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

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AGENDA

Dental Pilot Project #100 "Oregon Tribes Dental Health Aide Therapist Pilot Project"
Quarterly Dental Pilot Project Program Advisory Committee Meeting DPP #100
November 6, 2017, 10:00am – 12:00pm

Location: Portland State Office Building, 800 NE Oregon Street, Room 1E, Portland Conference Line: Dial-In Number: 1-888-273-3658 Participant Code: 547-182		
10:00-10:10	Official Introductions, Agenda Review	Bruce Austin, DMD Sarah Kowalski, MS, RDH
10:10-10:25	Cultural Competency; Training CE Opportunity	Rhiannon Simon, MPH Karen Phillips, RDH, EEP, MPH
10:25-10:30	Overview of Printed Materials	Sarah Kowalski, RDH, MS
10:30-10:45	Indian Health Services Data Brief, April 2017	Kelly Hansen
10:45-11:00	Chart Review Process, Outline, Participants	Bruce Austin, DMD Kelly Hansen
11:00-11:45	Review Summary Document, Discuss deliverables, Advisory Committee Recommendations, Feedback for the Project, Project Response	Sarah Kowalski, RDH, MS
11:45-11:50	Follow Up Items, Future Meeting Dates: Doodle Survey, Next Site Visit, Closing	Sarah Kowalski, RDH, MS
11:50-12:00	Public Comment Period	Public comments are limited to 2 minutes per individual

Next Meeting: Monday, February 5, 2018, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 10:00am – 12:00pm

Chart Calibration Training: Monday, February 5, 2018, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 1:00pm – 3:30pm

OHA hosted lunch, 12:00-1:00pm

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

October 31, 2017

To: Sarah Kowalski, OHA Dental Pilot Project Program

Fr: Pam Johnson, Northwest Portland Area Indian Health Board

This letter is in response to a request for clarification of some issues that were brought up at the Sept. 25, 2017 Project #100 Oversight and Advisory Committee meeting. We hope our responses satisfy the questions and concerns raised. We look forward to continued collaboration with the Advisory Committee to ensure success of our pilot.

Advisory Committee: Quarterly Meeting on September 25, 2017

a. **Reviewed response from NPAIHB from Annual Meeting in June**

b. **Concerns raised that questions remain unanswered or unclear from NPAIHB**
   i. Resubmit questions around complications as they relate to OHA monitoring of patient safety
      1. All procedures have the potential for complications, regardless of which providers are completing the procedures
      2. OHA is required to monitor for patient safety
         i. OHA must have a list of anticipated complications
      3. Projects are required to monitor their projects for patient safety and record complications
         i. Clarification on complications tracking and case management
         ii. Delineate difference between anticipated complications and unexpected; when to report out to OHA, items for review at site visit. See Adverse Event Section.
         iii. Committee members state their understanding of best practice to include the use of "dummy codes" to track complications and adverse events.

Project #100 Response: *After consultation with OHA, it is agreed that Project #100 will submit a list of potential complications to OHA by Nov. 31, 2017. While our monitoring plan already called for the supervising dentist to review all charts of patients that returned unexpectedly after a procedure that is preformed by a DHAT, we are now adding this list to better calibrate the review of those charts by the multiple reviewers that our plan built in for exceptional monitoring. The list will reference textbooks the DHATs use in training and should already be familiar with.*

c. **Committee requests clarification on clinical parameters as to when extractions are authorized for DHATs to complete on patients**
   i. OHA to review other states legislation: Minnesota, Maine, Vermont that have specific

clinical protocols outlined in their legislation

ii. Request clarification on clinical protocols that are utilized when the supervising dentist authorizes a DHAT to complete an extraction

iii. Is there mobility required? Are extractions only completed in cases of emergencies? Periodontal disease present?

Project #100 Response: *Supervising dentists are required to consult on extractions of permanent teeth that fall under the standard dental code 7140. Considerations used by the supervising dentist include include (but are not limited to): remaining tooth structure, restorative history, coronal angulation, number of roots presents, shape, length and form of root structure, endodontic history, size and status of existing restorations, tooth and/or approximation to anatomical structures that may increase complications such as but not limited to nerve spaces and sinus cavities, factors affecting localized bone density such as radiolucency and radiopacity, mobility of teeth, as well as the dentists ability to assess if the tooth can be removed without surgical intervention. The extraction does not have to be an emergency in order to be performed by the DHAT.*

d. **Clarification on Sutures**

i. NPAIHB response states that DHATs are not authorized to perform sutures.

ii. Advisory Committee requests clarification and justification as to why a simple extraction procedure would be part of the DHAT scope of practice but suturing is not.

iii. Concerns that it is inappropriate to not allow the DHAT a full access to a full armamentarium in the event of bleeding etc. that may necessitate the use of sutures or other hemostasis instruments/medicaments/etc.

i. Clarification needed on suturing as part of the scope of practice in Minnesota/Maine/Vermont.

