PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
DECEMBER 15, 2023

Oregon
Tina Kotek, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM**

DATE: **December 15, 2023**

TIME: **8:00 a.m. – 11:45 a.m.**

Call to Order – Chip Dunn, President **8:00 a.m.**

OPEN SESSION (Via Zoom)
https://us02web.zoom.us/j/82507761998?pwd=WmZLTm9uQUwzcmJ0dXdhMGxudlZyZz09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 825 0776 1998 ● Passcode: 589552

Review Agenda

1. Approval of Minutes
   - October 27, 2023 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - DAWSAC draft minutes from 10.27.2023 meeting

4 Executive Director's Report
   - Staff Update
   - OBD Budget Status Report
   - OBD – OMB updated IAA
   - Customer Service Survey
   - Staff Speaking Engagements
   - Dental Hygiene License Renewal Data
   - Dental Therapist License Update – one year in
   - AADB Annual Meeting - Award and Summary
   - Oregon Tribal-State Summit – Cancelled
   - 2024 OBD Calendar

5. Unfinished Business and Rules
   - SOS Filing - Temp fee rule to become permanent on Jan 1, 2024
   - Dec 15, 2023 Public Rulemaking Hearing Packet
     - Public Comment Period open November 16 until January 19, 2024
   - Dental Implant Rules – Effective Jan 1, 2024 FAQ Guidance
     - Communication and timeline for dental implant rules

6. Correspondence
   - CSG Analysis of AADB Compact

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

- Dr. Clark request to Board
    - OAR 818-042-0070
- Request for revisions of board-approved pit and fissure sealants curriculum – Bonnie Marshall

7. Other
    - Dental Pilot Project #300 “Dental Therapist Project: Dental Hygiene Model” Agenda
    - DPP #300 Dental Therapist Project: Dental Hygiene Model Power Point
    - Oregon’s Licensed Health Care Workforce Supply
    - The Diversity of Oregon’s Licensed Health Care Workforce
    - CODA upcoming site visits in Oregon
    - Rogue Community College seeks Dental Hygiene program accreditation
    - Tribes
    - Other Public Comment

8. Articles & Newsletters (No Action Necessary)
    - Oregon Wellness Program

EXECUTIVE SESSION **9:00 a.m.**

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

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

OPEN SESSION (Via Zoom) **11:30 a.m.**

https://us02web.zoom.us/j/82507761998?pwd=WmZLTm9uQUwzcmJ0dXdhMGxudlZyZz09

Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 825 0776 1998 ● Passcode: 589552

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

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

ADJOURN **11:45 a.m.**

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

APPROVAL OF MINUTES

OREGON BOARD OF DENTISTRY
MINUTES Draft
OCTOBER 27, 2023

MEMBERS PRESENT:	Chip Dunn, President Jennifer Brixey, Vice President Alicia Riedman, R.D.H.,E.P.P. Reza Sharifi, D.M.D. Jose Javier, D.D.S., Aarati Kalluri, D.D.S. Sheena Kansal, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H.,E.P.P. Michelle Aldrich, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/ Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager Samantha Plumlee, Examination and Licensing Manager Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT IN PERSON & VIA TELECONFERENCE*:	Mary Harrison, Oregon Dental Assistants Association; Barry Taylor, D.M.D., Oregon Dental Association (ODA); Jill Lomax, Chemeketa Community College; Katherine Landsberg (DANB), Emily Coates, Oleysa Salathe, D.M.D.; Daniel Martinez Tovar; Karan Bershaw; Lauren Malone, OAGD; Kristen Simmons; Laura Skarnulis; Mia Noren; Kari Hiatt; Jen Hawley Price; Karan Repogle; Amy Coplen; Sue Ritter

*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 9:18 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

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

NEW BUSINESS

Approval of Minutes

Dr. Javier moved and Ms. Riedman seconded that the Board approve the minutes from the August 25, 2023 Board Meeting as amended. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Salathe, D.M.D. thanked the Board for the opportunity to sit on the DAWSAC committee. Dr. Salathe reported the ODA had a great House of Delegates in September and the new ODA president is Mark Mutschler, D.D.S. Next weekend the ODA will hold a regional event in Florence, OR. Dr. Salathe announced the new American Dental Association president is Dr. Linda Edgar, from the State of Washington.

Oregon Dental Hygienists' Association (ODHA)
Karan Bershaw R.D.H.,E.P.P., the incoming ODHA president reported the ODHA annual conference will be November 10-11 at the Salem Convention Center. There will be 36 hours of continuing education available at the conference. The conference is a collaboration with the Oregon Dental Assistants Association.

Oregon Dental Assistants Association (ODAA)
Mary Harrison applauded the Board for their work on the DAWSAC committee and thanked the ODHA for their collaboration on the upcoming conference. Ms. Harrison noted the ODAA has met with the Lab Association. Ms. Harrison called attention to DANB's offering of the Radiation Health & Safety exam in Spanish, starting in January.

COMMITTEE AND LIAISON REPORTS

Rules and Oversight Committee meeting – October 3, 2023

Dr. Javier, Rules and Oversight Committee chair reported there were several rules ready to move forward to the Public Rule Making hearing, with three rules deserving additional Board review.

DANB Feedback on OBD proposed rules was included with broad discussion.

Dr. Javier moved and Ms. Ludwig seconded that the Board move OAR 818-026-0080 to the Anesthesia Committee for further review. The motion passed unanimously.

Ms. Riedman moved and Dr. Aldrich seconded that the Board move OAR 818-042-0080, 818-042-0110 and 818-042-0113 back to the Rules Oversight Committee for further discussion. The motion passed unanimously.

Dr. Javier moved and Dr. Kansal seconded that the Board send OAR 818-012-0005, 818-012-0060, 818-012-0010, 818-012-026-0050, 818-026-0055, 818-035-0030, 818-042-0020, , 818-042-0100, 818-042-0114, 818-042-0115 & 818-042-0117 to a public rule making hearing as presented. The motion passed unanimously.

818-012-0005
Scope of Practice
(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;

(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.
(5) A dentist may place ~~endosseous~~ **dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited ~~graduate~~ **postdoctoral** dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
(6) A dentist placing ~~endosseous~~ **dental** implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).

818-021-0060
Continuing Education — Dentists
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists

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

OAR 818-026-0010
Definitions
As used in these rules:
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
(2) "Anxiolysis" means the diminution or elimination of anxiety.
(3) "General Anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
(4) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require

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

OAR 818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

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

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

OAR 818-026-0055
Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation
(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or

(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with ~~818-026-0050(7) and (8)~~ **Board rules.**
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with ~~818-026-0050(7) and (8)~~ **Board rules.**
(3) Under indirect supervision, a dental therapist may perform procedures for which they hold the appropriate license for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with Board rules.

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

for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

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

OAR 818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility
(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.
(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services.
(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.
(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.
(6) Dental assistants may take physical impressions and digital scans.

OAR 818-042-0080
Certification — Expanded Function Dental Assistant (EFDA)
The Board may certify a dental assistant as an expanded function assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) If the assistant submits a completed application, pays the fee and provides evidence of;
(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a

course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic, Infection Control or Certified Dental Assisting (CDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by **an Oregon** licensed dentist that the applicant has successfully polished six (6) amalgam or composite surfaces, removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments; placed temporary restorative material in three (3) teeth; preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth; removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated four (4) temporary crowns and/or fixed partial dentures (bridges) and temporarily cemented the crowns and/or
fixed partial dentures (bridges); polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; placed matrix bands on four (4) teeth prepared for Class II restorations. **The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function duties until EFDA certification is achieved.**

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

soon as is reasonably appropriate.

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

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

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

Dr. Clark offered a brief recap of the first DAWSAC committee meeting, taking place earlier this morning. Committee discussion centered around three topics: 1) Why does Oregon not have as many dental assistants as it should, 2) review other states and their credentialing programs, 3) report back to the Board on a quarterly basis. The next DAWSAC meeting will be February 23, 2024.

OHA-Dental Pilot Project #100 Anesthesia administration training for Dental Therapists was shared as an example of an overview of the OHA's proffered anesthesia training.

CODA information on Dental Hygiene and Dental Therapy Standards were shared.

Oregon Board of Dentistry Committee and Liaison Assignments
The Oregon Board of Dentistry Committee and Liaison Assignments for May 2023 - April 2024 were included for reference.

EXECUTIVE DIRECTOR'S REPORT

Board Updates
Mr. Prisby noted that the Board will have three openings next spring when the terms of Dr. Jose Javier 4/1/2024, Alicia Riedman, RDH 3/31/2024 and Jennifer Brixey 4/6/2024 end in the spring of 2024. Mr. Prisby attached documents summarizing the process, responsibilities and an overview of board service to help promote interest in joining the Board next year. Information about the board openings has been publicized in the OBD summer newsletter, email blasts and emails sent directly to the professional associations and tribal partners. Candidates need to apply through the state's Workday system and be vetted by early December 2023 to make it through the steps & process to be confirmed by the Senate in February 2024.

OBD Budget Report
Mr. Prisby attached the first budget report for the 2023 – 2025 Biennium. The report, which is from July 1, 2023 through August 31, 2023 shows revenue of $397,103.16, and expenditures of $300,105.66.

The Legislature typically increases all state agencies' expenditure limits to account for these salary increases. However, most of the OBD's revenue (96%) is from applicants & licensees which may not increase enough to keep up with the projected increase in expenses due to salary increases and other cost increases. Another financial concern looming ahead is the OBD transitioning to support from the Medical Board to DAS for all financial, budgeting, accounting, and HR support.
Here is a budget note contained in the OBD's 2023 – 2025 Budget

Budget Notes

Transition to the Department of Administrative Services Shared Financial Services
The Oregon Board of Dentistry, in consultation with the Department of Administrative Services Chief Financial Office and Oregon Medical Board, shall review the most cost effective and programmatically efficient approach to transition its budget and accounting services from the Oregon Medical Board to the Department of Administrative Services (DAS), Shared Financial Services (SFS) beginning in the 2025-27 biennium. The agency shall submit a report to the Interim Joint Committee on Ways and Means or Emergency Board before January 2024 on its findings and include for consideration a plan to complete the transition in the most cost effective and efficient way, including the workload impact on both the Oregon Medical Board and DAS SFS.

Mr. Prisby discussed the possible financial impact regarding the OBD Budget and finite resources (people, revenue, and time).

Customer Service Survey
Mr. Prisby shared the legislatively mandated survey results from July 1, 2023 – September 30, 2023. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Staff Speaking Engagement
Mr. Prisby noted that Dr. Angela Smorra presented an "OBD Update and Jurisprudence" presentation to Exceptional Needs Dental Services in Tigard on Friday, September 15, 2023.

Dental Hygiene License Renewal
The license renewal period started on August 1 and ended September 30. Mr. Prisby reported that the final results will be ready and presented at the December Board meeting.

FY 2023 Annual Performance Progress Report
Mr. Prisby attached the OBD's FY 2023 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.

Governor Kotek's Expectations of Agency Leaders
Mr. Prisby shared an update of the OBD's compliance on the Governor's expectations of agency leaders.

M365 Sensitivity Labels on communications & documents
Mr. Prisby reported that state documents & communications will now need to be defined & labeled appropriately. The statewide policy was also provided for context.

HPSP Year 13 Reports
Mr. Prisby provided the Year 13 HSPS reports for review.

AADA & AADB Annual Meetings along with proposed updated AADB Bylaws
Mr. Prisby reported on The American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) annual meetings which were held in Los Angeles, Ca. October 18 – 21, 2023. He reported that Lori Lindley, was awarded the AADB Citizen of the Year Award. Due to timing of the press release on this, and more additional information on the meeting released late for this report: all will be included in his report at the December Board Meeting.

UNFINISHED BUSINESS AND RULES

The Board held a virtual public rulemaking hearing on this fee rule on October 4, 2023 and no public comment was received at the public hearing. The Board also accepted comment/feedback between August 29 - October 13, 2023, but none was received.

Dr. Javier moved and Dr. Kansal seconded that the Board approve OAR 818-001-0087 as a permanent rule effective January 1, 2024. The motion passed unanimously.

Mr. Prisby presented a memo with two proposals regarding acceptable CE timeframes for a licensee's first license renewal cycle. After discussion, the Board decided no changes are necessary to the CE rules.

COORESPONDENCE

CSG Memo RE: Dentist and Dental Hygienist Compact addressed allegations and specific points of disinformation CSG has received over the past months.

CRDTS Special News Bulletin assembled information regarding two dental and dental hygiene licensure compacts that are being circulated to help CRDTS Members and non-member dental boards better understand what information is currently available.

Steve Bush recommended changing OAR 818-012-0002 to include a definition of study model.

(21) "Study model" means a replica of a patient's teeth and surrounding structures, typically made from either a physical impression or a scanned impression of the patient's mouth. It is used primarily for diagnostic and treatment planning purposes, allowing the dentist to study the patient's teeth and jaw alignment and plan procedures such as orthodontic treatment, restorative dentistry or prosthetic treatment. A study model is distinguished from a "working model," which is fabricated in a similar fashion as a study model and may be a more precise and accurate replica of the patient's teeth and jaw (where applicable). A working model would be used for the fabrication of dental appliances, including without limitation orthodontic aligners, retainers, crowns and bridges or removable dentures.

Dr. Javier moved and Dr. Kansal seconded that the Board move the language presented by Mr. Bush to the Licensing and Standards Committee for review. The motion passed unanimously.

OTHER ISSUES

The Oregon Wellness Program (OWP) shared their mission statement and program overview. Promoting wellness for healthcare professions in Oregon through coordinated counseling services, education and research.

Articles & News

Wisconsin's Dentistry Examining Board, under the Department of Safety and Professional Services voted to make Wisconsin's only dental school -- Marquette University's School of Dentistry -- a testing organization, allowing Marquette Dental Graduates automatic licensure.

Public notice from OHA: The OHA will submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services to increase the fee-for-service rates for dental services.

DANB to offer RHS exam translated to Spanish.

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

OPEN SESSION: The Board returned to Open Session at 2:45 p.m.

CONSENT AGENDA

2024-0011, 2023-0181, 2024-0017, 2024-0012, 2024-0027, 2024-0004, 2024-0033, 2019-0009, 2024-0010, 2022-0088, 2019-0222

Ms. Brixey moved and Ms. Riedman seconded that the Board close the matters with a finding of No Violation or No Further Action. Ms. Ludwig recused herself from cases 2024-0011 and 2023-0181. The motion passed unanimously.

COMPLETED CASES

2024-0026, 2023-0094, 2023-0195, 2023-0166, 2023-0151, 2023-0170, 2023-0171
Ms. Brixey moved and Dr. Javier seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

Erica R. Brown R.D.H.; 2023-0098
Dr. Sharifi moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action incorporating a Reprimand and a $250.00 civil penalty. The motion passed unanimously.

Marco A. Gutierrez, D.D.S.; 2023-0127
Dr. Kalluri moved and Ms. Brixey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a $5,000.00 civil penalty within 90 days, pay $6000.00 restitution to patient OF within 90 days, and take 4 hours of continuing education related to record keeping within 30 days, unless the Board grants an extension, and advises Licensee in writing. This ordered CE is in addition to the CE required for the licensure period April 1, 2022 to March 31, 2024. The motion passed unanimously.

Audrey I Herman, R.D.H.; 2023-0106
Dr. Kansal moved and Ms. Riedman seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand; a $1500.00 civil penalty payable within 120 days of the effective date of the Order; a requirement that the licensee complete four hours of Board approved continuing education (CE) in the area of infection control within 60 days of the of the effective date of the Order; a requirement that the licensee complete six hours of Board-approved continuing education (CE) in the area of medical emergencies within 60 days of the of the effective date of the Order; a requirement that the licensee complete four hours of Board-approved continuing education (CE) in the area of cultural competency within 60 days of the of the effective date of the Order; and a requirement that the licensee submit evidence of completion of the balance of 54 hours of CE for the licensure period October 1, 2018 through September 30, 2022 within 90 days of the effective date of the Order; These sixty-eight hours of Board-required CE will be in addition to the 40 hours of continuing education required for licensure period April 1, 2022, to March 31, 2024.The motion passed unanimously.

Richard S. Horacek, D.D.S.; 2022-0131 & 2023-0066
Ms. Ludwig moved and Dr. Javier seconded that the Board combine the cases; issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $1500.00 civil penalty to be paid within 60 days of the effective date of the order, a refund of $1286.00 to patient BM to be paid within 60 days of the effective date of the order, a refund of $367.80 to patient ML to be paid within 60 days of the effective date of the order, six hours of

continuing education related to restorative dentistry within 30 days of the effective date of the order, and eight hours of continuing education related to endodontic treatment within 30 days of the effective date of the order, unless the Board grants an extension, and advises Licensee in writing. This ordered CE is in addition to the CE required for the licensure period April 1, 2022 to March 31, 2024. The motion passed unanimously.

2023-0156
Dr. Javier moved and Ms. Riedman seconded that the Board close the matter with a letter of concern reminding licensee to assure his advertising does not make a representation that is misleading as to the credentials, education, or the licensing status of his license; that he may not claim a degree, credential, or distinction granted by a professional organization or institution of higher learning that has not been earned, and to assure the heat sterilizing devices are tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. The motion passed unanimously.

Brian Hale Nelson, D.M.D.; 2023-0095
Dr. Aldrich moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; refund in the amount of $1,950.00 by single payment, in the form of a cashier's, bank, or official check made payable to patient DC and delivered to the Board within 30 days of the effective date of the Order; pay a $7,000.00 civil penalty, in the form of a cashier's check, bank, or official check, made payable to the Oregon Board of Dentistry within 120 days of the effective date of the Order; and pass the Dental Jurisprudence Test within 30 days of the date of the effective date of the Order. The motion passed unanimously.

Dennis G Perala, D.M.D.; 2023-0186
Ms. Riedman moved and Dr. Kansal seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; refund and restitution in the amount of $3,606.00 by single payment, in the form of a cashier's, bank, or official check made payable to patient DM and delivered to the Board within 120 days of the effective date of the Order; take 4 hours of CE on dental recordkeeping within 60 days of the effective date of the Order; and take and pass the Dental Jurisprudence Test within 30 days of the date of the effective date of the Order. The motion passed unanimously.

2023-0140
Dr. Sharifi moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he documents his patient treatment record notes more thoroughly and that he follows-up with his patients as appropriate when he changes the office location where he practices. The motion passed unanimously.

2023-0092
Dr. Kalluri moved and Dr. Kansal seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he document a full periodontal chart showing data collection for each tooth, that he diagnose mucogingival deformities with appropriate referral to a periodontist to treat such, that he documents and performs an acceptable full mouth occlusal adjustment considering centric occlusion and excursive movements, and that he provides written documentation of any implant placed to the patient. The motion passed unanimously.

2023-0076
Dr. Kansal moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure all continuing education hours, including infection control and medical emergencies, have been completed during the licensure renewal period. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

Thomas Lant Haymore, D.M.D.; 2021-0109 & 2021-0176
Ms. Ludwig moved and Dr. Kansal seconded that the Board combine the cases and issue an Amended Proposed Order incorporating the disciplinary costs and incorporate a reprimand, a 60-day suspension of his license to practice dentistry, effective as of issuance of the Board's final order; Licensee will not be allowed to practice dentistry or give clinical advice for the duration of the suspension; a civil penalty in the sum of $7500.00 to be paid within 90 days of the effective date of the order, complete and unconditionally pass the PROBE: Ethics & Boundaries Program by CPEP within 12 months from the effective date of the order. Licensee will be responsible for the cost of the program and will report the outcome to the Board within 10 days of completion; Licensee is prohibited from practicing dentistry on co-workers until further notice of the Board; and is assessed the costs in the total amount of $75,000.00 within 12 months of the effective date of the order. The motion passed unanimously.

Russel G. Leoni, D.M.D.; 2023-0072
Dr. Javier moved and Ms. Riedman seconded that the Board issue a Final Default Order to incorporate a reprimand, a $6,000.00 civil penalty to be paid within 90 days of the effective date of the Order, complete 10 hours of continuing education in record keeping within 30 days of the effective date of the Order and complete a Board approved course on ethics within six months of the effective date of the Order. The motion passed unanimously.

LICENSE & EXAMINATION ISSUES

Request for reinstatement of an expired license – Jeffrey Reddicks, D.M.D.
Dr. Aldrich moved and Dr. Kansal seconded that the Board approve the reinstatement of license for Jeffrey Reddiks, D.M.D. The motion passed unanimously.

1991-0251
Ms. Riedman moved and Dr. Sharifi seconded that the Board remove from the website and other publicly accessible print and electronic publications under the Board's control all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the board during the disciplinary proceedings. The motion passed unanimously.

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

ADJOURNMENT
The meeting was adjourned at 3:03 p.m. Mr. Dunn stated that the next Board Meeting would take place on December 15, 2023 via Zoom.

Charles ‘Chip’ Dunn
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES (DAWSAC) Draft
October 27, 2023

MEMBERS PRESENT:	Terrence Clark, D.M.D., Co-Chair Aarati Kalluri, D.D.S. Co-Chair Olesya Salathe, D.M.D. - ODA Rep. Susan Kramer, R.D.H. - ODHA Rep. Ginny Jorgensen - ODAA Rep. Jill Lomax Lynn Murray Terri Dean Alexandria "Alex" Case Jessica "Jessie" Andrews Gail Wilkerson Alyssa Kobylinsky
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager Samantha Plumlee, Licensing Manager Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT: IN PERSON & VIA TELECONFERENCE*	Mary Harrison, ODAA; Alicia Riedman, R.D.H.,E.P.P.; Michelle Aldrich, D.M.D.; Amanda Nash – OAGD; Jen Hawley-Price – DANB, Katherine Landsberg – DANB, Barry Taylor – ODA, Sarah Kowalski, Laura Vanderwerf

*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 Chair at 8:03 am at the Board office at 1500 SW 1st Ave., Suite 770, Portland, Oregon.

Chair Terrence Clark, D.M.D. welcomed everyone to the meeting and had the Members, Lori Lindley, and Stephen Prisby introduce themselves.

Self-Introductions of Committee Members
Committee members introduced themselves and shared information about their history and current positions in the dental assisting field.

Review HB 3223 and Identified goals of the DAWSAC Committee
HB3223 was presented. Dr. Clark called attention to sections five and six which identify the goals of the committee: to study the dental assistant workforce shortage, review the requirements for a dental assistant certification in other states and provide advice to the Board of Dentistry.

DAWSAC packet introduced
Dr. Clark introduced a worksheet addressing the Dental Assistant Workforce Shortage and asked committee members to study and provide feedback at the February meeting. Recruitment and retention processes and ideas were shared.

It was determined to look deeper at states bordering Oregon for comparable credentialing requirements, as well as states with lesser to zero requirements. The committee wanted to look at Minnesota as well, which had the highest scope of practice and highest dental assistant salaries.

Dental Assistants desire to administer Local Anesthesia
The Oregon Dental Association was in support of dental assistants administering local anesthesia after proper education.

The DAWSAC committee will look at whether dental assistants administering local anesthesia would make a difference in dental assistant workforce retention. Dr. Clark called attention to the educational requirements, stating the DAWSAC committee will be asked to provide guidance on this topic to the Board.

Academy of General Dentistry - Dental Assistant Training
OAGD is starting a program in January.
Dr. Kalluri pointed out that students may be sponsored in this program by dentists or donations from the local community.

DANB RHS Exam Translated to Spanish
DANB is now offering the DANB RHS exam in Spanish. HB3223 requires that any examination administered must be offered in plain language in English, Spanish and Vietnamese.

ADJOURNMENT
The meeting was adjourned at 9:00 a.m. Chair Clark stated that the next Board meeting would be chaired by Dr. Kalluri and take place February 23, 2024.

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
December 15, 2023

Staff Update

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

OBD Budget Status Report

Attached is the latest budget report for the 2023 - 2025 Biennium. This report, which is from July 1, 2023 through, October 31, 2023 shows revenue of $845,864.15 and expenditures of $644,137.97. **Attachment #1**

OBD - OMB updated IAA

The costs for select services provided by the Oregon Medical Board per the interagency agreement are going up and the updated agreement is attached. **Attachment #2**

Customer Service Survey

The customer service surveys received from July 1, 2023 – November 30, 2023 are attached and a majority rate their experience with us positively. **Attachment #3**

Board and Staff Speaking Engagements

I gave an OBD "Board Updates" Presentation to the BPD Dental Hygiene Study Club via Zoom on November 20, 2023.

Dental Hygiene License Renewal Data

In 2023.	**In 2022.**	**In 2021.**
Renewed 1908	**Renewed: 1884**	**Renewed: 1888**
Retired: 29	Retired: 36	Retired: 50
Expired: 165	Expired: 202	Expired: 223
Resigned: 0	Resigned: 0	Resigned: 0
Deceased: 0	Deceased: 0	Deceased: 1

- In 2020 Renewed 1948
- In 2019 Renewed 1946
- In 2018 Renewed 1954

Dental Therapist License Update

HB 2528 (2021) was signed by Governor Kate Brown in July 2021. The bill was incorporated into ORS 679.603 authorizing our agency to start regulating this new type of Licensee. The OBD created a new standing Committee named the "Dental Therapy Rules Oversight Committee." This new Committee was created because the OBD sought a dedicated and focused group of committee members to draft new dental therapy rules in a deliberate, fair and equitable manner for the OBD to consider. The Committee met five times throughout the end of 2021 into 2022.

The Board convened a special board meeting: dedicated solely to dental therapy, in March 2022 to review and finalize initial rules and policies. The inaugural dental therapy rules and Division 38 were incorporated into the Dental Practice Act effective July 1, 2022. The first Dental Therapist license was issued on November 1, 2022.

As of November 1, 2023 there have been 17 dental therapy licenses issued by the OBD. 13 of the 17 are dual licensed providers, who also have a dental hygiene license. Only 4 solely possess a dental therapy license.

AADB Meeting Oct 2023 – Award and Summary

The Citizen of the Year Award recognizes an AADB member who has made significant contributions to the dental profession. Ms. Laura Richoux, RDH, Chair of the Award Selection Committee, acknowledges Lori H. Lindley, Senior Assistant Attorney General, Oregon Board of Dentistry for exemplifying professional excellence.

Since 1998, Ms. Lindley has been assigned to the Oregon Dental Board, Oregon Chiropractic Examiners Board, Oregon Board of Massage Therapists, Oregon Board of Optometry, Oregon Medical Board, and Oregon Board of Nursing. She has represented state agencies that provide occupational medical licenses to Oregonians since 2000 and is responsible for daily advice, attending board meetings, prosecuting contested cases, and providing advice on public meetings and public records. Lori is currently a co-chair of the American Association of Dental Board's Attorney Round Table group that meets biannually, has spoken at numerous conferences, and assisted in several trainings with agency staff and investigators.

AADB President Chamberlain and the AADB Board of Directors would like to thank Lori Lindley for her dedicated service over the years. Lori Lindley has been an invaluable asset to the dental profession and we congratulate her on being AADB's 2023 Citizen of the Year.

An AADB Meeting summary distributed by AADB is also attached. **Attachment #4**

Oregon Tribal-State Summit – Cancelled

The Oregon Tribal-State Summit was to be hosted by the Cow Creek Band of Umpqua Tribe of Indians in Canyonville Dec 5 - 6. The Governor's Office was informed in November that the White House has set its dates for the White House Tribal Nations Summit as December 6 - 7. Oregon Tribal Chairs will be traveling December 5 – 8 so it was cancelled. I anticipate this summit to be rescheduled and plan to attend it.

