COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

Healthcare Branch
Colorado Dental Board

POLICIES

EFFECTIVE JULY 13, 2016

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SECTION 1: ADMINISTRATIVE POLICIES

1.A. ACCEPTANCE OF CLINICAL EXAMINATIONS (Adopted 8/15/2001; Amended 2/24/2016)

The Dental Practice Act declares in section 12-35-102 of the Colorado Revised Statutes (C.R.S.) that it is "…a matter of public interest and concern that the dental profession merit and receive the confidence of the public and that only qualified dentists and dental hygienists be permitted to practice dentistry or dental hygiene in this state." Thus, the Colorado Dental Board ("Board") may only grant licenses to qualified dentists and dental hygienists interested in practicing dentistry or dental hygiene in Colorado. In addition, the Board recognizes that the public's oral health care is facilitated and enhanced by sufficient numbers of qualified dentists and dental hygienists practicing in Colorado.

One means by which dentists and dental hygienists are determined to be qualified (or competent) to practice in Colorado is through successful completion of a clinical examination. Clinical examinations were historically developed and administered by individual states and groups of states that formed regions. The model has now slightly evolved to where 2 of the 5 "regional" testing agencies administer the clinical examination developed by the American Board of Dental Examiners (ADEX), while the 3 remaining testing agencies develop and administer their own examinations. The testing agencies that currently administer the clinical dental and dental hygiene examinations developed by ADEX include The Commission on Dental Competency Assessments (CDCA), which was formerly the North East Regional Board (NERB); and the Council of Interstate Testing Agencies, Inc. (CITA). The testing agencies that currently develop and administer their own examinations are the Central Regional Dental Testing Services, Inc. (CRDTS); the Southern Regional Testing Agency, Inc. (SRTA); and the Western Regional Examining Board (WREB). Only one state (Delaware) still develops and administers its own clinical examination.

Over the last several years, other methodologies designed to test a dentist's clinical skills and knowledge have emerged in the United States. California has developed a "Hybrid Portfolio" as an initial licensure pathway that is administered by the 5 Commission of Dental Accreditation (CODA) approved dental schools in the state of California under direct oversight and regular auditing by the Dental Board of California. Some states accept completion of a clinically-based postdoctoral general practice or specialty dental residency program, of at least 1 year's duration, in a hospital or dental facility, which is referred to as PGY-1. The Canadian Objective Structured Clinical Exam (OSCE) is accepted by one state (Minnesota) and administered in a handful of border states.

The exclusivity of these state and "regional" examinations, or other state methodologies designed to test the applicant's clinical skills and knowledge does not well serve the need to license competent practitioners educated and examined outside of the state or region in which the clinician desires to practice. Because of the inherent restrictive nature that requiring one specific state or "regional" examination, or a state specific methodology creates, the Board establishes the following policy:

> The Colorado Dental Board accepts all U.S. dental and dental hygiene clinical examinations that provide adequate assurance of competency and safety to practice for dental and dental hygiene licensure candidates, which currently includes the exams developed by ADEX and administered by CDCA and CITA; and the exams developed and administered by Delaware, CRDTS, SRTA, and WREB. All parts of a clinical examination are required to be successfully completed and no part of an examination is considered optional for purposes of Colorado licensure. Periodontal testing for dentists is required, as are other exam components that may be made optional by testing agencies or other state boards.
>
> The Colorado Dental Board accepts successful completion of a PGY-1, portfolio, or OSCE requirement in lieu of a clinical examination for dentists. Dentists submitting successful completion of a PGY-1 or portfolio model for consideration are required to be first licensed in the state/jurisdiction where the PGY-1 or portfolio was completed, or in another jurisdiction where a state board has

reviewed and accepted it towards licensure before applying for licensure in Colorado.

Examinations and, in the case of dentists only, other methodologies designed to test the applicant's clinical skills and knowledge, which may include residency and portfolio models, must meet the statutory requirement of sections 12-35-119(1)(c) or 12-35-127(1)(b), C.R.S., in order to be accepted in Colorado.

1.B. REVIEW AND APPROVAL OF SEDATION AND ANESTHESIA PERMIT APPLICATIONS (Adopted 2/25/2015; Amended 7/13/2016)

i. Review of Dental Hygienist Applications for Local Anesthesia Permits by Division staff

A. The Colorado Dental Board ("Board") and the assigned Licensing Panels delegate to the Division staff authority to approve dental hygienist applications for Local Anesthesia Permits that satisfy the requirements of the application process, including section 12-35-140, C.R.S., and Board Rule XIV, 3 Code Colo. Reg. 709-1.
B. The assigned Licensing Panel will review applications where there is uncertainty whether an application satisfies all requirements.

ii. Review of Dentist Applications for Sedation and Anesthesia Permits by Anesthesia Application Consultant Committee and Division Staff

A. Purpose of the Anesthesia Application Consultant Committee

1. The Board recognizes that technical knowledge and expertise regarding dental anesthesia aids the Board and its Licensing Panels in reviewing dentist applications for a permit to administer minimal sedation, moderate sedation, or deep sedation/general anesthesia ("Anesthesia Applications") pursuant to sections 12-35-102, 12-35-107(1)(h) and (3), and 12-35-140, C.R.S. To provide such technical knowledge, expertise, and consultation in furtherance of the Board's duty to protect the public and to regulate open and safe access to dental anesthesia care, the Board may request and authorize individual volunteer consultants to serve on an Anesthesia Application Consultant Committee ("Committee"). The Board may request and authorize the Committee to make specific recommendations to the Licensing Panel regarding Anesthesia Applications.

2. The purpose of the Committee is to provide technical knowledge, expertise, and consultation regarding dental anesthesia to the Board and its Licensing Panels, review Anesthesia Applications, and make recommendations to the assigned Licensing Panel regarding each applicant's compliance with section 12-35-140, C.R.S., Board Rule XIV, and related requirements.

3. The assigned Licensing Panel retains all decision-making functions and authority to grant, deny, or take other lawful action on all Anesthesia Applications, regardless of the Committee's recommendation.

B. Composition of the Anesthesia Application Consultant Committee

1. The Committee may consist of no more than five (5) individual authorized volunteer members ("Members") with specialties or credentials as follows and as may be further determined by the Board from time to time:

a. Each Member must possess a valid license to practice dentistry in the state of Colorado;
b. Each Member must possess a valid permit to administer moderate sedation or deep sedation/general anesthesia;
c. At least two Members must possess a valid Deep Sedation/General Anesthesia

Permit; and

d. At least 2 members must possess a valid Pediatric Designation.

2. The Board will designate Members as consultants to serve on a volunteer basis for an initial three or four-year commitment, commencing on February 25, 2015. The Board may designate Members for one additional four-year commitment, regardless of the length of the original designation. Thereafter, all designations will be for a four-year commitment. Each Member serves at the Board's discretion.

3. Each Member's participation in the Committee is conditioned upon: serving as a consultant within the requests of the Board and the assigned Licensing Panel to protect the public; and signing a confidentiality agreement relating to confidential and protected information, such as proprietary information, scholastic achievement data, and patient records.

C. Meetings of the Anesthesia Application Consultant Committee

1. The Program Director or other Division staff delegatee will conduct the Committee meetings.

2. The Committee will organize at such times, places, and in the manner requested by the Board or the Program Director.

3. The quorum for a Committee recommendation is three (3) Members, with at least one (1) Member who possesses a Deep Sedation/General Anesthesia Permit.

D. Procedure for Reviewing Anesthesia Applications

1. Anesthesia Applications

a. Except as described in this Policy, the Committee will receive and review all Anesthesia Applications, including all necessary documentation.

b. With its overall recommendation, the Committee will first provide the Applicant with a written statement identifying each instance where the Anesthesia Application does not comply with section 12-35-140, Board Rule XIV, or related requirements, including the specific provision or subsection thereof. The Applicant will be afforded an opportunity to cure any deficiency through the Committee before a recommendation and cited deficiencies are sent to the Licensing Panel for consideration.