Project #100 Response: *We apologize that our last response concerning sutures was miscommunicated. DHATs have received instruction in the education program on how to perform sutures if necessary. DHATs, and their supervising dentists, are also taught to not select extractions that have a likelihood of requiring suturing.*

e. **Clarify patient restraint policies**

i. Addendum to application states that DHATs are not using papoose boards in the pilot projects in Oregon

ii. Active restraint: clarification on whether this is being used in the clinics by the DHATs

iii. Definitions of restraint used in dentistry

a. Papoose Board

Active restraint

Project #100 Response: *Clinical protocols at NARA and CTCLUSI for "restraint" include having children sit on their hands and having parents hold their children in their lap during the procedure. The DHATs will use their knowledge of child behavioral management and these clinic protocols.*

f. **Nitrous Oxide**

i. Advisory Committee requests clarification and justification as to why nitrous oxide would is not part of the DHAT scope of practice.

ii. Clarification is needed about whether Nitrous Oxide is utilized in the clinics.

iii. Clarification is needed about whether DHAT trainees working on patients that are placed under Nitrous Oxide or other analgesics

iv. OHA to review other states legislation: Minnesota, Maine, Vermont that have specific clinical protocols outlined in their legislation with regard to the use of

Nitrous Oxide

Project #100 Response: *Our scope of practice is modeled after the AK program, and reflects what our DHATs are trained to do. Nitrous Oxide is not readily available in remote villages in AK, is hard to transport, store, and is seen as a luxury, not a necessity in treating patients safely. Understanding the context of working in this environment is important to understand how the DHAT scope of practice was developed. Nitrous is used at both NARA and CTCLUSI, but for the purposes of this pilot we have decided at this point not to modify our application to include additional training in Oregon on Nitrous Oxide for DHATs. DHATs are able to provide treatment to a patient that is placed under Nitrous Oxide or other analgesics.*

I**. Supervising Dentist**

i. Concern over relationships with new supervising dentist and turnover
ii. Relationship between the supervising dentist and DHAT is stressed as a key to the success of the workforce model yet Indian Health Services has high turnover rates and a difficult time recruiting dentists, clarification is requested on how the project handles this issue.
iii. Clarification requested regarding process of new supervising dentist and preceptorship process; is a new preceptorship required?

Project #100 Response: *Supervising dentists, per our original application, are required to receive supervising dentists training. This requirement is for every supervising dentist. As with any successful relationship between supervisor and employee, establishing trust, constructive communications, and shared expectations are beneficial to both parties. If there is a situation where there is high turnover in dentists, the DHAT can provide continuity of care and a sense of stability for both the patients and the clinic. While there are no requirements in the AK CHAP standards concerning "new" preceptorships with a new supervising dentist, there is often an initial practice of direct supervision to begin establishing that relationship. To that end, we will recommend new supervising dentists and DHATs spend at least 80 hours in a direct supervisory relationship.*

Quarterly Dental Pilot Project
Program Advisory Committee Meeting Minutes

Date: Monday, November 6, 2017

Time: 10:00 AM – 12:00 PM

Location: OHA Public Health Division
800 NE Oregon Street
Portland, OR 97232
Conference Room 1D – First Floor

Attendees:

Advisory Committee Members: Paula Hendrix, Connor McNulty, Shannon English, Len Barozzini, Kyle Johnstone, Karen Hall, Carolyn Muckerheide**,** Kelli Swanson Jaecks

Advisory Committee Members Absent: Leon Asseal, Teri Barichello, Jennifer Clemens, Steven Duffin, Tony Finch, Jill Jones, Richie Kohli, Linda Mann, Brandon Schwindt, Kenneth R Wright, Gita Yita

Public Attendees: Britny Chandler, Pam Johnson, Heather Simmons, Jennifer Lewis-Goff, Jona Kushner

Oregon Health Authority (OHA) Staff: Sarah Kowalski, Rhiannon Simon, Bruce Austin, Laurie Johnson, Amy Umphlett, Karen Phillips, Cate Wilcox, Kelly Hansen, Caroline Tydings

Official Introductions, Agenda Review: Bruce Austin and Sarah Kowalski

There was an ice breaker game and agenda review.

Cultural Competency; Training CE Opportunity: Rhiannon Simon and Karen Phillips

Rhiannon Simon:
The advisory committee meeting format will be changing slightly. There was a request that the advisory committee receive more education on the context of the project and the topics of cultural responsiveness, health equity and access to care. We will add an educational component (15-20 minutes) at the beginning of every meeting focusing on those topics. We want to provide the committee with useful information surrounding culturally responsive high quality clinical care while respecting your time.

Providing this kind of education in these time blocks has advantages and disadvantages. The advantage is that we can continue through this work with a shared understanding of these topics and talk about it with shared terminology. An example of what we will talk about is preference of using the term “cultural responsiveness rather than “competency” which infers that you are educated all at once and you then know all there is to know. This is a growing educational process where we can apply this education in the field. A disadvantage is that these are heavy issues and there is a lot of trauma associated with this topic so it can be a lot to take in during a short amount of time. So we will consider these introductions to these topics. We will also compile a list of resources, trainings and

workshops that address these topics more fully that you can do on your own. When possible, we will focus them specifically on oral health.

It was asked if there were any suggestions for the components, speakers and/or resources to be shared with the group. It was requested that if members notice educational gaps in regards to cultural responsiveness, to submit them so they have an opportunity to be addressed at these meetings. Anonymous submission is fine.