2024 Calendar

Important dates are noted on the attached calendar. **Attachment #5**

Agency 834

Appn Year			2025		
			Monthly Activity	Biennium to Date	Budget
Fund	Budget Obj	Budget Obj Title			
3400	1000	REVENUES	63,489.11	845,864.15	3,972,405.00
	2500	TRANSFER OUT	0.00	0.00	267,000.00
	3000	PERSONAL SERVICES	88,840.51	376,392.41	2,273,180.00
	4000	SERVICES AND SUPPLIES	92,251.98	267,745.56	1,968,770.00
3400 Total			**244,581.60**	**1,490,002.12**	**8,481,355.00**
Grand Total			**244,581.60**	**1,490,002.12**	**8,481,355.00**

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	04
Rpt Fiscal Mm Name	OCTOBER 2023
Load Date GI	11/17/2023

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	55,679.00	701,274.00	3,495,149.00
				0210	OTHER NONBUSINESS LICENSES AND FEES	1,850.00	2,350.00	14,900.00
				0410	CHARGES FOR SERVICES	363.50	6,990.50	148,355.00
				0505	FINES AND FORFEITS	0.00	114,839.70	240,000.00
				0605	INTEREST AND INVESTMENTS	5,516.61	18,405.12	60,000.00
				0975	OTHER REVENUE	80.00	2,004.83	14,001.00
			REVENUES Total			**63,489.11**	**845,864.15**	**3,972,405.00**
		2500	TRANSFER OUT	2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	0.00	267,000.00
			TRANSFER OUT Total			**0.00**	**0.00**	**267,000.00**
		3000	PERSONAL SERVICES	3110	CLASS/UNCLASS SALARY & PER DIEM	58,915.14	244,107.26	1,403,771.00
				3115	BOARD MEMBER STIPENDS	0.00	8,007.00	46,900.00
				3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,585.00
				3170	OVERTIME PAYMENTS	0.00	164.37	6,669.00
				3180	SHIFT DIFFERENTIAL	0.00	1.00	0.00
				3190	ALL OTHER DIFFERENTIAL	591.25	2,365.00	41,510.00
				3210	ERB ASSESSMENT	15.33	56.94	404.00
				3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	10,916.38	46,542.17	255,636.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	04
Rpt Fiscal Mm Name	OCTOBER 2023
Load Date GI	11/17/2023

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	3000	PERSONAL SERVICES	3221	PENSION BOND CONTRIBUTION	3,204.77	13,684.20	80,296.00
				3230	SOCIAL SECURITY TAX	4,505.36	19,305.06	116,198.00
				3241	PAID FAMILY MEDICAL LEAVE INSURANCE	189.08	962.91	5,391.00
				3250	WORKERS' COMPENSATION ASSESSMENT	12.79	48.77	351.00
				3260	MASS TRANSIT	357.02	1,479.71	9,521.00
				3270	FLEXIBLE BENEFITS	10,133.39	39,668.02	301,948.00
			PERSONAL SERVICES Total			**88,840.51**	**376,392.41**	**2,273,180.00**
		4000	SERVICES AND SUPPLIES	4100	INSTATE TRAVEL	2,227.66	3,610.02	55,194.00
				4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,220.00
				4150	EMPLOYEE TRAINING	4,382.58	5,962.58	58,929.00
				4175	OFFICE EXPENSES	1,932.47	3,193.61	99,149.00
				4200	TELECOMM/TECH SVC AND SUPPLIES	649.24	2,204.68	27,088.00
				4225	STATE GOVERNMENT SERVICE CHARGES	36,033.83	43,220.59	94,114.00
				4250	DATA PROCESSING	5,433.04	32,010.09	163,405.00
				4275	PUBLICITY & PUBLICATIONS	0.00	213.31	16,145.00
				4300	PROFESSIONAL SERVICES	17,408.00	87,662.14	458,367.00
				4315	IT PROFESSIONAL SERVICES	0.00	0.00	161,038.00
				4325	ATTORNEY GENERAL LEGAL FEES	7,898.05	26,671.75	338,907.00
				4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	120.00	766.00
				4400	DUES AND SUBSCRIPTIONS	0.00	574.90	11,331.00
				4425	LEASE PAYMENTS & TAXES	8,191.40	32,288.42	206,576.00
				4475	FACILITIES MAINTENANCE	0.00	0.00	634.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	04
Rpt Fiscal Mm Name	OCTOBER 2023
Load Date GI	11/17/2023

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	4000	SERVICES AND SUPPLIES	4575	AGENCY PROGRAM RELATED SVCS & SUPP	1,652.92	5,909.45	142,660.00
				4650	OTHER SERVICES AND SUPPLIES	3,014.39	20,675.62	94,383.00
				4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	6,343.00
				4715	IT EXPENDABLE PROPERTY	3,428.40	3,428.40	25,521.00
			SERVICES AND SUPPLIES Total			**92,251.98**	**267,745.56**	**1,968,770.00**

DAFR9210 Agency 834 - month end

INTERAGENCY AGREEMENT

Oregon Medical Board & Oregon Board of Dentistry

Amendment 02

This is Amendment 02 to the Interagency Agreement between the Oregon Medical Board (OMB) and the Oregon Board of Dentistry (Agency) signed into effect June 30, 2021. This amendment will go into effect December 01, 2023, and will stay in effect until superseded or the Agreement is terminated.

The Agreement, Exhibit A, is hereby amended as follows (new language is indicated by bold, underlined print and deleted language is indicated by italics and strikethrough):

EXHIBIT B

Costs for Provision of Services

Services to be provided		Monthly Fee
Financial Services include:		~~*$ 913.00*~~
Budget Development, Reporting, Execution, and Allotments		**$1,350.00**
Cash Receipts entry into SFMA		
Cash Disbursements		
Annual ~~*CAFR*~~ **ACFR** reporting		
Fixed Asset adjusting entries into SFMA		
General Accounting Activities related to the above services		
Internal Control Activities related to the above services.		
Human Resource Services include:		~~*$ 483.00*~~
Leave Management services		**$863.00**
Records Management services		
Recruitment Services		
Position Management Services		
HR Advice and CBA Interpretation Services		
Employee Investigations & Audits		
Worker Compensation and safety support and reporting		
Fee per Staff/Board Position:	~~*$ 27.00*~~ **$ 49.00**	
Staff/Board Positions	**17.62 FTE**	
	TOTAL	~~*$1396.00*~~ **$2,213.00**

Hourly Services include:

Administrative Coordinator (contracting) services	$ ~~35.00~~ **45.00**/hour
Information Technology services	$ ~~55.00~~ **70.00**/hour

Signatures:

Oregon Medical Board

Signature: _____ By (print name): Nicole Krishnaswami

Title: Executive Director Date: _____

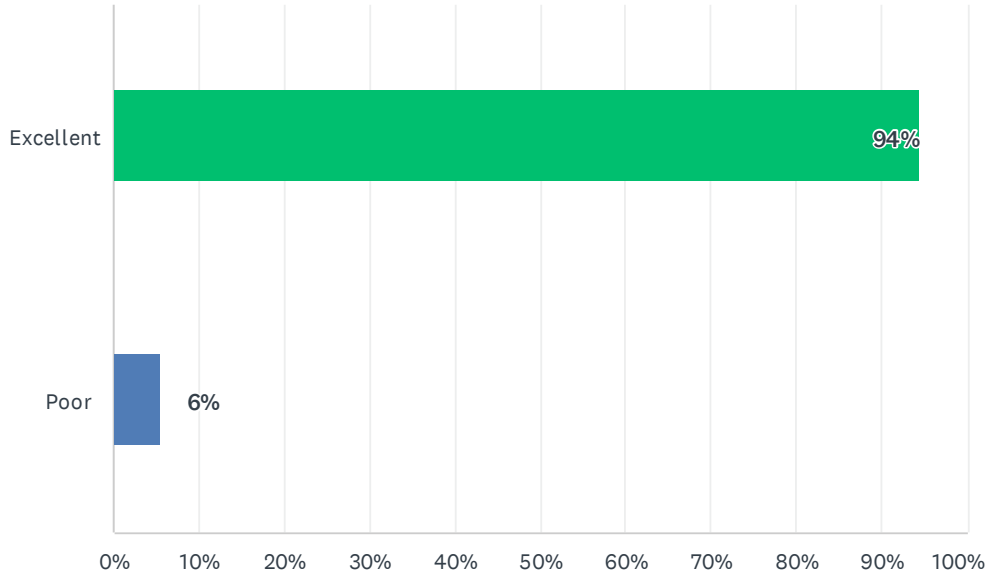
Oregon Board of Dentistry

Signature: _____ By (print name): Stephen Prisby

Title: Executive Director Date: 11/9/2023

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

Answered: 18 Skipped: 0

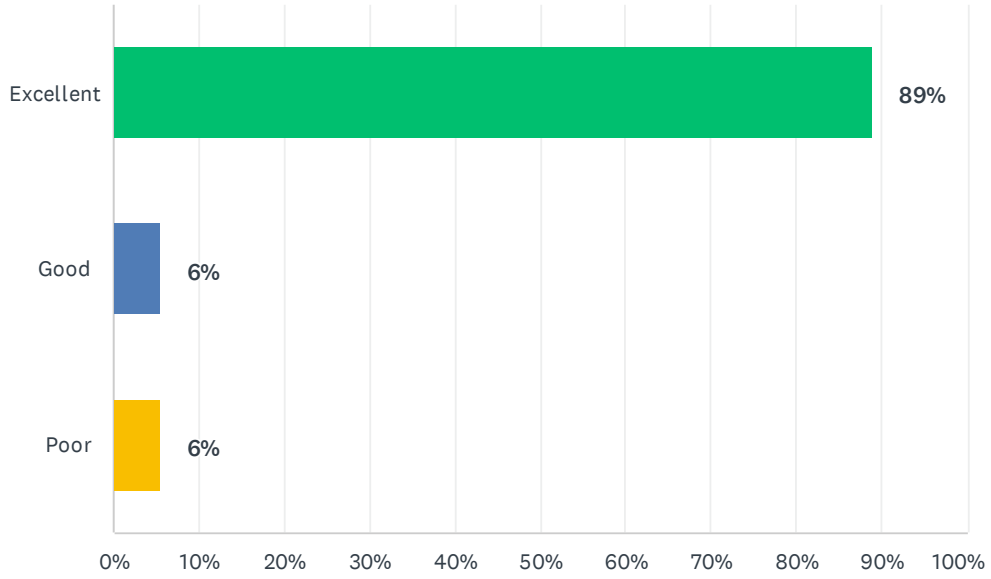


ANSWER CHOICES	RESPONSES	
Excellent	94%	17
Poor	6%	1
TOTAL		18

Attachment #3

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

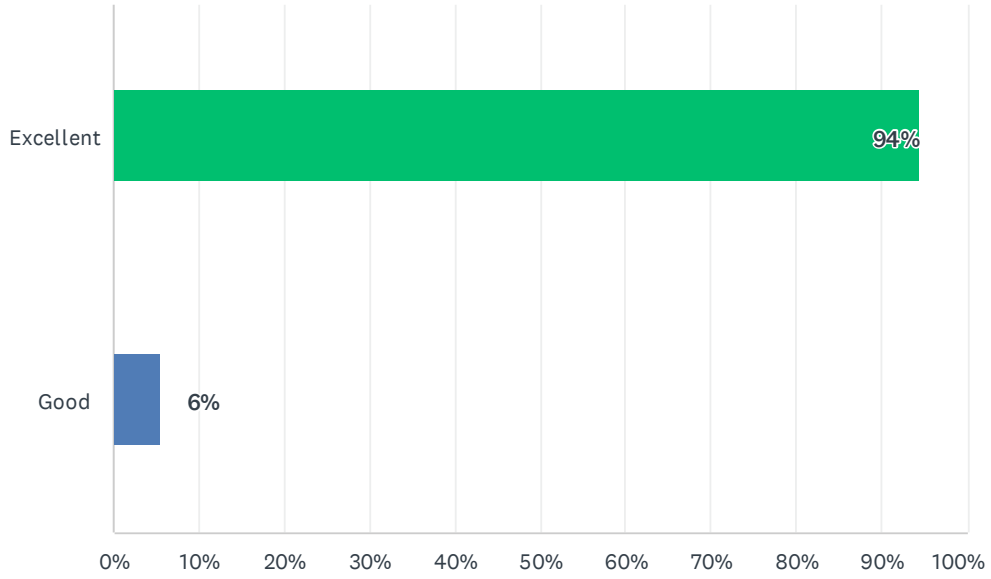
Answered: 18 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	89%	16
Good	6%	1
Poor	6%	1
TOTAL		18

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

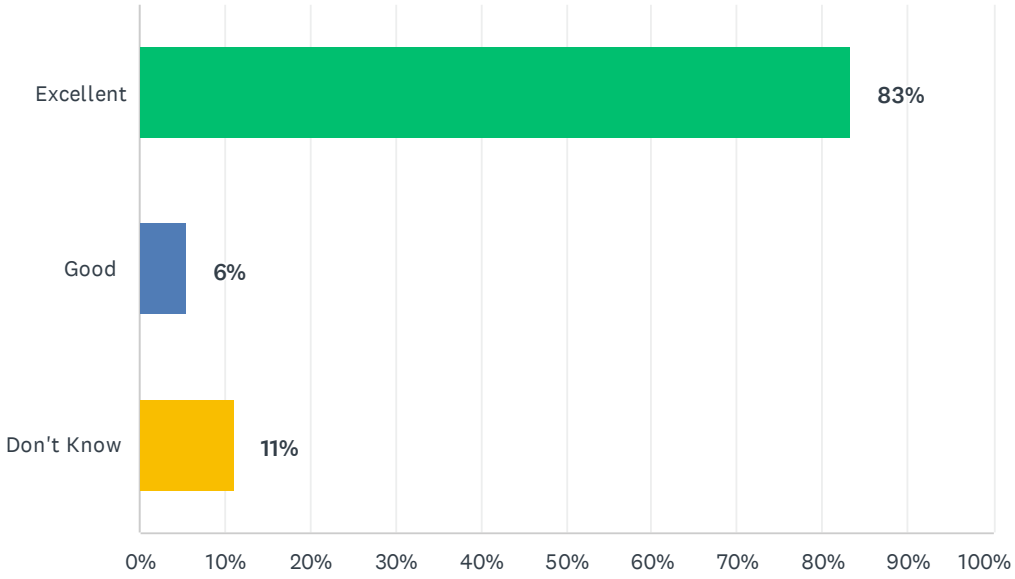
Answered: 18 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	94%	17
Good	6%	1
TOTAL		18

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

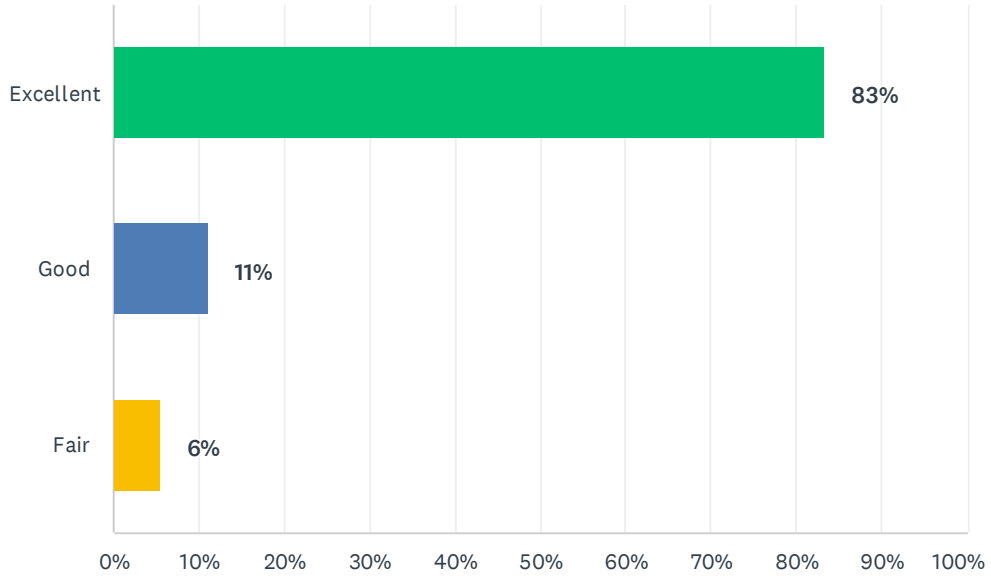
Answered: 18 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	83%	15
Good	6%	1
Don't Know	11%	2
TOTAL		18

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

Answered: 18 Skipped: 0

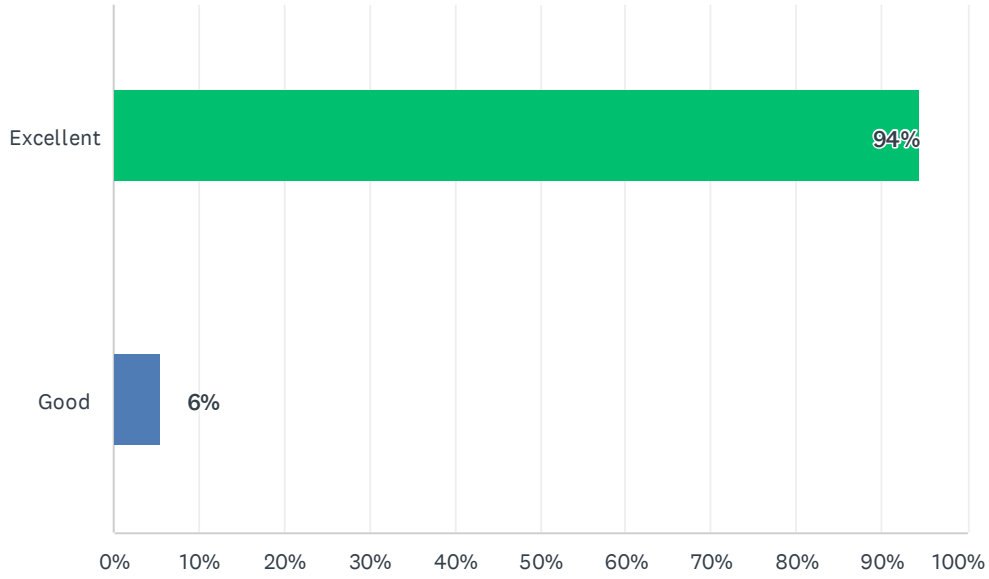


ANSWER CHOICES	RESPONSES	
Excellent	83%	15
Good	11%	2
Fair	6%	1
TOTAL		18

Attachment #3

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

Answered: 18 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	94%	17
Good	6%	1
TOTAL		18

Attachment #3

American Association of Dental Boards

October 27, 2023

Hello from the American Association of Dental Boards! It was wonderful to see so many colleagues from across the US during our 140th Annual Meeting in Hollywood, CA, on October 20-21, 2024! Thank you to all who traveled; we hope you enjoyed the various sessions, social gatherings, and networking with fellow attendees.

AADB Annual Meeting Summary

The 140th Annual Meeting was well attended thanks in part to the announcement of our new leadership, focus, and mission. With the additional announcement of the AADB Dental and Dental Hygiene Compact, the AADB Board of Directors welcomed all attendees to an Annual Meeting full of energy and interaction. President James Sparks, DDS, and the Board of Directors were thrilled to share the new mission and goals of AADB, including renewed support of our Member State Dental Boards, renewed focus on public protection, updated bylaws, a new Interim Executive Director and Legal Counsel, and more. Incoming President, Dr. Dale Chamberlain, thanked Dr Sparks for his time and dedication.

A new session, the "Board Member Orientation and Certification Course," provided a wealth of information essential to the function and execution of the duties expected of a sitting State Dental Board Member. We appreciate Ms. Susan Rogers, Esq, Executive Director and Legal Counsel, Oklahoma Board of Dentistry, Mr. Bobby White, Esq, Executive Director and Legal Counsel, North Carolina Board of Dental Examiners and Ms. Lori Lindley, Senior Assistant Attorney General, Oregon Board of Dentistry for their masterful presentation. Roles, legislation, statute vs. rules, Board Member conduct, quorum rules, and discipline were just a few of the subjects covered.

Dr. Guy Shampaine provided an excellent presentation explaining the history and concept of licensure compacts outlining in detail the differences between the CSG DDH Compact and the AADB Dental and Dental Hygiene Compact. The presentation utilized language from the documents, providing an easy-to-understand comparison. Attendees overwhelmingly voiced support for the AADB Compact in a straw poll following the presentation. We encourage you to visit the AADB Compact website at www.aadbcompact.org for up-to-date, relevant information, including Frequently Asked Questions and Fact Sheets for Boards of Dentistry, Legislators and Dental and Dental Hygiene professionals. The AADB Compact website is a one-stop shop to gain additional knowledge about this timely development sweeping the country.

The AADB Bylaws updates were distributed before the 140th Annual Meeting for review, and other than some minor clarifications, the AADB General Assembly approved the changes. Changes take effect on January 1, 2024.We'll issue additional information closer to that date.

Dr. Bobby Carmen, Oklahoma, moderated elections. We're pleased to welcome Mr. Arthur "Rusty" Hickham, DDS, Esq., Louisiana, as the Administrator Member, Dominic Totman, Esq., North Carolina, Public Member, and Ms. Diane Klemann, RDH, Montana, as the Dental Hygiene Member of the AADB Board of Directors! President Dr. Dale Chamberlain thanked our departing Directors, Brian Barnette, Administrator; Laura Richoux, RDH, Dental Hygiene; and Yvonne Bach, Public Member.

The Attorney's Roundtable panelists shared cases impacting State Boards nationwide. This highly anticipated session is a favorite of attendees from year to year. Thanks to Susan, Bobby, Lori, and all the contributing attorneys for their dedication in gathering this detailed and informative report each year!

Dr. Frank Maggio moderated the AADB State Dental Board Forum. In the forum, State Board Members are provided an opportunity to share pertinent issues affecting their state and interact with other State Dental Board Members facing the same concerns.

Finally, Ms. Lori Lindley, Esq, Oregon, is the 2023 AADB Citizen of the Year. The award recognizes an AADB member who has made significant contributions to the dental profession. Congratulations, Lori; your service is greatly appreciated.

We look forward to welcoming you in Chicago, IL, for the AADB Mid-year meeting on April 12-13. Save the date!!

OBD 2024 Calendar

JANUARY

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

FEBRUARY

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

MARCH

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

APRIL

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

MAY

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

JUNE

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

JULY

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

AUGUST

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

SEPTEMBER

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

DECEMBER

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Office Closed

Evaluator Meeting

Board Meeting

Attachment #5

UNFINISHED BUSINESS & RULES

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

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

PERMANENT ADMINISTRATIVE ORDER

FILED
11/01/2023 9:37 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

OBD 4-2023
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board is increasing some fees in its 2023-2025 Legislatively Approved Budget.

EFFECTIVE DATE: 01/01/2024

AGENCY APPROVED DATE: 10/27/2023

CONTACT: Stephen Prisby
971-673-3200
stephen.prisby@state.or.us

1500 SW 1st Ave
#770
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

AMEND: 818-001-0087

REPEAL: Temporary 818-001-0087 from OBD 2-2023

NOTICE FILED DATE: 08/29/2023

RULE SUMMARY: The Board is increasing some fees which are included in the Legislatively approved 2023-2025 OBD Budget

CHANGES TO RULE:

818-001-0087
Fees ¶

(1) The Board adopts the following fees:¶
(a) Biennial License Fees:¶
(A) Dental -$~~394~~40;¶
(B) Dental - retired - $0;¶
(C) Dental Faculty - $3~~3~~85;¶
(D) Volunteer Dentist - $0;¶
(E) Dental Hygiene -$2~~30~~55;¶
(F) Dental Hygiene - retired - $0;¶
(G) Volunteer Dental Hygienist - $0;¶
(H) Dental Therapy - $2~~30~~55;¶
(I) Dental Therapy - retired - $0;¶
(b) Biennial Permits, Endorsements or Certificates:¶
(A) Nitrous Oxide Permit - $40;¶
(B) Minimal Sedation Permit - $75;¶
(C) Moderate Sedation Permit - $75;¶
(D) Deep Sedation Permit - $75;¶
(E) General Anesthesia Permit - $140;¶
(F) Radiology - $75;¶
(G) Expanded Function Dental Assistant - $50;¶
(H) Expanded Function Orthodontic Assistant - $50;¶
(I) Instructor Permits - $40;¶

(J) Dental Hygiene Restorative Functions Endorsement - $50;¶
(K) Restorative Functions Dental Assistant - $50;¶
(L) Anesthesia Dental Assistant - $50;¶
(M) Dental Hygiene, Expanded Practice Permit - $75;¶
(N) Non-Resident Dental Background Check - $100.00;¶
(c) Applications for Licensure:¶
(A) Dental - General and Specialty - $~~3~~4445;¶
(B) Dental Faculty - $~~3~~4405;¶
(C) Dental Hygiene - $2~~1~~180;¶
(D) Dental Therapy - $2~~1~~180;¶
(E) Licensure Without Further Examination - Dental~~,~~ - $890.¶
(F) Licensure Without Further Examination - Dental Hygiene and Dental Therapy - $~~790.~~820¶
(d) Examinations:¶
(e) Jurisprudence - $0;¶
(f) Duplicate Wall Certificates - $50.¶
(2) Fees must be paid at the time of application and are not refundable.¶
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200, 680.205, 679.615

OREGON BOARD OF DENTISTRY
PUBLIC RULE MAKING HEARING

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

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

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

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

MEETING NOTICE

PUBLIC RULEMAKING HEARING

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

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

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

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

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

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

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

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

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

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

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

OAR 818-042-0020

Dentist, Dental Therapist and Dental Hygienist Responsibility

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

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

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

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

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

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

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

OAR 818-042-0114

Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)

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

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

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

OAR 818-042-0117

Initiation of IV Line and Phlebotomy Blood Draw

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.

(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

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

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 818
OREGON BOARD OF DENTISTRY

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

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

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

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

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

1500 SW 1st Ave
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

HEARING(S)

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

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

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

NEED FOR THE RULE(S)

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

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Board and Committee meeting agendas, minutes and correspondence.

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

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

FISCAL AND ECONOMIC IMPACT:

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

COST OF COMPLIANCE:

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

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

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

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

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

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

AMEND: 818-012-0005

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

CHANGES TO RULE:

818-012-0005
Scope of Practice ¶

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

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

AMEND: 818-021-0060

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

CHANGES TO RULE:

818-021-0060
Continuing Education - Dentists ¶

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

AMEND: 818-026-0010

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

CHANGES TO RULE:

818-026-0010
Definitions ¶

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

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

AMEND: 818-026-0050

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

CHANGES TO RULE:

818-026-0050
Minimal Sedation Permit ¶

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

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

AMEND: 818-035-0030

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

CHANGES TO RULE:

818-035-0030
Additional Functions of Dental Hygienists ¶

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

ADOPT: 818-038-0022

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

CHANGES TO RULE:

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

AMEND: 818-042-0020

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

CHANGES TO RULE:

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

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

AMEND: 818-042-0100

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

CHANGES TO RULE:

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

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

AMEND: 818-042-0114

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

CHANGES TO RULE:

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

AMEND: 818-042-0115

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

CHANGES TO RULE:

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

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

AMEND: 818-042-0117

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

CHANGES TO RULE:

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

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

OBD Guidance on NEW Dental Implant Rules – effective January 1, 2024

At its June 17, 2022 meeting, the Board voted to change the effective date of the rules from July 1, 2022 to January 1, 2024.

Historically, dentists have received training in the surgical placement of implants in a variety of different ways. Beginning January 1, 2024, Oregon dentists will be required to complete 56 hours of hands on clinical implant course(s), at an appropriate postgraduate level, prior to surgically placing dental implants. The Oregon Board of Dentistry (OBD) recommends that proof of meeting the training requirements be maintained indefinitely, as copies may be requested at random audits or complaint investigations.

Graduates of specialty training programs in Oral and Maxillofacial Surgery, Periodontics, and Prosthodontics that comply with CODA standard 4 curriculum guidelines (or similar educational requirements) who have been trained to competency in surgical implant placement may qualify to surgically place implants with documentation of completing the required training.

Accredited universities, independent study clubs, formal mentoring agreements, and dental product manufacturers may also offer hands on implant training on surgical placement. However, only hours completed as part of CODA accredited graduate dental programs, or through education providers that are AGD PACE or ADA CERP approved will qualify to meet the initial 56-hour training requirement.

Additionally, beginning January 1, 2024, Oregon dentists will be required to complete seven hours of continuing education related to the placement and/or restoration of dental implants each licensure renewal period. Dentists renewing in Spring 2023, and all subsequent renewing dentists, will be required to complete the required seven hours of dental implant CE to be in compliance, if they are placing dental implants.

FAQs for Dental Implants:

What language (effective January 1, 2024) was added to the Scope of Practice Rule OAR 818- 012-0005?

> (4)A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), by the American Dental Association Continuing Education Recognition Program (ADA CERP) or by a Commission on Dental Accreditation (CODA) approved graduate dental education program.
> (5)A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective January 1, 2024.)

What language (effective January 1, 2024) was added to the Continuing Education Rules of OAR 818-021-0060?

> **(8) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective January 1, 2024.)**

How and why did the OBD decide to implement these rule changes regarding dental implants?

The OBD investigated 82 dental implants cases between February 2014 and August 2017. Of those cases, 41% resulted in Disciplinary Action, which was equally distributed between specialists and general practitioners. During Strategic Planning in 2016, the OBD identified dental implant complications and the subsequent complaints as a significant problem in Oregon. Dental implant safety was codified in the OBD's 2017-2020 Strategic Plan as a priority issue, and it has remained an ongoing safety concern of the Board through the present. At the April 21, 2017 Board Meeting, in order to effectively protect the public, and per ORS 679.280, the OBD established an ad hoc Committee named the "Dental Implant Safety Workgroup" to research, review, and discuss dental implants, implant complications, and the resulting investigations. The Workgroup's ultimate goal was to advise the OBD on the most effective actions to protect the public and educate dentists regarding dental implants. The Workgroup included OBD Board Members, OBD Staff and Licensees (both specialists and general practitioners).