2. Minimal Sedation Permit Applications

a. Review. Based on its assessment of the Application's compliance with Board Rule XIV, the Committee will make a recommendation to the Licensing Panel whether to grant or deny a Minimal Sedation Permit Application.

b. Delegation to Division staff to Approve Minimal Sedation Permit Applications under Board Rule XIV(I) by residency or educational criteria for Moderate Sedation or Deep Sedation/General Anesthesia Permit, or renewal of a Minimal Sedation Permit. The Licensing Panel delegates authority to Division staff to review and approve the education program of an applicant who has completed a specialty residency or renewal of any Minimal Sedation Permit as long as there is no uncertainty whether an application satisfies all requirements. If Division staff does not exercise such delegated authority, the Committee will review the Application and make its recommendation to the Licensing Panel.

3. Moderate Sedation Permit Applications

    a. Review. Based on its assessment of the application's compliance with Board Rule XIV, the Committee will make a recommendation to the Licensing Panel to grant or deny an Inspection Permit for Applicant to undergo a clinical on-site inspection in accordance with Board Rule XIV(L).

    b. Delegation to Division staff to Approve Inspection Permit for Moderate Sedation Permit Applications by Education-Only Route under Rule XIV(J)(1). The Licensing Panel delegates authority to Division staff to review and approve the education program of an applicant who has completed an oral surgery or dental anesthesiology residency in compliance with Board Rule XIV(J)(1). If Division staff does not exercise such delegated authority, the Consultant Committee will review the Application and make its recommendation to the Licensing Panel.

    c. Inspection Permit to Undergo Clinical On-Site Inspection. Upon the delegatee or Licensing Panel's approval, Division staff will issue an Inspection Permit for Applicant to undergo a clinical on-site inspection in accordance with Board Rule XIV(L).

    d. Inspection Report. Upon an Applicant's completion of a clinical on-site inspection under an Inspection Permit, the Committee will review the Inspection Report and will make a recommendation to the Licensing Panel whether to grant or deny a Moderate Sedation Permit.

4. Deep Sedation/General Anesthesia Permit Applications.

    a. Delegation to Division Staff to Approve Inspection Permit for Deep Sedation/General Anesthesia Permit Applications from Certain Applicants. The Licensing Panel delegates authority to Division staff to review and approve the education program of an applicant who has completed an oral surgery or dental anesthesiology residency or post-doctoral training program in compliance with Board Rule XIV(K). If Division staff does not exercise such delegated authority, the Committee will review the Application and make its recommendation to the Licensing Panel.

    b. Inspection Permit to Undergo Clinical On-Site Inspection. Upon the delegatee or Licensing Panel's approval, Division staff will issue an Inspection Permit for Applicant to undergo a clinical on-site inspection in accordance with Board Rule XIV(L).

    c. Inspection Report. Upon an Applicant's completion of a clinical on-site inspection under an Inspection Permit, the Committee will review the Inspection Report and will make a recommendation to the Licensing Panel whether to grant or deny a Deep Sedation/General Anesthesia Permit.

E. Requests for Extensions of Time for Inspection Permits Approved by Delegation

For an Inspection Permit approved by delegation through this Policy, the Licensing Panel delegates authority to Division staff to review and grant one request for extension of time for up to ninety (90) days. The Licensing Panel may consider any subsequent requests.

iii. Ratification

The Licensing Panel will receive and be asked to ratify a list of Applicants detailing the approval

category administratively approved and Inspection Permits approved by delegation since the previous Licensing Panel meeting.

iv. Audit for Compliance with Continuing Education Requirements

The Committee will review all materials submitted in response to an audit and based on its assessment of compliance with Board Rule XIV(R)(5), it will forward any findings of non-compliance to the appropriate Inquiry Panel for potential disciplinary action.

1.C. BOARD RECORDS AND DOCUMENTS (Adopted 5/24/1990) (Amended 8/24/1994) (Amended 6/2/2004; Amended 1/15/2009; Amended 7/13/2016)

i. The Division staff shall be responsible for maintaining as a public record the following documents:

A. Notice of charges or formal complaints of the Office of the Attorney General after service has been made upon the licensee;

B. Formal answers filed by licensees;

C. Initial decisions of administrative law judges;

D. Final board/agency orders;

E. Any judicial review decisions;

F. Stipulations (unless confidential pursuant to statutory authorization at the time executed);

G. Letters of Admonition when the document becomes a public record;

H. Orders of suspension, orders of summary suspension, orders vacating suspensions, and interim cessation of practice agreements; and

I. Final cease and desist orders (unauthorized practice or restricting an area or areas of practice), injunctions, temporary restraining orders, contempt citations, and other documents addressing unauthorized practice.

ii. No other documents maintained in a disciplinary record will be available for public inspection.

iii. Documents that are not considered part of the public record shall be released only through discovery procedures upon referral for formal disciplinary proceedings. Such documents include, but are not limited to the following:

A. Complaints;

B. Reports of investigations;

C. Exhibits; and

D. Patient records.

iv. Complaints dismissed by the Board without any action taken are not public records and shall not be available for inspection by the public nor shall they be required to be released through formal discovery. The Board shall release said documents only pursuant to a court order.

v. Disciplinary and investigatory information may be provided to other licensing boards and

regulatory/law enforcement agencies.

vi. On occasion, Division staff and investigators may return original patient records and x-rays to licensees, patients, or other parties involved in a case. However, unless a case has been dismissed by the Board, the Division staff and assigned investigator(s) must obtain and retain on file adequate duplications of patient records and x-rays prior to releasing the originals.

1.D. CHILD SUPPORT ENFORCEMENT (Adopted 6/10/1998; Amended 7/13/2016)

The Board delegates to the Department of Regulatory Agencies (DORA) through its Division of Professions and Occupations authority to suspend and reinstate licenses and if applicable, permits, upon notification from the Colorado Department of Human Services (CDHS) of noncompliance and compliance with Court Ordered Child support.

1.E. CONSIDERATION OF INITIAL DECISIONS (Adopted 3/16/1988; Amended 1/1999; Repealed 7/13/2016)

1.F. BOARD CONSULTANTS (Adopted 8/21/1996;Amended 7/10/2008; Amended 7/13/2016)

The Colorado Dental Board may elect to retain external consultants to provide expertise on matters before the Board when performing its duties.

i. Consultants to the Board include, but are not limited to the following:

   A. Committee members,

   B. Clinical on-site inspectors,

   C. Infection control inspectors,

   D. Case experts,

   E. Evaluators, and

   F. Practice monitors.

ii. Consultants to the Board are required to be currently practicing, licensed for at least 5 years, and have no history of previous discipline. Exceptions to this requirement may be made for certain consultants at the Board's discretion.

iii. Consultants to the Board must currently hold an active license in good standing issued by a regulatory agency and cannot be currently under investigation by that regulatory agency or the subject of current disciplinary proceedings. Exceptions to this requirement may be made for certain consultants at the Board's discretion.

iv. Consultants to the Board can have no financial interest in the licensee's practice, unless it is to be paid for services as a clinical on-site inspector, practice monitor, evaluator, and/or to provide education/training in infection control.

v. A consultant is immune from liability in any civil action brought against him or her for acts occurring

while acting in his or her capacity as a Board consultant pursuant to section 12-35-129.2(4), C.R.S.

1.G. PRACTICE MONITOR CONSULTANT (Adopted 8/20/1986; Amended 8/18/1993; Amended 7/13/2016)

The following apply in addition to Policy 1(F):

i. Licensees requiring monitoring must pay a Board-approved practice monitor for such service. Remuneration will be a reasonable fee negotiated between the practice monitor and the licensee.

ii. A practice monitor must be approved by the Board prior to the start of any practice monitoring requirement outlined in a Board-authorized Stipulation and Final Board/Agency Order.

iii. The practice monitor must be knowledgeable in the licensee's area of practice and practice setting.

iv. The monitor is responsible for periodic assessment of a licensee's practice as directed by the Board or its agent(s).

v. The monitor shall have access to all patient records, files, and materials to effectively monitor a licensee's practice.

vi. The monitor may elect to observe the licensee in the execution of certain procedures.

vii. The monitor shall be required to submit practice monitor reports on form(s) supplied by the Board and on a schedule to be determined by the Board. If a practice monitor report is late, Division staff will promptly notify the licensee that he/she must come into compliance with the terms of his/her Stipulation within 14 days. If the licensee does not come into compliance, then the non-compliance will be presented to the appropriate Board panel to determine whether imposition of a suspension pursuant to section 12-35-129.1(5), C.R.S., and/or additional disciplinary proceedings are warranted.

viii. A practice monitor whose reports are not timely and complete on at least 2 occasions shall be deemed to have failed to perform his/her duties as a practice monitor and may be terminated as the practice monitor at the discretion of the Board. If the monitor is terminated as the licensee's practice monitor, the licensee shall be instructed to nominate a new practice monitor subject to Board-approval within 30 days of the date of notification. A licensee's probationary period shall be tolled pursuant to the terms of the licensee's Stipulation.