Suggestions:

1. Two different presentations at the ODA convention two years ago. One was a female dentist talking about cultural differences in treating dental patients of different backgrounds. She talked about Latino patients and the specifics for treatment so they feel their customs are respected.
    a. Karen (Irani?) from Los Angeles
    b. ODA representatives offered to share information on cultural responsive speakers
2. Karen Hall is offering a cultural competency session for oral health providers at the oral health workshop on November 17, 2017. She is working with a community health worker in creating an adult learner style cultural competency class. She will submit it to the Office of Equity and Inclusion to see if it can get credentialed. Karen will provide information if the class credentialing is accepted.
3. It would be really nice to hear from a dentist that has worked in these communities like Alaska or Oregon. It would be good if they could talk about their experience and discuss what the challenges were and what was successful.

Karen Phillips:
The Office of Minority Health federal agency offers this cultural competency program for oral health providers: https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers. It is free, has 3 module, provides 6 free hours of CE, and allows you to go at your own pace. It is an overview of the national standards on culturally and linguistically appropriate services and that is the CLAS standards. One of the modules offers a self-assessment and an office assessment. It provides the fundamentals for cultural competency. Module 1 is Defining the CLAS Standards. Module 2 is Practice Management for dental offices and also other hospital and school settings and community health clinics. Module 3 is Communications and Health Messaging with Patients.

- There was expressed concern that only 2-3 hours of that CE would count for dental hygienists licensure.
    - Information was provided that Dentists are allowed 4 hours of “patient relations” every cycle and hygienists are allowed 2 hours of “patient relations” every cycle.
    - Information was provided that it doesn’t typically take 6 hours to complete the modules.

Overview of Printed Materials: Sarah Kowalski

The full appendix of the actual application that was approved by OHA is in the Dropbox. It includes the approved evaluation plan. The actual document in the appendix is roughly 300 pages but there were excerpts made available at the meeting that cover oral health.

One handout covers what is happening in different areas of the country: Maine passed legislation a few years ago but there are no operating programs. Vermont does not have administrative rules written. It is used to compare scope of practice between the different models. There was an explanation that the last page on that handout covers different models internationally and looks at

scope of practice for different countries: The origin of the Alaska model was New Zealand but even though the initial cohort was trained there, the models are still different. The Alaska model is a little more stand alone.

- There was a request by someone on the phone that the handouts be sent out by email after the meeting.

Information was shared that OHA will conduct a site visit on February 26, 2018 at the NARA site in Portland. There was a sign-up sheet passed around for those interested in signing up. Anyone on the phone who is interested in signing up can email Sarah Kowalski to sign up. If there are more than five people interested, there will be a random choosing.

Periodic and annual site visits by OHA are required. Those attending go to the site location where the trainees are practicing and then return to PSOB to conduct interviews with participants, trainees, supervising dentist and more. This is an all-day event so those who do sign up will be required to remain present for the whole day. Our chief responsibility is to determine that adequate patient safeguards are being utilized. It will also must be validated that the project is complying with the approved or amended application. Projects should not be practicing outside the bounds of what they said they were going to do. Whether or not patients will be interviewed, is undetermined. There will be survey review but there are some issues related to actually interviewing patients. More information will become available soon regarding how to address interviews vs. surveys.

- There was a question regarding whether or not the chart review process will be on the same day as the clinic visit.
    - The chart review process will not be on the same day.

Indian Health Services Data Brief, April 2017: Kelly Hansen

The Data Brief is available in the Dropbox. The goal of this portion was to provide an introduction to the state of public health research in dentistry in Oregon especially when it comes to native populations.

Some of the data sources used in public health come through either looking at utilization such as claims data or through surveys like BRFFS (Behavioral Risk Facture Surveillance System). There are various surveys looked at which ask people to describe their own thoughts on their oral health experience, last time they went to a dentist or received certain amounts of care. Other data sources show more of a clinical health look which are often basic screening surveys. There are a standard set of guidelines by ASTDD for these surveys. The data source in the brief provided at this meeting is a basic screening survey when is when clinicians go look at peoples oral health status. This is not the same as a diagnostic screen, it is very high level basic screening survey.

One place where a lot of these data sources come together in Oregon is the Oregon Oral Health Surveillance System. Kelly offered to provide more information to anyone with questions.

Healthy People 2020 is a group of federal objectives for public health and there are specific oral health objectives. They also host a website showing data for national level markers for the objectives. Two major objectives include: 1) Increase the proportion of children, adolescents and adults who use the oral health care system and 2) Reduce the proportion of children, adolescents and in primary or permanent teeth.

The 2017 State Population Health Indicators gathers information based on the response to the question, “when was the last time you saw a dentist?” It is a telephone study based on BRFSS that is nationwide but can be looked at from the state level. That can be weighted based on other types of

demographic factors. Looking at the results from 2015, 68% of adults had seen a dentist in the past year. It should be recognized that in some minority groups there were not have enough numbers available to be able to report on all groups because they did not meet standards for statistical certainty before those numbers can be released.

The National Survey of Children's Health is a similar asking survey where parents are asked, "Does your child have oral health problems?" This survey is very subjective because providers are not being asked. The graph for Oregon in 2016 was shown. The issue when looking at it is that they cover Hispanic, white, black, non-Hispanic and other so it does not specify information about other populations.