The Workgroup held its first meeting in September 2017 and held a total of four meetings, with the last meeting taking place in July 2018. The Workgroup invited other interested parties to share their input, and all the meetings were open to the public. The meetings included robust discussion among specialists and general dentists. The passionate and respectful discourse resulted in valuable input from all parties. The Workgroup wrestled with many interesting data points in how to address dental implant complications. The Workgroup's recommendations to the OBD, some of which have already been implemented, and some of which continue to undergo additional refinement, appear below:

- Require a written informed consent form for dental implant placement. The level of detail that should be included in such a form remains under debate.
- Develop the educational requirements/prerequisites for dentists who wish to place implants.
- Develop a plan for "grandfathering in" licensees with a great deal of experience and success placing and restoring dental implants.
- Require a certain amount of CE pertaining to dental implants be required of licensees practicing implant dentistry for each renewal cycle.

- Determine whether all licensed dentists will be required to complete a certain amount of CE pertaining to dental implants each renewal cycle.
- Communicate with the Oregon Dental Association regarding developing a set of specific "guidelines" for Oregon licensed dentists practicing implant dentistry.
- Develop a requirement for how important information related to the implant (such as type/ manufacturer) is properly documented and provided to the patient.

The following Board Members, Staff and Oregon dentists served on the Dental Implant Safety Workgroup:

Board Members:
Dr. Gary Underhill; Dr. Julie Ann Smith; Dr. Todd Beck

Board Staff:
Dr. Paul Kleinstub; Dr. Daniel Blickenstaff

Oregon Dentists:
Dr. Normund Auzins; Dr. Cyrus Javadi; Dr. James Katancik; Dr. Russell Lieblick; Dr. Donald Nimz; Dr. S. Shane Samy; Dr. Duy Anh Tran

I obtained my Oregon dental license prior to January 1, 2024. Am I required to take 56 hours of hands on clinical implant course(s) prior to placing dental implants?

Yes. Per the recommendation of the Dental Implant Safety Workgroup, the OBD has implemented new requirements to ensure that all Oregon-licensed dentists placing implants have the necessary skills, training, and knowledge. If you have already completed the required training hours, the OBD recommends that you obtain a letter of verification, signed by your training director, certifying that you have completed the required training as stated in the rule. The OBD recommends you maintain easily accessible copies of that documentation throughout your career in Oregon.

I obtained my Oregon dental license on, or after, January 1, 2024. Am I required to take 56 hours of hands on clinical implant course(s) prior to placing dental implants?

Yes. Once you have completed the 56 hours of hands on clinical course(s), or if you have already completed the required training hours, the OBD recommends that you obtain a letter of verification, signed by your training director, certifying that you have completed the required training as stated in the rule. The OBD recommends that you maintain easily accessible copies of that documentation throughout your career in Oregon.

In what timeframe do I need to take my 56 hours of hands on clinical implant course(s)?

There is no specific timeframe required; therefore the training may be completed over any timeframe - months or years apart. However, all 56 hours must be completed before a dentist may place endosseous implants to replace natural teeth.

Are the 56 hours of hands on clinical implant course(s) cumulative, or do they need to be completed in a single program?

The hands on clinical course(s) taken to meet the 56 hour requirement may be completed in multiple courses. It is not a requirement that it be in one course.

Does the course need to include practice on human patients? Or can it be on a manikin/typodont or an animal jaw?

The Board does not specify whether or not the implants need to be placed in a human. As long as the course meets the requirements of OAR 818-012-0005(4) it is acceptable.

Do the 56 hours of hands on clinical course(s) need to be direct patient care? Or can didactic course instruction be included in the 56 hours?

The Board defers to the course instructor to define "clinical hands on," and determine how many hours of the course are dedicated to topics and format as stated in the rule. This could include some didactic instruction, provided it is under direct supervision as stated in the rule.

I only restore implants and do not place them. Do I need to meet the 56 hour requirement? Do I need to do 7 hours of CE related to implants?

If you do not place endosseous implants, and you only restore them, you do not need to complete the 56 hours or the 7 hours of CE related to placing/restoring implants.

I am concerned that I will not be able to obtain proof of completion of my 56 hours of hands on clinical implant training, because some or all of those hours were completed long ago. Many records retention policies limit to seven years or less. Will I just be "out of luck" if I can't pull together proof of certain courses?

This information will be reviewed on a case-by-case basis, typically as part of a CE audit or an investigation. It is expected that the Licensee would put in their best effort to obtain this information in the event that the training was completed many years ago. The Board will review all relevant information and circumstances before taking any action.

I have placed a great number of implants over the years with a high success rate. Can I be "grandfathered" into placing implants without taking 56 hours of hands on clinical courses?

There is not currently a portion of the rules that allows this. In order to place implants after January 1, 2024, you will need to meet the 56 hour requirement in 818-012-0005(4).

I just completed a CODA-accredited specialty program, a GPR, or AEGD program. Does this automatically qualify me to surgically place dental implants in Oregon?

No. If you completed hands on clinical implant training as part of completing a CODA-accredited specialty program, GPR, or AEGD program, and the training meets the requirements included in the rule, you may count those hours towards the 56 hours of hands on clinical course(s) required by the rule. As with all implant training, you would need to maintain specific documentation of completion of the required training, such as a letter from the Program Director or Chair certifying that you completed the required training, as stated in the rule, as part of your CODA-accredited specialty program(s), GPR, or AEGD program(s).

Why don't the rules offer differential treatment for specialists and generalists, or consideration for individuals who have been placing implants who have been doing this work for some time?

Specialists and general dentists collaborated on the Dental Implant Safety Workgroup where recommendations for the rule changes started. The 56 hours of hands on clinical implant course work can be completed over many years, giving general dentists a greater opportunity to meet the requirements, even if they did not complete a specialty program.

I have not completed the required 56 hours of hands on clinical implant course(s). Can I continue to provide bone grafts in extraction sites, sinus lift procedures, and periodontal surgical procedures related to implants?

A dentist can continue to perform implant site development procedures related to dental implants, as long as they have the proper training and skill. The quality and type of bone grafts, soft tissue grafts, or other related procedures, are expected to meet clinical standards equivalent to the training standards of a specialist. Complications with implant site development, implant placement, and sinus lift procedure are another frequent area of litigation.

I have completed the required 56 hours of hands on clinical implant course(s). Can I harvest extraoral bone for my implant placement?

Under OAR 818-012-0005(2), only dentists that have successfully completed a CODA-accredited OMS specialty residency may harvest bone extra orally. Additionally, dentists who hold privileges issued by a credentialling committee of a JCAHO-accredited hospital or AAAHC-accredited ambulatory surgical center may harvest bone extra orally in the hospital or ambulatory surgical center setting.

Can I place endosteal implants, transosteal implants, subperiosteal implants, zygomatic implants, interim implants, mini-implants, eposteal implants, or other future technical advancements?

You still need to complete the required 56 hours of hands on clinical course(s) related to surgical implant placement, regardless of the terminology you are using.

What kind of ongoing CE is required once I meet the initial qualification to surgically place implants? Does this CE need to be AGD PACE or ADA CERP approved? Can I complete it online?

A dentist placing endosseous implants must complete at least seven hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. Effective January 1, 2024, you must complete a minimum of seven hours of CE related to surgical placement of implants as set forth in ORS 818-021-0060. The seven hours of CE required for each renewal cycle needs does not necessarily need to be AGD PACE or ADA CERP approved and can be completed online.

I completed a residency in OMS, Periodontics, or Prosthodontics, do I still need to take the CE related to the placement and/or restoration of dental implants every license renewal?

Yes. Seven hours of CE related to the placement and/or restoration of dental implants will also need to be completed every licensure renewal period. The implant placement surgeon is expected to complete ongoing CE every licensure period to stay current with the therapeutic practice of implants.

What information is the dentist placing dental implants required to provide to the patient?

Per the recommendation of the Dental Implant Safety Workgroup, the following rule went into effect on January 1, 2020. The information is requested in investigations involving dental implant complications.

> **OAR 818-12-0070(4) Patient Records**
> (4) When a dental implant is placed the following information must be given to the patient in writing and maintained in the patient record:
> (a) Manufacture brand;
> (b) Design name of implant;
> (c) Diameter and length;
> (d) Lot number;
> (e) Reference number;
> (f) Expiration date;
> (g) Product labeling containing the above information may be used in satisfying this requirement.

What other information might a dentist document when restoring dental implants?

OAR 818-012-0070 (1) (d) requires “Date and description of treatment or services rendered.” This documentation *may* include the prosthodontic procedures performed, such as size, location, type and angulation of the dental implant, size and type of abutment used, type of prosthesis fabricated and materials used, type of connection — screw or cement, and osseointegration status, etc. Laboratory prescriptions and other communications should also be maintained in the patient

record. One should always document the type, quantity, and interpretation of radiographic images, as well as any informed consent, recognized complications, and referral options.

Where can I direct additional questions and/or feedback about the dental implant rule changes?

Any additional questions about the dental implant rule changes can be directed to the OBD by emailing information@obd.oregon.gov or by calling 971-673-3200. The OBD always welcomes feedback from our Licensees, other dental healthcare professionals, and/or members of the public!

Communication from the OBD about new dental implant rules (effective January 1, 2024)

- **Many people are inquiring about the dental implant rule changes. This information is to give you context on their development and need. These rule changes have been under consideration and discussed in public meetings going back to 2018.**

- **Anyone licensed by the Board or up to date on rules should not be surprised or feel there has been limited notice.**

- **OBD staff strive keep all informed of decisions and rules changes that impact safe dentistry in Oregon. Public rulemaking is an open and transparent process.**

- **As a Licensee, you need to stay engaged with the Board and up to date on the Dental Practice Act. There have been over 100 rule changes over the last six years.**

- **The Board's highest priority is the protection of the public, and dental implant complications, failures and harm to patients has been a top safety concern of the Board.**

Background

The OBD investigated 82 dental implants cases between February 2014 and August 2017. Of those cases, 41% resulted in Disciplinary Action, which was equally distributed between specialists and general practitioners. During Strategic Planning in 2016, the OBD identified dental implant complications and the subsequent complaints as a significant problem in Oregon. Dental implant safety was codified in the OBD's 2017-2020 Strategic Plan as a priority issue, and it has remained an ongoing safety concern of the Board through the present. At the April 21, 2017 Board Meeting, in order to effectively protect the public, in accordance with ORS 679.280, the OBD established an ad hoc Committee named the "Dental Implant Safety Workgroup" to research, review, and discuss dental implants, implant complications, and the resulting investigations. The Workgroup's ultimate goal was to advise the OBD on the most effective actions to protect the public and educate dentists regarding dental implants. The Workgroup included OBD Board Members, OBD Staff and Licensees (both specialists and general practitioners).

The Workgroup held its first meeting in September 2017 and held a total of four meetings, with the last meeting taking place in July 2018. The Workgroup invited other interested parties to share their input, and all the meetings were open to the public. The meetings included robust discussion among specialists and general dentists. The passionate and respectful discourse resulted in valuable input from all parties. The Workgroup wrestled with many interesting data points in how to address dental implant complications. The Workgroup's recommendations to the OBD, some of which have already been implemented, and some of which continue to undergo additional refinement, appear below:

- Require a written informed consent form for dental implant placement. The level of detail that should be included in such a form remains under debate.
- Develop the educational requirements/prerequisites for dentists who wish to place implants.
- Develop a plan for "grandfathering in" Licensees with a great deal of experience and success placing and restoring dental implants.
- Require a certain amount of CE pertaining to dental implants be required of Licensees practicing implant dentistry for each renewal cycle.
- Determine whether all licensed dentists will be required to complete a certain amount of CE pertaining to dental implants each renewal cycle.
- Communicate with the Oregon Dental Association regarding developing a set of specific "guidelines" for Oregon licensed dentists practicing implant dentistry.
- Develop a requirement for how important information related to the implant (such as type/ manufacturer) is properly documented and provided to the patient.

The following Board Members, Staff and Oregon dentists served on the Dental Implant Safety Workgroup:

Dr. Gary Underhill: Dr. Julie Ann Smith; Dr. Todd Beck Dr. Paul Kleinstub; Dr. Daniel Blickenstaff Dr. Normund Auzins; Dr. Cyrus Javadi; Dr. James Katancik; Dr. Russell Lieblick; Dr. Donald Nimz; Dr. S. Shane Samy; Dr. Duy Anh Tran

A summary of Communication and updates on public rulemaking for new Dental Implant Rules:

- The OBD 2016-2020 Strategic Plan (approved 8.19.2016) highlighted dental implant failures and complications as a priority issue that the Board should address
- The OBD created the Dental Implant Safety Workgroup (established 4.21.2017) which had four meetings
- Fourth and Final Dental Implant Safety Workgroup Meeting – July 26, 2018, which made recommendations to the Board
- Board Meeting – December 14, 2018 reviewed all recommendations and moved some to the Licensing, Standards and Competency Committee
- Licensing, Standards & Competency Committee Meeting - May 24, 2019 moved recommendations back to the Board
- Board Meeting – August 23, 2019 moved recommendations to the Rules Oversight Committee
- Rules Oversight Committee Meeting – June 18, 2021 moved recommendations back to the Board
- Board Meeting – August 20, 2021 voted to open comment period and hold public rulemaking hearing
- Public Rulemaking Hearing – September 15, 2021
- Public Comment Period – August 31, 2021 to October 8, 2021
- Board Meeting - October 22, 2021 in which the Board reviewed public comments and voted on rule changes. The Board deliberately chose an effective date of July 1, 2022 (*not Jan 1*) to give dentists and others time to get acclimated to the new rules changes and requirements
    - Eblast dates & posted on OBD Website for all these meetings were sent out systematically:
    - 9/1/2021 – Notice of Public Rulemaking Mailed and Emailed
    - 9/9/2021 – Notice of Rule Changes Emailed
    - 1/3/2022 – Rule Changes Emailed
    - 5/9/2022 – Rule Changes Emailed
- Board Meeting – June 17, 2022 – Board voted to change the effective date of the implant rules from July 1, 2022 to January 1, 2024.

If you would like to be added to the list to receive notices of OBD meetings, including public rulemaking hearings, please email information@obd.oregon.gov

CORRESPONDENCE

EMWNLAW

Embry Merritt Womack Nance, PLLC
Chase Tower, 201 E. Main St., Ste. 1402
Lexington, KY 40507

P 859.543.0453
F 800.505.0113
W emwnlaw.com

MEMORANDUM

To: Council of State Governments, National Center for Interstate Compacts
From: Samantha Nance
Date: October 1, 2023
Re: Analysis of AADB Compact

I. Introduction and Background

This memo was drafted to describe critical issues that have been identified in the AADB Dental and Dental Hygiene Compact as proposed by the American Association of Dental Boards (hereinafter, the "AADB Compact"). This Compact is styled as proposed legislation and was reviewed in light of the legal principles governing the creation and operation of interstate compacts and their commissions, and the standards historically applied during judicial review of interstate compact statutes. Current draft version is published at https://aadbcompact.org/wp-content/uploads/2023/09/AADB-Compact-official-draft-Aug-31-final-version-Clean.pdf and it is that language upon which this memorandum's analysis is based.

This review revealed significant legal concerns, ranging from state constitutionality concerns to possible violations of federal antitrust laws. Moreover, the language, style, and overall drafting of the compact fails to enact many best practices in compact drafting that have been identified over the years, yielding a structure that will likely have significant administrative challenges even if adopted. . In short, this Compact, if enacted in its current state, would be materially insufficient to establish an effective interstate compact commission, and it would almost certainly give rise to potentially fatal legal challenges. It is imperative to ensure that a compact is legally and mechanically sound before it is circulated to potential member states. The AADB Compact simply does not meet this standard.

II. Fundamental Legal Concerns

a. Non-Delegation Doctrine Violation

As with most occupational licensure compacts, the AADB Compact provides its compact commission with rulemaking authority. The Supreme Court has repeatedly held that any delegation of legislative (read "rulemaking") authority by a legislature to another entity must be based on some "intelligible principle" to describe the limits of the delegated authority. *J. W. Hampton, Jr. & Co. v. United States*, 276 U.S. 394, 406 (1928) ("In determining what [Congress] may do in seeking assistance from another branch, the extent and character of that assistance must be fixed according to common sense and the inherent necessities of the government co-ordination"); *see also A. L. A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 530 (1935), and *Panama Refining Co. v. Ryan*, 293 U.S. 388, 421 (1935).

The AADB Compact explicitly incorporates the Association by statute, requiring that the commission be organized "within the American Association of Dental Boards," (Section 3(d)), requiring member state dental boards to utilize and accept materials from the AADB's recordkeeping services (Section 4(d)), and requiring member states to accept any continuing education course accredited by the

AADB (Section 4(e)). Further, the definition of "Bylaws" seems to suggest that the Bylaws would be enacted by AADB.

These structural feature are combined with rather broad rulemaking authority: Section 13(a) empowers the Commission to act in any way deemed reasonably necessary to "enforce the provisions and rules of the Compact"; Section 11(a) limits the commission to establishing "reasonable rules in order to effectively and efficiently achieve the purposes of the Compact" but never defines those purposes; Section 11(b) appears to require any proposed rule to include a preliminary determination that the rule is appropriate for the operation of the commission, (Section 8(a) allows the commission to define its own authority by authorizing it to "develop rules for … other provisions as determined by the AADB Compact Commission").

Where a statute does not sufficiently limit the rulemaking authority delegated by the legislature, courts in most states have found that statute to be inconsistent with the separation of powers inherent in their state's constitution. While the specific requirements differ in each state[1], they are all ideologically consistent with the mandate that "important subjects … must be entirely regulated by the legislature itself" while other agencies may be employed only to "act under … general provisions to fill up the details." *Wayman v. Southard*, 23 U.S. 1, 43 (1825). Where a statutory grant of authority amounts to a fundamental delegation of legislative power, that statute is likely to be held to be unconstitutional and invalidated accordingly.

b. Anti-Competitive Concerns and Deficient *Parker* Immunity

Moreover, this grant of authority is given (in part, and in practical effect) to AADB who is a non-governmental, private entity Establishing the commission as "a separate body within the American Association of Dental Boards" immediately recalls the non-delegation concerns described in part (a) above, as this provision suggests that the commission could be subject to the oversight, supervision, or even direct control of the AADB. Given that the commission is empowered to enact rules which have the force of law in the member states, this would appear to allow the AADB itself to exercise legislative authority—possibly even overriding conflicting state statutes. This is blatantly in conflict with the aforementioned nondelegation doctrine.

Further, as the compact creates clear economic advantages for AADB by codifying the organization's position at the exclusion of others, there is a significant risk that the compact itself (or the commission's actions pursuant thereto) would amount to anti-competitive conduct in violation of federal antitrust law. The AADB Compact is particularly vulnerable here, as the broad rulemaking authority granted to the commission and the absence of any government oversight of AADB's operations could likely preclude the AADB from claiming immunity under the state-action doctrine. *See Parker v. Brown*,

[1] See https://www.ncsl.org/about-state-legislatures/separation-of-powers-delegation-of-legislative-power. (Researchers often divide the states into three general groups: the "strict standards and safeguards" category, which permit "delegation of legislative power only if the statute delegating the power provides definite standards or procedures" to which the recipient must adhere; the "loose standards and safeguards" category, which views delegation as acceptable "if the delegating statute includes a general legislative statement of policy or a general rule to guide the recipient in exercising the delegated power."; and the "procedural safeguards" category, which "find[s] delegations of legislative power to be acceptable so long as recipients of the power have adequate procedural safeguards in place.")

317 U.S. 341 (1943) (providing immunity from federal antitrust standards for non-state actors only if: (1) there is a clearly articulated legislative intent to displace competition; and (2) the non-state actors are under active government supervision). Absent such immunity, fundamental features of the AADB Compact Commission's structure are subject to a host of anti-trust challenges and concerns.

To be clear, these concerns are not common to all occupational license compacts, but rather a unique feature of the AADB Compact attempting to vest an inordinate amount of authority in AADB. All of these issues may be properly avoided in a correctly-drafted compact structure, such as that developed in connection with the National Center for Interstate Compacts for Dentists and Dental Hygienists as model compact legislation.

III. Deficient Provisions Relating to Compact Administration

a. Mechanical and Logical Inconsistencies

The AADB Compact contains a host of technical and logical inconsistencies, including but not limited to the inconsistent use of specific terms and drafting errors, and provisions which are simply legal impossibilities. While imprecise legal drafting may be corrected in some circumstances, a draft compact statute is intended to be widely circulated at a national level, and will be closely reviewed by myriad legislators, lawyers, regulators, and other interested professionals; the importance of deliberate and careful drafting simply cannot be overstated. This concern is only amplified when the document is intended to provide a detailed and specific reflection of a complex agreement reached between multiple state governments which will govern the conduct of an independent organization whose membership and scope of authority is intended to ultimately span across the country. Prior to adoption, compact statutes must be as close to identical as possible to reduce the risk of adverse judicial action; after they are enacted, even technical corrections require coordinated efforts across numerous state legislatures and become all but impossible. If the AADB Compact is to be advanced for further consideration, it must undergo substantial and immediate editorial review.

b. Inclusion of AADB Marketing Statements and Value Signals

In addition to the non-delegation and regulatory capture concerns discussed above, the AADB Compact includes several provisions which serve no legal purpose and whose only rhetorical impact is to underscore the value and importance of the AADB itself. See Section 1(i), Section 2(a), Section 2(j). Including such language in a compact statute would enshrine this in state law. Specifically naming private entities in a compact statute creates fundamental mechanical risks for the compact. As legislative creations, interstate compacts and their commissions can persist for many years, and the continued existence and operation of the AADB should not be tethered to statutory law. Best practices in statutory draft of compacts dictates that the statutes should be drafted so that the Compact and its commission, can continue to exist and operate regardless of whether the AADB (or any specific, private entity) continues to exist and operate as it currently does. The current form of the AADB Compact would be essentially nullified if the AADB were to cease to exist, reorganize, divide operations, or even simply cease providing certain business functions. States cannot rely upon a licensure scheme that requires the existence of a particular private entity to maintain status quo in order for the statute to function.

c. Rigidity of Compact Participation

It is noted that the AADB Compact has extremely narrow requirements for Compact participation—for participation, a dentist or dental hygienist must have never been convicted, received adjudication, deferred adjudication, community supervision or deferred disposition for **any** offense by a court of appropriate jurisdiction and further must have never been a subject of discipline by a board through **any** adverse action, order or other restriction of the licensee by the board with the exception of failure to pay fees or failure to complete continuing education. While this is included under the auspices of public protection, this narrow approach to compact participation both (a) degrades the overall value to states and practitioners by excluding a large swath of otherwise qualified participants and (b) is extremely divergent from state law trends in more flexible treatment of individuals with prior offenses.

d. Compact Model

Finally, the "letter of approval" model is one that has less utility than a compact privilege structure for this occupation. The burden on states in such a model is that it is much more expensive to administer and can result in delay of administration for Licensees. All features of this model that address public protection concerns (attestation of the licensee's primary state of residence as to the primary source verification, background checks, and the sharing of information regarding adverse actions and the existence of a pending investigation) are addressed under the compact privilege model, with the advantage of being less expensive and more streamlined for states to administer. In short, the privilege model of practice developed for the DDH Compact with NCIC is more appropriate for the current demands of the profession.

IV. Conclusion

The current draft of the AADB Compact is largely inconsistent with established jurisprudence regarding the operation of interstate compacts and its structure includes several significant legal deficiencies. The specific references to non-government entities create ethical and legal risks to the commission's ongoing operations, and the compact's structure would grant largely unchecked legislative authority the commission and possibly to the AADB itself while providing no public accountability or safeguards. Most notably, none of these issues inherently arise from the desire to utilize the AADB's services to facilitate the functioning of the compact and the commission, but rather from the manner in which this compact seeks to accomplish that objective. It is simply essential that discretion and authority under a compact are vested in an independent commission that is responsible fully and solely to its members, and no others. For those reasons, the AADB Compact should be rejected by state legislatures as a flawed and defective model legislation.

DDH Dentist and Dental Hygienist Compact

For the past two years, The Council of State Governments (CSG) has facilitated the development process for the Dentist and Dental Hygienist Compact (DDH Compact) in partnership with the American Dental Association (ADA), American Dental Hygienists' Association (ADHA), and other industry stakeholders. The compact will increase mobility and multistate practice for licensed dentists and dental hygienists while preserving state sovereignty and public protection.

The American Association of Dental Boards (AADB) chose not to engage with CSG during the development process and instead focused their efforts on repeatedly mischaracterizing the goals and function of the DDH Compact. These comments go far beyond a simple misunderstanding of the Compact and appear instead to be a deliberate disinformation campaign.

AADB has now drafted alternative compact language (the AADB Compact) which was drafted in less than three months with no public input. The AADB Compact is materially insufficient and likely to give rise to legal challenges. It is imperative to ensure that a compact is legally and mechanically sound before it is circulated to potential member states. The AADB Compact simply does not meet this standard.

Significant Distinctions Between DDH Compact and AADB Compact

	DDH Compact	AADB Compact
Compact Model	Employs compact privilege model which authorizes practice in a remote state in a streamlined, cost-efficient manner without requiring the practitioner to obtain a license.	Modeled after medical compact. Compact issues licenses to practitioners in an expedited manner. Licensees practicing in multiple states are still required to maintain multiple licenses. IMLC costs $700 for each use. This would be cost-prohibitive for many practitioners.
Clinical Assessment	Preserves state sovereignty by allowing multiple clinical examination pathways	ADEX exam required exclusively (licensees who passed another regional "psychomotor" exam prior to January 1, 2024 are grandfathered). All new dentists and dental hygienists would be required to pass the ADEX exam.
License/Criminal History Restrictions	No restrictions based on criminal history. Background check is required, but licensure decisions are left to states.	Ban on anyone who has ever had their licensed disciplined (other than CE violations) or been convicted of any crime regardless of the offense.
Governance	Governed and administered a commission made up of the member states. The commission is an instrumentality of the member states.	Named "AADB Compact". The commission is housed within AADB exclusively. The compact commission is an instrumentality of AADB, not states.

DDH Dentist and Dental Hygienist Compact

Key Points of Emphasis[1]

- **Constitutionality:** Conflicts with many state constitutions due to violation of non-delegation principles (a state delegating their legislative authority to another entity, namely AADB).

- **Compact Model:** The AADB Compact is modeled after the Interstate Medical Licensure Compact (IMLC) which creates an expedited path to obtaining a physician license. The IMLC still requires the physician to maintain multiple licenses if the physician is practicing in multiple states (maintenance of continuing education, renewal fees, etc.). The DDH Compact authorizes practice in other member states without the need for obtaining multiple licenses. All features of the IMLC that address public protection concerns (primary source verification, background checks, and the sharing of information regarding adverse actions and the existence of a pending investigation) are addressed under the compact privilege model, with the advantage of being less expensive for the licensee and more streamlined for states to administer.

- **Anti-Competitive Concerns:** The AADB Compact creates clear economic advantages for AADB, CDCA-WREB-CITA, and the ADEX exam by codifying their status in the compact at the exclusion of others.

- **Limiting Mobility by Requiring ADEX Exam:** New dentists and dental hygienists (practicing under 5 years) who took an exam other than ADEX, or any dentist who took the DLOSCE or completed a PGY-1 are excluded from participating and would be forced to re-examine if they wanted to utilize the compact. The AADB Compact reduces mobility for these dentists.

- **Naming AADB in Statutory Language:** The continued existence and operation of the AADB should not be tethered to statutory law. The Compact and its commission should continue to exist and operate regardless of whether the AADB continues to exist and operate as it currently does. The current form of the AADB Compact would be essentially nullified if the AADB were to cease to exist, reorganize, divide operations, or even simply cease providing certain business functions.

- **Rigidity of Compact's Eligibility Requirements Related to Criminal/License Discipline History:** The AADB Compact bans any licensee who has ever had their license disciplined by a dental board or any licensee who has ever had a criminal conviction of any kind. This diverges from state policy trends in more flexible treatment of individuals with prior offenses.

For these reasons, the AADB Compact should be rejected by state legislatures as flawed and defective model legislation.

---

[1] See link for full legal analysis on these points.

WILSONVILLE
DENTAL GROUP
Compassion • Integrity • Excellence

TERRENCE A CLARK, DMD, FAGD | THOMAS E CLARK, DMD | QUINN WALKER, DDS

October 31, 2023

Oregon Board of Dentistry
1500 SW 1st Ave, Suite #770
Portland, OR 97201

Dear Oregon Board of Dentistry,

I'm writing to ask you to consider adding language in the dental practice act for EFDA dental assistants to remove or reinsert implant healing abutments, screws, and impression copings, and to fit check final restorations under the dentist's indirect supervision. Like other final restorative procedures, final restorations would of course need to be verified with final torquing to be performed by a dentist. I see language regarding hygienists removing healing abutments and inserting impression abutments, but I can find nothing regarding assistants performing the same task.

Dental assistants seem well suited to this task, more so than hygienists, as they already remove temporary crowns and insert final crowns for verification by a dentist. Risk of aspiration of implant components does not seem any greater than for standard crowns. I am hard pressed to think of a good reason why this could not be part of the approved job description of an assistant.

Would the board please discuss this and consider modifying 818-042-0070 to include language that allows EFDA dental assistants to remove healing abutments, place/remove impression abutments, and perform initial fit check for final implant crowns, under the indirect supervision of a dentist? Thank you for your kind consideration.