1.H. CRDTS: ADDITIONAL AND CANCELED EXAMINATIONS (Adopted 7/15/1998; Repealed 7/13/2016)

1.I. CRDTS: COMMITTEE MEMBER RESPONSIBILITIES (Adopted 6/11/1997; Repealed 7/13/2016)

1.J. CRDTS: DEPUTY EXAMINER QUALIFICATION CRITERIA (Adopted 11/19/1986) (Amended 2/19/1992, 8/18/1993; Repealed 7/13/2016)

1.K. CRDTS: EXAMINATION REVIEW COMMITTEE (ERC) (Adopted 2/18/1998; Repealed 7/13/2016)

1.L. CRDTS: EXAMINER SELECTION AND REIMBURSEMENT POLICY (Adopted 9/17/2003; Repealed 7/13/2016)

1.M. CRDTS: MINUTES, REVIEW OF (Adopted 6/11/1997; Repealed 7/13/2016)

1.N. CRDTS: STEERING COMMITTEE (Adopted 2/18/1998; Repealed 7/13/2016)

1.O. DENTAL HYGIENE: PROFESSIONAL DESIGNATION (Adopted 4/30/1997; Repealed 7/13/2016)

1.P. EMERGENCY/SPECIAL MEETINGS (Adopted 4/20/1988; Amended 7/13/2016)

When an issue arises that may necessitate an emergency or special Full Board or Panel meeting, the Program Director shall confer with the Board or Panel Chairperson. The Chairperson will determine if a meeting shall be held and may authorize an emergency/special meeting. Emergency/special meetings may be conducted in-person, by telephone conference call, or online.

1.Q. LEGISLATIVE UPDATES TO THE BOARD (Adopted 9/18/1996; Repealed 7/13/2016)

1.R. LICENSURE: ADMINISTRATIVELY APPROVED (Adopted 2/20/1992; Amended 6/23/1993; Amended 2/16/1998; Amended 7/7/2004; Amended 7/13/2016)

The Board delegates to the Office of Licensing and/or the Program Director or his/her designee the authority to license dentists and dental hygienists by original licensure, endorsement, renewal, reactivation, and reinstatement who meet all licensing criteria. The Board also delegates the same authority to issue a separate permit in addition to licensure, including, but not limited to local anesthesia (see Policy 1(B)) and interim therapeutic restorations for dental hygienists; and minimal sedation, moderate sedation, and deep sedation/general anesthesia for dentists, including a pediatric designation, if applicable, in accordance with Policy 1(B).

The Board will review all applications where there is uncertainty if requirements are met. If all reactivation or reinstatement requirements have been met and the license has been inactive, expired, or retired for less than 2 years but it appears the applicant may have practiced on an inactive or expired license, or practiced outside of what is allowed for a retired license; the licensee will be reinstated prior to Board review. However, those applications for persons believed to have practiced on an inactive or expired license, or practiced outside of what is allowed for a retired license will then be referred to the Board for review to determine if additional action is warranted.

At each meeting, the Board will receive and be asked to ratify a list of the applicants administratively licensed and issued a permit since the previous meeting.

Any applications deemed incomplete where there is not an uncertainty if requirements are met, may be administratively closed if all required documentation is not received within 1 year of receipt of the application.

1.S. LICENSURE REINSTATEMENT: ADMINISTRATIVELY APPROVED (Adopted 8/24/1994; Amended 12/16/1998; Repealed 7/13/2016)

1.T. MALPRACTICE COMPLAINT PROCESSING (Adopted 11/20/1991; Repealed 7/13/2016)

1.U. MALPRACTICE JUDGMENTS OR SETTLEMENTS (Adopted 7/15/1992; Amended 6/23/1993; Amended 7/13/2016)

The Board recognizes that licensees frequently elect to settle complaints amicably to preserve their relationship with the patient. When a payment is made to a patient, which is a refund or forgiveness of the fees charged to the patient in an amount that does not exceed the cost of the dental services, then such a settlement need not be reported to the Board.

To avoid duplication, all malpractice complaints received by Division staff are to be cross checked for dates of occurrences, specifics and amounts of settlements prior to new case numbers being assigned for the same licensee.

Division staff will not initiate a case number for malpractice judgments found in the favor of the licensee, judgments of zero monetary value, and refunds that do not exceed the cost of the services provided.

If a case number is issued for a malpractice settlement, Division staff will request information on the settlement from the named licensee. If there is no response received from the staff request, staff shall refer the matter to and the Office of Investigations to obtain needed information.

1.V. NATIONAL BOARD PROCTOR PAYMENTS (Adopted 3/12/1997; Repealed 7/13/2016)

1.W. PEER ASSISTANCE PROGRAM (PAP): ACCESS TO CLOSED BOARD MEETING INFORMATION (Adopted 5/1/1996; Repealed 7/13/2016)

1.X. PRESENTATIONS TO THE FULL BOARD AND PANELS (Adopted 11/16/1994; Amended 1/18/1995; Amended 7/13/2016)

The Board will not entertain presentations at its Full Board or Panel meetings regarding a case before it for consideration and will only consider requests made by an applicant regarding a pending application before a Panel for good cause shown. The Dental Practice Act sets forth the forum for adjudicating disciplinary actions. The Board will not review nor discuss the merits of a case, either pending or completed with the parties involved in a case or other interested parties, unless it is for purposes of settlement through the Office of Expedited Settlement or Office of the Attorney General, or for purposes of mediation and/or litigation through the Office of the Attorney General.

In limited circumstances, the Board may allow a presentation to the Full Board, as long as it is not related to a specific complaint or application. The Board will only permit presentation of a matter when the request has been made in writing, setting forth the reason for the presentation and the issues to be discussed. The Board reserves the right to deny any request for presentation or to limit the issues presented. If such request is granted, the presentation will be limited to those issues set forth in the request or as limited by the Board. Any deviation from these issues may be grounds for termination of the presentation.

1.Y. REFUND OR FORGIVENESS OF FEES: DEFINITION (Adopted 6/15/1988; Repealed 7/13/2016)

1.Z. REPORTS OF INVESTIGATION AND USE OF CONSULTANTS (Adopted 7/15/1987; Amended 8/18/1993; Amended 2/22/2008; Ratified 4/23/2008; Amended 7/13/2016)

i. The Board may request investigators to forward a case directly to an outside expert to act as a consultant for the Board in specific situations. The Board may provide specific questions to be presented to the consultant for a response.

ii. Written reports/responses from consultants, subsequent treating licensees, and any other experts will not be summarized in a report of investigation. This information should be included in full with a report of investigation and listed as an attachment.

iii. If a complaint involves any of the following allegations, it will be forwarded directly to the Office of Investigations, without a 30-day request for a response being sent by Division staff to the licensee in the case:

   A. Allegations involving drugs or alcohol;

   B. Allegations of sexual misconduct;

   C. Allegations of unlicensed practice;

   D. Allegations relating to infection control;

   E. Allegations relating to insurance fraud;

   F. Allegations relating to practice beyond the statutory or customary scope of practice; and

   G. Any other complaint where it is apparent to the Program Director that an immediate investigation is needed.

iv. If an investigation is conducted pursuant to Policy 1(Z)(iii), the assigned investigator is to submit a 30-day request for a response to the allegation(s).

v. Any unannounced inspection shall be conducted during normal business hours. The investigator may be accompanied by a consultant who has expertise in the conduct being investigated.

vi. A consultant retained by the Board to review a case or related cases involving more than one licensee should submit a separate report containing findings and a summary specific to each licensee for Board consideration. The summary of each consultant report should clearly articulate a determination as to whether substandard care occurred, and/or a violation of the Colorado Dental Practice Act and/or Board rules.

vii. A consultant retained by the Board to review a case involving infection control should clearly separate his/her findings and summaries for each report into the following 2 parts when determining whether section 12-35-129(1)(kk), C.R.S., and Board Rule XVI have been violated:

   A. Non-compliance with an OSHA standard (employee safety)—the Board should refer these findings to OSHA first for potential action if OSHA has not already addressed the violation(s). If action is taken by OSHA, then the Board may incorporate those findings into any potential disciplinary action it takes, but cannot do so until OSHA has first taken action.