The Oregon Smile Survey, performed by OHA, is done every 5 years and we are currently undergoing data collection for 2017. In 2012 there was enough numbers to report on Asian, Black/African American, Hispanic and Latino, and white populations but not Native American Populations. Overall, it was found that 52% of children ages 6-9 years old has had some sort of dental caries experience. This basic screening survey is very basic and can underestimate disease. When looking at a basic screening survey, it is only looked at whether or not there is treated or untreated decay in primary or permanent teeth. Decay numbers can be underestimated because if there are pre-cavitated pit and fissure caries or smooth surface caries, if there is no cavitation, it is not counted as decay.

The IHS Basic Screening Survey 2016-2017 looks specifically at the Native American Population. It can be noticed that there was not much change over time between 2012-2017 in caries experience in 6-9 year olds in American Indian and Alaskan Native school children. There was not any significant difference found in change over time. It was found that in the 2016-2017 school year 87% of 6-9 year olds who are American Indian or Alaskan Native had some experience with dental caries. This is compared to 52% of Oregonian children ages 6-9 with dental caries experience. American Indian and Alaskan Native children are 5 times more likely to have untreated dental caries in their permanent teeth than the general population.

These data briefs are all available at Https://Ihs.gov/doh

Super Summary: there is a significant problem with increased dental disease amongst the American Indian and Alaskan Native population in both children and adults, specifically in Oregon.

Chart Review Process, Outline, Participants: Bruce Austin and Kelly Hansen

There will be different aspects of the chart reviews when it comes to the site visit. A certain number of chart reviews will pulled for each classic procedure that is done. There are 49 specific procedures but that is not feasible so some will be grouped together.

For every chart we will look at the consistencies that should be on every chart, what is the health history sign, PARQs, etc. For the clinical procedures where we do have pre or post operation photos, we will look at the quality and have the clinicians calibrate ahead of time so that we mostly agree.

After the calibration training and after the site visit on the 26th, OHA will arrange several opportunities to come. OHA is hoping to host three sessions which will take a few hours each because a minimum number of procedures done for each classification need to be covered. General information for each chart will not be reviewed because that does not require technical expertise. Chart information about procedures will be the main focus.

Providers are only allowed to evaluate procedures that are within normal scope of practice. OHA would like as many clinicians as possible participate. Hygienists cannot judge restoration. A doodle poll will be sent out to assess what dates work for everyone for the training.

A **clarification** was made that it is not prerequisite to participate in the site visit at NARA and the interviews in order to participate in the chart review. It is desired that everyone who can participate in the chart review does. Whereas, only so many people can join at NARA. If someone wants to participate in the chart reviews to be calibrated so you must attend the February 5, 2018 meeting.

If anyone would like to participate in designing the training, they can contact Kelly or Bruce. If anyone has photos that they could share please do so as well.

Review Summary Document, Discuss deliverables, Advisory Committee Recommendations, Feedback for the Project, Project Response: Sarah Kowalski

The summary document sent out to the project after the last meeting has OHA action items and Indian Health Board Action Items.

There was a long conversation including concerns that were raised that the committee had felt were unanswered. OHA met with the project and used The Sturdevant's Art and Science of Operative Dentistry textbook. The project needs to be tracking items that are likely and unlikely complications. OHA will ask for all charts flagged with complications which will then be reviewed and to see if they were appropriately dealt with. The project has agreed to go through and do that and then the committee will talk about it. It is going to be a challenge, once they submit their complications, to try and get the committee to reach consensus about what falls under each box. OHA has been trying to obtain a list of complications from the project for over a year. A template was provided to the project. There is a concern that the project is not tracking for complications in a systemized way.

Extractions

When the project applied and was approved, they were approved to operate under the Community Health Aide Program Certification Standards and Procedures. The project heavily cited this document in their application. The CHAP Standards spell out the scope of practice. It is very prescriptive about what trainees can and cannot do once they are certified.

Last meeting, there were a lot of questions about the ambiguity about what a simple extraction means and that it was too vague. Section 2.30.610 of the standards states that "Dental health aid therapist services may be performed under this section by a dental health aide therapist under the supervision of a dentist provided the dental health aide therapist has met the requirements of this section. Pupal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aid therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment."

The project has said that they don't have to be a medical emergency. This directly conflicts with what we have approved. The issue is that if they don't want to require that they be a medical emergency, they are going to need to apply for a modification for their application. They now need to provide justification as to why they feel this is appropriate. If they do submit this modification, the advisory would need to meet and discuss to take input and feedback on whether or not we would approve it.

It was noted that this limitation was put on adult teeth and is not there for primary teeth. The medical emergency limitations are for adult teeth only.

- There has not been a clean definition of medical emergency. Concern was shared that if it is a true medical emergency, than a dentist and/or the patient's physician should be handling that medical emergency. The desire was expressed to hear the project's specification on what a medical emergency is.
- Concern was expressed that it is worded as medical emergency vs. dental emergency.
- There was concern that there is not enough specification about what a medical emergency is.

The CHAP standards are cited multiple times as a part of the application. When the technical review board made the conclusion that the project is following these standards, OHA became obligated to make sure that the project is complying with these standards. We will let the project know what the conclusion is and what they need to do moving forward.