Respectfully,

Thomas E. Clark DMD

Wilsonville Dental Group • 29292 SW Town Center Loop E, Suite A • Wilsonville, OR 97070
Office: (503) 682-0431 • Fax: (503) 682-3873 • www.wilsonvilledental.com

818-042-0070
Expanded Function Dental Assistants (EFDA)

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:

(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge;

(2) Remove temporary crowns for final cementation and clean teeth for final cementation;

(3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;

(4) Place temporary restorative material in teeth providing that the patient is checked by a dentist before and after the procedure is performed;

(5) Place and remove matrix retainers for any type of direct restorations;

(6) Polish amalgam or composite surfaces with a slow speed hand piece;

(7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;

(8) Fabricate temporary crowns, and fixed partial dentures (bridges) and temporarily cement the temporary crown or fixed partial dentures (bridges). The cemented crown or fixed partial dentures (bridge) must be examined and approved by the dentist prior to the patient being released;

(9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

Statutory/Other Authority: ORS 679 & 680
Statutes/Other Implemented: ORS 679.020, 679.025 & 679.250

PLUMLEE Samantha * OBD

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

---

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

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

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

Sincerely,
Bonnie Marshall
503.209.8450

ATTACHMENT 1 - PROPOSED CURRICULUM CHANGES

OREGON BOARD OF DENTISTRY
BOARD APPROVED COURSE IN PLCEMENT OF PIT AND FISSURE SEALANTS

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

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

INTRODUCTION
Board of Dentistry Administrative Rule 818-042-0090 allows Expanded Function Dental Assistant (EFDA)s) to place sealants under the following circumstances:

"Upon successful completion of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may apply pit and fissure sealants under the indirect supervision of a dentist providing the patient is examined before the sealants The sealants must be placed within 45 days of the procedure being authorized by a dentist and the sealants must be checked by a dentist prior to the patient's dismissal. "

"Indirect Supervision" means supervision requiring that the dentist authorize the procedure and a dentist be on the premises when the procedures are performed. (ORS 679.010 (9))

The Board approved course should offer instruction on the purpose, techniques and safety considerations of sealant placement and the Expanded Function Dental Assistant's role as the operator under indirect supervision of the dentist.

PREREQUISITIES
1) The attendee must be an Oregon Expanded Function Dental Assistant.
2) The attendees must provide a copy of their EFDA certification with course registration.
3) A dentist must have signed the prescription form no more than 45 days prior to the placement of the pit and fissure sealants. (OAR 818-42-0090)

SUGGESTED TEXTS
Finkbeiner and Johnson, Comprehensive Dental Assisting: Mosby ~~Torres and Ehrlich~~ Bird and Robinson, Modern Dental Assisting, ~~5th edition, Sauders or~~, 12th edition, Elsevier or, any text used by Dental Hygiene or Dental Assisting Programs.

COURSE FORMAT

This course should be presented in a 3-part lecture/lab/clinic format and should be completed within four (4 months. All tests, labs, and clinic forms should be transmitted to the instructor within four (4) months to receive a certificate of completion.

LECTURE

The lecture/didactic portion of this course can be presented either in person or through a webinar or a zoom presentation by the board approved instructor.

To include the following regarding purpose, techniques, and safety issues for placement of sealants:

1) OAR Div. 42 rule regarding placement of sealants by an EFDA
2) Patient health history review
    a. Is the history current
    b. Noted allergies.
    c. Medications
    d. Other health considerations
3) Infection control issues
    a. Principles of disease transmission
    b. Need for safety glasses for the patient.
    c. Universal precautions
4) OSHA regulations
    a. Operator injury
    b. Spill cleanup
5) Use of dental equipment and instruments
    a. Use of appropriate fulcrum
    b. Intra-oral use of hand-mirror
6) Use of slow speed handpiece
    a. Use of rheostat
    b. Maintaining appropriate rpms
7) Indications/Contraindications for sealant placement
    a. Radiograph review
    b. Age of patient
    c. History of decay occurrence
8) Appropriate technique
    a. Maintaining a dry environment
9) Materials
    a. Light cured.
    b. Resin-based
    c. Glass ionomer
    d. Chemically cured
10) Tray set up and armamentarium.
11) Terminology
12) Current and future trends

Written Exam:

Class participants must take a 25 question, multiple choice exam with a minimum passing score of 80%prior to commencing the lab portion of the course.

If the EFDA dental assistant is enrolled in a webinar or zoom class, the instructor must maintain and record of the successful passage of the exam for the attendee to continue with the in-office lab work.

Lab:

Attendees should be provided with knowledge and skills to perform pit and fissure sealants on two extracted molars or premolars. The following criteria and instruction apply to the EFDA dental assistant enrolled in a webinar or zoom class:

1) The instructor must provide a video and zoom instructions (performance criteria) prior to the lab work.
2) The office that the EFDA dental assistant is employed by must record and document the successful accomplishment of the pit and fissure sealant placement on two extracted molars or premolars, under direct supervision, prior to moving on to the clinical portion of the course. The evaluation must be done by the dentist of record, the hygienist of record or a certified sealant dental assistant and transmitted to the instructor of record. (Attachment #1)

Clinical:

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

1) The dentist of record, the hygienist of record or certified sealant dental assistant will work directly with the EFDA dental assistant to accomplish the successful completion of the in-office clinical portion of the class.
    a. The EFDA dental assistant must successfully place ten (10) sealants under direct supervision of the dentist of record, hygienist of record or a certified sealant dental assistant.
2) Upon completion of the form (attachment 2), the form must be transmitted to the class instructor with a copy of the dentist of record, hygienist of record, or a certified sealant dental assistant license.
3) Upon receiving the forms, the instructor will review the documentation and transmit the Sealant Certificate to the attendee of the class.
4) The instructor will maintain records of documentations for 5 years.

Intent:

Upon approval of the changes to previous approved “Pit and Fissure Sealants” course, I, Bonnie Marshall, intend to work closely with the Oregon Dental Assistants Association to offer this class throughout the State of Oregon.

Rational:

This class will offer EFDA dental assistants the opportunity to accomplish their Sealant class wherever they are employed in the state without the need to travel and will allow dentists, offices, and patients to benefit from their successful completion of the course.

ATTACHMENT 2 - CURRENTLY APPROVED CURRICULUM

OREGON BOARD OF DENTISTRY

BOARD APPROVED COURSE IN PLACEMENT OF PIT AND FISSURE SEALANTS

INTRODUCTION

Board of Dentistry Administrative Rule 818-042-0090 allows Expanded Function Dental Assistants (EFDAs) to place sealants under the following circumstances:

"Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may apply pit and fissure sealants under the indirect supervision of a dentist providing the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist and the sealants must be checked by a dentist prior to the patient's dismissal."

"Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. (ORS 679.010 (9))

This Board approved course should offer instruction on the purpose, techniques and safety considerations of sealant placement and the Expanded Function Dental Assistant's role as the operator under indirect supervision of the dentist.

PREREQUISITES

1) The attendee must be an Oregon Expanded Function Dental Assistant.
2) The attendee must provide a copy of their EFDA certification with course registration.
3) A dentist must have signed the prescription form no more than 45 days prior to the placement of the pit and fissure sealants. (OAR 818-042-0090)

SUGGESTED TEXTS

Finkbeiner and Johnson, Comprehensive Dental Assisting; Mosby Torres and Ehrlich, Modern Dental Assisting; fifth edition, Saunders or, any text used by accredited Dental Hygiene or Dental Assisting programs

COURSE FORMAT

The course should be presented in a 3-part lecture/lab/clinic format for a total of at least six (6) hours.

Lecture: To include the following in regards to purpose, techniques and safety issues for placement of sealants:

1) OAR Div. 42 rule regarding placement of sealants by an EFDA
2) Patient health history review
   - ✓ is the history current
   - ✓ noted allergies
   - ✓ medications
   - ✓ other health considerations
3) Infection control issues
   - ✓ principles of disease transmission
   - ✓ need for safety glasses for the patient
   - ✓ universal precautions
4) OSHA regulations
   - ✓ operator injury

- ✓ spill cleanup

5) Use of dental equipment and instruments
   - ✓ use of appropriate fulcrum
   - ✓ intra-oral use of hand mirror
6) Use of slow speed handpiece
   - ✓ use of rheostat
   - ✓ maintaining appropriate rpms
7) Indications/Contraindications for sealant placement
   - ✓ radiograph review
   - ✓ age of patient
   - ✓ history of decay occurrence
8) Appropriate technique
   - ✓ maintaining a dry environment
9) Materials
   - ✓ light cured
   - ✓ chemically cured
10) Tray set up and armamentarium
11) Terminology
12) Current and future trends

Written Exam: Class participants must take a 25 question, multiple choice exam with a minimum passing score of 80% prior to commencing the lab portion of the course.

Lab: Attendees should be provided with knowledge and skills to perform pit and fissure sealants on two extracted molars or premolars. This laboratory work must be evaluated by the instructor and successfully accomplished before moving on to the clinical portion of the course.

Clinical: Attendees shall successfully place sealants on at least two fully erupted molars or premolars teeth on a patient in accordance with the dentist's prescription (Attachment 1). An evaluation of the sealants must be made by an Oregon licensed dentist (Attachment 1) prior to the dismissal of the patient.

INSTRUCTOR QUALIFICATIONS

Instructors of this Board approved course in sealant placement should have background in, and current knowledge of, dental pit and fissure sealants, **and be**

- ✓ A Dentist licensed in Oregon, or

- ✓ A Dental Hygienist licensed in Oregon who has completed a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Oregon Board of Dentistry, or

- ✓ A Dental Assistant who:
  1. holds an Oregon Expanded Function Dental Assistant certificate issued by the Dental Assisting National Board;
  2. has successfully completed a course of instruction in placement of sealants given by either an ADA accredited program or a Board approved course; and
  3. shows proof of having placed sealants on not less than ten (10) patients and on not less than twenty-five (25) teeth. (Attachment 3)

Instructor application forms are attached (Attachments 2 and 3).

ATTACHMENT 1

PRESCRIPTION FOR PLACEMENT OF PIT AND FISSURE SEALANTS

I,_____DMD/DDS have examined the patient _____on _____and find the patient to be in need of the protection offered by the placement of pit and fissure sealants. I hereby prescribe that _____place sealant material on the following tooth surfaces: (must be at least two molars or premolars)

_____.

_____
(Signature)

I,_____DMD/DDS hereby certify that_____has successfully placed sealants on teeth #s_____on the above named patient.

Dated: _____ Signed: _____

This document must be returned to the prescribing dentist for placement in the patient's chart.

ATTACHMENT 2

Rev. 2141

Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395
(971) 673-3200

APPLICATION FOR APPROVAL AS INSTRUCTOR
IN PIT AND FISSURE SEALANTS
Instructor Permit Fee $40.00

NAME OF PERSON(S) CONDUCTING COURSE:
(NAME OF SCHOOL, IF APPLICABLE)

_____

_____

MAILING ADDRESS: _____

City _____ State _____ Zip _____

Phone _____ Email _____

(Please provide contact information that is approved for public use, as this will appear on the list of Board-approved instructors and is widely distributed. Dental assistants in search of an instructor may contact you to inquire about taking your course.)

LIST QUALIFICATIONS BELOW AND SUBMIT COPIES OF CURRENT LICENSES AND/OR CERTIFICATES THAT APPLY:

_____
_____
_____

I certify this application is correct and agree to teach the course according to the outline provided, and as approved by the Board.

_____ _____
Date Signature

INSTRUCTOR QUALIFICATIONS:

Instructors should have background in and current knowledge of pit and fissure sealants and must be either a Dentist with an Oregon license; or

A Dental Hygienist licensed in Oregon who has completed a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Oregon Board of Dentistry on pit and fissure sealants (818-035-0040); or

A Dental Assistant certified by the Dental Assisting National Board, Inc., as a current Oregon “EFDA” who has successfully completed a course of instruction approved by the Oregon Board of Dentistry on pit and fissure sealants and shows proof of having successfully placed sealants on not less than ten (10) patients and on not less than twenty-five (25) teeth (Attachment 3).

ATTACHMENT 3

VERIFICATION OF PLACEMENT
OF PIT AND FISSURE SEALANTS
FOR INSTRUCTOR APPLICATION

EMPLOYER/DENTIST

Name _____

Address _____

City _____ State _____Zip _____ Telephone _____

I hereby certify that _____
(Assistant's Name)

has successfully performed _____ sealants on _____ patients.

_____ _____
Date Dental Assistant's Signature

_____ _____
Date Dentist's Signature

(Use more than one form if necessary)

OTHER ISSUES

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

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
Fax: 971-673-0231
www.healthoregon.org/dpp

AGENDA

Dental Pilot Project #300 "Dental Therapist Project: Dental Hygiene Model"

Advisory Committee Meeting DPP #300

November 6, 2023
9:00am – 10:30am

Location: Remote meeting via MS Teams.
Link to MS Teams Meeting

Call in option: 971-277-2343 **Meeting ID:** 343 842 93#

9:00-9:05	Agenda Review, Meeting Review	Sarah Kowalski, MS, RDH Dental Pilot Project Program Coordinator
9:05-9:15	Official Introductions	Sarah Kowalski, MS, RDH
9:15-9:20	Dental Pilot Project #300 Updates	Shannon English, DDS Dental Pilot Project #300
9:20-9:30	Dental Therapist Credentialing Requirements, Claims Processes	Jessica Dusek, Policy Analyst, Health Systems Division, Oregon Health Authority
9:30-9:45	Q&A, Feedback	Advisory Committee, Invited Guests Oregon Health Authority
9:45-10:20	Update from Dental Therapist Trainees and Supervising Dentists	Dental Therapist Trainees and Supervising Dentists from DPP#300
10:20-10:25	Follow Up Items, Future Meeting Dates, Site Visit	Sarah Kowalski, MS, RDH
10:25-10:30	Public Comment Period	Public comments are limited to 2 minutes per individual; Public comments are accepted via in-person oral testimony or submission of written comments via email to oral.health@state.or.us or US Mail.

Next Meeting: TBD

DT Pilot Project #300 Advisory Committee

Dental Therapists:
Outcome data for tracking measurements

November 2, 2023

Oregon Health Authority

House Bill 2528 (Oregon Legislative Assembly 2021)

SECTION 10.

(3) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority rule, or patients located in dental care health professional shortage areas, as determined by the authority.

Capturing Outcomes for Provider-Type Sustainability

OHA needs a process to measure outcomes for:

HB 2528 compliance

Demonstrating long-term impacts

- Provider
- Patient populations

Analyzing cost-effectiveness

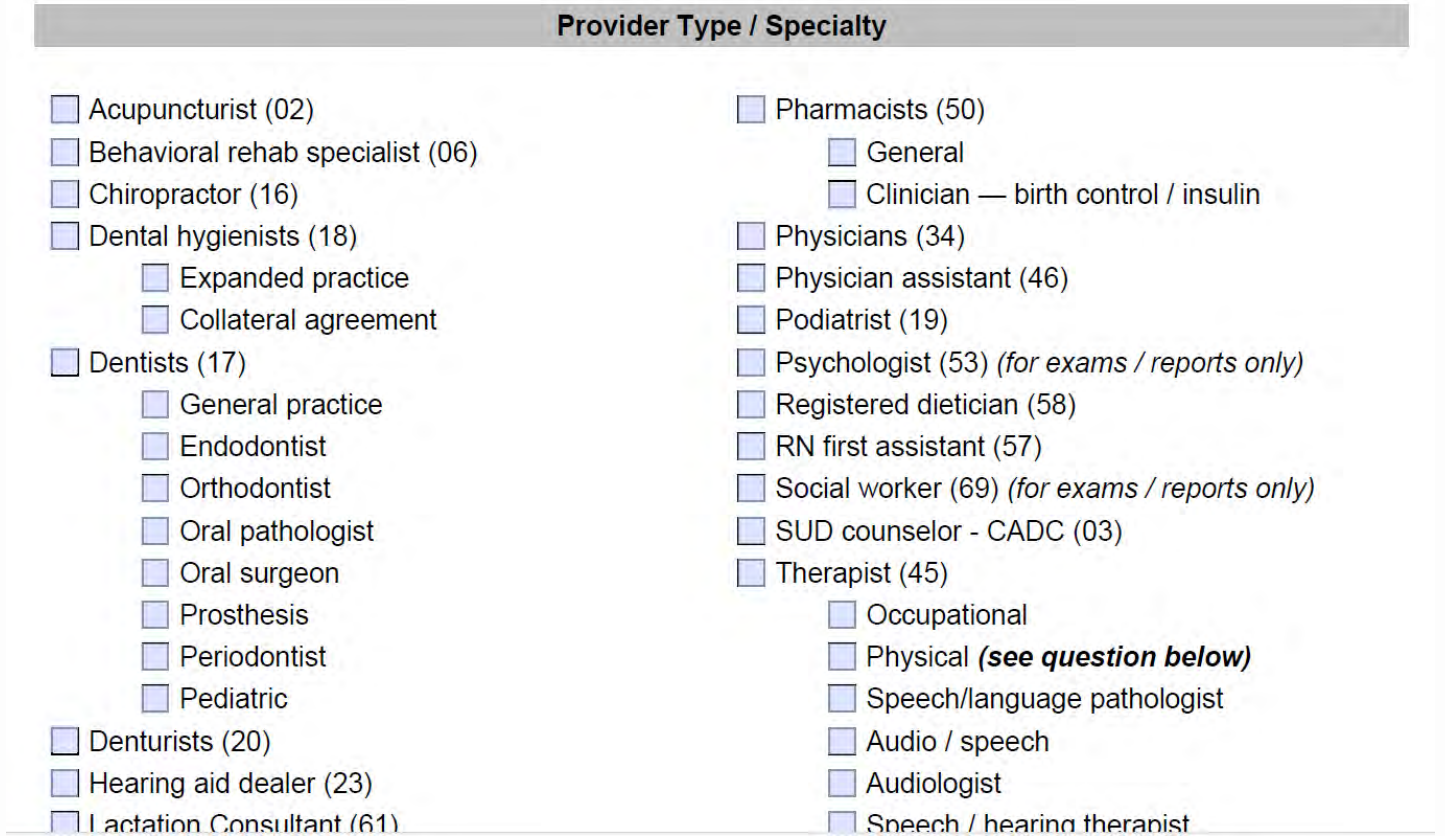
Current process does not support tracking

Barriers and issues to tracking DT outcomes:

- Credentialed Provider Type different than “Dental Therapist”
- DTs not being listed as the Rendering Provider on claims
- Not having a DMAP number

Provider Type/Specialty pending update

Dental Therapist is not a selection option as Dentist (17) Specialty Type



Using Minnesota as a program model

In 2009, Minnesota became the first state government in the U.S. to authorize the licensing of dental therapists.

Minnesota's law created two levels of dental therapist practice

- Dental Therapist
- Advanced Dental Therapist

These providers are required to primarily serve low–income, uninsured and underserved patients, or practice in a dental health professional shortage areas.

Dental Therapists and Advanced Dental Therapists play a key role in increasing access to dental care and preventing emergency room visits for dental–related problems.

Using Minnesota as a program model

- All DTs providing services for Minnesota Health Care Programs must enroll and be identified as the treating provider on claims.

- DTs providing services to members in a managed care organization (MCO) must contact the MCO directly for enrollment requirements and coverage policy.

Website link: Minnesota Health Care Program Dental Therapist (DT) Overview

Q & A and discussion

2022
Oregon's Licensed Health Care Workforce Supply

Based on data collected from 2014 through January 2022

January 2023
Oregon Health Authority
Office of Health Analytics

Oregon Health Authority

Health Care Workforce Reporting Program

Contents

Executive Summary

Findings

Supplemental Material

About the data in this report

Oregon's Health Care Workforce Reporting Program (HWRP) was created in 2009. As directed by Oregon Revised Statute 676.410, the HWRP collects and tabulates information from licensees of 17 health licensing boards upon license renewal. This report builds on previous reports by presenting data collected from licensed workers between January 2020—January 2022.

Some of the data in this report was collected during the COVID-19 pandemic of 2020-2022. At this time, it is unclear how the pandemic impacted the composition of the licensed health care workforce supply in Oregon.

Executive Summary

Report Objectives

This report on Oregon's licensed health care workforce aims to answer the following questions:

- How many professionals are licensed and practicing in Oregon?
- How much of practicing professionals' time is spent with patients?
- Which counties are professionals working in and how many professionals are there relative to the population?
- How many professionals specialize in primary care, behavioral health and oral health?

Why is it Important to Measure Health Care Workforce Supply?

The health care workforce is a large contributor to the economy.

Understanding the supply of the licensed health care workforce in Oregon is essential in informing evidence-based policy decisions about health care access, cost and quality. Additionally, health care workforce supply has serious implications for the broader state economy.[1] The health care sector is the largest employer in the United States, with employment in health care occupations expected to increase 13 percent from 2021 to 2031.[2] Nationally, about 1 in 8 people who are employed work as health care professionals or within a health system, with similar rates reported in Oregon.[3,4,5] Historically, jobs in health care have been relatively resilient in times of recession[6] and are good opportunities for improving social class, particularly for women.[1] The health care industry pivots on its workforce, with labor costs comprising about 50 percent of health care spending in the United States.[7,8] At the same time, increased shortages of health care professionals are predicted due to the health care demands of aging populations and increases in chronic diseases.[9-15]

Demands on health care are increasing in Oregon.

Over the next decade, the population of people 65 years of age and older will likely grow at over 3 times the rate of the population 64 years and younger.[16] Currently, just over half of the population has one or more chronic condition.[17] At the same time, more Oregonians had insurance coverage in 2021 at 95.4 percent compared with the national average of 90.8 percent.[18,19]

The COVID-19 pandemic has put unprecedented strain on the health care workforce.

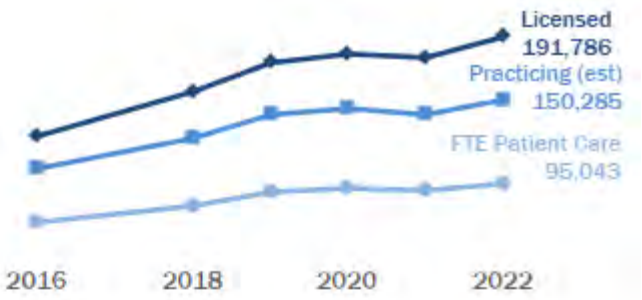
While the full impact of the COVID-19 pandemic on supply and care delivery is not yet fully understood, it is clear that the pandemic has put unprecedented strain on the health care workforce at both the institutional and individual level.[20, 21] Many components of the educational and training pipeline for health care professionals were disrupted by the pandemic — for instance, the Oregon Center for Nursing reported difficulties with nursing students completing clinical rotations in 2020.[22] Currently practicing professionals also faced excess pressures, often dealing with challenges to both mental and physical health.[23,24] Future reports will continue to describe and assess the consequences of the COVID-19 pandemic on the licensed health care workforce supply.

Explore these data and learn more:
Oregon's Licensed Health Care Workforce Supply Dashboard

Key Insights

Data from nearly 192,000 licensed health care professionals are included in this report.

Three important supply numbers are provided, including 1) number of licensed providers, 2) estimated number of actively practicing providers and 3) estimated full-time equivalent (FTE) providers of direct patient care (page 5).

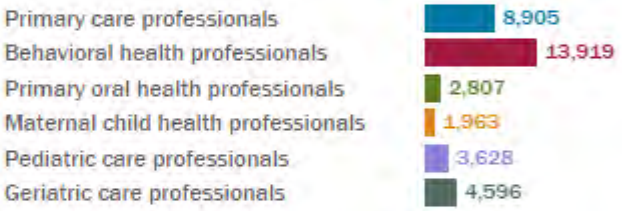


Direct patient care FTE has increased between 2020 and 2022 for some occupations but not others.

Growth in direct patient care FTE was greatest for counselors and therapists, clinical social work associates, nurse practitioners, and physician assistants (page 7). Clinical nurse specialists, licensed massage therapists, certified registered nurse anesthetists and pharmacists lost the most direct patient care FTE on average.

Licensed behavioral health professionals were the largest specialty group with 13,919 licensees actively practicing.

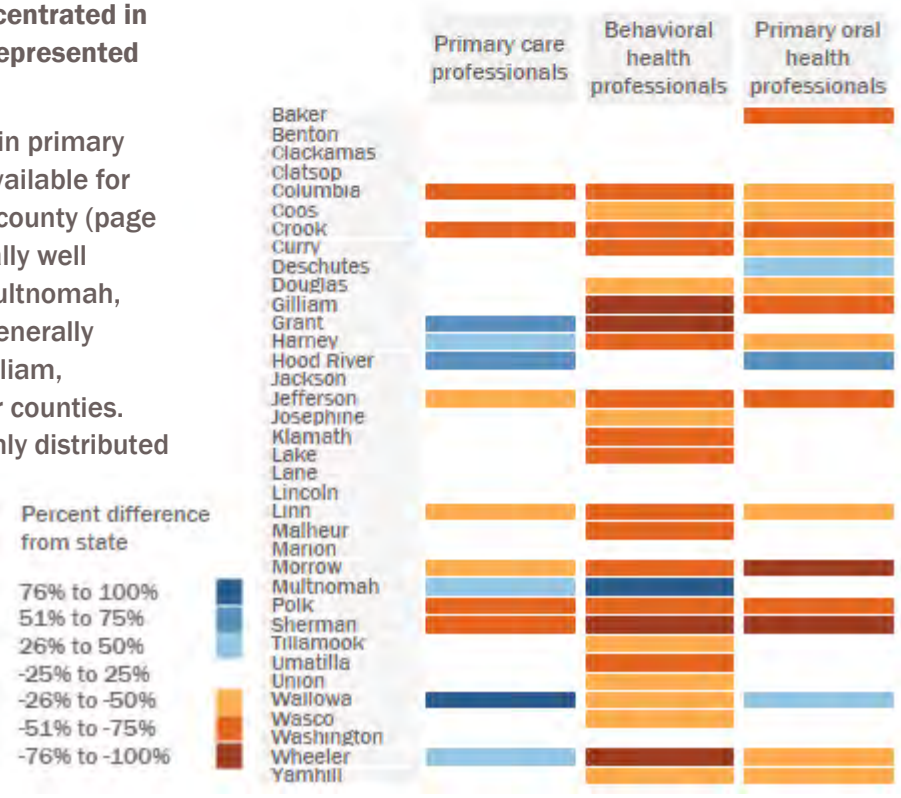
Other specialty groups include primary care, oral health, maternal child health, pediatric care and geriatric care professionals (page 9).



Behavioral health professionals are concentrated in Multnomah county and relatively underrepresented throughout the rest of the state.

The number of health care professionals in primary care, behavioral health and oral health available for every 1,000 Oregonians was mapped by county (page 10). Health care professionals are generally well represented in Deschutes, Hood River, Multnomah, Wallowa and Washington counties and generally underrepresented in Columbia, Crook, Gilliam, Jefferson, Morrow, Sherman and Wheeler counties. Primary care professionals are more evenly distributed throughout the state compared with behavioral and oral health professionals.

Orange colors indicate that the county supply is less than supply statewide. Blue colors indicate that the county supply is higher than supply statewide. In both cases, the darker the color the larger the difference.



