTAL SCHOOLS WITH A PREDOCTORAL SENIOR CLASS	66	–	66	–
TOTAL SIZE OF SENIOR CLASS	6,808	100%	3,095	100%

Notes: Percentages may not total 100% because of rounding. Senior students in dental doctoral degrees at U.S. dental schools include the third-year students at the University of Pacific, Arthur A. Dugoni School of Dentistry (Dugoni School) and the fourth-year students at the remainder of U.S. dental schools. Dugoni School has a three-year dental doctoral degree program. The senior student population figures reflect senior student enrollment at the beginning of the academic year. The ADEA Survey of Dental School Seniors is conducted at the end of the academic year. The total number of seniors students calculated based on Commission on Dental Accreditation reporting is slightly larger (0.1%) than the total number of senior students that received the ADEA 2022 survey, given that some schools did not include their advanced-standing students in the survey. The "Not Listed" gender category for the ADEA 2022 Survey response sample includes respondents who did not respond to this question, do not wish to report their gender identity, are non-binary, transgender and other gender identities.

U.S. Census region according to the U.S. Census Bureau "Region and Division Codes and Federal Information Processing System (FIPS) Codes for States." U.S. Census Bureau, Population Division, Internet Release Date: May 2018

Source: Analysis of American Dental Education Association (ADEA) Survey of Dental School Seniors, Class of 2022; American Dental Association, Health Policy Institute, 2021-22 Survey of Dental Education data.

TABLE A2

Preparedness to Practice Statement and Abbreviated Form, 2022

ABBREVIATED STATEMENT	FULL STATEMENT OF PREPAREDNESS TO PRACTICE
Ethical/professional values	I understand the ethical and professional values that are expected of the profession.
Communication skills	I have the communication skills necessary to interact with patients and health professionals.
Management of common conditions	I have a fundamental understanding of common conditions and their management.
Continuing education	I believe that continuing education requirements are necessary for practitioners.
Basic skills in clinical decision-making	I have basic skills in clinical decision-making and the application of evidence-based information to dental practice.
Working with diverse staff and/or patients	I believe I am adequately prepared to work with diverse, multicultural staff and/or patients.
Clinical skills to begin practice in general dentistry	I am confident that I have acquired the clinical skills required to begin practice in general dentistry.
Legal and regulatory context	I understand the legal and regulatory context within which dental care services may be provided.
Leading a successful team	I am prepared to lead a successful team; I can hire and retain staff, create a positive work culture, manage conflicts, etc.
Individuals with special needs	I can assess the treatment needs of individuals with special needs.
Management of a successful business	I am prepared to manage a successful business; I can manage finances, enact a business plan, ensure efficient scheduling and billing, obtain appropriate credentialing, etc.

Source: American Dental Education Association (ADEA) Survey of Dental School Seniors, Class of 2022.

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ADEA | THE VOICE OF DENTAL EDUCATION

ABOUT ADEA: The American Dental Education Association (ADEA) is The Voice of Dental Education. Our mission is to lead and support the health professions community in preparing future-ready oral health professionals. Our members include all 79 U.S. and Canadian dental schools, more than 800 allied and advanced dental education programs, over 50 corporations and approximately 15,000 individuals. Our activities encompass a wide range of research, advocacy, faculty development, meetings and communications, including the esteemed Journal of Dental Education®, as well as the dental school application services ADEA AADSAS®, ADEA PASS®, ADEA DHCAS® and ADEA CAAPID®.