   B. Non-compliance with CDC guidelines (patient safety)—the Board may take action on these findings without referral to another agency; however, if there is overlap between CDC guidelines and an OSHA standard, then the process outlined in subparagraph (A) above must first be

followed. Examples that fall exclusively under CDC guidelines include, but are not limited to instrument reprocessing/sterilization, spore testing, water testing, operatory turn-around/set-up, cross contamination, one time us of disposable items, and proper handling of IV medications.

viii. If an infection control report is generated by the infection control consultant or inspector, a copy of that report is to be provided to the licensee for a response within 30 days. However, if the infection control report, or any other report provided by an expert consultant or an investigator, demonstrates that the public health, safety and/or welfare imperatively requires emergency action and/or that there is a willful violation, the Board may take emergency action as set forth in section 24-4-104(4)(a), C.R.S.

1.AA. RETENTION OF PATIENT RECORDS AND X-RAYS IN THE BOARD OFFICE (Adopted 4/20/1988; Repealed 7/13/2016)

1.BB. SUBPOENA ENFORCEMENT (Adopted 9/28/1994; Amended 7/13/2016)

When, in the course of an investigation of a complaint, a subpoena needs to be enforced pursuant to the Dental Practice Act and the Administrative Procedures Act, the Colorado Dental Board authorizes the Program Director to refer such matter directly to the Office of the Attorney General for enforcement. The referral will be submitted to the Board at its next meeting for ratification.

1.CC. DELEGATED AUTHORITY (Adopted 1/10/2008; Amended 1/15/2009; Amended 7/13/2016)

In order to assist the Board in carrying out its duties, the Board delegates to the Program Director or designee the authority to:

i. Sign Letters of Concern, Letters of Admonition, Cease and Desist Orders, Stipulations, Final Board/Agency Orders, and other orders authorized by the Board.

ii. Perform the initial review of complaints relating to the practice of persons under the Board's jurisdiction and to issue 30-day letters relating to the complaints.

iii. Sign and issue investigatory subpoenas and otherwise gather information in the course of a pending Board matter.

iv. Initiate complaints and issue 30-day letters to licensees currently under Stipulation or other Final Board/Agency Order for failure to comply with any of the terms of the Stipulation or Final Board/Agency Order.

v. Initiate complaints and issue 30-day letters where otherwise authorized by the Board.

vi. Utilize services of the Office of Investigation as necessary to carry out the duties of the Board.

vii. Perform additional delegated duties as set forth by the Board, including but not limited to issuing licenses and permits, including renewal, reactivation, and reinstatement; and performing audits of licensees for compliance with continuing education requirements.

1.DD. PANEL AND LICENSING SUBCOMMITTEE MEETING PROCEDURES (Adopted 1/13/2011; Amended 7/13/2016)

It is the policy of the Board and its Panels that the Board Chairperson may participate in all Panel discussions.

The Board Chairperson will not make motions or vote on Panel matters, except as may be required to establish or maintain a quorum.

If the Board Chairperson has considered any complaint as a member of an Inquiry Panel, the Board Chairperson shall not take any part in consideration of the matter by a Hearing Panel.

1.EE. PROCESS FOR HANDLING COMPLAINTS INVOLVING BOARD MEMBERS (Adopted 7/13/2016)

It is the policy of the Colorado Dental Board that any signed complaint received by the Board against a dentist or dental hygienist who is currently serving as a Board member or one who has served on the Board within the past 5 years, or a dentist or dental hygienist who has an ongoing formal relationship with the Board (e.g. consultant), will be assigned to the inquiry panel in which the current board member is not serving on. If the complaint alleges:

i. A violation of the Dental Practice Act—the complaint will be sent to the Office of Investigations (OI) within the Division of Professions and Occupations for processing; or

ii. Substandard practice—OI will process the complaint and also have the case reviewed by an independent dentist or dental hygienist consultant selected by OI.

Upon completion of the investigation, the report of investigation will be referred back to the assigned inquiry panel for review, discussion, and appropriate action.

SECTION 2: DISCIPLINARY POLICIES

2.A. COMPLAINTS RECEIVED AGAINST PERSONS HOLDING A REVOKED LICENSE (Adopted 3/26/2003; Amended 7/13/2016)

When a complaint is received against a person whose license has already been revoked, Division staff will send the complainant a letter that states the license of the practitioner has already been revoked, and the complaint will be retained in the licensee record without assigning a complaint number.

2.B. BOARD-ORDERED CONTINUING EDUCATION (Adopted 12/15/1993; Amended 1/12/1994; Amended 1/10/2008; Amended 7/13/2016)

i. Board-ordered continuing education may be obtained by viewing or listening to audio and/or video courses, and/or participating in internet courses. Credit, after pre-approval is obtained, will be given in the following instances:

   A. Submission of proof of passing the post-test provided with the audio/internet/visual program, or;

   B. Submission of a typed, one-page paper summarizing the information in the audio/internet/visual program. The paper shall be 250-300 words.

ii. 50% of each required area of study may be obtained by viewing or listening to audio and/or video tapes, and/or participating in an internet course. The Board may make exceptions to this allowance based on course availability or other case-by-case circumstances.

iii. Course providers must be recognized by any of the following organizations (or a successor organization):

A. American Dental Association (ADA) Continuing Education Recognition Program (CERP),

B. Academy of General Dentistry (AGD) Program Approval for Continuing Education (PACE),

C. American Medical Association (AMA) Physician Recognition Award (PRA) and credit system as Category 1 credit, or

D. Commission on Dental Accreditation (CODA) accredited institutions.

iv. Course providers outside of those recognized in the subparagraph above may be accepted on a case-by-case basis.

v. A licensee may not repeat the same continuing education course in order to meet the requirements of a specific Stipulation, unless it is the ProBE course or another substitute ethics course in which the licensee did not receive an unconditional pass.

vi. In order to satisfy continuing education requirements in a Stipulation, a licensee must submit course offerings for PRIOR approval by the Board. The Board will consider course offerings that are in the required area of study and which specify course title, presenter, credit hours, and sponsor. The Board reserves the right to require additional information upon which to base its decision.

vii. Upon completion of continuing education, the licensee must submit a certificate of completion or letter from the presenter or sponsor verifying successful completion.

viii. The Board may, at its discretion, accept courses relevant to the required area of study that have been completed subsequent to the date(s) of the disciplinary violation(s). The requirement for Board approval of completed education courses are the same as set forth above. The Board will determine whether completed credit hours will satisfy the terms of continuing education required in a Stipulation.

ix. Continuing education completed as a condition of a disciplinary action, i.e. terms in a Stipulation or Consent Order/Agreement, will not be accepted towards compliance with continuing education required to maintain an active license or permit in Colorado.

2.C. CONTINUING EDUCATION: COURSE REPETITION (Adopted 11/17/1993; Repealed 7/13/2016)

2.D. CONTINUING EDUCATION: STIPULATION VERIFICATION (Adopted 2/19/1991) (Amended 3/16/1994; Repealed 7/13/2016)

2.E. DISCIPLINARY REPORTING IN THE NEWSLETTER (Adopted 10/24/1990; Amended 8/24/1994; Amended 1/12/2000; Amended 2/16/2000; Repealed 7/13/2016)

2.F. MENTAL AND PHYSICAL EXAMINATIONS: CONFIDENTIALITY OF (Adopted 9/21/1988; Amended 7/13/2016)

It is the Board's policy that confidentiality extends to the information obtained pursuant to a Board ordered mental or physical examination. Therefore, all documents in which the details of the examinations, the

results thereof and/or the diagnosis rendered will be released upon request to the licensee but will not be available to the public.