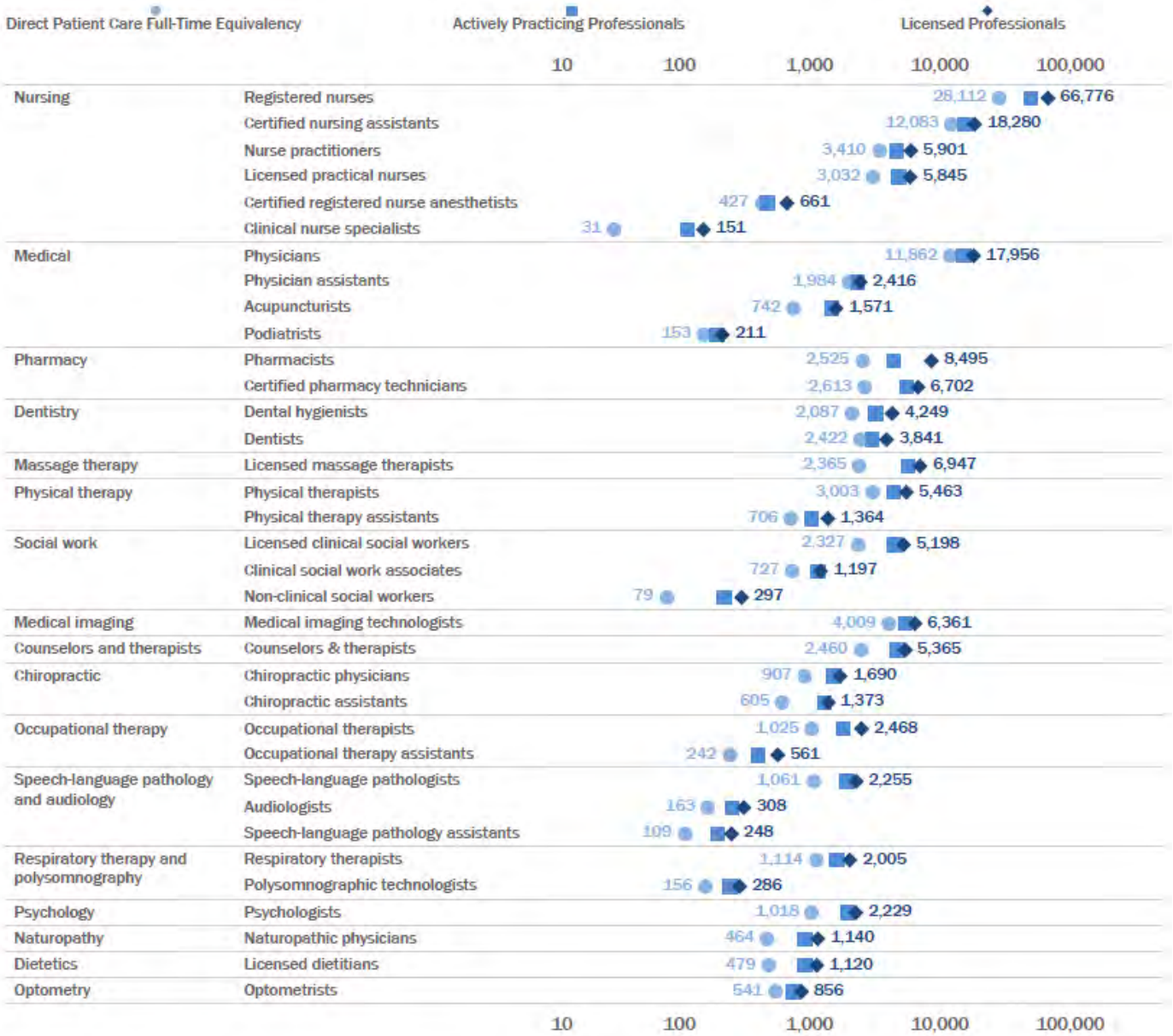
Findings

Supply Estimates for Licensed Health Care Professionals

This analysis takes in a wide range of occupations and includes licensees practicing physical health, behavioral health and allied health care occupations. The nursing workforce is by far the largest group with 97,614 licensed professionals, followed by the medical, pharmacy and dentistry groups.

Because the number of hours worked per week and the amount of time spent in patient care varies by profession, direct patient care full-time equivalent (FTE) is estimated from the number of licensed and actively practicing professionals, with 1 FTE equal to 40 hours per week of direct patient care. Knowing the number of licensed and actively practicing professionals helps us to understand the potential capacity of the workforce, while examining FTE provides information on the supply of licensed professionals currently available to provide health care to the Oregon population.

For example, there were 66,776 registered nurses (RNs) holding an active license in Oregon in 2022. Of those licensed, an estimated 49,501 RNs were actively practicing, meaning they reported providing services to Oregon residents. Of all actively practicing RNs, there were an estimated 28,112 FTE providers of direct patient care.



Supply Estimates Over Time by Occupation and Workforce

The number of hours worked per week and the amount of time spent in direct patient care are practice characteristics that vary by occupation, workforce and year affecting supply estimates over time. For example, optometrists who held an active license in Oregon in 2022 actively practiced in Oregon at a higher average rate (87 percent; 742 actively practiced of 856 licensed) compared with pharmacists (51 percent; 4,343 actively practiced of 8,495 licensed).

This active practice rate varies between occupations and also by year. For dentists, this rate remains relatively steady over time while for nurse practitioners, the rate seems to be decreasing slightly over time. In terms of time spent in direct patient care, physicians spend more time in direct patient care on average (79 percent of time or 11,862 FTE from 14,956 who actively practiced) compared with psychologists (53 percent of time or 1,018 FTE from 1,928 who actively practiced). Occupational therapists, pharmacists, counselors and therapists spend about 50 to 60 percent of time in direct patient care on average. Professionals can also report spending time in administration and management, teaching, doing research or some other activity.

More information about these graphs

When assessing the supply of the health care workforce, it is essential to understand how factors like practice characteristics and license renewal cycles impact supply estimates and longitudinal trends. Importantly, these factors often vary by occupation. Longitudinal trends are affected by changes in Health Care Workforce Reporting Program methodology, duration of participation in the program by health licensing boards and differing renewal cycles.

For some occupations, the number of licensed professionals is available 2010 and onward while other occupations are only included 2018 or 2019 and onward. Reliable estimates for actively practicing and direct patient care FTE are available for 2016 and onward where the number of licensed professionals is known.

Licensing boards have either annual or biennial renewal cycles and supply estimates fluctuate for occupations that renew on biennial periodic cycles (pharmacy, occupational therapy, physical therapy, and speech-language pathology and audiology occupations). For those occupations, the number of licensees is higher in renewing years compared with non-renewing years as licensees generally leave the workforce at time of license renewal, which is reflected the following year. Beginning in 2018, supply estimates have been reported annually (instead of biennially).

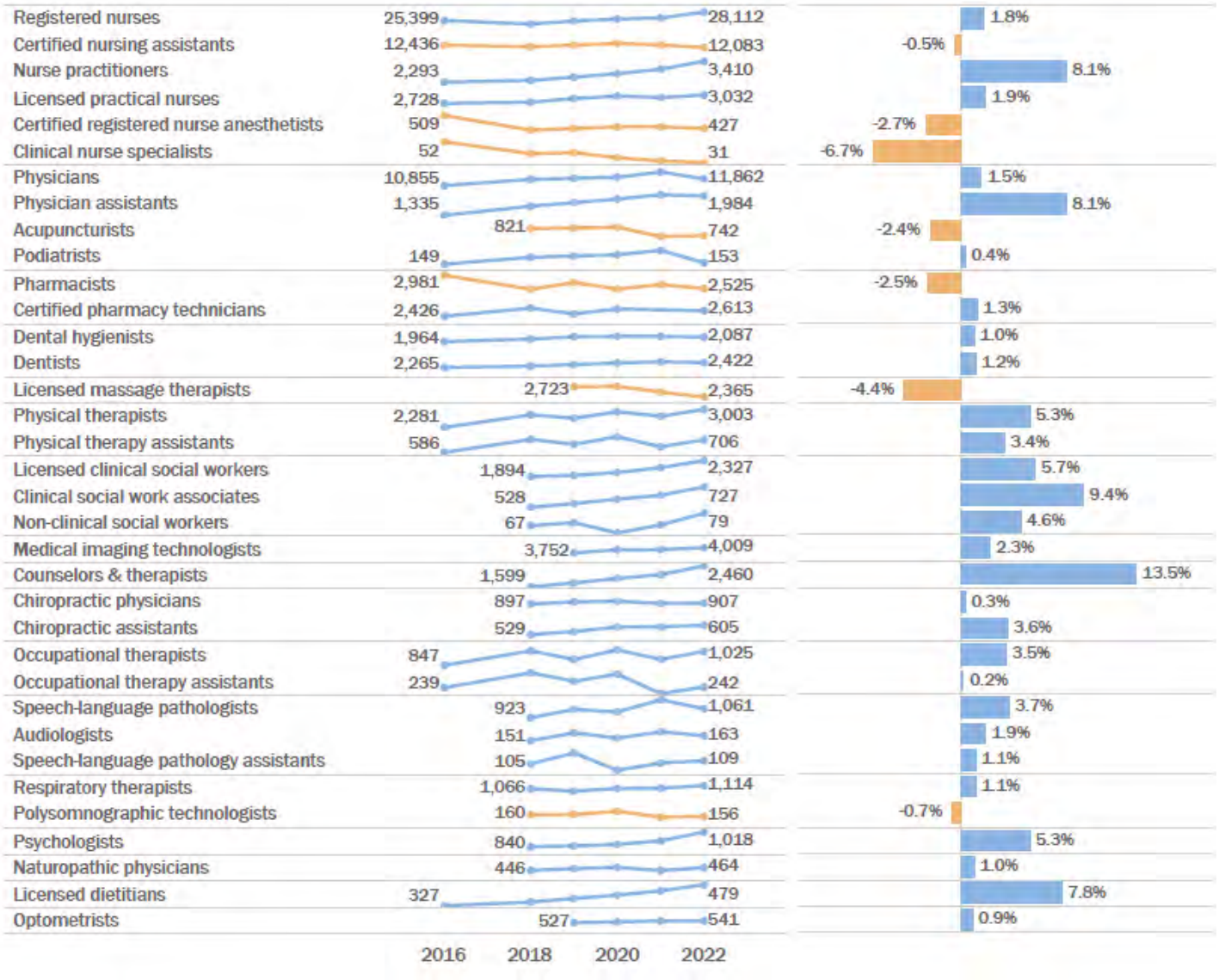
*Note: Estimates for physicians, physician assistants, podiatrists and acupuncturists for 2019 are an average of 2018 and 2020 estimates.

Average Annual Percent Change in Direct Patient Care FTE

As Oregon's population grows, the supply of direct patient care FTE must also grow to ensure continued access to health care professionals. Average annual percent change was calculated as follows:

$$\text{Average annual percent change} = \frac{\left(\frac{\text{last year FTE} - \text{first year FTE}}{\text{first year FTE}}\right)}{\text{\# years}}$$

This change in direct patient care FTE varies by occupation, with some occupations keeping pace with the Oregon population's average annual growth of 0.68 percent during the same time period. Noteworthy growth was observed for physician assistants, counselors and therapists, licensed dietitians, nurse practitioners, physical therapy occupations, and occupational therapy occupations. For advanced practice registered nurses, an 8.1 percent average annual growth for nurse practitioners overshadowed a 6.7 percent average annual decline in clinical nurse specialists and a 2.7 percent average annual decline in certified registered nurse anesthetists. Note that vertical axes are independent for each occupation and may not be directly comparable.

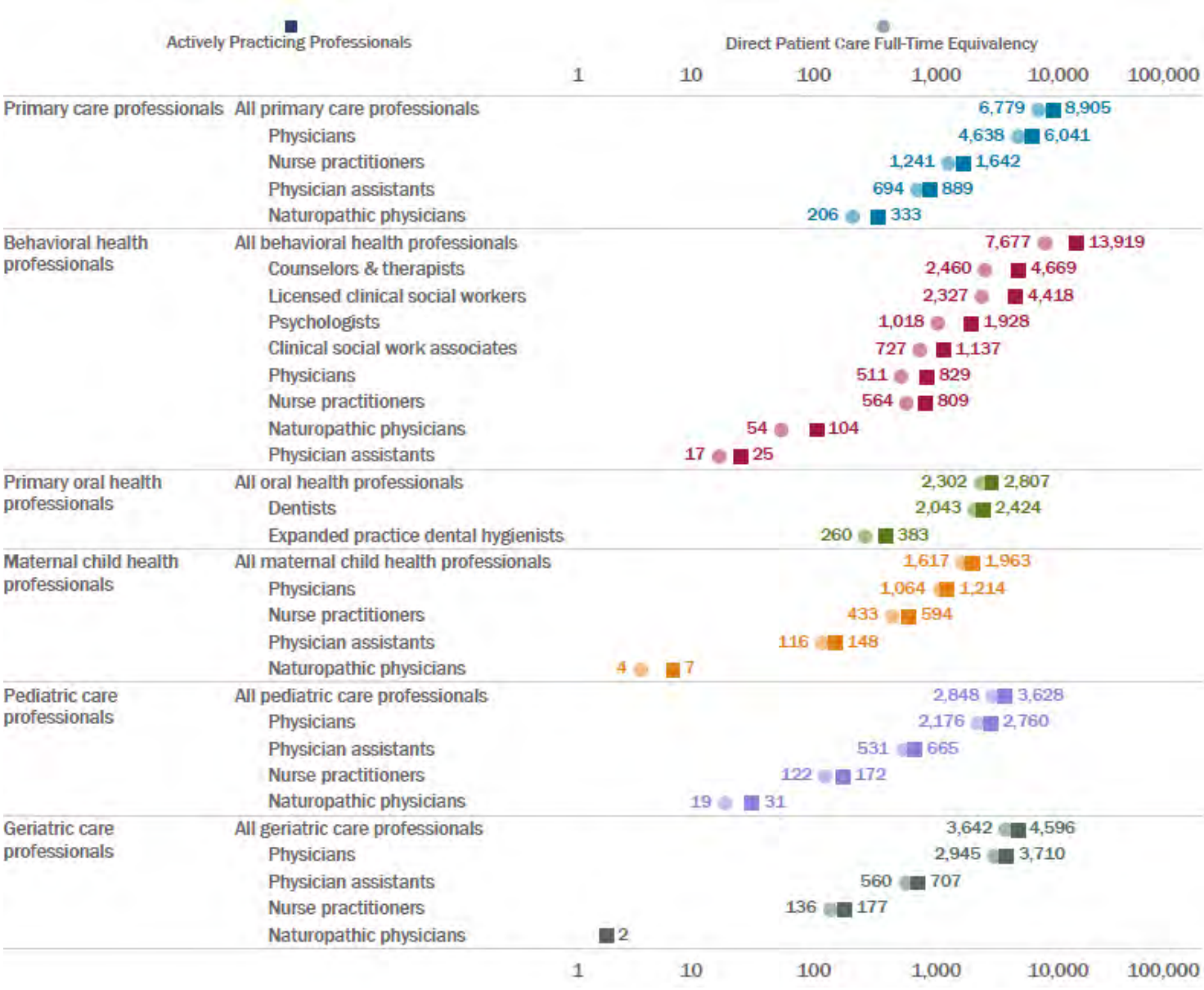


Explore these data and learn more:
[Oregon's Licensed Health Care Workforce Supply Dashboard]

Supply Estimates for Specialty Groups

In addition to evaluating the health care workforce supply by occupation, it is important to evaluate it through a multidisciplinary lens that groups health care professionals by specialty rather than by occupation. For example, physicians, nurse practitioners, physician assistants and naturopathic physicians may all specialize in primary care and provide this service to Oregonians. Supply estimates for primary care, behavioral health, oral health, maternal child health, geriatric care and pediatric care specialty groups show the occupational diversity by specialty.

Behavioral health professionals are the largest specialty group, with 13,919 licensees actively practicing. There are an estimated 8,905 primary care professionals actively practicing in Oregon, the majority of which are physicians. Because specialty providers are identified by their self-reported specialty and they may report multiple specialties, providers may fall into more than one of the specialty groups shown here — for instance, geriatric care and pediatric care professionals are subgroups of primary care professionals.



Note: Some professionals are included in more than one specialty group; specialty groups are not mutually exclusive.

County Provider-to-Population Ratios Show Differences in Geographic Distribution of Professionals

Determining whether the supply of health care professionals is sufficient to meet the needs of Oregonians across the state requires more than knowing the number of actively practicing professionals or direct patient care FTE for different health care occupations and specialty groups — it requires the assessment of supply estimates relative to the population at state and county levels. This sort of analysis gives insight into the density of health care professionals across Oregon. For measures that assess the supply of the workforce relative to a county's population, supply estimates for direct patient care FTE are used. The darker the color on the map, the higher the county ratio.

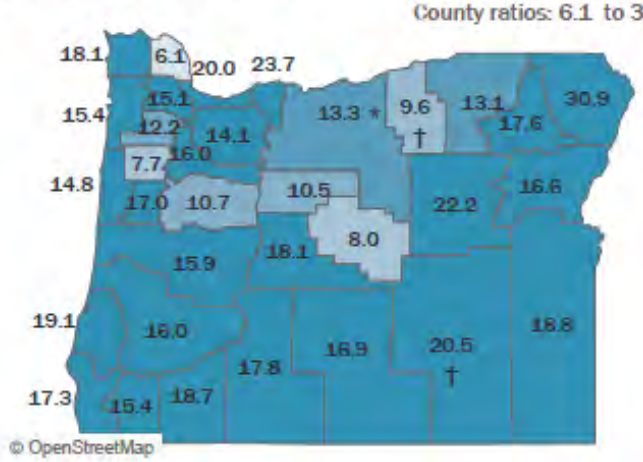
Statewide, there were an estimated 16.2 primary care professionals per 10,000 Oregonians, although this provider-to-population ratio differs depending on county. County provider-to-population ratios for primary care providers range from 30.9 per 10,000 in Wallowa county to 6.1 per 10,000 in Columbia county, while some counties fall closer to the statewide average, like Douglas county at 16.0 per 10,000.

Statewide there were an estimated 17.1 behavioral health professionals per 10,000 Oregonians with 2.3 per 10,000 observed in Grant county and with the highest density observed in Multnomah (31.9 per 10,000).

Statewide there were an estimated 5.8 oral health professionals per 10,000 Oregonians, with 0.7 per 10,000 observed in Morrow county and with the highest density observed in Hood River (9.2 per 10,000).

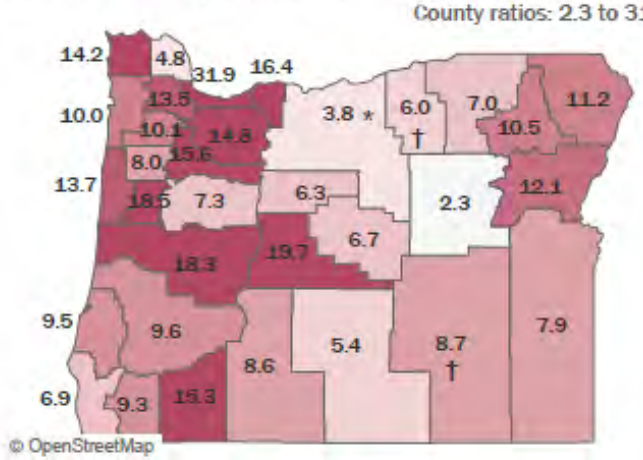
Primary care professionals

Statewide ratio: 16.2 per 10,000
County ratios: 6.1 to 30.9 per 10,000



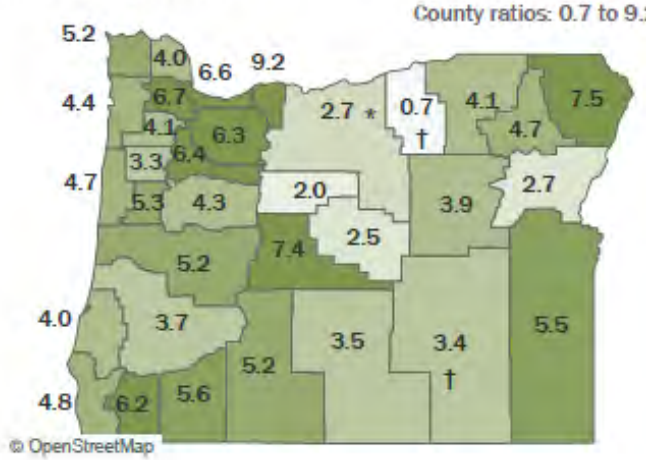
Behavioral health professionals

Statewide ratio: 17.1 per 10,000
County ratios: 2.3 to 31.9 per 10,000



Oral health professionals

Statewide ratio: 5.8 per 10,000
County ratios: 0.7 to 9.2 per 10,000



Population estimates sourced from 2021 Portland State University Population Research Center.

* Gilliam, Sherman, Wasco and Wheeler aggregated due to small numbers

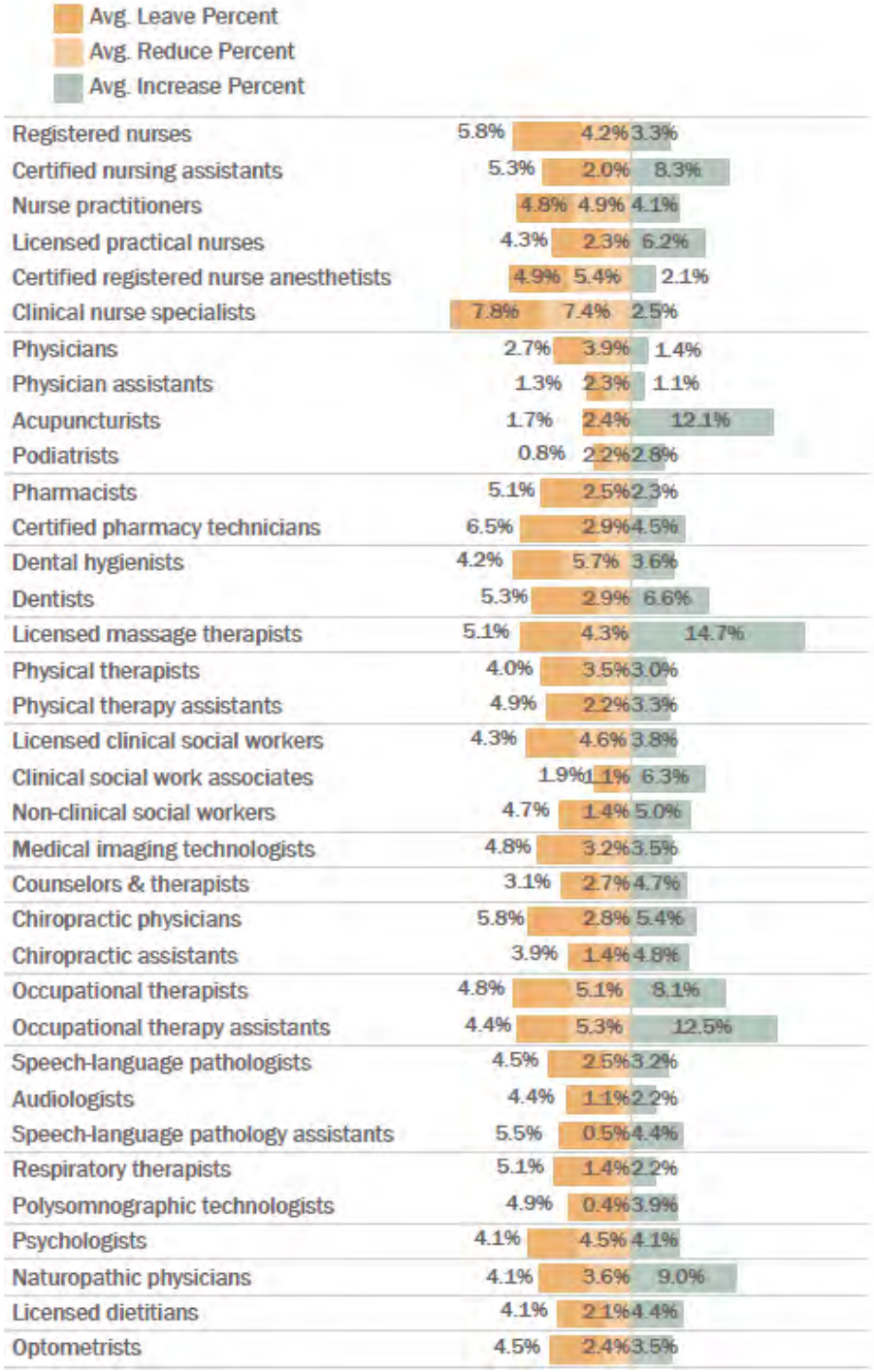
† May be statistically unreliable due to small numbers, interpret with caution

On telehealth and mobile practices

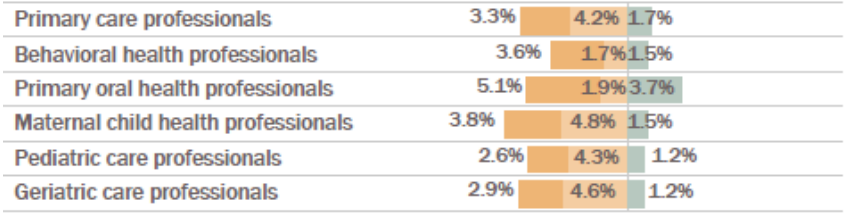
These data currently focus on physical practice locations where the professionals deliver care and do not reflect areas where telehealth is available, nor do they fully reflect providers with a mobile practice. Future reports will assess telehealth and mobile practice in more detail.

Future Plans to Increase Hours, Reduce Hours or Leave the Workforce

All occupations



Specialty groups



Health care professionals reported plans for their practices over the next two years, including intentions to maintain, increase or decrease their practice hours, as well as intentions to leave the occupation or to move out of state. Those who intended to leave the Oregon workforce at the highest rates were clinical nurse specialists (7.8 percent), certified pharmacy technicians (6.5 percent) and chiropractic physicians (5.8 percent).

Those who intended to increase practice hours at the highest rates were licensed massage therapists (14.7 percent), Occupational therapy assistants (12.5 percent), acupuncturists (12.1 percent), naturopathic physicians (9.0 percent) and certified nursing assistants (8.3 percent). Note that plans to increase practice hours do not necessarily reflect the ability to do so; for example, providers might try to increase their hours but lack sufficient patient demand for services.

Out of the specialty groups, oral health professionals indicated the intention to leave the Oregon workforce at the highest rate of 5.1 percent, while 3.7 percent indicated that they intended to increase their practice hours over the next two years.

Supplemental Materials

The Health Care Workforce Reporting Program (HWRP)

The HWRP collaborates with the 17 health regulatory licensing boards shown in **Table 1** to collect, process and analyze data for over 35 occupations to understand Oregon's health care workforce; inform public and private educational and workforce investments; and inform policy recommendations for the Governor's Office, legislative leadership and state agencies regarding Oregon's health care workforce (Oregon Revised Statute (ORS) 676.410; Oregon Administrative Rule (OAR) 409-026). Data has been collected from seven boards since 2009 and ten boards since 2016 and 2017.

For more information about methodology and results, visit https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

Table 1: Participating Licensing Boards

Oregon Board of Chiropractic Examiners
Oregon Board of Dentistry
Oregon Board of Examiners for Speech-Language Pathology and Audiology
Oregon Board of Licensed Clinical Social Workers
Oregon Board of Licensed Dieticians
Oregon Board of Licensed Professional Counselors and Therapists
Oregon Board of Massage Therapists
Oregon Board of Medical Imaging
Oregon Board of Naturopathic Medicine
Oregon Board of Optometry
Oregon Board of Pharmacy
Oregon Board of Physical Therapy
Oregon Board of Psychology
Oregon Medical Board
Oregon Occupational Therapy Licensing Board
Oregon State Board of Nursing
Respiratory Therapist and Polysomnographic Technologist Licensing Board

Limitations

The HWRP collects data on occupations that are licensed in Oregon and covered by Oregon Revised Statute 676.410, so this dataset does not represent the entire health care workforce. The program does not currently collect data for many unlicensed health care professionals including traditional health workers, health care interpreters, qualified mental health professionals, addiction counselors, peer support specialists, licensed professional counselor interns, lab scientists/technicians, medical assistants, ophthalmologist technicians and more.

Survey data comes only from renewing licensees, so this report assumes that new licensees would respond similarly to renewing licensees. There is a time lag in reporting, so estimates reflect a historical point in time. Length of participation in the HWRP varies by board, so reliable estimates over time vary by occupation. Currently we are unable to estimate the number of professionals who provide telehealth. For those reasons, data from this report should not be compared with data from earlier reports. Data is collected for up to two practice locations, so data may not be accurate for health care professionals who have three or more practice locations or who have a mobile practice. Lastly, diversity of the workforce is not in the scope of this report; please find the most recent licensed health care workforce diversity report on our website.

Methodology and Definitions

Data sources for this report include workforce data from HWRP for 2014 through the first quarter of 2022. HWRP collects workforce-related information directly from health care professionals via a survey embedded in the license renewal process. Health care professionals with an active license in each reporting year (January 2018-2022; month of verification varied by occupation in 2016), were included in this report. Estimates are dependent on licensees who completed the survey. Each licensee can report workforce data for up to two practice locations. Please refer to the HWRP's General Methods documentation on the website for further details. Other data sources for this report include population estimates from Portland State University (PSU) for 2014 through 2021.[25]

Definitions

Workforce supply measures are stratified by occupation (license type), by specialty group or a combination of both.

- **Specialty groups** include primary care professionals, behavioral health professionals, oral health professionals, maternal child health professionals, pediatric care professionals and geriatric care professionals. Specialty groups are not mutually exclusive, so some professionals are included in more than one.
- **Primary care professionals** include physicians and physician assistants who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine or obstetrics and gynecology; nurse practitioners who specialize in family practice, geriatrics, pediatrics, internal medicine or obstetrics/gynecology/women's health; and naturopathic physicians who specialize in family medicine, pediatrics, geriatrics or obstetrics.
- **Behavioral health professionals** include all psychologists, counselors and therapists, licensed clinical social workers and clinical social work associates; physicians and physician assistants who specialize in psychiatry (addiction, neurology, child, adolescent, geriatric or forensic) or psychoanalysis; nurse practitioners who specialize in psychiatry/mental health; and naturopathic physicians who specialize in mental health.
- **Oral health professionals include** dentists who specialize in oral health, pediatric dentistry or public health; and expanded practice dental hygienists who specialize in oral health, pediatric dentistry or public health and who report holding an expanded practice permit.
- **Maternal child health professionals** include physicians and physician assistants who specialize in obstetrics and gynecology, neonatology/perinatal or maternal and fetal medicine. Also included are primary care physicians and physician assistants who answer a subsequent question saying they provide maternal child health in their practice (important for rural communities where primary care physicians provide the bulk of maternity care); nurse practitioners who specialize in maternal-child health, obstetrics/gynecology/women's health and naturopathic physicians who specialize in obstetrics.
- **Pediatric and geriatric care professionals** are subgroups of primary care professionals and include nurse practitioners and naturopathic physicians who specialize in pediatrics or geriatrics respectively, as well as physicians and physician assistants who report any of the primary care specialties in addition to acknowledging in subsequent questions that they provide pediatric or geriatric services.