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On January 1, 2022, Senate Bill (SB) 501 (Glazer, Chapter 929, Statutes of 2018) significantly changed how General Anesthesia (GA), Medical General Anesthesia (MGA), Conscious Sedation (CS), and Oral Conscious Sedation (OCS) for Minors permits are issued by the Board. The SB 501 – Anesthesia and Sedation Regulatory file which makes modifications to Title 16, of the California Code of Regulations, sections, 1021, 1043, 1043.1, 1043.2, 1043.3, 1043.4, 1043.5, 1043.6, 1043.7, 1043.8, 1043.8.1, 1044, 1044.1, 1044.2, 1044.3, 1044.4 [not repealed], 1044.5, & 1070.8, adopt section 1017.1, and the adoption of a new Article 5.1 and regulations sections 1043.9, 1043.9.1 and 1043.9.2, was submitted to the Office of Administrative Law on July 21, 2022, for final review and the regulations were approved on August 16, 2022 and take effect immediately. With this approval, the application and instructions for the GA permit and pediatric endorsement can be found at https://dbc.ca.gov/licensees/dds/permits/anesthesia_permit_dentist.shtml. The MGA permit, and pediatric endorsements can be found at https://dbc.ca.gov/licensees/dds/permits/anesthesia_permit_physician.shtml. The application and instructions for the new Moderate Sedation permit and pediatric endorsement can be found at https://dbc.ca.gov/licensees/dds/permits/moderate_sedation_permit.shtml. The application and instructions for the new Pediatric Minimal Sedation permit can be found at https://dbc.ca.gov/licensees/dds/permits/pediatric_sedation_permit.shtml.

Below is a chart which outlines existing permit changes, requirements for new permits and pediatric endorsements, and patient monitoring requirements.

Existing General Anesthesia (GA) Permit Holders	New Applicants for General Anesthesia (GA) Permit and Existing GA Permit Holders Who Expire On or After 01/01/2022
GA Permit Requirements for Patients 7 and Older	
Existing GA permit holders can continue to practice under the terms of their existing permit, until it expires. (Business and Professions Code (BPC), § 1646.11.)	For GA permits renewed or issued on or after 01/01/2022, permit holders may administer or order the administration of deep sedation or general anesthesia to patients 7 years of age and older. (BPC, § 1646.1.)

<table>
<tr><th colspan="2">GA Permit Requirements for Patients Under 7</th></tr>
<tr><td>Existing GA permit holders can continue to practice under the terms of their existing permit, until it expires. (BPC, § 1646.11.)</td><td>For GA permits renewed or issued on or after 01/01/2022, permit holders must apply for and maintain a Pediatric Endorsement to administer or order the administration of deep sedation or general anesthesia to patients under the age of 7. (BPC, § 1646.1, subd. (b).)</td></tr>
<tr><th colspan="2">GA Permit Monitoring Requirements for Patients 13 and Older</th></tr>
<tr><td>Monitoring requirements for the administration of deep sedation or general anesthesia include, but are not limited to, the following:
(1) Any dentist performing dental procedures cannot have more than one patient undergoing deep sedation or general anesthesia on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer deep sedation or general anesthesia (BPC, § 1682, subd. (a)).
(2) Any dentist with patients recovering from deep sedation or general anesthesia must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from deep sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)).
(3) Any dentist with patients who are undergoing deep sedation or general anesthesia must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)):
(A) Auscultation of breath sounds using a precordial stethoscope.</td><td>Monitoring requirements for the administration of deep sedation or general anesthesia include, but are not limited to, the following:
(1) Any dentist performing dental procedures cannot have more than one patient undergoing deep sedation or general anesthesia on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer deep sedation or general anesthesia (BPC, § 1682, subd. (a)).
(2) Any dentist with patients recovering from deep sedation or general anesthesia must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from deep sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)).
(3) Any dentist with patients who are undergoing deep sedation or general anesthesia must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)):</td></tr>
</table>