An Initial Decision or a Final Board/Agency Order which references a violation of section 12-35-129(1)(e), C.R.S., but which does not discuss the results of the examination conducted pursuant to section 12-35-129.5, C.R.S., will be deemed a public record.

2.G. REPORTING LANGUAGES IN STIPULATIONS (Adopted 12/6/2000; Amended 7/13/2016)

Reporting language is required in any public disciplinary action taken by the Board and will not be negotiated during settlement proceedings.

2.H. REQUEST OF DISMISSED COMPLAINTS (Adopted 4/28/1999; Repealed 7/13/2016)

2.I. TERMINATION OF DISCIPLINARY MATTERS (Adopted 12/21/1988; Amended 6/30/1996; Repealed 7/13/2016)

2.J. WITHDRAWAL OF A COMPLAINT OR FILING OF AN ANONYMOUS COMPLAINT (Adopted 8/19/1987; Amended 8/15/2001; Amended 7/13/2016)

i. If a complaint is withdrawn, the Board will be notified of all factors surrounding the withdrawal of the complaint at the time the matter is reviewed by the Board, and the following process will occur:

   A. When the investigation process has not begun, i.e. a request for a response has not been issued or the matter has not been referred to the Office of Investigations (OI): the complaint and the letter of withdrawal will be provided to the Board at its next meeting to consider whether to dismiss the complaint or to investigate it as a Board-initiated complaint. If the allegations are serious in nature such as sexual misconduct, etc. then the investigation will proceed as a Board-initiated complaint.

   B. While Division staff is obtaining a response from the licensee: the Board will initiate its own complaint and Division staff will continue its process.

   C. After the matter has been referred to the Office of Investigations (OI): the Board will initiate its own complaint and OI will continue its process. If the investigation cannot continue because of lack of cooperation with the complainant, the Board will be notified.

ii. If a complaint is filed anonymously, but the allegations are clearly articulated and the Board has jurisdiction, then the investigation will proceed as a Board-initiated complaint. If not, then the Program Director may dismiss it on behalf of the Board.

2.K. CASES DISMISSED WITH LETTERS OF CONCERN: CLARIFICATION OF BASIS FOR DISMISSAL, REOPENING OF SUCH CASES, AND CASE RETENTION PERIOD (Adopted 4/27/2011; Amended 7/13/2016)

Complaints that are dismissed with a confidential letter of concern are not dismissed as being without merit but rather are dismissed due to no reasonable cause to warrant further action at that time. Cases that are dismissed with a confidential letter of concern will be retained in the Board's files for a period of 5 years.

The Board may reopen a case that was dismissed with a confidential letter of concern in the face of a change in circumstances. Such a change in circumstances would include but not be limited to:

i. Discovery of new evidence supporting the underlying charges; and/or

ii. Evidence that the licensee has engaged in further unprofessional conduct/grounds for discipline following issuance of the letter of concern in which there is a nexus between the new conduct and that was addressed in the case that was dismissed with the letter of concern.

After 5 years from the date of the confidential letter of concern, the file will be disposed of in accordance with the Division's records management procedures. If the licensee has other active cases pending at the end of the 5 year retention period, the letter of concern may be kept for a longer period of time at the discretion of the Board.

2.L. PROCESS FOR HANDLING INITIAL DECISIONS RENDERED BY AN ADMINISTRATIVE LAW JUDGE (ALJ) (Adopted 11/2/2011; Amended 7/13/2016)

It is the policy of the Colorado Dental Board that any Initial Decision of an Administrative Law Judge (ALJ) from the Office of Administrative Courts (OAC) will be appropriately served with the approved Board Procedural Order Regarding Review of Initial Decision ("Order") upon parties involved in a case or cases before a Panel of the Board.

The Board delegates authority to the Deputy Director or his/her designee to issue procedural orders for the appropriate Hearing Panel and to rule upon motions, including but not limited to requests for extensions of time for good cause.

The Board further delegates authority to the Program Director or his/her designee and the prosecuting attorney(s) to determine whether or not to file exceptions on behalf of the appropriate Inquiry Panel if it is unable to timely meet or present a quorum in order to deliberate on the matter.

SECTION 3: LICENSING POLICIES

3.A. CREDENTIALS: CALCULATIONS FOR WORK EXPERIENCE TO QUALIFY FOR LICENSURE (Adopted 4/30/1997; Repealed 7/13/2016)

3.B. MALPRACTICE AND BOARD ACTION INFORMATION FOR LICENSURE APPLICATION (Adopted 6/11/1997; Repealed 7/13/2016)

3.C. REINSTATEMENT APPLICATIONS (Adopted 6/16/1999; Repealed 7/13/2016)

3.D. REINSTATEMENT OF LICENSES (Adopted 9/18/1993; Amended 1/10/2008; Repealed 7/13/2016)

3.E. APPROVAL OF CPR COURSES (Amended 2/28/2004; Repealed 7/13/2016)

3.F. BOARD AND LICENSING SUBCOMMITTEE PROCEDURES RELATING TO APPLICATIONS FOR ISSUANCE, RENEWAL, REACTIVATION, AND REINSTATEMENT (Adopted 1/21/2009; Amended 7/13/2016)

For the purposes of this policy, reference to "unprofessional conduct" means the causes for denial of issuance, renewal, reactivation, or reinstatement of a license or permit from the Board pursuant to sections 12-35-129(1), 12-35-129.2(5), and 24-34-110, C.R.S. "Unprofessional conduct" is defined in Rule I(G).

It is the policy of the Board and its Licensing Subcommittees to consider in open session, unless administratively delegated pursuant to Policy 1(B) and Policy 1(R), all licensing and permitting matters, including initial issuance, renewal, reactivation, and reinstatement that do not concern or involve allegations of any unprofessional conduct. It is the policy of the Board and its Licensing Subcommittees to consider in closed session all licensing and permitting matters, including initial issuance, renewal, reactivation, and reinstatement that concern or involve allegations of any unprofessional conduct; also where the applicant has been subject to disciplinary action by any state in which the applicant is or has been previously licensed, so that the Licensing Subcommittee may consider whether to deny or restrict the license and/or permit pursuant to sections 12-35-129(1) and 12-35-129.2(2), C.R.S.

Where the Board or Licensing Subcommittee has authorized a license or permit, or renewal, reactivation, or reinstatement of one with a restriction of any kind, such as an admonition, probationary term, or other limitation; the Board or Licensing Subcommittee delegates to the Program Director the authority to sign the Stipulation and Final Board/Agency Order reflecting the Board or Licensing Subcommittee's guidance. The final action of the Board and Licensing Subcommittee shall be open to the public.

Where the Board or Licensing Subcommittee has determined in closed session not to proceed with denial or restriction of any kind of a license and/or permit, including initial issuance, renewal, reactivation, or reinstatement of one, the Board or Licensing Subcommittee delegates to the Program Director the authority to administratively approve such applications and grant an unrestricted license and/or permit. Such action shall be subsequently ratified by the Licensing Subcommittee in open session and reflected in the open session minutes.

With respect to the Board's maintenance of records relating to applications for issuance, renewal, reactivation, or reinstatement of a license or permit from the Board, this policy is not intended and shall not be interpreted to affect the Board's obligation or ability to allow or deny public inspection thereof pursuant to state and federal law.

SECTION 4: PRACTICE POLICIES

4.A. AFTER HOURS/EMERGENCY CARE AND ONCALL COVERAGE (Adopted 8/14/2002; Amended 7/13/2016)

The Board determines on call coverage for a dentist or dental hygienist to be adequate when a mutually arranged covering dentist or dental hygienist is identified and the procedure to reach that professional is made readily available to patients of record or their guardians. Protocols for after-hours and emergency care should be clearly communicated to the patient or the patient's guardian.

4.B. AMALGAM DENTAL FILLINGS: REMOVAL OF (Adopted 8/21/1996; Amended 9/18/1996; Amended 7/13/2016)

The Colorado Dental Board recognizes that patients have the right to request the removal of amalgam dental fillings by a licensed dentist. Upon such request, the dentist may remove the amalgam dental

fillings.

The diagnosis and treatment recommendations for mercury toxicity and other systemic medical conditions that are within the scope of the practice of medicine are to be left to licensed physicians.