Workforce supply measures include licensed, actively practicing, direct patient care full-time equivalency (FTE), provider-to-population ratios and provider-to-selected target population ratios at the state and county levels.

- **Licensed professionals** include all health care professionals who hold an active license from an Oregon health licensing board.
- **Actively practicing professionals** are estimated by multiplying the number of licensed professionals by the proportion of survey respondents who indicate they currently provide services to Oregon residents and have a practice location in Oregon.
- **The equivalent number of professionals providing full-time direct patient care (direct patient care FTE)** is estimated by multiplying the number of actively practicing professionals by the average hours spent in direct patient care per week divided by 40 (note that this calculation caps the number of hours per week at 80 per practice location).
- **Provider-to-population ratios** are calculated by dividing direct patient care FTE by the PSU population estimate for the reporting year. PSU estimates for 2016, 2017, 2018, 2019, 2020 and 2021 are used for the HWRP reporting years 2016, 2018, 2019, 2020, 2021 and 2022 (respectively).

References

1. World Health Organization. Five-year action plan for health employment and inclusive economic growth (2017-2021) [Internet]. Geneva: World Health Organization; 2018. Available from: https://www.who.int/publications/i/item/five-year-action-plan-for-health-employment-and-inclusive-economic-growth
2. U.S. Bureau of Labor Statistics. Occupational Outlook Handbook: Healthcare Occupations. Available from: https://www.bls.gov/ooh/healthcare/home.htm
3. Martiniano R, Chorost S, Moore J. Health Care Employment Projections, 2014-2024: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation [Internet]. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; 2016 Apr. Available from: https://www.chwsny.org/wp-content/uploads/2016/04/BLS-Health-Care-Employment-Projections_2016.pdf
4. Bureau of Labor Statistics. Occupational outlook handbook [Internet]. 2020 Sep [cited 2020 Oct 1]. Available from: https://www.bls.gov/ooh/
5. Kaiser Family Foundation. Health Care Employment as a Percent of Total Employment [Internet]. 2018 May [cited 2020 Oct 1]. Available from: https://www.kff.org/other/state-indicator/health-care-employment-as-total/
6. Teasdale B, Schulman KA. Are U.S. Hospitals Still "Recession-proof"? N Engl J Med. 2020 Jul 1;383(13):e82.
7. Glied S, Ma S, Solis-Roman C. Where The Money Goes: The Evolving Expenses Of The US Health Care System. Health Affairs. 2016 Jul 1;35(7):1197–203.
8. Turner A, Hughes-Cromwick P. Connecting U.S. Health Expenditures with the Health Sector Workforce. Business Economics. 2013;48(1):42–57.
9. Bodenheimer T, Chen E, Bennett HD. Confronting The Growing Burden Of Chronic Disease: Can The U.S. Health Care Workforce Do The Job? Health Affairs. 2009 Jan 1;28(1):64–74.
10. Kavilanz P. The US can't keep up with demand for health aides, nurses and doctors. CNN Business [Internet]. 2018 May 4 [cited 2020 Oct 1]; Available from: https://money.cnn.com/2018/05/04/news/economy/health-care-workers-shortage/index.html
11. Bersell CH. Access to Oral Health Care: A National Crisis and Call for Reform. J Dent Hyg. 2017 Feb;91(1):6–14.
12. Covino NA. Developing the Behavioral Health Workforce: Lessons from the States. Adm Policy Ment Health. 2019 Nov;46(6):689–95.
13. Lin V, Zhang X, Dixon P. Occupational Therapy Workforce in the United States: Forecasting Nationwide Shortages. PM R. 2015 Sep;7(9):946–54.
14. Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected Workforce of Psychiatrists in the United States: A Population Analysis. Psychiatr Serv. 2018 Jun 1;69(6):710–3.
15. Juraschek SP, Zhang X, Ranganathan V, Lin VW. United States Registered Nurse Workforce Report Card and Shortage Forecast(). Am J Med Qual. 2019 Oct;34(5):473–81.
16. PSU Population Research Center. Population Forecasts: Oregon Final Forecast Table by Age [Internet]. 2022 [cited 2022 Oct 12]. Available from: https://www.pdx.edu/population-research/population-forecasts
17. Health Promotion and Chronic Disease Prevention. Adult Chronic Conditions Data Portal [Internet]. Oregon Health Authority; 2018 [cited 2020 Oct 1]. Available from: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Adult-Prevalence.aspx
18. Oregon Health Insurance Survey. (2021). *Health Insurance Coverage in Oregon.* Interactive display accessed 2023 Mar 1. Salem, OR: Oregon Health Authority. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx
19. Keisler-Starkey K, Bunch, LN. Health Insurance Coverage in the United States: 2021 [Internet]. United States Census Bureau; 2022 Sep [cited 2023 Mar 1]. Report No.: P60-278. https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf
20. Blumenthal D, Fowler EJ, Abrams M, Collins SR. Covid-19—Implications for the health care system. New England Journal of Medicine. 2020 Oct 8;383(15):1483-8.
21. Vanhaecht K, Seys D, Bruyneel L, Cox B, Kaesemans G, Cloet M, Van Den Broeck K, Cools O, De Witte A, Lowet

K, Hellings J. COVID-19 is having a destructive impact on health-care workers' mental well-being. International Journal for Quality in Health Care. 2021;33(1):158.
22. Oregon Center of Nursing. NOT WORKING WELL: Clinical Placement for Nursing Students in an Era of Pandemic [Internet]. Oregon Center of Nursing; 2020 [cited 2023 Mar 1] Available from: https://oregoncenterfornursing.org/reports/
23. Oregon Health Authority. Impact of COVID-19 on Oregon's health care providers [Internet]. 2020 Sep 15 [cited 2020 Oct 1]. Available from: https://www.oregon.gov/oha/OHPB/Pages/OHPB-Meetings.aspx
24. Shaukat N, Ali DM, Razzak J. Physical and mental health impacts of COVID-19 on healthcare workers: A scoping review. International Journal of Emergency Medicine. 2020 Dec;13:1-8.
25. PSU Population Research Center. 2021 Annual Population Report Tables [Internet]. Portland State University; 2022 Apr 19. Available from: https://www.pdx.edu/population-research/population-estimates
26. Icons made by Tyler Gobberdiel and Adrien Coquet from The Noun Project, 2020.

For questions about this report, contact

Health Care Workforce Reporting Program
Research and Data
Oregon Health Authority
Wkfc.Admin@dhsoha.state.or.us
971-283-8792

Report authored by Andy Davis, Sara Grusing, Meredith Halling, Derek Reinke and Piper Block. Thank you to the licensing boards who supported this analysis. All errors are the authors'.

Suggested Citation

Oregon Health Authority. (2023). DRAFT Oregon's Licensed Health Care Workforce Supply: Based on data collected from 2014 through January 2022. Portland, OR: Oregon Health Authority. https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Health-Care-Workforce-Reporting.aspx

Oregon Health Authority

HEALTH POLICY AND ANALYTICS
Office of Health Analytics

2022
The Diversity of Oregon's Licensed Health Care Workforce

Based on data collected from 2014 through January 2022

Published March 2023
Oregon Health Authority
Office of Health Analytics

Oregon Health Authority

Health Care Workforce Reporting Program

Contents

About the data in this report:

Oregon's Health Care Workforce Reporting Program (HWRP) was created in 2009. As directed by Oregon Revised Statute 676.410, the HWRP collects and tabulates information from licensees of 17 health licensing boards upon renewal. This report presents data collected from 125,584 licensed workers between January 2020—January 2022.

Some of the data in this report was collected during the COVID-19 pandemic of 2020-2022. At this time, it is unclear how the pandemic impacted the composition of the licensed health care workforce supply in Oregon.

This report begins the reporting of HWRP data using the REALD data collection and reporting standards for Race, Ethnicity and Disability. Caution should be used when interpreting this new data, especially in relation to previous versions of this report.

Executive Summary

Report Objectives

This report explores the race, ethnicity, gender, language and disability makeup of Oregon's nearly 126,000 licensed health care professionals compared with that of the state. This report aims to answer the following questions:

- What is the racial and ethnic composition of Oregon's licensed health care workforce?
- How is the workforce composition changing over time?
- How culturally and linguistically representative is the workforce of the population that it serves?
- What portion of the workforce report living with some form of disability?

Why is Workforce Diversity Important?

Across the country, health access and outcomes remain inequitable by race, ethnicity, gender, disability, language and other characteristics.[1] For instance, life expectancy, infant mortality and preterm birth rates, as well as prevalence of obesity and hypertension all differ by race and ethnicity. Additionally, there are differences in access to care between racial and ethnic groups. People of color are less likely to have insurance coverage and receive needed dental care. Individuals with physical disabilities or cognitive limitations have higher prevalence of chronic conditions compared with individuals with no disabilities,[2] and patients with limited English proficiency are more likely to experience adverse events in US hospitals (including higher levels of physical harm) compared with patients who speak English.[3] The COVID-19 pandemic had a disproportionate impact on communities of color, tribal communities and other historically underrepresented communities, with many historical inequities widening during that time.

There is a long, well-documented history of explicit practices meant to exclude people of color from the health care workforce, especially professions that require higher levels of education and offer higher salaries.[4] Additionally, lack of support and experiences of racism with patients and other providers present challenges to retaining providers of color who do enter the health care workforce.[5, 6, 7] Although many Oregon initiatives are working to counteract the historical and continued structural racism effecting the health care workforce, racial and ethnic disparities are still observed.

Evidence suggests that greater diversity in the health care workforce advances cultural competency and increases access to high-quality health care.[8, 9] Accordingly, increasing the proportion of underrepresented US racial and ethnic groups among health care professionals in the workforce may improve quality of care.

Given these health inequities, it is important to foster a workforce that is culturally and linguistically representative of the communities it serves. This report aims to examine the current makeup of the workforce in Oregon and the extent to which it is representative of Oregon's population.

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

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

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

This definition recognizes that people are often differentially impacted by the health system depending on their race and ethnicity, languages spoken and/or disability status.

Key Insights

- Overall, Oregon's licensed health care workforce is less racially and ethnically diverse than the population being served (**Figure 2**). White and Asian persons are overrepresented in the workforce, though this is not true for all subgroups. Latino/a/x, American Indian/Alaska Native, Black/African American and Native Hawaiian/Pacific Islander persons are underrepresented. However, Latino/a/x licensees are sometimes overrepresented in fields with fewer barriers to entry (e.g. certified nursing assistants, chiropractic assistants) (**Table 1**).
- While women are overrepresented in most health care professions, men are overrepresented in the higher-paying medical professions that require more advanced training (e.g. dentistry and medicine) (**Table 1**).
- Previous iterations of this report showed that the racial and ethnic makeup of many occupations was changing, and most occupations appeared to be growing more diverse over time. Between 2016 and 2020, the percentage of White providers decreased from 83.4 to 80.3 percent (a change of 3.1 percent), while the percentage of providers from most other racial and ethnic groups increased. Over the same time period the White population of Oregon decreased by 2.1 percent (from by 77.6 to 76.0 percent), suggesting that the differences between the workforce and the state's demographics are decreasing. We examine the current state of diversity across occupations in the licensed health care workforce, but because of the change in collection and reporting using REALD standards, drawing conclusions on time trends in the workforce is not possible.
- 19.2 percent of Oregon's health care professionals reported speaking languages other than English; of that group, 58.0 percent self-report either advanced proficiency or being a native speaker of another language and 46.4 percent report using a language other than English with patients (**Figure 6**). Spanish is the most reported language spoken other than English among the health care workforce as well as among the Oregon population. While 9.6 percent of the workforce reports speaking Spanish, only 4.7 percent report advanced proficiency or being a native speaker of Spanish. Of the Spanish-speaking workforce, 69.5 percent report using Spanish with patients while providing care.
- Similar patterns were seen in the composition of specialty providers (**Figure 2b**). People of color, except for providers of Asian descent, tend to be underrepresented relative to Oregon's population among primary care providers and oral health care professionals. Among behavioral health professionals, health care providers of color are underrepresented. White health care providers are overrepresented in all of these groups, but this is especially pronounced among behavioral health providers, where people of color comprise 14.5 percent of licensed behavioral health providers, compared with 25.0 percent of the population (**Figure 2b**).

Findings

Race, Ethnicity and Gender

This report compares race, ethnicity and gender data from the overall Oregon population to Oregon's licensed health care workforce in order to understand how representative the health care workforce is of the population it serves. The REALD system of collecting and reporting race and ethnicity data poses novel challenges for presenting trend data for both the overall Oregon population and Oregon's licensed health care workforce. Implementing REALD procedures allows for the collection and reporting of both race and ethnicity "parent" groups and subgroups. For a more detailed description of REALD procedures and a table displaying how race and ethnicity "parent" and subgroups relate, please see page 20 in the methods section of this report.

It is important to note that because REALD data only exists for the most recent data collection cycle, it is not possible to compare the data directly to that of previous cycles. Additionally, data for this report is collected in different ways for each licensing board and license type. See page 18 in the Supplemental Materials and Methodology section for a comprehensive explanation of data collection.

The data representing Oregon's overall population presents additional challenges. **Figure 1** demonstrates how moving to the REALD system impacted how the racial and ethnic composition of Oregon's overall population is **reported**. This is **not** directly indicative of a change in the underlying population. Rather, some individuals who would have been categorized in one racial and ethnic category using the previous method are now categorized differently. In the 2016-2021 period, we used American Community Survey (ACS) Public Use Microdata Sample (PUMS) 5-year data for estimating the Oregon population. This report uses ACS PUMS data for race, ethnicity and gender.

For the 2022 cycle, we use data provided by Oregon Health Authority's Equity and Inclusion Division that imputes REALD race and ethnicity category values from the data contained in the ACS PUMS statistical file. Additional data points in the ACS PUMS data set such as language, ancestry and place of birth are used to impute values that compare to the REALD category values for both "parent" and granular level data.[13]

Read more about REALD implementation in their guide.

One notable change is that it is possible to reallocate individuals who were previously reported in the multiracial

What is REALD?

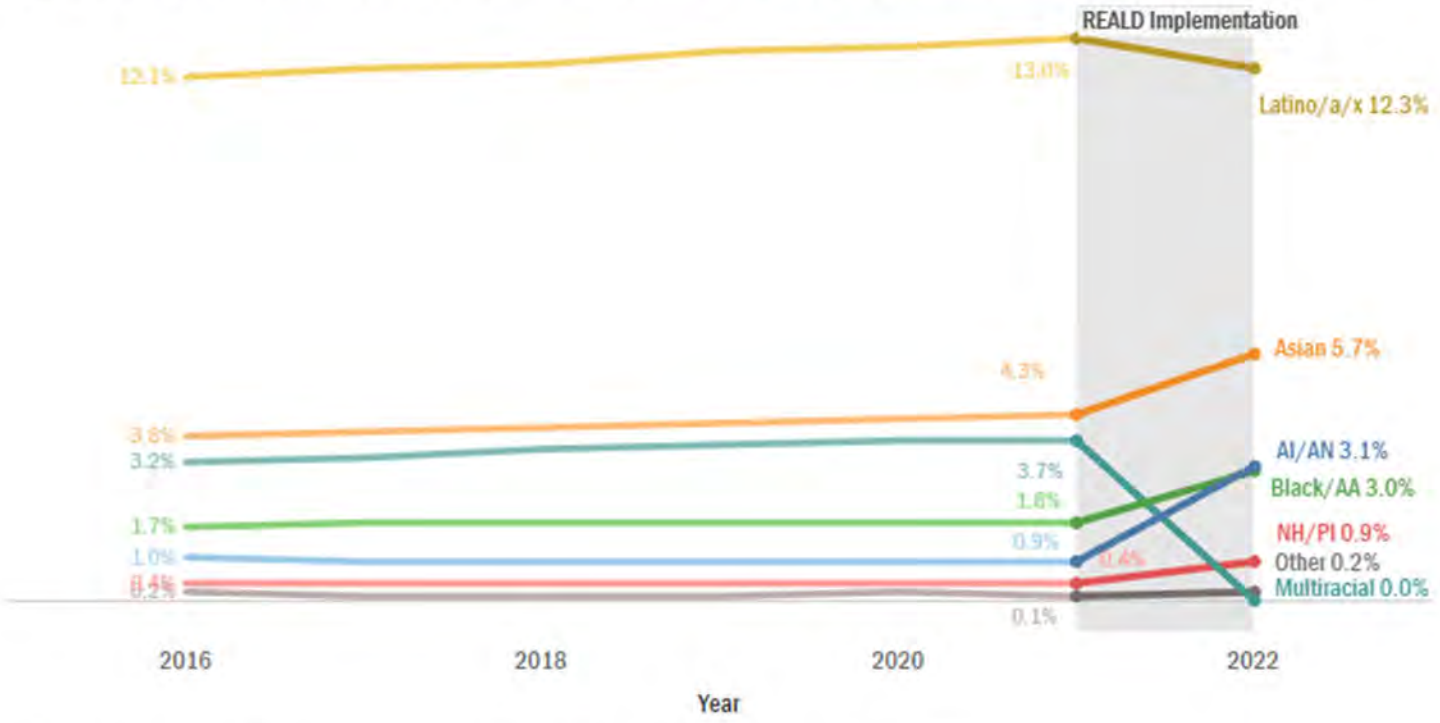
REALD is an effort to increase and standardize Race, Ethnicity, Language and Disability (REALD) data collection across the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA). REALD was advanced through the passage of House Bill 2134 passed by the Oregon legislature in 2013.

Data collection for HWRP before 2021 included only the five racial groups in accordance with guidelines set by the US Office of Management and Budget. However, data at this level may not capture racial and ethnic identity adequately to determine whether the workforce is representative of the communities that it serves.

HWRP updated demographic survey questions in January of 2021 to reflect the REALD standards. **This allows health care professionals licensed in Oregon to report their demographic identities with more granularity, if they so choose, while also supporting state planning efforts to equitably promote a diverse and culturally responsive workforce for communities across the State.**

The statutory authority for these rules is codified in the Oregon Revised Statutes (ORS 413.042 and 413.161). In 2014 the administrative rules detailing the data collection standards were completed (OARs 943-070-0000 thru 943-070-0070). Additional information, including an implementation guide, is available on the REALD website.

Figure 1: Changing measures of the racial/ethnic composition of Oregon's population



Note: AA = African American, AI/AN = American Indian or Alaska Native, NH/PI = Native Hawaiian or Pacific Islander

category into component parts of their racial identity, and to then assign them to a primary race category. REALD implementation recommends that "you could use a 'most identify and rarest group first' method where you apply an algorithm to assign those with multiple identities to one primary race"[10] and this is performed here to report the imputed data with the highest level of representation for the rarest race categories. Examples given include coding someone who would identify as both Western European and African American as African American because African American is the more rare segment in the overall Oregon population.

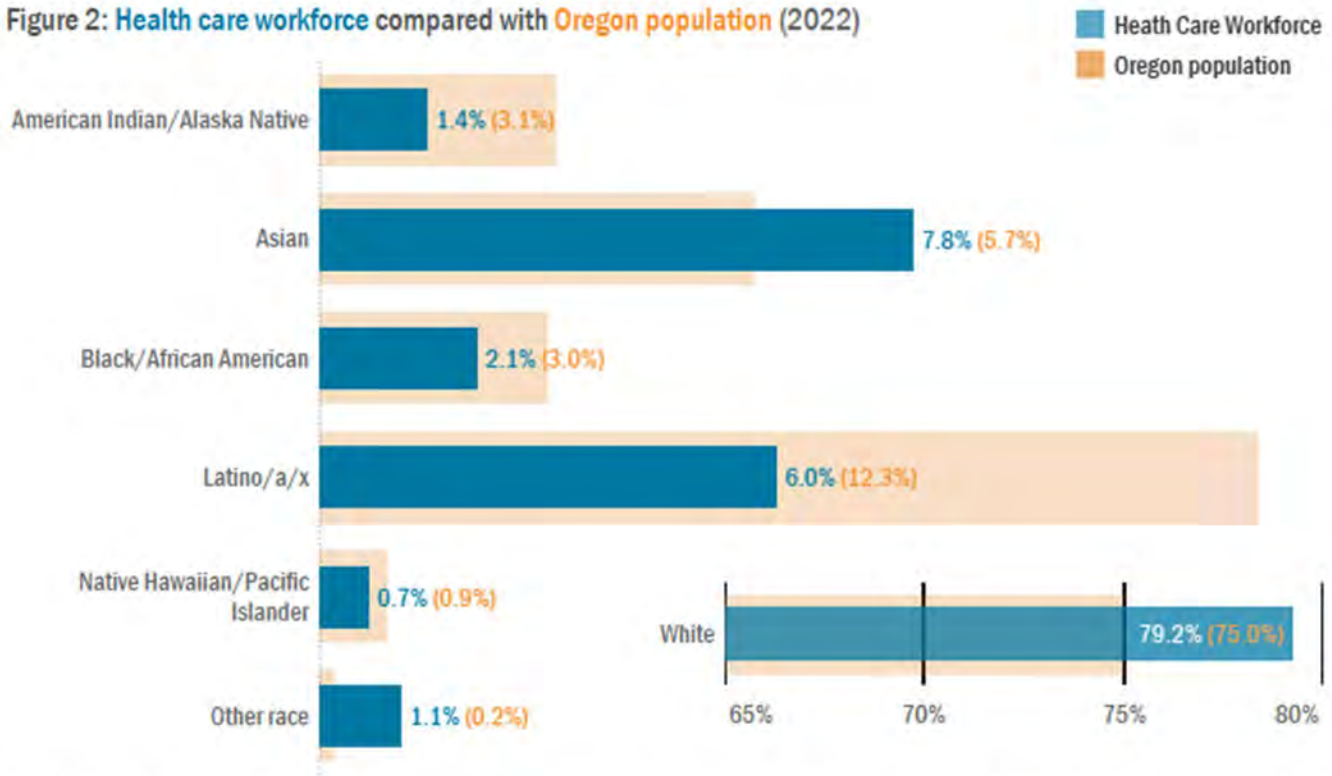
One of the core functions of this report is to compare the composition of the licensed health care workforce to the overall population in Oregon. **Figure 2** uses the REALD data collected by the Workforce survey and the imputed REALD values from the ACS PUMS data to create this comparison.

Overall, Oregon's licensed health care workforce in 2022 is less racially and ethnically diverse than the population being served. White and Asian persons are overrepresented in the workforce. Other people of color are underrepresented, with the largest difference seen in the Latino/a/x population, which make up only 6.0 percent of the licensed health care workforce compared with 12.3 percent of the Oregon population. It is important to note that this general characterization across the whole workforce varies between specific occupations, which we examine in the next table.

The Workforce survey gives respondents the option of affirmatively selecting "multiracial," or to select a specific primary race they identify with. Of our survey respondents, 4.2 percent selected that they do not identify with a primary race or that they consider themselves multi– or biracial. We have reported them using the rarest race methodology here to reassign them into the single category that will show the greatest degree of representation and be directly comparable to the imputed ACS PUMS data.

Figure 2a: We now have the capacity to conduct some comparisons between subcategories within the larger race

Figure 2: Health care workforce compared with Oregon population (2022)



Note: Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Middle-Eastern and White combined for this presentation. Participants choosing multi-race recategorized using rarest race methodology.

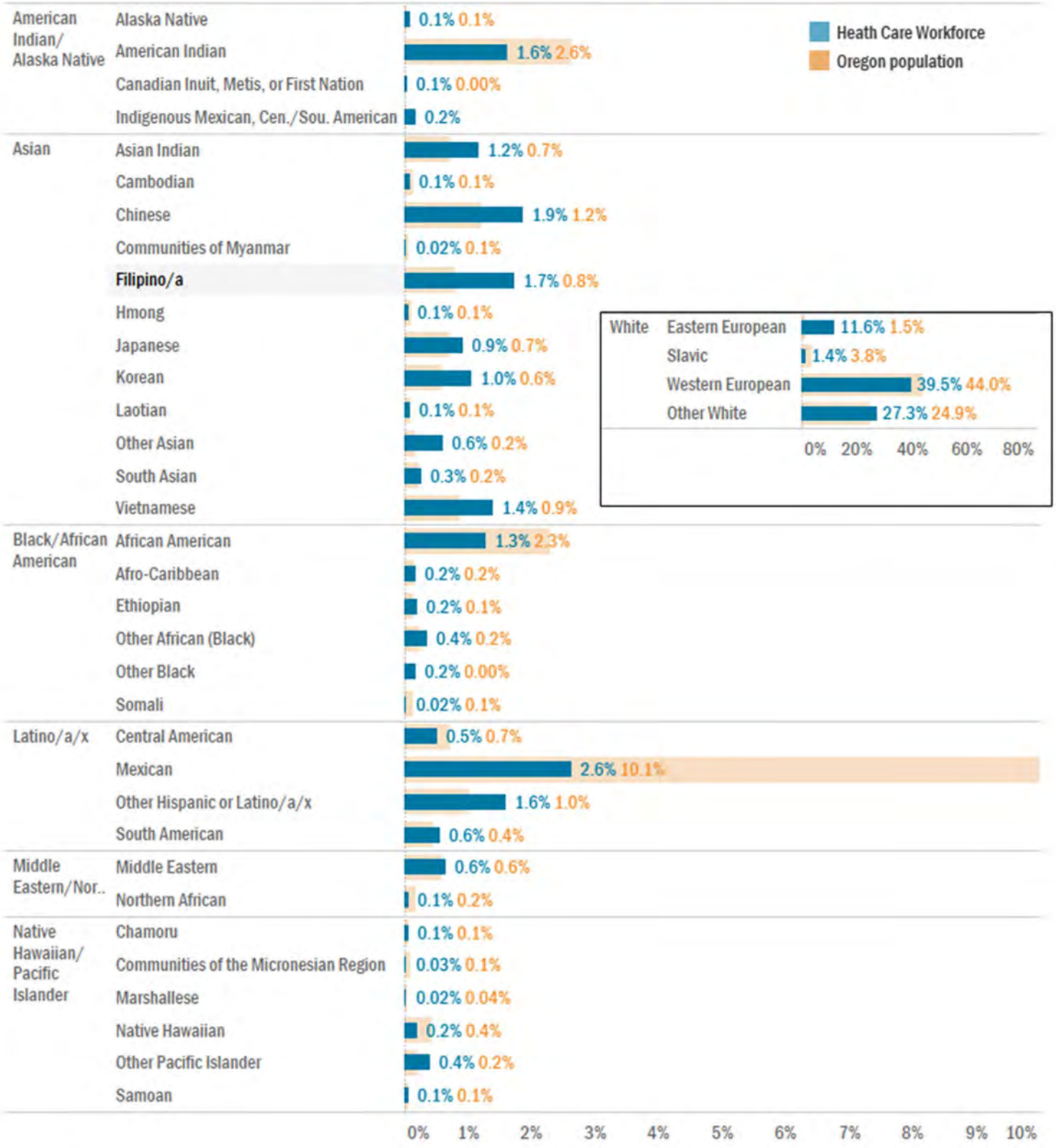
"parent" categories, and we show that here. These comparisons reveal differences within larger race "parent" groups. For example, while Latino/a/x licensees (6.0 percent) overall are underrepresented compared to the Oregon population (12.3 percent), this is especially stark for those who identify as Mexican in origin (2.6 percent of workforce compared to 10.1 percent of Oregon population), while other subgroups such as South American have nearly one to one representation and "other Latino/a/x" have slight overrepresentation (1.6 percent of workforce vs. 1.0 percent of Oregon population).

Table 1 shows the breakdowns of "parent" race categories within each occupation. While we only have subgroup data for a portion of licensed workers, we have parent-level data for all occupations. The overall distribution of health care workers shows overrepresentation of White and Asian workers compared to the Oregon population, while most non-White races are underrepresented.

This pattern is not universal across occupations. Asian workers are especially overrepresented in some occupations, with dentists, physicians, pharmacists and optometrists all exceeding a 3:1 ratio compared to the baseline population. In contrast, Asians are underrepresented in other areas like social work, counseling, medical imaging, and speech and language pathology.

We see different patterns for some underrepresented groups. Latino/a/x workers are overrepresented in areas like chiropractic assistants and certified nursing assistants, while rates for physicians, podiatrists, dentists and pharmacists are lower than the average for all occupations. American Indian or Alaska Native, Black or African American, Latino/a/x, and Native Hawaiian/Pacific Islander workers are underrepresented in fields with the highest educational barriers to entry.