(B) Monitoring for the presence of exhaled carbon dioxide with capnography.	(A) Auscultation of breath sounds using a precordial stethoscope. (B) Monitoring for the presence of exhaled carbon dioxide with capnography.
GA Permit Additional Monitoring Requirements for Patients Under 13	
Monitoring requirements for the administration of deep sedation or general anesthesia include, but are not limited to, the following: (1) Any dentist performing dental procedures cannot have more than one patient undergoing deep sedation or general anesthesia on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer deep sedation or general anesthesia (BPC, § 1682, subd. (a)). (2) Any dentist with patients recovering from deep sedation or general anesthesia must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from deep sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)). (3) Any dentist with patients who are undergoing deep sedation or general anesthesia must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)): (A) Auscultation of breath sounds using a precordial stethoscope. (B) Monitoring for the presence of exhaled carbon dioxide with capnography.	For GA permits renewed or issued on or after 01/01/2022, permit holders must meet patient monitoring requirements for patients under the age of 13 as follows (BPC, § 1646.1, subd. (d)): (1) The operating dentist and at least two additional personnel shall be present throughout the procedure involving deep sedation or general anesthesia. (2) If the operating dentist is the permitted anesthesia provider, then both of the following shall apply: (A) The operating dentist and at least one of the additional personnel shall maintain current certification in Pediatric Advanced Life Support (PALS) or other board-approved training in pediatric life support and airway management. The additional personnel who is certified in PALS and airway management or other board-approved training in pediatric life support and airway management shall be solely dedicated to monitoring the patient and shall be trained to read and respond to monitoring equipment including, but not limited to, pulse oximeter, cardiac monitor, blood pressure, pulse, capnograph, and respiration monitoring devices. (B) The operating dentist shall be responsible for initiating and administering any necessary emergency response. (3) If a dedicated permitted anesthesia provider is monitoring the patient and administering deep sedation or general anesthesia, both of the following shall apply: (A) The anesthesia provider and the operating dentist, or one other trained personnel, shall be present throughout the procedure and shall maintain current certification in PALS and airway management or other board-approved training in pediatric life support and airway management.

	(B) The anesthesia provider shall be responsible for initiating and administering any necessary emergency response and the operating dentist, or other trained and designated personnel, shall assist the anesthesia provider in emergency response. In addition, monitoring requirements for the administration of deep sedation or general anesthesia include, but are not limited to, the following: (1) Any dentist performing dental procedures cannot have more than one patient undergoing deep sedation or general anesthesia on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer deep sedation or general anesthesia (BPC, § 1682, subd. (a)). (2) Any dentist with patients recovering from deep sedation or general anesthesia must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from deep sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)). (3) Any dentist with patients who are undergoing deep sedation or general anesthesia must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)): (A) Auscultation of breath sounds using a precordial stethoscope. (B) Monitoring for the presence of exhaled carbon dioxide with capnography.

Existing Medical General Anesthesia (MGA) Permit Holders	New Applicants for Medical General Anesthesia (MGA) Permit and Existing GA Permit Holders Who Expire On or After 01/01/2022
MGA Permit Requirements for Patients 7 and Older	
Existing MGA permit holders can continue to practice under the terms of their existing permit, until it expires. (BPC, § 1646.11.)	For MGA permits renewed or issued on or after 01/01/2022, permit holders may administer deep sedation or general anesthesia in the office of a licensed dentist for dental patients 7 years of age and older. (BPC, § 1646.9.)
MGA Permit Requirements for Patients Under 7	
Existing MGA permit holders can continue to practice under the terms of their existing permit, until it expires. (BPC, § 1646.11.)	For MGA permits renewed or issued on or after 01/01/2022, permit holders must apply for and maintain a Pediatric Endorsement to provide deep sedation or general anesthesia to patients under the age of 7. (BPC, § 1646.9, subd. (e).)
MGA Permit Monitoring Requirements for Patients 13 and Older	
No change. Refer to the Medical Board of California, physician and surgeon acting within their scope of practice under BPC, Division 2, Chapter 5 (commencing with Section 2000).	No change. Refer to the Medical Board of California, physician and surgeon acting within their scope of practice under BPC, Division 2, Chapter 5 (commencing with Section 2000).
MGA Permit Additional Monitoring Requirements for Patients Under 13	
No change. Refer to the Medical Board of California, physician and surgeon acting within their scope of practice under BPC, Division 2, Chapter 5 (commencing with Section 2000).	No change. Refer to the Medical Board of California, physician and surgeon acting within their scope of practice under BPC, Division 2, Chapter 5 (commencing with Section 2000).

Existing Conscious Sedation (CS) Permit Holders	Existing Conscious Sedation (CS) Permit Holders Who Expire On or After 01/01/2022
CS Permit Requirements	
Existing CS permit holders can continue to practice under the terms of their existing permit, until it expires. (BPC, § 1647.10.)	Existing CS permit holders will no longer be able to renew and must apply for the Moderate Sedation (MS) Permit after 01/01/2022. (BPC, § 1647.10.) Please see MS permit information below.