Although the Board recognizes the right of the patient to request removal of amalgam dental fillings by a licensed dentist, the dentist may not make a diagnosis of mercury toxicity nor make a claim that removal of amalgam dental fillings will result in a cure, alleviation, or improvement, of any systemic medical condition. If a dentist believes that amalgam dental materials may be detrimental to a patient's medical health, it is incumbent upon the dentist to make a referral to a licensed physician for examination and evaluation of the suspected medical condition.

4.C. ELECTRONIC RECORDS (Adopted 8/14/2002; Repealed 7/13/2016)

4.D. EXAMINATION, DIAGNOSIS, AND RECORD KEEPING (Adopted 3/12/1997; Repealed 7/13/2016)

4.E. INDEPENDENT MEDICAL EXAMINATIONS (IMEs) (Adopted 6/11/1997; Amended 2/13/2002; Amended 7/13/2016)

For the purposes of this policy, the Colorado Dental Board defines an Independent Medical Examination, or IME, as an examination performed by an independent Colorado licensed dentist at the request of a third party for the purposes of determining one or all of the following: insurance policy coverage, adequacy of care to date, reasonableness of fees, recommendation for further care and/or additional diagnostic work and needed referrals. This definition of IMEs does not include second opinions performed at the request of the patient or the treating dentist.

Section 12-35-113 (1)(m) and (r), C.R.S., states that “a person is practicing dentistry if the person” “gives, or professes to give, interpretations or reading of dental X rays or roentgenograms, CT scans, or other diagnostic methodologies” or “gives or professes to give interpretations or readings of dental charts or records or gives treatment plans or interpretations of treatment plans derived from examinations, patient records, dental X rays, or roentgenograms”.

The Board recognizes that, in the course of doing business, a third party is entitled to seek an IME and that a third party is entitled to advise the subscriber of policy coverage. However, when a third party provides a subscriber with an interpretation of charts or radiographs, diagnosis, opinion on treatment or treatment plan, then it is the Board’s position that the conduct of the third party as well as the independent dentist constitutes the practice of dentistry. These interpretations can only be provided to the patient or guardian by an individual licensed to practice dentistry in the state of Colorado. Doing so without an appropriate license is the unauthorized and unlicensed practice of dentistry in violation of the Dental Practice Act. Licensees that provide such interpretations, diagnostic opinions, or treatment plans are held to the same standard as any Colorado licensed dentist who performs direct clinical examination, diagnosis, and treatment planning to a patient.

4.F. ON CALL COVERAGE (Adopted 8/14/2002; Repealed 7/13/2016)

4.G. PATIENT ABANDONMENT (Adopted 8/14/2002; Amended 7/13/2016)

The Colorado Dental Board defines patient abandonment as the unilateral termination of care of a patient of record on the part of the dentist or dental hygienist. As a patient and dentist or dental hygienist enter

into a professional relationship, that dentist or dental hygienist has the responsibility for continuity or continuous care until either party chooses to discontinue the relationship. At the time at which the dentist or dental hygienist chooses to discontinue, he or she must notify the patient in writing noting with due diligence that the clinician will be available for emergency care and/ or appropriate referrals for 30 days from the date of the letter. The Colorado Dental Board defines a patient of record as one who has been treated by that dentist or dental hygienist within the previous 2 years.

4.H. PATIENT RECORDS: CHARGES FOR COPYING (Adopted 7/15/1998; Repealed 7/13/2016)

4.I. PATIENT RECORDS: REFUSAL TO RELEASE (Adopted 11/20/1991; Amended 7/13/2016)

i. When a complaint is received that the patient has provided a written request to the licensee for his/her records and the licensee has not complied, the complaint is to be reviewed by the Board.

ii. When neither the patient nor the licensee has complied with the statute requirements, the Division staff will send a letter to both parties explaining the provisions and responsibilities under the statute.

iii. When both the licensee and the patient have been notified of the provisions of the statute, the patient provided a written request to the licensee, and the licensee does not comply, the complaint is to be reviewed by the Board.

4.J. PROTECTIVE STABILIZATION (Adopted 8/11/2004; Amended 7/13/2016)

i. The benefits to utilizing protective stabilization include the following:

   A. Reduction or elimination of untoward movements.

   B. Protection of the patient, staff, dentist, or parent or guardian from injury.

   C. Facilitation of quality dental care.

ii. The risks to utilizing protective stabilization include the following:

   A. Physical or Psychological harm.

   B. Loss of dignity.

   C. May be a violation of patient's rights.

   D. Psychological trauma can have a lasting detrimental effect on brain function.

   E. Parents may experience distress.

4.K. VOLUNTEER DENTAL AND DENTAL HYGIENE PRACTICE UNDER RETIRED LICENSE STATUS (Adopted 4/30/2003; Amended 7/13/2016)

Licensees with a retired license status may provide dental services to indigent patients, pursuant to

section 12-35-123(6), C.R.S. If a retired licensee provides such services for a program or entity that charges a nominal fee for such services, and if the retired licensee provides such services on a limited basis and receives no fee for doing so, the licensee does not violate section12-35-123(6), C.R.S.

4.L. SCALING AND ROOT PLANING (Adopted 9/26/2001; Repealed 7/13/2016)

4.M. WHITENING PROCESS SYSTEMS (Adopted 1/12/2000; Amended 4/25/2001; Amended 7/13/2016)

The use of tray, light, or light and tray whitening process systems available only to dentists require direct supervision for dental assistants and indirect supervision for dental hygienists.

4.N. Smoking Cessation (Adopted 7/10/2008; Amended 7/13/2016)

The Board recognizes the treatment of tobacco/nicotine cessation is within the scope of dentistry and dental hygiene. However, prescription writing is limited to the scope of dentistry pursuant to sections 12-35-113 (1)(p) and 12-35-114, C.R.S., and is subject to the record keeping requirements of Board Rule IX.

4.O. Quad Regulator Policy for Prescribing and Dispensing Opioids (Adopted 7/24/2014)

Policy for Prescribing and Dispensing Opioids

Colorado Dental Board, Colorado Medical Board, State Board of Nursing, and State Board of Pharmacy

In collaboration with the Nurse-Physician Advisory Task Force for Colorado Healthcare

PREAMBLE

Prescribing and dispensing medication for the appropriate treatment of pain is a priority for Colorado healthcare providers. However, in 2013 the misuse and abuse of prescription opioids became a public health epidemic in the United States in general, and Colorado in particular, leading to drug addiction, death from overdose, and increased costs to society.

In order to address this crisis, the Colorado Dental Board, Colorado Medical Board, State Board of Nursing, State Board of Pharmacy, and the Nurse-Physician Advisory Task Force for Colorado Healthcare collaborated to identify opportunities and provide meaningful guidance to prescribers and dispensers in Colorado.

The Boards recognize that reversing the trend of opioid misuse and abuse requires coordinated efforts to increase public awareness, take-back events for safe disposal, addiction treatment and recovery options, and enforcement, among others. The Boards and the practitioners they license are one part of a multi-pronged solution.

The Boards recognize the complexities faced by prescribers in the appropriate management of pain.[1] The demands on practitioners considering opioid prescribing differ depending on patient diagnosis, practice settings, and/or conditions. Importantly, long-term therapies addressing cancer-related treatment, palliative and/or hospice care involve different considerations from short-term therapies appropriate for acute or chronic non-cancer pain.

Pain and addiction specialists play an important role in healthcare and the communities they serve to compassionately and safely care for patients. Many of the tools and practices referenced in this policy were developed by such specialists. The need for therapeutic care of pain in Colorado patients exceeds the supply of specialists in the state. However, other types of providers can successfully treat many painful conditions and achieve the function and relief the patient seeks. Accordingly, this policy is intended to educate prescribers and dispensers broadly by providing useful tools that may be utilized at the point-of-care to support clinical decision making.

The Boards further recognize that decreasing opioid misuse and abuse in Colorado should be addressed by collaborative and constructive policies aimed at improving prescriber education and practice, decreasing diversion, and establishing the same guidelines for all opioid prescribers and dispensers. This includes opioid therapies for both acute and chronic non-cancer pain, [2] because the Boards find that treatment for pain often does not fall clearly into one category or another.