Figure 2a: Health care workforce (2022) compared with Oregon population (granular)



Note: This table represents the 61.9 percent of licensed health care workers who responded to READLD-compliant surveys. Of the 38.1 percent missing, 84.0 percent can be considered missing at random based on licensing board data collection practices. Interpret these data with caution and consult the Supplemental Material and Methodology Section for more information about data collection and missing data. Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity.

Table 1: Race, Ethnicity and Gender Distribution: 2022 Workforce compared with Population

Comparison to state distribution

Similar to state | Below state | Above state | No representation

		AI/AN	Asian	Black /AA	Latino /a/x	NH/PI	Other race	White	Female	Male
Oregon		3.1%	5.7%	3.0%	12.3%	0.9%	0.2%	75.0%	50.4%	49.6%
Chiropractic	Chiropractic assistants	3.1%	6.1%	1.1%	17.7%	0.9%	0.8%	70.4%	83.4%	13.2%
	Chiropractic physicians	2.1%	7.2%	0.5%	3.1%	0.6%	0.8%	85.7%	30.3%	64.5%
Counselors/Therapists	Counselors & therapists	2.9%	2.8%	1.6%	4.8%	0.7%	0.9%	86.3%	75.6%	20.0%
Dentistry	Dental hygienists	1.9%	7.0%	0.4%	5.9%	0.5%	0.9%	83.4%	93.9%	3.0%
	Dentists	0.6%	18.2%	1.0%	3.7%	0.8%	1.0%	74.7%	29.8%	66.5%
Dietetics	Licensed dietitians	1.9%	6.6%	0.2%	2.8%	0.2%	0.0%	88.3%	92.2%	4.6%
Massage therapy	Licensed massage therapists	2.1%	4.6%	1.0%	5.0%	0.6%	1.2%	85.6%	78.6%	15.4%
Medical	Acupuncturists	0.1%	11.0%	0.2%	3.4%	0.2%	1.8%	83.5%	71.6%	28.2%
	Physician assistants	0.4%	5.6%	1.3%	2.6%	0.1%	2.2%	87.9%	65.2%	34.7%
	Physicians	0.2%	17.4%	1.1%	2.1%	0.1%	3.2%	75.9%	41.1%	58.9%
	Podiatrists	0.0%	12.3%	0.9%	0.0%	0.0%	1.8%	85.1%	22.5%	77.5%
Medical imaging	Medical imaging technologists	1.2%	3.9%	0.8%	5.7%	0.7%	1.0%	86.7%	62.4%	32.7%
Naturopathy	Naturopathic physicians	2.9%	6.3%	0.9%	4.6%	0.8%	0.8%	83.8%	73.8%	20.8%
Nursing	Certified nursing assistants	2.0%	6.9%	7.5%	18.1%	1.4%	1.3%	62.6%	83.7%	14.3%
	Certified registered nurse anesthetists	0.6%	7.0%	0.6%	3.8%	0.0%	1.5%	86.6%	47.2%	46.3%
	Clinical nurse specialists	0.0%	4.2%	0.0%	1.1%	0.0%	1.1%	93.7%	91.7%	4.6%
	Licensed practical nurses	1.9%	5.5%	5.7%	9.3%	0.8%	0.9%	75.9%	84.9%	12.8%
	Nurse practitioners	1.3%	4.7%	2.2%	4.2%	0.3%	0.7%	86.6%	84.8%	12.6%
	Registered nurses	1.4%	5.9%	1.5%	4.8%	0.6%	0.7%	85.0%	83.7%	13.5%
Occupational therapy	Occupational therapists	0.2%	5.3%	0.5%	3.1%	0.3%	0.7%	89.9%	85.9%	12.6%
	Occupational therapy assistants	0.0%	2.9%	1.1%	4.3%	0.4%	0.7%	90.6%	88.1%	10.0%
Optometry	Optometrists	1.1%	17.8%	0.2%	2.0%	0.6%	0.6%	77.7%	45.5%	49.6%
Pharmacy	Certified pharmacy technicians	1.0%	8.6%	1.4%	10.4%	1.0%	0.5%	77.1%	77.4%	19.3%
	Pharmacists	1.4%	26.5%	2.0%	2.7%	1.1%	1.0%	65.3%	56.7%	39.0%
Physical therapy	Physical therapists	1.2%	9.2%	0.7%	3.2%	0.7%	0.4%	84.7%	62.5%	34.9%
	Physical therapy assistants	1.3%	3.2%	1.1%	4.6%	0.3%	0.4%	89.1%	66.5%	29.1%
Psychology	Psychologists	1.3%	5.4%	1.3%	4.9%	0.3%	0.9%	85.8%	62.7%	34.2%
Respiratory therapy and polysomnography	Polysomnographic technologists	3.4%	4.5%	3.4%	5.6%	0.0%	1.1%	82.0%	48.0%	46.7%
	Respiratory therapists	3.3%	4.7%	2.6%	7.1%	1.5%	1.8%	79.0%	59.6%	35.8%
Social work	Clinical social work associates	3.4%	6.0%	7.5%	11.1%	0.8%	1.5%	69.7%	78.1%	16.6%
	Licensed clinical social workers	1.7%	2.6%	1.8%	4.1%	0.4%	0.8%	88.5%	78.6%	18.3%
	Non-clinical social workers	0.8%	4.1%	0.8%	7.4%	1.6%	0.8%	84.4%	83.0%	14.1%
Speech-language pathology and audiology	Audiologists	0.0%	8.0%	0.5%	2.1%	0.0%	0.0%	89.3%	72.5%	22.7%
	Speech-language pathologists	1.7%	3.7%	0.9%	4.4%	0.6%	0.8%	87.8%	88.9%	7.5%
	Speech-language pathology assistants	2.7%	3.4%	0.7%	11.0%	0.0%	0.0%	82.2%	94.4%	3.3%
Grand Total		1.4%	7.9%	2.1%	6.1%	0.7%	1.1%	80.7%	73.1%	24.1%

Note: Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Individuals reporting multiple races are recategorized using rarest race methodology. AA = African American, AI/AN = American Indian or Alaska Native, NH/PI = Native Hawaiian or Pacific Islander

Gender Distribution

Table 1 also shows the breakdown of gender by occupation as compared with the population. (Note: The percentages omit those who declined to answer [2.4 percent] and do not show the percent that preferred to self-describe [0.4 percent]). Women are overrepresented in most professions, while men tend to be overrepresented in higher-paying fields requiring more advanced training (e.g. dentistry and medicine).

Of those choosing to self-describe (0.4 percent, n=471), the frequently reported self-descriptions included: non-binary (45.7 percent), transgender (7.2 percent), genderqueer (5.3 percent) and genderfluid (4.3 percent).

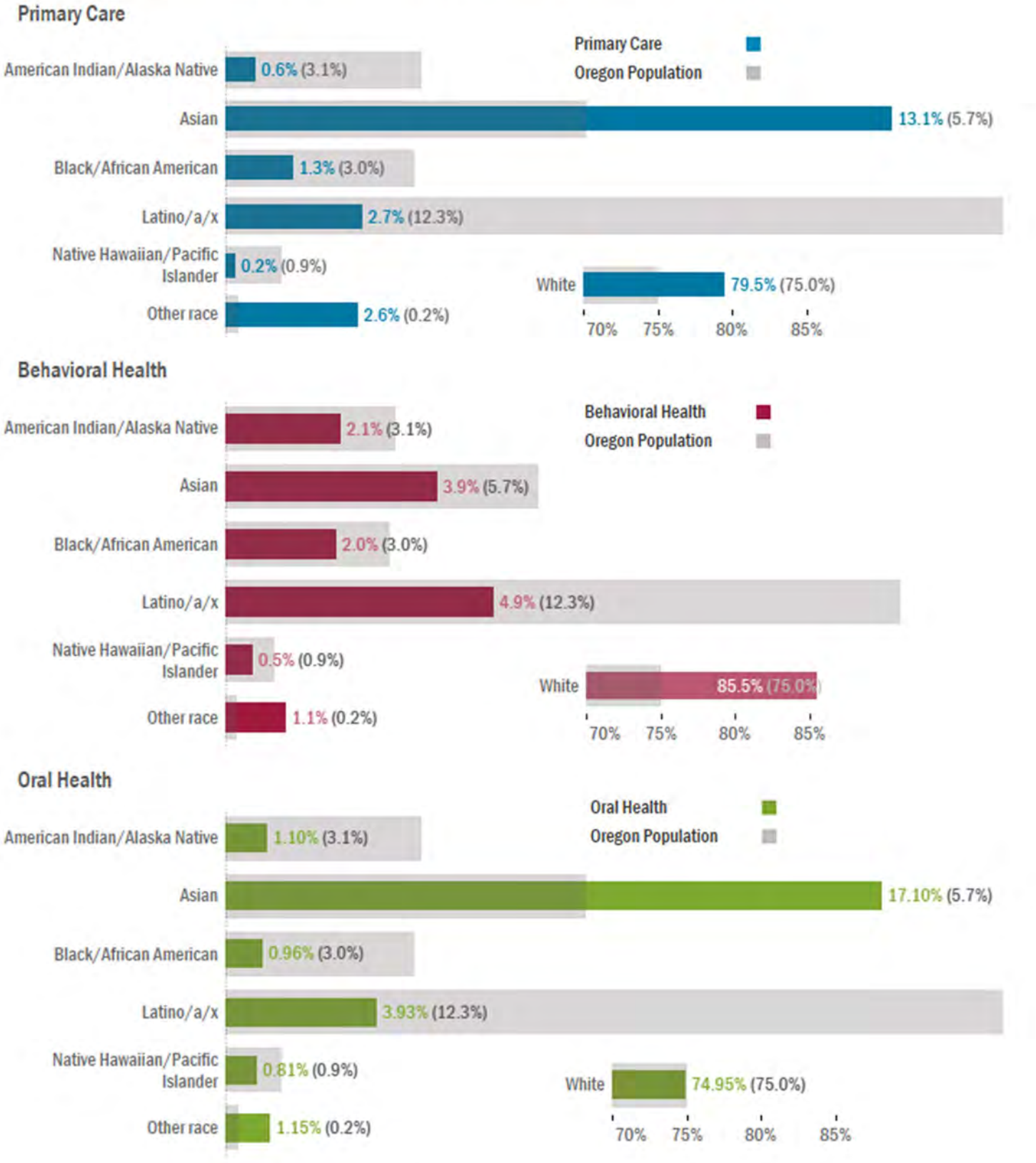
Race and Ethnicity Distribution within Specialty Groups

Figure 2b shows the racial and ethnic distribution of Oregon's primary care, behavioral health and oral health workforce in 2022 compared with Oregon's population. White health care providers are overrepresented in all of these groups.

Primary care providers (PCPs), including nurse practitioners, physicians, physician assistants and naturopathic physicians, make up approximately 6.0 percent of the health care workforce. Most people of color tend to be underrepresented among PCPs, except for providers of Asian descent.

There is a similar pattern among oral health care professionals where Asian dentists are overrepresented relative to Oregon's population, while other minority races are underrepresented. Behavioral health care providers, including psychiatric nurse practitioners, physicians, physician assistants, psychologist examiners, licensed professional counselors and therapists, and licensed clinical social workers, make up approximately 8.4 percent of the health care workforce. Among all behavioral health professionals, people of color are underrepresented.

Figure 2b: Specialty workforce groups compared with population (2022)



Note: Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Middle-Eastern and White combined for this presentation. Participants choosing multi-race recategorized using rarest race methodology.

Workforce Changes Over Time

Previous versions of this report have shown year-over-year changes in the racial and ethnic composition of Oregon's health care workforce. Due to the discontinuity resulting from introducing REALD data collection and reporting standards in this data cycle, accurately comparing data year-over-year with previous reporting periods is not possible.

As a replacement, HWRP chose to examine the age cohorts across the health care workforce. This allows us to make predictions about the future of the workforce and to have some measure of the success of initiatives aiming at bringing more people of color into the pipeline for health care professions.

Figure 3 shows the age and race and ethnicity structure of the health care workforce in 2022. It is presented in two segments. The contents on the left side of the figure show the proportion of age cohorts in the workforce within the "parent" race and ethnicity groups. The right side shows the current proportion of each race and ethnicity group in the composition of the total workforce.

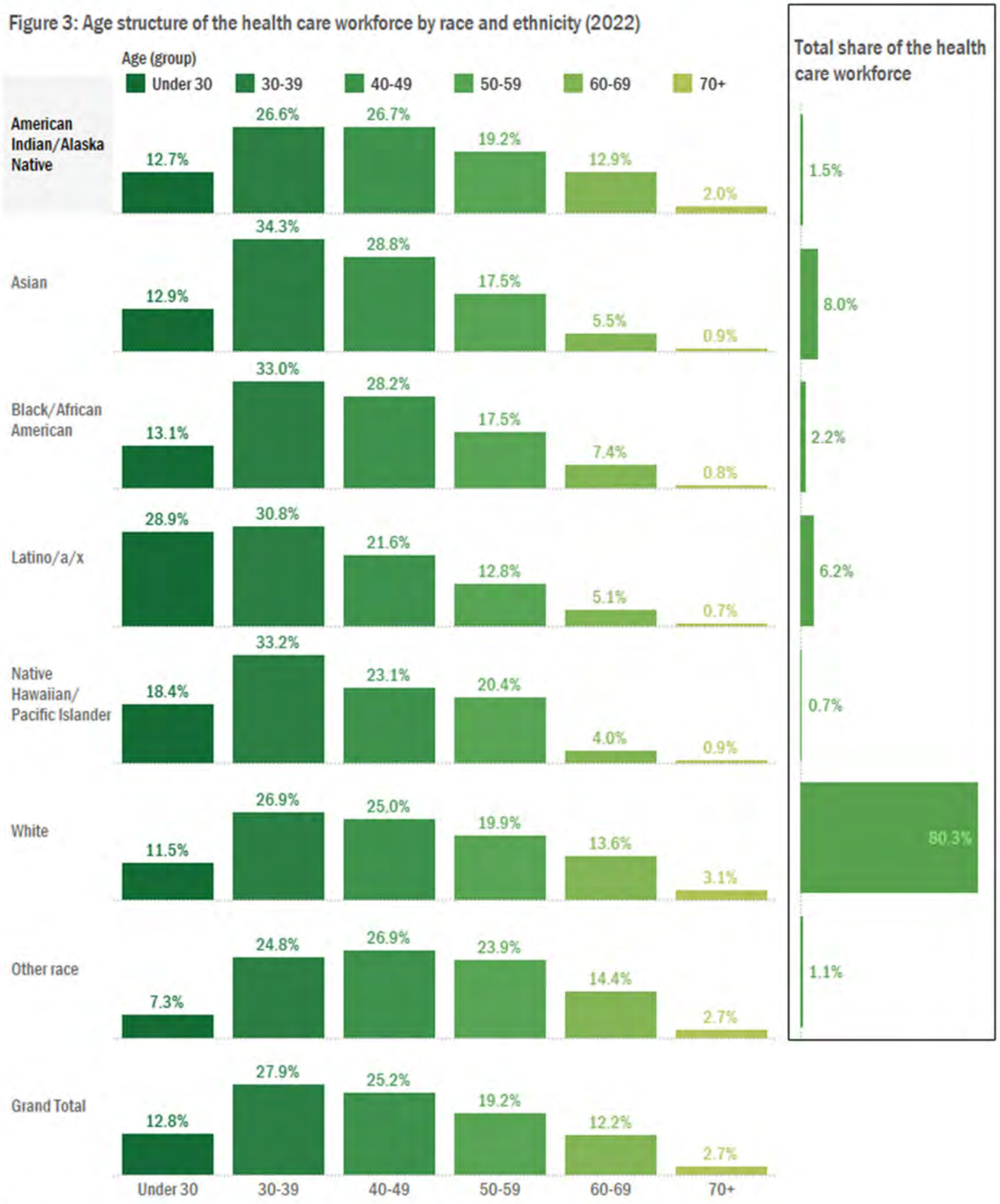
This figure shows the extent to which a race and ethnicity group is growing demographically or aging out of the workforce based on whether the larger share of the race and ethnicity group is weighted toward the younger or older ends of the spectrum.

Aging cohorts: American Indian/Alaskan Native, White and Other Race persons show a similar pattern. They each have a larger share of workers in the 60-69 and 70+ age brackets compared to other racial and ethnic groups. They also have lower than average shares in the under 30 and 30-39 brackets compared to other groups. If the current workforce is retained in equal measure across race and ethnicity groups, we would expect that over time the proportion of American Indian/Alaskan Native, White and Other Race workers would decline as these cohorts exit the workforce.

Growing cohorts: On the other end of the spectrum, some cohorts show potential for growth over time. Asian, Black/African American, Latino/a/x and Native Hawaiian/Pacific Islander workers all show the opposite pattern of the aging cohorts. In these cases, the under 30 and 30-39 cohorts are higher proportions than the average in the workforce, and their 60-69 and 70+ cohorts are much lower. If it is maintained, their proportional representation in the workforce is likely to grow over time.

The total share of each race and ethnicity category compared to the population is shown in the far right column. This is included to give a sense of how changes in each category relate to the size of the full population of each race and ethnicity group. For example, while workers in the White category are showing the potential for decline as a proportion of the workforce based on their age cohort balance, they currently make up 80.3 percent of the workforce in this figure. The Oregon average for White persons as a share of the population is 75.0 percent, so that category can decline considerably before being underrepresented in proportion to the population.

Figure 3: Age structure of the health care workforce by race and ethnicity (2022)

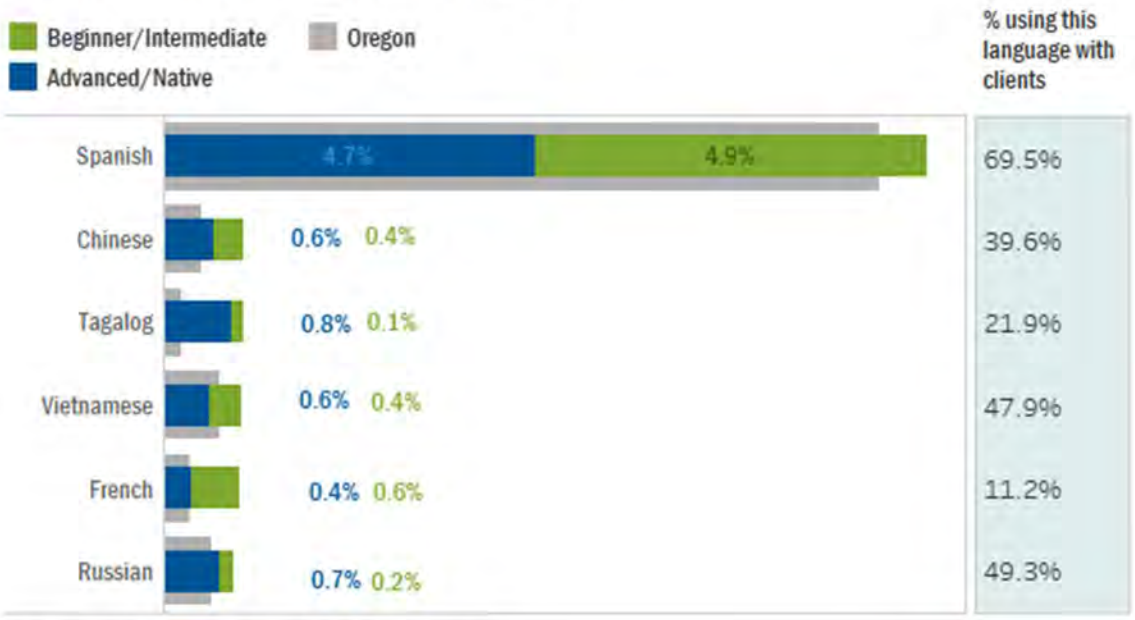


Note: Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Middle Eastern and White combined for this analysis. Participants choosing multiple races recategorized using rarest race methodology.

Language Proficiency

Of Oregon's health care professionals, 19.2 percent report speaking languages other than English. Of that group, 58.0 percent self-report either advanced proficiency or being a native speaker of another language and 46.4 percent report using a language other than English with patients (**Figure 4**). Spanish is the most frequently reported language spoken other than English among the health care workforce as well as among the Oregon population. While 9.6 percent of the workforce reports speaking Spanish, only 4.7 percent report advanced proficiency or being a native speaker of Spanish. Of the Spanish-speaking workforce, 69.5 percent report using Spanish with patients while providing care.

Figure 4: Top Languages Spoken by the Workforce
Workforce stratified by proficiency, compared to Oregon Population



Note: Chinese includes Mandarin and Cantonese.

The Role of Health Care Interpreters

There is no guarantee that a provider who speaks a particular language will be available when a non-English-speaking client needs one. Health care interpreters (HCI) help to fill the gaps. The use of language services, such as interpretation by qualified and certified HCIs, has been shown to improve cross-cultural communication, leading to increased compliance with recommended treatment plans, improved health care outcomes and ultimately, reduction in health disparities.[11] Additionally, increased patient engagement as a result of this improved communication may lead to a reduction in health care cost.[12] Oregon's Health Care Interpreter program is based on Title VI of the federal Civil Rights Act and Oregon law (ORS 413.550). To comply with these laws, OAR 333-002 was implemented to develop an HCI workforce and ensure the availability of quality health care interpretation for patients who are considered Limited English Proficient (LEP) and deaf and hard of hearing.

Certified and qualified interpreters must have formal training and experience and certified interpreters must pass national certification exams. As of December 2022, Oregon had 972 qualified and 284 certified health care interpreters. These numbers have increased from 257 and 91, respectively, since January 2017.

In 2021, the Health Care Workforce Reporting program (HWRP) carried out a pilot study of certified and/or

qualified HCIs in Oregon. Of the 719 HCIs in Oregon at that time, 149 completed the survey (response rate: 21.8 percent), with 94.0 percent of the respondents reporting that they were actively working in the field. Of the 149 respondents, 90 (60.4 percent) were qualified or certified as Spanish HCIs. The next most commonly reported language was American Sign Language (ASL), with 15 HCIs (10.0 percent of the sample) reporting being qualified or certified.

The clients served by the HCIs were concentrated in the Tri-County Metro Area, with 57.0 percent of survey respondents reporting serving clients in Multnomah County. No HCIs in the survey sample reported serving clients in Clatsop, Wheeler, Grant, Lake, Harney, Union, Baker or Malheur Counties.

You can find the HWRP Health Care Interpreter Pilot Study here.

Disability

Starting in January of 2021, HWRP began administering a series of six disability-related questions with one optional follow-up each. All licensing boards participated in this addition with the exception of Oregon Medical Board (OMB). The following questions were added:

- Are you deaf or do you have serious difficulty hearing?
- Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- Does a physical, mental or emotional condition limit your activities in any way?
- Do you have serious difficulty walking or climbing stairs?
- Do you have difficulty dressing or bathing?
- Because of a physical, mental or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

In the case of an affirmative answer to any of these questions, the licensee would be given a follow-up question "At what age did this condition begin?"

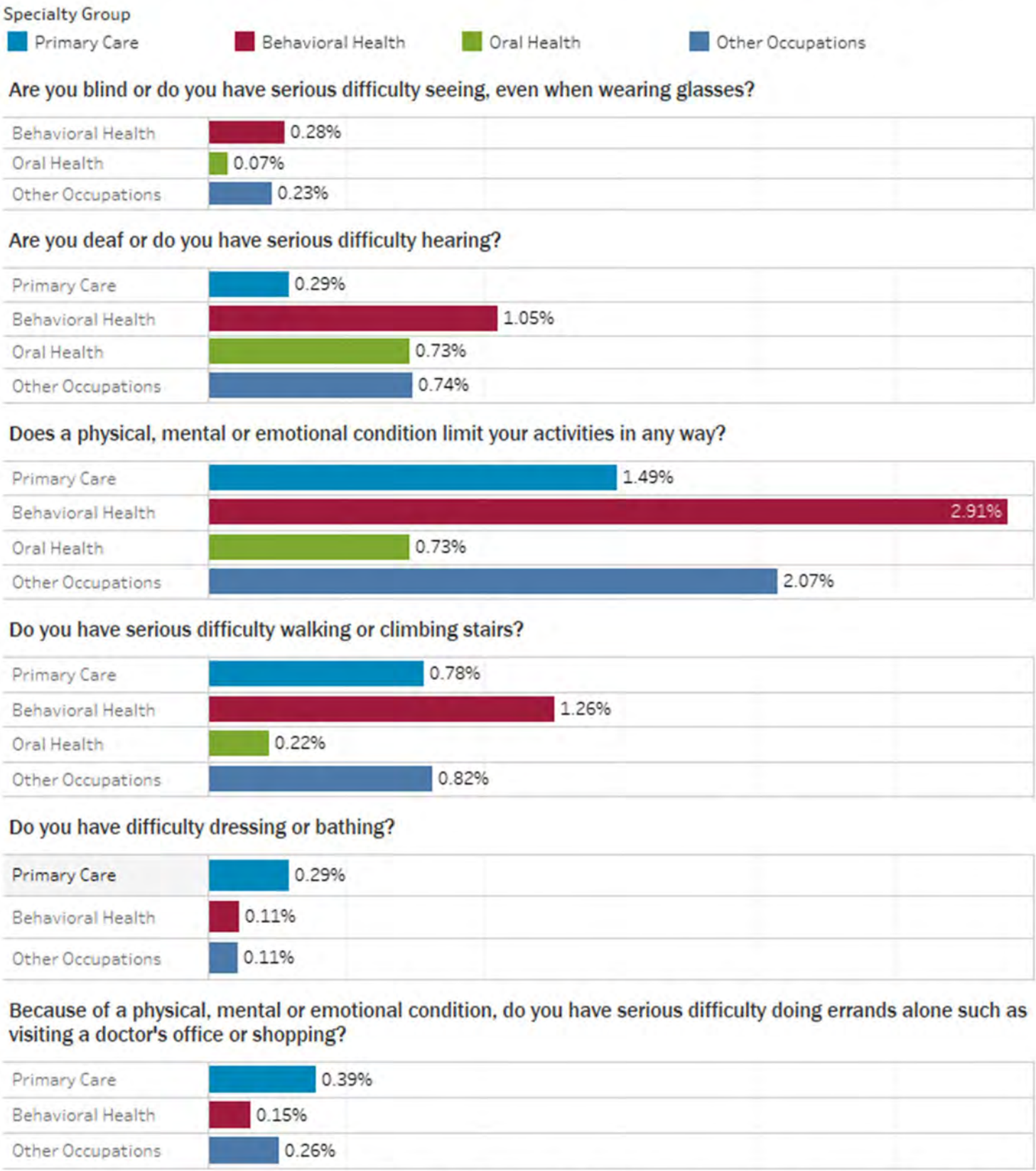
Figure 5 shows the findings from the first administration of these questions. As with the race and ethnicity question update, there is a significant portion of licensees who have not been asked these questions yet because of the renewal cycles particular to their board. These questions have been answered by 61.9 percent of the currently licensed health care workers in Oregon, and HWRP should approach 100 percent data collection for this measure by the next reporting cycle (excluding the Oregon Medical Board).

The current overall rate of Oregon residents with disabilities is 14.8 percent, with 1.7 percent of residents having two or more disabilities.[13] The rate of disability within the licensed health care workforce is much lower, at 2.6 percent for a single disability, and 0.5 percent reporting more than one disability.

Rates of specific disability by specialty group are shown in Figure 5. Because of the exclusion of Oregon Medical Board, the Primary Care data should be interpreted cautiously. This group currently includes nurse practitioners who specialize in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health; and naturopathic physicians who specialize in family medicine, pediatrics, geriatrics or obstetrics.

Overall, disability rates are highest within Behavioral Health occupations. The highest reported frequencies of disability are in conditions that limit activities, deafness or difficulty in hearing, and difficulty walking or climbing stairs.

Figure 5: Percentage and specialty area of licensed health care workers living with disability (2022)



Note: This table represents the 61.9 percent of licensed health care workers who responded to REALD-compliant surveys. Of the 38.1 percent missing, 84.0 percent can be considered missing at random based on licensing board data collection practices. Interpret these data with caution and consult the Supplemental Material and Methodology Section for more information about data collection and missing data. Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Categories with no affirmative answers excluded from figure.

Supplemental Material and Methodology

The Health Care Workforce Reporting Program (HWRP)

The HWRP collaborates with 17 health regulatory licensing boards, shown in **Table 2**, to collect, process and analyze data for over 35 occupations to understand Oregon's health care workforce; inform public and private educational and workforce investments; and inform policy recommendations for the Governor's Office, legislative leadership and state agencies regarding Oregon's health care workforce (Oregon Revised Statute [ORS] 676.410; Oregon Administrative Rule [OAR] 409-026).