Conscious Sedation (CS) Permit	New Applicants for Moderate Sedation (MS) Permit After 01/01/2022
MS Permit Requirements for Patients 13 and Older	
Conscious Sedation permits will no longer be issued after January 1, 2022. (BPC, § 1647.10.)	After 01/01/2022, MS permit holders may administer or order the administration of moderate sedation to patients 13 years of age and older. (BPC, § 1647.2.)
MS Permit Requirements for Patients Under 13	
N/A	MS permit holders must apply for and maintain a Pediatric Endorsement to administer or order the administration of moderate sedation to patients under 13 years of age. (BPC, § 1647.2, subd. (b).)
MS Permit Monitoring Requirements for Patients 13 and Older	

N/A	A dentist who orders the administration of moderate sedation to a patient 13 years of age or older shall be physically present in the treatment facility while the patient is sedated. (BPC, § 1647.2, subd. (c)(1).) In addition, (1) Any dentist performing dental procedures cannot have more than one patient undergoing moderate sedation on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer moderate sedation (BPC, § 1682, subd. (a)). (2) Any dentist with patients recovering from moderate sedation must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from moderate sedation. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)). (3) Any dentist with patients who are undergoing moderate sedation must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)): (A) Auscultation of breath sounds using a precordial stethoscope. (B) Monitoring for the presence of exhaled carbon dioxide with capnography.
MS Permit Monitoring Requirements for Patients Under 13	

N/A	MS permit holders must meet patient monitoring requirements for patients under the age of 13 as follows (BPC, § 1647.2): • The operating dentist and at least two additional support personnel shall be present at all times during the procedure involving moderate sedation. (BPC, § 1647.2, subd. (c)(1).) • The operating dentist and at least one of the additional personnel shall maintain current PALS certification and airway management or other board-approved training in pediatric life support and airway management. (BPC, § 1647.2, subd. (c)(2).) • The personnel member with current PALS certification and airway management or other board-approved training in pediatric life support and airway management shall be dedicated to monitoring the patient during the procedure involving moderate sedation and may assist with interruptible patient-related tasks of short duration, such as holding an instrument. (BPC, § 1647.2, subd. (c)(2).) In addition, (1) Any dentist performing dental procedures cannot have more than one patient undergoing moderate sedation on an outpatient basis at any given time unless each patient is being continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer moderate sedation (BPC, § 1682, subd. (a)). (2) Any dentist with patients recovering from moderate sedation must have the patients closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from moderate sedation. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one (BPC, § 1682, subd. (b)). (3) Any dentist with patients who are undergoing moderate sedation must have these patients continuously monitored during the dental procedure with a pulse oximeter or similar

	or superior monitoring equipment and ventilation continuously monitored using at least two of the three following methods (BPC, § 1682, subd. (c)): (A) Auscultation of breath sounds using a precordial stethoscope. (B) Monitoring for the presence of exhaled carbon dioxide with capnography.

Current Oral Conscious Sedation for Minors (OCS-M) Permit Holders	Existing Oral Conscious Sedation for Minors (OCS-M) Permit Holders Who Expire On or After 01/01/2022
OCS-M Permit Requirements for Patients Under 13	
OCS-M permits will no longer be issued after January 1, 2022. (BPC, § 1647.35.)	Existing OCS-M permit holders will no longer be able to renew and must apply for the Pediatric Minimal Sedation (PMS) permit after 01/01/2022, to administer or order the administration of pediatric minimal sedation to pediatric dental patients under 13 years of age. (BPC, § 1647.35.) Please see PMS permit information below.

Oral Conscious Sedation for Minors (OCS-M) Permit	New Applicants for Pediatric Minimal Sedation (PMS) Permit After 01/01/2022
PMS Permit Requirements for Patients Under 13	
N/A	Existing OCS-M permit holders will no longer be able to renew and must apply for the PMS permit after 01/01/2022. (BPC, § 1647.35.) For PMS permits issued after 01/01/2022, permit holders may administer pediatric minimal sedation to patients under the age of 13. (BPC, § 1647.31.)