Diversion and "doctor shopping" accounts for 40% of drug overdose deaths.[3] To address the dual issues of access to appropriate pain management and opioid-related adverse outcomes, prescribers have dual obligations: to manage pain and improve function while reducing problems resulting from misuse and abuse of prescription opioids in the patient and community. Pharmacists share a corresponding responsibility with the prescriber to

[1] "Boards" as used in this policy means the Boards overseeing prescribing and dispensing of opioids and involved in the drafting of this policy: the Colorado Medical Board, State Board of Nursing, Colorado Dental Board, and the State Board of Pharmacy.

[2] Pain is categorized by a number of descriptors ranging from duration, impact, or physiological response, among others. For the purpose of this policy, the term "chronic, non-cancer pain" is utilized to refer to pain that lasts longer than 90 days and is non-terminal. It does not include conditions such as cancer, scleroderma, multiple sclerosis, muscular dystrophy, or rheumatoid arthritis.

[3] Paulozzi, L., Baldwin, G., Franklin, G., Ghiya, N., & Popovic, T. (2012). CDC Grand Rounds: Prescription drug overdoses — a U.S. epidemic. *Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), 61*(01), 10-13. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm

assure that a prescription order is valid in all respects and is appropriate for the patient and condition being treated.

Therefore, the Boards have agreed to the following guidelines regarding opioid prescriptions in Colorado. Providers prescribing and/or dispensing opioids should:

- Follow the same guidelines
- Use the Colorado Prescription Drug Monitoring Program (PDMP)
- Be informed about evidence-based practices for opioid use in healthcare and risk mitigation
- Educate patients on appropriate use, storage and disposal of opioids, risks and the potential for diversion
- Collaborate within the integrated healthcare team to decrease over-prescribing, misuse and abuse of opioids.

Opioid prescribers and dispensers must conform to the regulations set forth by the respective licensing board and other laws.

To this end, we, the Boards regulating the prescribers and dispensers in Colorado, have developed this joint policy incorporating the guidelines above.

This policy provides guidelines, and does not set a standard of care for prescribers and dispensers. This policy represents the Boards' current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind Boards or the public. Prescribers may use an alternative approach if the approach satisfies the requirements of the applicable statutes, regulations, and standard of care. The Boards will refer to current clinical practice guidelines and expert review in approaching cases involving the management of pain. [4]

[4] A "policy" is adopted by a board to provide guidance to licensees regarding the board's position on various subjects. Policies are unlike statutes or rules in that they are not law. Conversely, "board rules" have the force of law and set forth requirements to which licensees must adhere.

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Develop and maintain competence

Prescribers, including prescribers who dispense, must maintain competence to assess and treat pain to improve function. This includes understanding current, evidenced-based practices and using other resources and tools related to opioid prescribing and dispensing. In some clinical situations consultation with a specialist is appropriate. Pharmacists must maintain competence in the appropriateness of therapy. See the Appendix for a list of resources and tools for developing and maintaining competence.

Utilize safeguards for the initiation of pain management

The decision to prescribe or dispense opioid medication for outpatient use may be made only after a proper diagnosis and complete evaluation which should include a risk assessment, pain assessment, and review of relevant PDMP data. These safeguards apply to acute and chronic, non-cancer pain but not to palliative end-of-life care.

Not all pain requires opioid treatment. Prescribers should not prescribe opioids when non-opioid medication is both effective and appropriate for the level of pain.

1. Diagnose

Prescribers should establish a diagnosis and legitimate medical purpose appropriate for opioid therapy through a history, physical exam, and/or laboratory, imaging or other studies. A bona fide provider-patient relationship must exist.

2. Assess Risk

Prescribers should conduct a risk assessment prior to prescribing opioids for outpatient use and again before increasing dosage or duration. Risk assessment is defined as identification of factors that may lead to adverse outcomes and may include:

- Patient and family history of substance use (drugs including alcohol and marijuana)
- Patient medication history (among other reasons, this is taken to avoid unsafe combinations of opioids with sedative-hypnotics, benzodiazepines, barbiturates, muscle relaxants or to determine other drug-drug interactions)
- Mental health/psychological conditions and history
- Abuse history including physical, emotional or sexual
- Health conditions that could aggravate adverse reactions (including COPD, CHF, sleep apnea, elderly, or history of renal or hepatic dysfunction)
- Prescribers and dispensers should observe the patient for any aberrant drug-related behavior and follow-up appropriately when aberrant drug-related behavior is presented. See the Appendix for a description of such behaviors.

See the Appendix for additional resources related to assessment, including resources for alcohol and substance use screening and guidelines for treating patients with risk factors.

If the assessment identifies risk factors, prescribers should exercise greater caution before prescribing opioids as detailed in subsequent sections, consider conducting a drug test or consulting a specialist and put in place additional safeguards as part of the treatment plan.

3. Assess Pain

An appropriate pain assessment should include an evaluation of the patient's pain for the:

- Nature and intensity
- Type
- Pattern/frequency
- Duration
- Past and current treatments
- Underlying or co-morbid disorders or conditions
- Impact on physical and psychological functioning

4. Review PDMP

Prescribers and dispensers should utilize the Prescription Drug Monitoring Program (PDMP) prior to prescribing or dispensing opioids.

Collaborate with the healthcare team

Prescribers and dispensers should collaborate within the healthcare team to prevent under-prescribing, over-prescribing, misuse and abuse of opioids. See the Appendix for additional resources.

WHEN PRESCRIBING OR DISPENSING

Verify a provider-patient relationship

A bona fide provider-patient relationship must exist. The prescriber or dispenser should verify the patient's identification prior to prescribing or dispensing opioids to a new or unknown patient.

For pharmacists, this includes exercising judgment and conducting research if appropriate (such as use of the PDMP or communication with the prescriber or relevant pharmacies) when the prescription order is:

- For a new or unknown patient
- For a weekend or late day prescription
- Issued far from the location of the pharmacy or patient's residential address
- Denied by another pharmacist.

Additional Safeguards

Ensure the dose, quantity, and refills for prescription opioids are appropriate to improve the function and condition of the patient, at the lowest effective dose and quantity, in order to avoid over-prescribing opioids.

Factors that have been associated with adverse outcomes include: 1) opioid doses greater than 120 mg morphine equivalents per day 2) certain formulations and 3) treatment exceeding 90 days. Additional safeguards have been found to reduce these risks.

Dosage

Opioid doses >120 mg morphine equivalents per day is a dosage that the Boards agree is more likely dangerous for the average adult (chances for unintended death are higher) over which prescribers should use clinical judgment, put in place additional safeguards for the treatment plan (such as utilizing a treatment agreement), consult a specialist or refer the

patient; and dispensers should be more cautious.[5] Benzodiazepines are known to potentiate the effects of opioids and may increase the risk of adverse outcomes. See the Appendix for additional resources on dose calculators

Formulation

In addition to noting and responding to this dosage marker, prescribers and dispensers must use clinical judgment regardless of dose, especially when:

- The prescription is considered an outlier to what is normally prescribed, or
- Transdermal, extended relief or long-acting preparation is prescribed.

Duration

Treatment **exceeding 90 days** should be re-evaluated as opioids may no longer be as effective.

One way to distinguish pain is as either acute (that lasting less than 90 days) or chronic (that lasting 90 days or greater). Management of each presents its own unique challenges. The overwhelming majority of prescribers treat patients with acute pain; in fact the pain for these patients lasts considerably less than 90 days.

If a prescriber extends short-term treatment, and results in exceeding 90 days, prescribers should re-conduct the risk and pain assessments, review the PDMP and undertake the additional safeguards.

Prescribing and Dispensing for Advanced Dosage, Formulation or Duration

Tools and Trials

Prior to issuing prescriptions that are outliers to the dosage, formulation and duration guidelines described above (for chronic, non-cancer pain), prescribers should determine whether the patient improves functionally on opioids, which could include an opioid trial, and whether the pain relief improves his/her ability to comply with the overall pain management program.

Monitoring

The prescribing and dispensing of opioids for chronic pain must be monitored on an ongoing basis, such as:

- assessing for improved function
- rechecking the PDMP, and
- random drug screening according to the prescriber's clinical assessment.