It was noted that it is important that we recognize this as a pilot project/ a demonstration project and that the purpose of a demonstration project is to test things so they need to be clear with what they want and what they are doing.

In Alaska, they are preforming under the CHAP standards. OHA is not trying to box the project into technicalities but we do have to make sure they comply with what they have applied for and what OHA has already approved. Clarification is necessary.

Last time the committee wanted to talk about what is happening in other areas. Alaska has the standards that says it has to be a medical emergency. Maine, Minnesota, and Vermont is very similar. They can extract primary teeth. Maine can perform nonsurgical extractions of periodontally diseased permanent teeth if authorized. Minnesota is a little more prescriptive. New Zealand and Australia do not do any permanent teeth extractions. It is hard to find out what the parameters are for other countries however the majority of them limit extractions by dental therapists to primary teeth.

The project's response was that it was up to the supervising dentist to make the determination. What we are asking the project to do is make a modification on this point. It would be a change in the scope or nature of the project according to the CHAP standards.

The question was asked that: They have said to us, these standards are already in the CHAP. So how are they documenting the medical emergency?

- The response was provided that the project is saying that it does not have to be a medical emergency. This is a departure from what they are approved to do. For example, they pre-appoint extractions which doesn't fit the definition of an emergency. OHA will talk to the project and explain the concerns and ask that if it is their intention to perform extractions as non-emergency, they need to apply for a modification. So they need to define what the criteria are.

The advisory committee would discuss any modification and determine an appropriate response.

The question was asked: In the discussion regarding this discrepancy, do they not think it is a problem that they are not following their own standards?

- Answer: It was the intention that committee discuss this issue before going to the project about it. OHA has not contacted the Project about this issue yet. The information and suggestions from this meeting will be taken to the project to talk about it. OHA will then ask them to comply with these rules and stop other extractions until they follow through with a modification.

The question was asked: What is the timeline for these discussions?

- Answer: There will be a conversation this week about them stopping further action that conflicts with the standards. If a modification comes through, we will allow time for comments before approving the modification. We can schedule a special meeting to discuss modifications if that is what we decide to do.

Suturing:

Maine allows suturing. Minnesota and Vermont allow suture removal. There is nothing in the CHAP standards that covers suturing. The committee agrees that the project should be able to do this and can recommend to the project that trainees should be doing this.

The project responded and said that they had misspoke and said that do training for suturing. The issue is that it is not in the CHAP standards which are extremely prescriptive on what they can do. Even though the committee agrees that the project should be able to suture and the project is performing it, we need specific standards regarding suturing.

Sarah has not found any evidence to support that they are trained in suturing so they would need to provide that. They would also need to go through the same modification request as for extractions. The advisory committee meeting will need to decide.

There was concern expressed that the project had said that they are trained to do sutures but they are also trained to select teeth that probably won't need suturing. The confusion was that it is unclear if the project have suture training in case they need it in an emergency. There also needs to be clarification on what the training is in the first place because here has not been any information found regarding their training so OHA is still looking for that.

Nitrous

The project did not include nitrous in the model because, in Alaska, they don't have a lot of the resources available. It is expensive to have it and transport it so they never included it as their scope of practice. A lot of the travel to these sites are by air so it is not practical for these remote sites to have it.

The project has responded and said that it is being utilized at the sites. DHATs are not trained on Nitrous. The last statement was that "DHATs are able to provide treatment to a patient that is placed under nitrous or other analgesics." This is not going to work because looking at the Board of Dentistry Anesthesia Administrative Rule, there are rules in place for patient safety and we are going to work inside the bounds of those. If you are a hygienist and the patient is under nitrous and under something else, you cannot work on them. The term "other analgesics" is concerning.

There are two problems 1) A DHAT who is not trained in nitrous is able to treat patients who are being administered nitrous. That is a conflict of Dental Practice Act 2)The other problem is that, what is analgesics mean?

- Multiple people share this concern.

They need to follow the Board of Dentistry Anesthesia rules. OHA will follow up on that with the project.

It was expressed that the understanding is that the dentist can turn on the nitrous, the dental assistant is trained to monitor but not change anything regarding the nitrous. Who turns it on could be the technology stipulation. This is not verified.

A comment was made that, in the past, the Oregon Board of Dentistry has said confirmed what was previously said. There was also another thing, a dental hygienist can do the same thing for a dentist who does not have their permit but a dentist still needs to be on site in order for a hygienist to preform nitrous.

It is up to the Project to clarify what they meant by that and we will go from there. There is considerable confusion as stated in the addendum to their application it specifically states the trainees will not be working with nitrous oxide as they are not trained with nitrous.

Informed Consent

- The project completed a large 24 page document of the PARQs. They have to provide informed consent for all procedures. The informed consent does not have to be written. That was the ambiguity in the rules.
- Our interpretation was that it did have to be written and the Department of Justice determined that consent could be verbal but the project had to submit to OHA what that informed consent stated.
- The Project has said there are written IC documents for some procedures, such as oral surgery. OHA has requested those but has not been provided with them yet.