PMS Monitoring Requirements for Patients Under 13	
N/A	PMS permit holders must meet patient monitoring requirements for patients under the age of 13 as follows (BPC, § 1647.31): (1) A dentist who administers or orders the administration of pediatric minimal sedation shall be physically present in the treatment facility while the patient is sedated (BPC, § 1647.31, subd. (b)). (2) A dentist with a PMS permit shall possess the training, equipment, and supplies to rescue a patient from an unintended deeper level of sedation (BPC, § 1647.31, subd. (c)).

LICENSE RATIFICATION

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

H8474	8/5/2022	ALVARADO	LIDIA	R.D.H.
H8475	8/5/2022	LOSLI	AVA LORRAY	R.D.H.
H8476	8/5/2022	WALKER	HOLLY	R.D.H.
H8477	8/5/2022	SPENCER	MYAH RAYN	R.D.H.
H8478	8/10/2022	HEIMEL	VICTORIA	R.D.H.
H8479	8/10/2022	BODNER	KATHERINE	R.D.H.
H8480	8/10/2022	SALEH	MARIA	R.D.H.
H8481	8/10/2022	SCHMAUTZ	MAGDALENA	R.D.H.
H8482	8/10/2022	WEGDAHL	TORI	R.D.H.
H8483	8/10/2022	DONOVAN	CHRISTINE	R.D.H.
H8484	8/10/2022	VINCENT	YURI	R.D.H.
H8485	8/10/2022	MOORE	LAUREN	R.D.H.
H8486	8/10/2022	PATTERSON	CASSIE	R.D.H.
H8487	8/10/2022	WALTON	DEANNA	R.D.H.
H8488	8/10/2022	ZIEHLKE	IVORY CAMYLLE DIANNE	R.D.H.
H8489	8/24/2022	MOORE	ALICIA	R.D.H.
H8490	8/24/2022	KIM	ELLY JIN	R.D.H.
H8491	8/24/2022	DANG	DIANA	R.D.H.
H8492	8/24/2022	CHONG	JANICE	R.D.H.
H8493	8/24/2022	HAMILTON	KAJLA JOLENE	R.D.H.
H8494	8/24/2022	HERBRANDSON-HARRIS	ALISON BETH	R.D.H.
H8495	8/31/2022	BULGARELLI	KAITLYN	R.D.H.
H8496	8/31/2022	NESS	KATIE	R.D.H.
H8497	8/31/2022	BEERY	THITAPORN	R.D.H.
H8498	8/31/2022	COOPER	MIRANDA YVONNE	R.D.H.
H8499	8/31/2022	ESTRADA-CARDENAS	MICHAEL	R.D.H.
H8500	9/7/2022	SNEED	MEGAN	R.D.H.
H8501	9/7/2022	BENAVIDES	CHARITY CHRISTINE	R.D.H.
H8502	9/7/2022	HUYNH	NINA	R.D.H.
H8503	9/7/2022	SHEPPARD	JAZZMIN	R.D.H.
H8504	9/7/2022	SPANGLER	AVALON	R.D.H.
H8505	9/7/2022	MAT	BREANNE AYLA	R.D.H.
H8506	9/7/2022	COLCORD	CARLI ANN	R.D.H.
H8507	9/7/2022	FINN	AMY RENAY	R.D.H.
H8508	9/12/2022	FUJIWARA	CAITLIN	R.D.H.
H8509	9/13/2022	FULLER	KELLY GRACE	R.D.H.
H8510	9/12/2022	MOULLET	OLIVIA	R.D.H.
H8511	9/12/2022	PELLATZ	CALLI RYANNE	R.D.H.
H8512	9/14/2022	GHERMAN	MELISA	R.D.H.
H8513	9/14/2022	TORBECK	CHARLES GEORGE FREDERICK	R.D.H.