These monitoring tools and others should be documented in a treatment agreement signed by the patient, described more below. Prescribers should not increase an initial opioid dosage without rechecking the PDMP.

Treatment Agreements

Prescribers should utilize treatment agreements (also commonly referred to as a plan or contract) and should ensure the patient understands the terms of the agreement. This may be accomplished by having the patient review and sign the treatment agreement.

[5] Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92.

A treatment agreement often includes information about proper:

- Goals of treatment
- Patient education (proper use, risks of addiction, alternatives)
- Controls (single prescriber, single pharmacy for refills)
- Random drug testing and restrictions on alcohol use
- Storage, disposal, and diversion precautions (including detailed precautions related to adolescents and/or children and visitors to the home).
- Process and reasons for changing/discontinuing the treatment plan; communicating reduction or increase of symptoms; and referring to a specialist.

See the Appendix for resources on sample agreements.

PATIENT EDUCATION

Prescribers should educate patients regardless of the dosage, formulation and duration of opioid therapy on proper use, risks of addiction, alternatives, storage, and disposal of opioids and the potential for diversion (see the Appendix for resources on disposal). Risks may include but are not limited to: overdose, misuse, diversion, addiction, physical dependence and tolerance, interactions with other medications or substances, and death.

Pharmacists should offer to review information with the patient about risks, disposal, and other applicable topics.

Providers should educate patients about the risks and benefits of medications that exceed the dosage, formulation and duration guidelines indicated above which may place them at increased risk for long-term dependence and unintended adverse drug effects. Patients who have a previous history of substance use disorder (including alcohol) are at elevated risk.

When alerted to these risk factors, patients can make more informed decisions about their healthcare treatment. For example, some patients have reduced or forgone opioids when alerted to the risk factors. If a decision is made to continue with opioid therapy, a satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function and/or improved quality of life. The use of an interdisciplinary team and family members may be considered as a part of the treatment plan and ongoing monitoring.

DISCONTINUING OPIOID THERAPY

The prescriber should consider discontinuing opioid therapy when:

- The underlying painful condition is resolved;
- Intolerable side effects emerge;
- The analgesic effect is inadequate;
- The patient's quality of life fails to improve;
- Functioning deteriorates; or
- There is aberrant medication use.

The prescriber discontinuing opioid therapy should employ a safe, structured tapering regimen through the prescriber or an addiction or pain specialist. There is a risk of patients turning to street drugs or alcohol abuse if tapering is not done with appropriate supports. Prescribers of opioids should be familiar with treatment options for opioid addiction. See the Appendix for tips on tapering.

PDMP

Colorado Prescription Drug Monitoring Program (PDMP):
http://www.hidinc.com/copdmp

Preventing diversion through appropriate disposal

In order to prevent diversion, providers should provide information regarding appropriate disposal, including the following:

- Secure unused prescription opioids until such time they can be safely disposed. Specifically, ensure that prescription opioids are not readily accessible to other family members (including adolescents and/or children) or visitors to the home.
- **Take-back events are preferable to flushing prescriptions down the toilet or throwing them in the trash.** Only some medications may be flushed down the toilet. See the FDA's guidelines for a list of medications that may be flushed: www.fda.gov
- **Utilize take-back events and permanent drop box locations**
- Utilize DEA disposal guidelines if take-back or drop boxes are unavailable. Those guidelines include:
  - **Take the drugs out of their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter; then put them in a sealable bag, empty can, or other container to prevent the medication from leaking out of a garbage bag;**
  - Before throwing out a medicine container, tell the patient to scratch out all identifying information on the prescription label to protect their identity and personal health information; and
  - Educate patients that prescriptions are patient specific. Patients may not share prescription opioids with friends, family or others and may pose serious health risks, including death.
- Use activated charcoal absorption technologies to inactivate unused medications or used fentanyl patches.

Record keeping

Prescribers who treat patients with opioids should maintain accurate and complete medical records according to the requirements set forth by their licensing board.

Discontinuing/tapering opioid therapy

Weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account several factors related to risk, symptom, and alternatives.

Opioid Taper Plan and Calculator:
"Interagency Guidelines on Opioid Dosing for Chronic Non-Cancer Pain" State of Washington Agency Medical Directors Group. 2010 Online: www.agencymeddirectors.wa.gov

Withdrawal Symptoms Assessment:
"Clinical Opiate Withdrawal Scale" The National Alliance for Advocates for Buprenorphine Treatment. Online at: www.naabt.org

Aberrant drug-related behavior

Prescribers and dispensers should use clinical judgment when aberrant drug-related behaviors are observed. Such behavior should be reported to the proper authorities and/or healthcare team as appropriate.

Aberrant drug-related behaviors broadly range from mildly problematic (such as hoarding medications to have an extra dose during times of more severe pain) to felonious acts (such as selling medication). These are any medication-related behaviors that depart from strict adherence to a prescribed therapeutic plan of care.

Prescribers and dispensers should observe, monitor and take precautionary measures when a patient presents aberrant drug-related behaviors such as:

- Requesting early and/or repeated refills
- Presents at or from an emergency department seeking high quantities of a prescription
- Denied by other prescribers or dispensers
- Presents what is suspected to be a forged, altered or counterfeit prescription.
- Forging prescriptions
- Stealing or borrowing drugs
- Frequently losing prescriptions
- Aggressive demand for opioids
- Injecting oral/topical opioids
- Unsanctioned use of opioids
- Unsanctioned dose escalation
- Concurrent use of illicit drugs
- Failing a drug screen
- Getting opioids from multiple prescribers
- Recurring emergency department visits for chronic pain management*

Prescribers and dispensers should be alert for subjective behaviors such as being nervous, overly talkative, agitated, emotionally volatile, and evasive, as these may be signs of a psychological condition that may be considered in a treatment plan or could suggest drug misuse.**

**"Interagency Guidelines on Opioid Dosing for Chronic Non-Cancer Pain" State of Washington Agency Medical Directors Group. 2010 Online: http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf*

***Webster LR, Dove B. Avoiding Opioid Abuse While Managing Pain. Sunrise River Press, North Branch, MN 2007.*

Practitioner Considerations

Healthcare team:
Consider that the patient may be receiving opioids from another prescriber. Contact the patient's healthcare team when appropriate which may include the following:

- Physician
- Specialist (pain, addiction, etc.)
- Dentist
- Advanced Practice Nurse (APN)
- Physician assistant
- Pharmacists
- Area emergency rooms

- Surrounding (within 5 miles) or historical pharmacies

Authorities:

- If the prescriber or dispenser suspects illegal activity, the matter should be referred to the Drug Enforcement Agency (DEA) and local law enforcement.
- If a prescriber or dispenser suspect illegal activity on behalf of another prescriber or dispenser, at a minimum, the matter should be reported to the appropriate licensing board.

Prescribers and dispensers should be aware that:

- There is no legal obligation to prescribe or dispense a prescription; and,
- Colorado law strongly encourages prescribers and dispensers of opiate antagonists "to educate persons receiving the opiate antagonist on the use of an opiate antagonist for overdose, including but not limited to instructions concerning risk factors for overdose, recognition of overdose, calling emergency medical services, rescue breathing and administration of an opiate antagonist." (Section 18-1-712(3)(b), C.R.S.)

Additional Resources and Tools

Establishing and maintaining competence:
Tenney, Lili and Lee Newman. "The Opioid Crisis: Guidelines and Tools for Improving Pain Management" Center for Worker Health and Environment, Colorado School of Public Health.

Functional and pain assessment:
"Functional Assessment" Colorado Division of Workers Compensation

Patient agreements:
"Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP - R)"
PainEDU.org Online at: www.painedu.org

Pain tool kit:
Various resources for assessing and managing pain including risk assessments, patient agreements, dose and conversion calculators among others.

Center for Worker Health and Environment, Colorado School of Public Health. Online at: http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Pages/Pain-Management-CME.aspx

Substance use screening and brief counseling:
SBIRT Colorado
www.ImprovingHealthColorado.org

Drug abuse resources:
Substance Abuse and Mental Health Services Administration: www.samhsa.gov

NIH National Institute on Drug Abuse: www.drugabuse.gov or www.nida.nih.gov