Follow Up Items, Future Meeting Dates: Doodle Survey, Next Site Visit, Closing: Sarah Kowalski

Next Meeting: Monday, **February 5, 2018,** Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 10:00am – 12:00pm

- OHA hosted lunch, 12:00-1:00pm followed by
- **Chart Calibration Training**: Monday, **February 6, 2018**, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 1:00pm – 3:30pm
  - This training will cover what the parameters are for the categories to avoid it being subjective. At the end of the training you will receive a "test" of how much everyone agrees with one another about the parameters to create statistical reliability.
  - **The Chart Calibration Training is not mandatory but if someone wants to participate in the chart reviews they must attend this training.**

There is a chance we may not hold the April 16th meeting. (tentative)

- Our Annual Meeting (all day) is June 18, 2018. We will invite the project to come.
- It was asked if the committee would like to see the curriculum and syllabus for each of the courses:
  - The sentiment was yes.
- The Chart Calibration Training Meeting invitation will be sent later today.

Public Comment: 2 minutes per individual

No public comments.

Action Items, Items for Clarification & Deliverables*

Site Visit Completed

a. Site visit completed September 11-12, 2017 to Alaska
   i. OHA developed draft site visit report completed on November 9, 2017.
   ii. A copy of the draft report was provided to NPAIHB on November 9th.
   iii. Project has requested to review draft for corrections, i.e. names/dates/etc.
      a) OHA needs corrections by end of the day Friday, November 17th.
   iv. OHA will submit the draft site visit report to the OHA Publications and Creative Services on Monday, November 20th so that it can be officially published.

OHA Action Items:**	• Complete site visit report by November 9th • Send to Publications by November 20th
NPAIHB* Action Items:**	• Submit items for clarification to OHA Deadline to OHA is November 17, 2017

NARA Site Visit

a. Dates
   i. Site visit date is scheduled for February 26, 2018.
   ii. Project was provided with confirmation of date, outline of the agenda for the day, and a list of individuals that must be interviewed.

b. Site Visit Process
   i. Site visit process documents are under development for DPP #100.
   ii. OHA sent examples of the site visit process utilized for DPP #200 to NPAIHB previously.
   iii. OHA will send site visit process documents to NPAIHB once the chart review process documents are complete. This is estimated to be completed mid-December.
   iv. The project proposed that it was redundant for OHA to interview individuals that they had already interviewed as part of their own evaluation process. OHA informed the project that per 333-010-0455 Program Responsibilities, OHA has specific administrative rules regarding site visits that outline the purpose of the site visits:

      (2) Site visits. (a) Site visits shall include, but are not limited to: (A) Determination that adequate patient safeguards are being utilized; (B) Validation that the project is complying with the approved or amended application; and (C) Interviews with project participants and recipients of care.

   v. OHA operates independently of the pilot projects and is responsible for oversight of the approved pilot projects.

c. Chart Review Process
   i. OHA is consulting with subject matter experts from the Advisory Committee to develop the process.
   ii. See "Chart Review Process" section for further details.

OHA Action Items:**	• Send site visit process documents to NPAIHB when completed – estimated deliverable mid-December • Develop chart review process (see below)

* These are action items, not minutes

** Oregon Health Authority (OHA)

*** Northwest Portland Area Indian Health Board (NPAIHB)

	• Confirm Advisory Committee members who will participate in the site visit
NPAIHB*** Action Items:	• Ensure all individuals identified as needing to be interviewed for the site visit on February 26th are available

Chart Review Process

a. The comprehensive chart review process is in development with Advisory Committee subject matter experts.
b. A sufficient number of randomized de-identified patient charts will be requested to provide a satisfactory number of charts for each procedure under review. In addition, charts will be reviewed for basic charting protocol, infection control protocol, informed consent, diagnosis and treatment planning, and anticipated and unanticipated adverse events.
c. The chart review process will include reviewer standardization guidelines to ensure interrater reliability. The guidelines are currently under development using the following sources:
    i. WREB documents/process
    ii. Indian Health Services Chart Review Document
    iii. DHAT Training Curriculum materials
    iv. Literature Review
d. A workgroup will be convened to develop the process with input from Advisory Committee members.
    i. Chart Review clinical parameters
    ii. Review NPAIHB chart review document
e. A Chart Calibration Training for Advisory Committee members has been scheduled for Monday, February 6, 2018 from 1:00 PM – 3:30 PM at the Portland State Office Building, 800 NE Oregon Street, Portland, OR.
    i. The training will cover what the parameters are for the categories to avoid it being subjective.
    ii. The Chart Calibration Training is not mandatory for all committee members, but those intending to participate in the chart reviews must attend this training.

OHA** Action Items:	• Develop chart review process for utilization during site visits
NPAIHB*** Action Items:	• Provide list of anticipated complications, by procedure, for chart review process Deadline to OHA is November 30, 2017

Informed Consent

a. The process of informed consent (IC) in the pilot project is almost complete.
b. NPAIHB submitted an IC document that they will use for verbal informed consent. It is under review by OHA and the Advisory Committee.
c. OHA has requested from the project IC forms that are provided to patients in the clinics.