H8514	9/14/2022	ALLMAN	SONJA GABRIELLE	R.D.H.
H8515	9/21/2022	KAHLER	BRITTANY	R.D.H.
H8516	9/21/2022	MILTENBERGER	KELSEY MARIE	R.D.H.
H8517	9/28/2022	DAVYDENKO	VALERIYA	R.D.H.
H8518	9/28/2022	ROBIRTS	SYDNEY ROSE	R.D.H.
H8519	9/28/2022	CURRIE	JORDAN MACKENZIE	R.D.H.
H8520	9/28/2022	NOLASCO	EMILY	R.D.H.
H8521	9/28/2022	GARCIA	JENNIFER	R.D.H.
H8522	9/28/2022	PLACK	RACHAEL DIANE	R.D.H.
H8523	10/4/2022	MACNALLY	MAILISA ROSE	R.D.H.
H8524	10/4/2022	SCHEER	BRYTNEY ANNE	R.D.H.

DENTISTS

D11676	8/5/2022	HOSKINS	MADELEINE	D.D.S.
D11677	8/10/2022	BATTIN	PATRICK	D.D.S.
D11678	8/10/2022	PHAM	EDWARD PEER	D.M.D.
D11679	8/10/2022	NGHIEM	CHRISTINE QUYNH-HUONG	D.M.D.
D11680	8/10/2022	ALEXANDER	GRANT MATHEW	D.M.D.
D11681	8/10/2022	TOEPLER	JON WILLIAM	D.D.S.
D11682	8/24/2022	BELHOUCHAT	DRISS	D.D.S.
D11683	8/24/2022	ALJEWARI	HAIDER	D.M.D.
D11684	8/24/2022	SOLIMAN	ASHLEY MARIE	D.D.S.
D11685	8/24/2022	JONES	MAI QUE-ANH	D.M.D.
D11686	8/24/2022	KELLNER	ELIZABETH	D.D.S.
D11687	8/24/2022	CAO	JANE THAO NGOC	D.M.D.
D11688	8/24/2022	CALLAN	LAUREN	D.M.D.
D11689	8/24/2022	SCHANER II	PAUL JOSEPH	D.M.D.
D11690	8/24/2022	SAHEBI	MISHAUN	D.D.S.
D11691	8/31/2022	SAWZAK	AUSTEN CIMONE	D.M.D.
D11692	8/31/2022	PETERSEN	ALEXANDER GREGORY O'NEAL	D.M.D.
D11693	8/31/2022	LIGHT	CHRISTINA PILAR	D.D.S.
D11694	8/31/2022	HIGGINS	ANDY	D.M.D.
D11695	8/31/2022	ABDELRAHMAN	MARWA	D.D.S.
D11696	8/31/2022	ELDOMIATY	WALIED	D.D.S.
D11697	9/7/2022	TISCHLER	STEPHEN LEONARD	D.D.S.
D11698	9/7/2022	HILL	GEMMA MODELL	D.D.S.
D11699	9/7/2022	CRUZ	GIANNCARLO	D.D.S.
D11700	9/13/2022	CHOW	JUSTIN	D.M.D.
D11701	9/13/2022	ANDERSON	EMARSHARAE LAVOTTIS FRANKIE LEE	D.M.D.
D11702	9/13/2022	ONG	LORAN EDWARD	D.D.S.
D11703	9/14/2022	HAWKER	RUSTIN GARY	D.D.S.
D11704	9/21/2022	TSAI	MATTHEW	D.M.D.
D11705	9/21/2022	ARBESFELD	ABRAHAM	D.D.S.
D11706	9/21/2022	SCHLAM	KIMBERLY KOCAK	D.M.D.
D11707	9/21/2022	EASTER	PATRICK	D.M.D.

D11708	9/21/2022	MENDAZONA	RACHEL LYNN	D.M.D.
D11709	9/21/2022	HAVENS	BRUCE ANDREW	D.D.S.
D11710	9/21/2022	GUSTAFSON	KERRI SUE	D.D.S.
D11711	9/28/2022	GOURLEY	JULIA	D.M.D.
D11712	10/4/2022	WANG	YU-WEN AMY	D.D.S.
DF0053	9/13/2022	STAUFFER	JACY	D.M.D.

LICENSE, PERMIT
&
CERTIFICATION

Nothing to report under this tab