For more information about methodology and results, visit: https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

Table 2: Participating Licensing Boards
Oregon Board of Chiropractic Examiners
Oregon Board of Dentistry
Oregon Board of Examiners for Speech-Language Pathology and Audiology
Oregon Board of Licensed Clinical Social Workers
Oregon Board of Licensed Dieticians
Oregon Board of Licensed Professional Counselors and Therapists
Oregon Board of Massage Therapists
Oregon Board of Medical Imaging
Oregon Board of Naturopathic Medicine
Oregon Board of Optometry
Oregon Board of Pharmacy
Oregon Board of Physical Therapy
Oregon Board of Psychology
Oregon Medical Board
Oregon Occupational Therapy Licensing Board
Oregon State Board of Nursing
Respiratory Therapist and Polysomnographic Technologist Licensing Board

Limitations

The HWRP collects data on occupations that are licensed in Oregon and covered by Oregon Revised Statute 676.410, so this dataset does not represent the entire health care workforce. The program does not currently collect data for many unlicensed health care professionals including traditional health workers, health care interpreters, qualified mental health professionals, addiction counselors, licensed professional counselor interns, lab scientists/technicians, medical assistants, ophthalmologist technicians and more.

As survey data is collected only from renewing licensees, data from new licensees is not included in this HWRP dataset. There is a time lag in reporting, so estimates reflect a historical point in time. Length of participation in the HWRP varies by board and reliability of estimates varies over time by occupation.

For this report, 12.1 percent of the licensed workforce declined to provide race and ethnicity data. 2.4 percent declined to provide data on gender. Individuals with missing data are excluded from the relevant charts in this report.

This report's collection period spans 2020 to 2022, and HWRP fully implemented REALD standards in January 2021. Since data collection is based on renewal cycles of licensed health care providers, and because the renewal cycles for licensing boards and license types vary, not all licensee types have full REALD data in this report. Fortunately, many licensing boards collect data annually, so they have complete REALD data based on collection from January 2021 to January 2022. However, some licensed occupations only renew every other year. If their collection falls on even numbered years, we will not have any REALD data until the 2022-2024 report. This is the case for acupuncturists, occupational therapists and pharmacy technicians. Another set of occupations renew over a two year period, with approximately half of their licensees renewing every year. This is true for dentists, dental hygienists, social workers, psychologists, massage therapists, radiographers and nurses. **Table 3** presents shows how many licensees have complete, missing at random, and missing not at random REALD data.

Table 3: REALD Data Collection Groupings

Data Characterization	N	Percent
Complete Data	77,741	61.9%
Data considered missing at random	40,195	32.0%
Data considered not missing at random	7,648	6.1%
Total	**125,584**	**100.0%**

The first group in **Table 3**, in green, has complete REALD data collection represented in this report (61.9 percent of the sample).

The second group in yellow, labeled "Data considered missing at random" is a group that has incomplete REALD data, but where the data collection has been done on a random basis. Licensed occupations within this group have renewal cycles based on either the birthdate of the licensee, or on an aspect of the license number, such as odd-numbered licenses renewing in odd-numbered years. We expect these subsamples to be sufficiently random to create a representative sample for their occupation group, and that there will be no correlation between birthdates or license numbers and demographic data. This portion of the sample represents 32.0 percent of our total licensed health care workforce population.

The final group in orange, labeled "Data considered not missing at random" is characterized by data collection that cannot be considered random and thus is more likely to introduce bias into the sample estimates. This includes a few smaller boards that have not yet collected appreciable REALD data on their licensees. These occupations have very small representation in the data set, and because they represent only the very beginning of license renewal periods the samples are very small and represent a self-selected group that may bias the sample. This portion of the sample represents 6.1 percent of our total licensed health care workforce population.

Missing data can be a serious issue when they are likely to change the results of an analysis, such as changing the proportions of various racial and ethnic groups compared to the full population. Certain types of missing data are more likely to change analysis results than others. Specifically, when data is missing not at random, some systematic characteristic about the survey respondents may be connected (correlated) to the reason their data are missing.[14] 6.1 percent of the responses fall within this category. The other 32.0 percent of missing data is unlikely to change the results of these analyses because they are missing at random, so it is reasonable to assume that the characteristics of licensees in this category without REALD data are similar to those with REALD data. Based on the REALD missing data described here, we encourage some caution in interpreting results of tables that include REALD data.

Table 3a presents REALD data completeness by board and occupation. The occupations with data missing not at random include acupuncturists (n=1,314), occupational therapists and occupational therapy assistants (n=1,743) and certified pharmacy technicians (n=4,729).

Table 3a: REALD Response Rate by Board and Occupation

Board	Occupation (s)	Total N	n with REALD	% REALD
Complete REALD Collection				
Board of Chiropractic Examiners	Doctors of Chiropractic, Chiropractic Assistants	2,179	2,179	100%
Medical Board	Physicians, Physician Assistants, Podiatrists	15,934	15,934	100%
Board of Naturopathic Medicine	Naturopathic Physicians	903	903	100%
Board of Pharmacy	Pharmacists	4,154	4,154	100%
Physical Therapy Licensing Board	Physical Therapists, Physical Therapists Assistants	4,480	4,480	100%
Board of Examiners for Speech-Language Pathology and Audiology	Audiologists, Speech-language Pathologists, Speech-language Pathologist Assistants	2,200	2,200	100%
	Subtotal:	29,850	29,850	100%
Partial REALD Collection, expectation of representative random sample				
Respiratory Therapist and Polysomnographic Technologist Licensing Board	Respiratory Therapists, Polysomnographic Technologists	1,610	1,608	99.9%
Board of Licensed Dieticians	Licensed Dieticians	743	739	99.5%
Board of Optometry	Optometrists	631	624	98.9%
Board of Licensed Professional Counselors and Therapists	Licensed Professional Counselors and Therapists	4,152	4,040	97.3%
Board of Psychology	Psychologists	1,752	1,267	72.3%
Board of Licensed Social Workers	Licensed Clinical Social Workers, Clinical Social Worker Associates, Non-clinical Social Workers	4,136	2,429	58.7%
State Board of Nursing	Nurse Practitioners, Certified Registered Nurse Anesthetists, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants	60,384	30,266	50.1%
Board of Dentistry	Registered Dental Hygienists	2,855	1,421	49.8%
Board of Dentistry	Dentists	2,675	1,292	48.3%
State Board of Massage Therapists	Licensed Massage Therapists	5,185	2,492	48.1%
Board of Medical Imaging	Radiographers, Radiation Therapists, Sonographers	3,825	1,575	41.2%
	Subtotal:	87,948	47,753	53.7%
Partial REALD Collection, small sample rate, unpredictable bias in population				
Medical Board	Acupuncturists	1,314	124	9.4%
Occupational Therapy Licensing Board	Occupational Therapists, Occupational Therapy Assistants	1,743	7	0.4%
Board of Pharmacy	Certified Pharmacy Technicians	4,729	7	0.1%
	Subtotal:	7,786	138	1.8%
	Total Sample:	**125,584**	**77,741**	**61.9%**

Methodology and Definitions

Data sources for this report include workforce data from the Health Care Workforce Reporting Program (HWRP) from 2014 through the first quarter of 2022. HWRP collects workforce-related information directly from health care professionals via a survey embedded in the license renewal process. Health care professionals with an active license in each reporting year (January 2018, 2019, 2020, 2021, 2022; month of verification varied by occupation in 2016), were included in this report. Estimates are dependent on licensees who completed the survey. Please refer to the HWRP's General Methods documentation on the website for further details.

Population data come from five-year ACS estimates (data collected over 60-month period, 2016–2020), imputed to represent REALD "parent" categories by the Equity and Inclusion Division. These estimates are not as current as the one-year estimates, but the primary advantage of using multiyear estimates is the data's availability and increased statistical reliability for less populated areas and small population subgroups. Population data reflect the total population (rather than the adult population), as the total population is served by the workforce.

Data were analyzed and tabulated with SAS 9.4; graphics were produced in Excel and Tableau 2022.

Race, Ethnicity, Language and Disability (REALD) demographic information:

Race & ethnicity: Both "parent" category and subgroup race and ethnicity categories in the workforce data were collected and analyzed using REALD procedures and methodology, as outlined in the REALD Implementation Guide. In brief, survey respondents were first asked an open-response question about how they identify their race, ethnicity, tribal affiliation, country of origin or ancestry (this open text identification was collected but not processed for use in this report). Respondents then selected all categories that apply from a list of 41 racial or ethnic identities (**Table 4**, see full form here). If a single category was selected, the respondent was assigned to that race or ethnicity category for data analysis. If more than one category was selected, respondents could indicate if they thought of one category as their primary racial or ethnic identity and they were assigned to the indicated primary race or ethnicity category for analysis. If no primary racial or ethnic identity was indicated but multiple race or ethnicity categories were selected, race or ethnicity category was assigned using the "rarest race first" methodology as described on page 94 of the REALD

Table 4:
REALD Race/Ethnicity Reporting Categories

"Parent" Group	Subgroup
American Indian or Alaska Native	American Indian
	Alaska Native
	Canadian Inuit, Métis or First Nation
	Indigenous Mexican, Central or South American
Asian	Asian Indian
	Cambodian
	Communities of Myanmar
	Chinese
	Filipino/a
	Hmong
	Japanese
	Korean
	Laotian
	South Asian
	Vietnamese
	Other Asian
Black or African American	African
	African American
	Afro-Caribbean
	Ethiopian
	Other African (Black)
	Other Black
Native Hawaiian or Pacific Islander	Guamanian or Chamorro
	Communities of the Micronesian Region
	Native Hawaiian
	Samoan
	Marshallese
	Other Pacific Islander
Middle Eastern/ North African	Middle Eastern
	North African
White	Slavic
	Eastern European
	Western European
	Other White
Hispanic or Latino/a/x	Mexican
	Central American
	South American
	Other Hispanic or Latinx

Implementation Guide.

In order to compare health care workforce data to the Oregon population, statewide population estimates were created from American Community Survey (ACS) Public Use Microdata Sample (PUMS) by the OHA Equity and Inclusion Division using the protocol described beginning on page 94 of the REALD Implementation Guide.

Language: Survey respondents were asked if they speak languages other than English. If the response was "yes", the individual could then select up to two languages that they speak other than English. Respondents also provided their proficiency level, if they had received training in medical terminology in the selected language(s), if they use the language(s) while providing patient care, and if they are certified as a bilingual provider or medical interpreter. All respondents were also asked about their English proficiency.

Disability: Survey respondents were asked if they experience functional difficulties, including difficulty hearing; seeing; walking or climbing stairs; concentrating, remembering or making decisions; dressing or bathing; learning how to do things; communicating; doing errands alone; or with mood, intense feelings, controlling their behavior, or experiencing delusions or hallucinations. Respondents who indicated "yes" to any of these were then asked at what age the condition began.

Specialty groups definitions

- **Primary care providers** include physicians and physician assistants who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology; nurse practitioners who specialize in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/ gynecology/women's health; and naturopathic physicians who specialize in family medicine, pediatrics, geriatrics or obstetrics.
- **Behavioral health providers** include all psychologists, counselors and therapists, licensed clinical social workers, and clinical social work associates; physicians and physician assistants who specialize in psychiatry (addiction, neurology, child, adolescent, geriatric, or forensic) or psychoanalysis; nurse practitioners who specialize in psychiatry/mental health; and naturopathic physicians who specialize in mental health.
- **Oral health providers** include dentists who specialize in general dentistry, pediatric dentistry or public health; and expanded practice dental hygienists who specialize in general dentistry, pediatric dentistry or public health and who report holding an expanded practice permit.

References

1. National Center for Health Statistics (US). Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. 2016.
2. Reichard A, Stolzle H, Fox, MH. Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States. Disability and Health Journal 2011; 4: 59-67.
3. Divi C, Koss RG, Schmaltz SP, Loeb, JM. Language proficiency and adverse events in US hospitals: a pilot study. International Journal for Quality in Health Care 2007; 19: 60-67.
4. Dent RB, Vichare A, Casimir J. Addressing Structural Racism in the Health Workforce. Med Care. 2021;59 (Suppl 5):S409-S412.
5. Watson S. Credentials don't shield doctors, nurses from bias. WebMD; 2017. Available from: www.webmd.com/a-to-z-guides/news/20171018/survey-patient-bias-toward-doctors-nurses.
6. Blackstock U. Why Black doctors like me are leaving academic medicine. First Opinion; 2020. Available at: www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/.
7. Serafini K, Coyer C, Brown Speights J, et al.. Racism as experienced by physicians of color in the health care setting. Fam Med. 2020;52:282–287.
8. Cohen, JJ, Gabriel, BA, Terrell, C. The case for diversity in the health care workforce. Health Affairs 2002; 21: 90-102.
9. Jackson CS, Gracia JN. Addressing health and health-care disparities: the role of a diverse workforce and the social determinants of health. Public Health Rep. 2014; 129 Suppl 2(Suppl 2): 57-61.
10. McGee, M.G. Race, ethnicity, language and disability (REALD) implementation guide. Portland, Oregon: Oregon Health Authority, Equity and Inclusion Division. 2020.
11. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Services Research 2007; 42: 727-754.
12. Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. Health Affairs 2015; 34: 431-7.
13. McGee, M.G. Imputed Values for REALD Interpretation of American Community Survey (ACS) Public Use Microdata Sample (PUMS) 5-year data. Portland, Oregon: Oregon Health Authority, Equity and Inclusion Division. 2022.
14. Rubin, D. Inference and missing data, *Biometrika*, Volume 63, Issue 3, December 1976, 581–592.

For questions about this report, contact

Health Care Workforce Reporting Program
Research and Data
Oregon Health Authority
Wkfc.Admin@dhsoha.state.or.us
971-283-8792

Report authored by Andy Davis, Meredith Halling, Sara Grusing, Derek Reinke and Piper Block. Thank you to the licensing boards who supported this analysis. All errors are the authors'.

Suggested Citation

Oregon Health Authority. (2023). The Diversity of Oregon's Licensed Health Care Workforce: Based on data collected from 2014 through January 2022. Portland, OR: Oregon Health Authority. https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Health-Care-Workforce-Reporting.aspx

Oregon Health Authority

HEALTH POLICY AND ANALYTICS
Office of Health Analytics

From: Molina, Bernadette <molinab@ada.org>
Sent: Thursday, November 16, 2023 10:40 AM
To: PRISBY Stephen * OBD <stephen.prisby@obd.oregon.gov>
Cc: Molina, Bernadette <molinab@ada.org>
Subject: State Board Participation on 2024 Accreditation Site Visits - OR

Dear Mr. Prisby:

The Commission on Dental Accreditation (CODA) would like to extend an invitation to your State Board for participation in the upcoming 2024 site evaluation. To aid the Commission in preparing for the site visit evaluation, please complete the attached "***Confirmation of State Board Participation***" form and return it by **December 15, 2023**. **If additional time is needed, please let me know**.

The institutions listed below have indicated a willingness to have a representative of your state board participate in CODA's 2024 on-site evaluations of the following dental education programs:

Dental Hygiene Education Initial Accreditation Site Visit:

Rogue Community College, Grants Pass, 1/24/2024 to 1/25/2024

Dental School Education Accreditation Site Visit:

Oregon Health & Science University School of Dentistry, Portland, 10/15/2024 to 10/17/2024

Appointment Process: In accordance with the attached policy statement for state board participation on site visit teams, the state board of dentistry is requested to submit the names of ***two*** representatives who are ***current members*** of the board for each site visit listed. The Commission will then ask the institution to select ***one*** individual to participate on the visit. You will be notified when the institution has selected a representative. Prior to the visit, the representative will receive an informational packet from the Commission and the self-study document from the institution.

Confirmation of State Board Participation Form (to be returned): The board of dentistry is requested to complete this form for each program identified above. It must be returned by the due date, regardless of whether the response from the State Board is yes or no.

Once the completed form is received, we will notify the institution of your availability to participate**. Please note, the state board reimburses its members for ALL expenses incurred during the site visit**.

Conflicts of Interest: When selecting its representatives, the state board should consider possible conflicts of interest. These conflicts may arise when the representative has a family member employed by or affiliated with the institution; or has served as a current or former faculty member, consultant, or in some other official capacity at the institution. Please refer to the enclosed policy statements for additional information on conflicts of interest.

Time Commitment: **It is important that the selected representative be fully informed regarding the time commitment required**. In addition to time spent reviewing program documentation in advance of the visit, the representative should ideally be available the evening before the visit to meet with the Commission's site visit team. Only one state board representative may attend each site visit to ensure that continuity is maintained; the representative is expected to be present for the entire visit.

Confidentiality and Distribution of Site Visit Reports: Please note that, as described in the enclosed documents, state board representatives attending CODA site visits must consider the program's self-study, site visit report, and all related accreditation materials confidential. Release of the self-study, report, or

other accreditation materials to the public, including the state board, is the prerogative of the institution sponsoring the program. **State Board representatives who attend a site visit will be requested to sign a confidentiality agreement. If the confidentiality agreement is not signed, the individual will not be allowed to attend the site visit.**

If the Commission can provide further information regarding its site visit evaluation process, please feel free to contact me. Thank you in advance for your efforts to facilitate the board's participation in the accreditation process.

Attachment: *(to be returned by December 15, 2023)*

- *Confirmation of State Board Participation Form*

Additional Informational Documents:

- *Policy on State Board Participation and Role During a Site Visit*
- *Policy on Conflict of Interest*
- *Policy on Public Disclosure and Confidentiality*
- *Name or Contact Information Change Form*

Thank you,
Bernadette

Bernadette Molina molinab@ada.org
Site Visit Coordinator
Commission on Dental Accreditation (CODA)
312-440-2668 Office

https://www.roguecommunity.net/

Rogue Community College Seeks Dental Hygiene Program Accreditation

October 24, 2023 / **RCC**

Jackson and Josephine counties (Oct. 24, 2023) – The proposed Dental Hygiene program at Rogue Community College (RCC) is seeking accreditation from the Commission on Dental Accreditation (CODA)—a specialized accrediting body recognized by the United States Department of Education.

RCC's program has the potential to meet the Accreditation Standards for Dental Hygiene Education Programs, so a site visit has been scheduled for Jan. 24-25, 2024. The site visit process includes an opportunity for the public/interested parties to submit written comments about the Dental Hygiene Program at RCC. Comments must pertain only to the Accreditation Standards for Dental Hygiene Education Programs or the policies and procedures used in the Commission's accreditation process.

Signed or unsigned comments will be considered. Signatures will be removed from comments before they are forwarded to the program. Individuals who desire to submit third party comments may contact the Commission office for submission guidance. Third party comments should be emailed to the appropriate Commission staff; comments should not be sent to the Commission office via the US Postal Service.

The Commission has established Accreditation Standards for Dental Hygiene Education Programs to guide program administrators, faculty and staff in developing and maintaining acceptable quality in educational programs.

These standards address 1) institutional effectiveness; 2) educational program; 3) administration, faculty and staff; 4) institutional support services; 5) health and safety provisions; 6) patient care services.

A copy of the dental hygiene accreditation standards and/or the Commissions policy on third-party comments may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611, or by calling 1-800-621-8099, extension 4653. Third party comments must be received by the Commission no later than Nov. 23, 2023.

For more information, email: **coda@ada.org**. Commission staff can be contacted at:

Katie Navickas, manager, 312-440-2695

Daniel Sloyan, coordinator, 312-440-2718

Zaira Perez Limon, senior project assistant, 312-440-2829

###

For general media inquiries or to schedule an interview with RCC staff, please contact Director, Marketing & Communications/PIO Kelly Gonzales at 541-955-7525, kgonzales@roguecc.edu.

Category: **In the News**

Previous Post

ROGUE COMMUNITY COLLEGE CELEBRATES FIRST-GENERATION COLLEGE STUDENTS

Next Post

NEED SOME SWAG?

RCC
Rogue Community College

Rogue Community College seeks the Oregon Higher Education Coordinating Commission's approval to offer an instructional program leading to an Associate of Applied Science Degree in Dental Hygiene.

Program Summary

This six-term program prepares students to meet requirements to become dental hygienists with expanded functions. Successful completion of the program leads to eligibility to sit for the Western Regional Exam Board (WREB). The curriculum is based in Dental Hygiene theory; students are trained in preventative procedures, periodontology therapy, pain management, dietary and health promotion, restorative treatment, and patient relations. Program students attend classes as part of a structured cohort that begins once each academic year. Students should apply early as the required mandatory orientation is scheduled several months prior to the scheduled start. If students intend to transfer to Oregon Tech's Bachelor's Degree in Dental Hygiene program after successfully completing RCC's AAS program, transfer courses should be chosen from the list of electives where possible. See an advisor or visit www.oit.edu.

1. ***Describe the need for this program by providing clear evidence***.
   According to the Department of Labor Growth by Major Industry Sector Statistics, health care and social assistance careers are expected to increase by more that 10 percent by 2024. Currently the need for dental hygienists are met through training outside the Rogue Valley and the industry demand for hygienists in our area validates the need for a local training opportunity.

2. ***Does the community college utilize systemic methods for meaningful and ongoing involvement of the appropriate constituencies?***
   This program was developed and endorsed by members of our dental advisory committee as necessary to support community health and industry need. Representatives from local dental offices were represented in the development of program goals and outcomes. Successful completion of the courses developed will provide students with both the didactic and hands-on practical experiences needed to sit for the Western Regional Exam Board (WREB).

3. ***Is the community college program aligned with appropriate education, workforce development, and economic development programs?***
   The curriculum in these courses is derived from a set of identified learning outcomes that are relevant to the discipline are based on Dental Hygiene theory; Students are trained in preventative procedures, periodontology therapy, pain management, dietary and health promotion, restorative treatment, and patient relations. This will prepare students to meet requirements to become Dental Hygienists with

expanded functions and meet industry needs. The degree aligns with the college mission to provide quality learning opportunities for students to achieve their goals and support the vitality of our community.

4. ***Does the community college program lead to student achievement of academic and technical knowledge, skills, and related proficiencies?***
   The Dental Hygiene, six-term AAS Degree prepares students for work in professional level positions in dental clinic settings. Students will learn all phases of patient care related to dental hygiene (including expanded functions) and comply with federal and state regulatory agency laws and regulations. Students will also be prepared to meet industry standard expectations upon graduation. The program includes over 700 hours of clinical experience so students experience hands on, practical application of their knowledge.

5. ***Does the community college identify and have the resources to develop, implement, and sustain the program?***
   Development and implementation of this program is believed to be sustainable through the industry need for well-trained dental hygienists combined with local training. Due to the projected increase of employment opportunities and the ability for students to circumvent relocating in order to access training, there is a high likelihood for sustainability. Due to the nature of the program, several courses can be delivered in a hybrid format decreasing costs and also increasing the likelihood for sustainability. The dramatic support from local industry and the support of a bond to provide the resources for a fully functioning ten operatory dental clinic will make the development and implementation of this program feasible.

Assurances

Rogue Community College has met or will meet the four institutional assurances required for program application.

1. *Access*. The college and program will affirmatively provide access, accommodations, flexibility, and additional/supplemental services for special populations and protected classes of students.
2. *Continuous Improvement*. The college has assessment, evaluation, feedback, and continuous improvement processes or systems in place. For the proposed program, there will be opportunities for input from and concerning the instructor(s), students, employers, and other partners/stakeholders. Program need and labor market information will be periodically re-evaluated and changes will be requested as needed.
3. *Adverse impact and detrimental duplication*. The college will follow all current laws, rules, and procedures and has made good faith efforts to avoid or resolve adverse *inter*segmental and *intra*segmental impact and detrimental duplication problems with other relevant programs or institutions.

4. *Program records maintenance and congruence*. The college acknowledges that the records concerning the program title, curriculum, CIP code, credit hours, etc. maintained by the Office are the official records and it is the college's responsibility to keep their records aligned with those of the Office. The college will not make changes to the program without informing and/or receiving approval from the Office.

NEWSLETTERS & ARTICLES OF INTEREST

Oregon Wellness Program
An Urgent Mental Health Counseling Program Serving
All of Oregon's 139,000 Licensed
Physicians, Advanced Practice Nurses, Nurses (RN, CAN, LPN), Dentists, Dental Hygienists, Dental Therapists, Acupuncturists and Physician Assistants

The Oregon Wellness Program (OWP) is a state-wide mental health counseling program dedicated to confidentially serving the urgent needs of Oregon's health care professionals. The OWP firmly believes that a healthy workforce is critical to the best care for all Oregonians. It provides services to clients who self-refer (not referred by employers or family or friends) and does not offer services to respond to drug or alcohol abuse disorders or practice competency concerns. These are in the purview of the relevant licensing boards.

OWP services are 100% confidential and free of charge to the client. No insurance is billed. The client is eligible for up to eight, one-hour counseling sessions per year.

Services are provided by a mental health care team of 35 professionals ranging from MSWs, PMHNPs, Psych Ds, PhDs to MD/DO Psychiatrists. All services are currently offered via telehealth. To participate in the program, the mental health care team member must be recommended by their professional colleagues, have experience in treating fellow health care professionals, be in good standing with their professional board, be in private practice, have in-force professional liability insurance, commit to see clients within three (3) business days of initial client contact and accept a standard one-hour fee for services with no supplemental billings.

Since its inception in 2018, the state-wide program has provided care to every individual who has requested services, totaling over 6,000 counseling sessions. The program began with services limited to physicians and physician assistants and it expanded to advanced practice nurses in 2020 and dentists in late 2021. Oregon's nurses were incorporated starting in the summer of 2022. In 2023, with the support of the Oregon Board of Dentistry, Dental Hygienists and Dental Therapists were incorporated.

The program is funded by multiple sources: license fees from physicians, nurses and physician assistants, dentists, dental hygienists, dental therapists, and donations from health systems and insurers.

LICENSE RATIFICATION

RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8734	POTTER, BRITTNEY R	2023-10-05	RDH
H8735	SCHREIBER, TODD LAYTON	2023-10-05	RDH
H8736	PRADO OROZCO, ARNOLDO	2023-10-13	RDH
H8737	QUINN, HEATHER DAWN	2023-10-13	RDH
H8738	RAMIREZ RODRIGUEZ, JOCELYN LILITH	2023-10-13	RDH
H8739	KEOMANIVONG, RENEE NOY	2023-10-13	RDH
H8740	LE, TRUC-LAN HOANG	2023-10-13	RDH
H8741	VO, THAO THI THU	2023-10-13	RDH
H8742	SAPIZHINSKA, VALENTYNA	2023-10-16	RDH
H8743	STUBBLEFIELD, JESSICA ROSE	2023-10-23	RDH
H8744	GILSON, EMILY ANN VIOLET	2023-10-23	RDH
H8745	EASTON, SHELLY CHRISTINE	2023-11-01	RDH
H8746	ESTRADA HERRERA, LEILANI MARIA	2023-11-01	RDH
H8747	LE, KATHY KIM	2023-11-03	RDH
H8748	HOYT, JESSICA TERRILL	2023-11-03	RDH
H8749	MITCHELL, KATHLEEN MARIE	2023-11-15	RDH
H8750	SHAHID, TABASSUM	2023-11-15	RDH
H8751	SAFAEI, ZAHRA	2023-11-15	RDH
H8752	MURILLO, TREISI N	2023-11-15	RDH
H8753	LEONCHIK, ALLA	2023-11-15	RDH
H8754	LAMA, CHIME DORJEE	2023-11-21	RDH
H8755	STROH, PAYTON	2023-11-22	RDH

DENTISTS

D11895	DERINGER, ELISE	2023-10-11	DDS
D11896	HRABIK, NICHOLAS FRANKLIN	2023-10-11	DDS
D11897	PARK, JOSHUA JAEYOON	2023-10-13	DDS
D11898	LACOSTE, AMY NICOLE	2023-10-13	DMD
D11899	CUDA, LAUREN ANNE	2023-10-13	DDS
D11900	NEWTON, ADRIENNE MEREDITH	2023-10-13	DMD
D11901	DAS, SUBHASHISH	2023-10-16	DDS

D11902	PATEL, MEGA HARSHAD	2023-10-23	DDS
D11903	TURNER, OLAIFA VERNA	2023-10-23	DMD
D11904	BURGSTAHLER, ELIZABETH	2023-10-23	DMD
D11905	HALAWEH, ANAS QAIS	2023-10-23	
D11906	HOPKINS, AUBREY RUSSELL	2023-10-31	DMD
D11907	GHATORE, KAREN KAUR	2023-10-31	DDS
D11908	KLEIN, MARGARET JOAN	2023-11-01	DDS
D11909	YANG, JING IRIS	2023-11-01	DMD
D11910	GOMEZ, NORMA	2023-11-01	DDS
D11911	TIAN, FUCONG	2023-11-06	
D11913	HOLT, JOHN BENJAMIN	2023-11-15	DMD
D11914	ZEGAROWSKI, BRANDON JAN	2023-11-15	DDS
D11915	ARCHER, WESLEY	2023-11-15	DMD
D11916	GROMAK, ADAM	2023-11-15	DDS
D11917	BAWEL, TARA ELIZABETH	2023-11-20	DDS
D11918	OWUSU-DOMMEY, AKUA	2023-11-20	DDS
D11919	WOODMANSEY, KARL FREDERICK	2023-11-21	DDS
D11920	CHONG, ISAAC	2023-11-21	DDS

DENTAL THERAPISTS

DT0018	MOSES, KRISTEN LOREE	2023-11-20	DT, RDH

LICENSE, PERMIT & CERTIFICATION

Nothing to report under this tab