OHA** Action Items:	• Review draft informed consent document submitted by NPAIHB • Submit the informed consent document to the Advisory Committee for comment and review • Discuss committee findings at the next Advisory Committee meeting in February

NPAIHB*** Action Items:	• Project submitted informed consent document to OHA for items which they will utilize verbal informed consent • Provide OHA with the informed consent documents that are utilized in the clinics Deadline to OHA is November 30, 2017

Preceptorship

a. DHAT trainees are required to complete a minimum 400-hour supervised preceptorship under the direct supervision of their supervising dentist at the pilot site clinic. (page 41 Approved Application)
b. According to the approved evaluation plan, "The DHAT is expected to perform the procedures eight times (unless otherwise noted on list), work independently each time, and in compliance with the established standards for review of each aspect of the procedure. If the DHAT has been recertified at least once by the CHAP Certification Board, they are only required to perform each procedure 4 times (unless otherwise noted on list) to demonstrate competency. (page 31 Evaluation Plan)
c. The project asked OHA what is the process if they need to amend the preceptorship process as outlined in the approved application and evaluation plan.
    i. If there is a plan to change the preceptorship process from the plan outlined in the approved application and evaluation plan, then a request for project modification will need to be submitted and sent to OHA for review. A determination will be made if the modification is approved.

NPAIHB*** Action Items:	• Submit modification request to OHA if the preceptorship process needs to be modified

Adverse Events

a. (6) A sponsor must report adverse events to the program the day they occur (333-010-0435).
b. Adverse events are not defined in the Oregon Administrative Rules (OARs).
    i. OHA is conducting a comprehensive literature review on the dentistry definition of "adverse events". This includes, but not limited to, complication, expected adverse events, unexpected adverse events, and serious unexpected adverse events.
    ii. OHA is collaborating with each pilot project to define what "adverse events" must be reported to OHA.

OHA** Action Items:	• Define adverse events vs. adverse outcomes vs. complications (anticipated/excepted/common vs. rare/unusual/unexpected) • Conduct literature review and reporting guidelines • Define OHA adverse event reporting procedure • Follow-up on process once complications list is received from the project. The project can anticipate a response from OHA in early January 2018
NPAIHB*** Action Items:	• See "Chart Review Process" section under complications for deliverable Deadline to OHA is November 30, 2017

DATA

* These are action items, not minutes

** Oregon Health Authority (OHA)

*** Northwest Portland Area Indian Health Board (NPAIHB)

Summarized Data and Raw Data

a. Quarterly Submission of Data
   i. Summarized data must be provided as part of the quarterly progress report. This information is part of the overall report and is available for all to review.
   ii. Projects are required to submit raw data to OHA in a format that OHA requires. This is not for dissemination. (Oregon Administrative Rule 333-010-0432, Evaluation and Monitoring: (5) "A sponsor must provide a report of information requested by the program in a format and timeframe requested.")
   iii. OHA template was provided to the project.
      1. First iteration was sent to project in 2016.
      2. Quarterly summary report template document was sent to project on 10/26/2017.
      3. Quarterly report and data submission for Quarter 3 2017 is due 11/30/2017.
      4. Quarterly report and data submission for Quarter 4 2017 is due 1/2/2018.
   iv. A one month lag time between the end of every quarter and the due date to OHA for both the progress report and summarized data will be granted. A revised version of the quarterly progress report template will be developed.

b. Specific Items are required to be reported to OHA on the Quarterly Report summary template:
   i. Dental staff patient care hours
   ii. Patient demographic summaries (including age, race/ethnicity and gender)
   iii. Procedure performed by each trainee, including number of patients seen and evaluating dentist reviews
   iv. Supervising dentist assessment of procedure; acceptable/not-acceptable
   v. Adverse events

c. Specific items required in the raw data report include above information per de-identified patient in addition to information on follow-up/recall, complications, and other information outlined in the Data Collection Plan section of the approved Evaluation Plan.

d. OHA requires raw data be submitted in one single report (excel format).

e. Submit credentials of the external evaluator (OAR 333-010-0435 Identification of an evaluator unaffiliated with the project and with no financial or commercial interest in the outcome of the project that will conduct the pilot project's evaluation.)

OHA** Action Items:	• OHA is outlining programmatic needs in response to questions asked by the project in regards to raw data. Clarification is forthcoming and will be sent to the project by November 21, 2017 • Revised version of the quarterly progress report template will be developed and sent to the project by November 22, 2017
NPAIHB*** Action Items:	• Deliver completed quarterly data via required excel template to OHA SUMMARIZED DATA: Deadline to OHA is November 30, 2017 RAW DATA: Deadline to OHA is December 8, 2017 • Submit credentials of external evaluator

Advisory Committee: Quarterly Meeting on November 6, 2017

1. Reviewed response from NPAIHB from Quarterly Meeting in September

2. Clarification is required on extractions
    a. Project applied to operate under CHAP Standards, as stated in the approved application.
    b. CHAP Section 2.30.610 of the standards states that "Dental health aid therapist services may be performed under this section by a dental health aide therapist under the supervision of a dentist provided the dental health aide therapist has met the requirements of this section. Pupal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aid therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment."
    c. Project response: "Supervising dentists are required to consult on extractions of permanent teeth that fall under the standard dental code 7140. Considerations used by the supervising dentist include (but are not limited to): remaining tooth structure, restorative history, coronal angulation, number of roots presents, shape, length and form of root structure, endodontic history, size and status of existing restorations, tooth and/or approximation to anatomical structures that may increase complications, such as but not limited to, nerve spaces and sinus cavities, factors affecting localized bone density such as radiolucency and radiopacity, mobility of teeth, as well as the dentists ability to assess if the tooth can be removed without surgical intervention. The extraction does not have to be an emergency in order to be performed by the DHAT."
    d. OHA and the Advisory Committee are concerned that this is in direct conflict of the approved application.
        i. The project must follow CHAP Standards and Procedures as outlined in their approved application – under section 2.30.610.
        ii. Trainees cannot perform extractions unless they meet the CHAP guidelines; project will be informed in writing.
    e. There are no clear definitions on medical emergency under the guidelines. The concern is that in instances of a medical emergency, a dentist should be providing treatment. Does this only occur in the absence of a dentist on-site? Further clarification is required.
        i. If the project intends to provide extractions as part of the DHAT scope of practice outside of the CHAP Standards that they were approved to operate under, then they must apply for a modification to their application.
3. Clarification on Sutures
    a. The project originally stated that DHATs are not authorized to perform sutures. The project responded that they miscommunicated this information, and DHATS are trained to do suturing. (see response)
    b. The Advisory Committee requests further clarification, as the process is not identified in CHAP standards which is very prescriptive.
    c. The Advisory Committee also requests clarification on when suturing is taught. There is no mention of suturing in the curriculum.
        i. If the project intends to provide suturing as part of the DHAT scope of practice outside of the CHAP Standards that they were approved to operate under, then they must apply for a modification to their application.
4. Nitrous Oxide
    a. The project stated that "Nitrous is used at both NARA and CTCLUSI, but for the purposes of this pilot, we have decided at this point not to modify our application to include additional training in Oregon on Nitrous Oxide for DHATs. DHATs are able to provide treatment to a patient that is placed under Nitrous Oxide or other analgesics."

b. An addendum to the application states: "The DHATs are not trained to use it; they will not be using Nitrous Oxide."
    i. The above statements are in conflict with each other. Clarification by the project on this point is required.
c. OHA received a response from the project on October 31, 2017 that states, "DHATs are able to provide treatment to a patient that is placed under Nitrous Oxide or other analgesics."
    i. The term analgesics is cause for significant concern by both OHA and the Advisory Committee. Analgesics range from common pain relievers to opioids. The term other analgesics may suggest treatment is being completed under minimal sedation, as defined by OAR 818-026-0010. There are prescriptive administrative rules as to whom can administer nitrous oxide, when direct supervision is required, and when certification is required. In addition, there are various levels of permits required by the Oregon Board of Dentistry.
    ii. If DHAT (trainees) are providing treatment to patients under "nitrous oxide or other analgesics," then OHA requires that the trainees participating in the approved pilot project follow the Oregon Board of Dentistry administrative rules for Anesthesia 818-026-0000 through 818-026-0120.
    iii. The project must provide clarification on the intention of using nitrous oxide by DHATs in the pilot project, as well as the training received and competency if operating as an Anesthesia Monitor, etc.
    iv. If it is the intention of the project trainees to utilize nitrous oxide or work on patients under nitrous oxide, then they must apply for a modification to their application.

5. Oregon Dental Practice Act
    a. While the Dental Pilot Project legislation in SB738 allows for demonstration projects to exist, established standards in the Dental Practice Act still apply.
    b. Dental Therapists are not a recognized provider type under the Oregon Dental Practice Act and currently operate under the approved application DPP #100 in the Dental Pilot Project Program.
    c. While specific licensing laws for Dental Therapists do not exist in the Oregon Dental Practice Act, all other applicable requirements that would apply to the Dental Therapist, if it were a recognized provider type, do apply to individuals operating as Dental Therapists in Oregon.

       Senate Bill 738:

       (4)(a) Notwithstanding ORS 679.020 and 680.020, a person may practice dentistry or dental hygiene without a license as part of a pilot project approved under this section under the general supervision of a dentist licensed under ORS chapter 679 and in accordance with rules adopted by the authority.

       (b) A person practicing dentistry or dental hygiene without a license under this section is subject to the same standard of care and is entitled to the same immunities as a person performing the services with a license.

6. The Advisory Committee has requested copies of the syllabus for the entire training program.
    a. Examples provided by the project are not sufficient enough for a thorough review by the Advisory Committee.
    b. See Copy of Course Catalog from Ilisagvik College attached.

c. The project must provide OHA a copy of each course syllabus that begins with the letter DHAT followed by the course number for review, e.g. DHAT 101, etc.	
OHA Action Items:**	• Send an official letter to the project requiring clarification and requirements for modification: extractions, sutures, nitrous oxide
NPAIHB* Action Items:**	• Submit copies of each syllabus, by course, to OHA (see attached course descriptions) - Combine syllabi into ONE pdf in numerical order, e.g. DHAT 101, DHAT 102, etc. • Respond to items requiring clarification and submit any needed requests for modification to the application Deadline to OHA is November 30, 2017

Submission Instructions:

Submission of **ALL** documents should be directly to Dr. Bruce Austin via email at Bruce.W.Austin@state.or.us

Next Meeting:

Quarterly Meeting: Dental Pilot Project (DPP) #100

February 6, 2018

9:00 AM – 12:00 PM

Portland State Office Building

800 NE Oregon Street

Portland, OR 97232