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

Oregon Health Authority

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

AGENDA

Dental Pilot Project #100 "Oregon Tribes Dental Health Aide Therapist Pilot Project"
Quarterly Dental Pilot Project Program Advisory Committee Meeting DPP #100
September 10, 2018, 10:00am – 12:00pm

Location: Portland State Office Building, 800 NE Oregon Street, Room 1D, Portland Conference Line: Dial-In Number: 1-888-273-3658 Participant Code: 76 64 09		
10:00-10:05	Official Introductions, Agenda Review	Bruce Austin DMD Sarah Kowalski RDH, MS
10:05-10:20	Review request to modify language in Stipulated Agreement; primary teeth – extractions	Gita Yitta, DDS
10:20-10:30	Review Post Meeting Feedback Survey	Kelly Hansen Sarah Kowalski RDH, MS
10:30-11:45	Scope of Practice Discussion – Review Survey	Kelly Hansen
11:45-11:50	Follow Up Items, Future Meeting Dates, Closing	Sarah Kowalski RDH, MS
11:50-12:00	Public Comment Period	Public comments are limited to 2 minutes per individual

Future Meetings:

Monday, December 3, 2018, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1D, 10:00am – 12:00pm

Monday, March 4, 2019, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 10:00am – 12:00pm

Monday, June 3, 2019, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1A, 9:00am – 4:00pm

Site Visit: Wednesday, September 20, 2018, NARA Residential Treatment Center, St. Helens, Oregon

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

Oregon Health Authority

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

Quarterly Dental Pilot Project Meeting: DPP 100 Meeting Minutes

Date: Monday, September 10, 2018
Time: 10:00 AM – 12:00 PM
Location: OHA Public Health Division
800 NE Oregon Street
Portland, OR 97232
Conference Room 1D – First Floor

Committee Members Present:
Len Barozzini, Jennifer Clemens, Paula Hendrix, Linda Mann, Connor McNulty, Carolyn Muckerheide, Karen Shimada, Brandon Schwindt,

Committee Members Present Phone:
Kyle Johnstone, Jill Jones

Committee Members Absent:
Leon Assael, Richie Kohli, Kenneth Wright

OHA Staff:
Bruce Austin, Danna Drum, Kelly Hansen, Sarah Kowalski, Amy Umphlett,

Public Attendees:
Azma Ahmed, Pam Johnson, Christina Peters, Jennifer Lewis-Goff, Allyson Lecatsas, Gita Yitta

---

Meetings was recorded and transcribed. *** indicate portions of the meeting that were not audible in the recording.**

[Brackets] indicate wording was modified for clarification or correction.

Meeting began at 10:04am. Committee Members and OHA Staff introduced themselves.

Speaker: **** report.

Next Speaker: I have no idea.

Next Speaker: Yeah.

Next Speaker: You wanna go ahead and get started?

Next Speaker: Yeah. Good morning. This is Bruce Austin. Uh, ****. Is anybody on the phone?

Next Speaker: Yes.

Next Speaker: Yes.

Next Speaker: Good morning.

Next Speaker: Yes.

Next Speaker: Kyle Johnstone on the phone.

Next Speaker: Uh, I'm sorry. Go ahead and introduce yourself please.

Next Speaker: Uh, this is Kyle Johnstone.

Next Speaker: ****.

Next Speaker: **** dental hygienist.

Next Speaker: Thanks.

Next Speaker: Jill Jones.

Next Speaker: Okay. Good mornin', Jill. **** LCC. All right.

Next Speaker: Yes.

Next Speaker: Okay. Anybody else on the phone?

Next Speaker: ****.

Next Speaker: Hi. This is Jennifer Clemens.

Next Speaker: Morning, Jennifer. Is, is there one more?

Next Speaker: Yes, this is Esmerelda Avilas.

Next Speaker: Okay. Good morning. I hope that's not ****.

Next Speaker: Morning.

Next Speaker: Okay, so is that it on the phone? We heard those four. Is that right? **** four, Sara? And who else just signed in on the phone?

Next Speaker: Hi, this is Julie Johnson, O-A-K ****.

Next Speaker: Thanks, Julie. Good morning.

Next Speaker: Morning.

Next Speaker: Let's go around the room then. Um, like I said, this is **** dental grafter and ****.

Next Speaker: Kelly [Hansen] with ****, oral health research analyst.

Next Speaker: Sarah [Kowalski], dental pilot project coordinator.

Next Speaker: Uh, Brandon [Schwindt], uh, Board of Dentistry.

Next Speaker: Conor [McNulty], Oregon Dental Association.

Next Speaker: Linda Mann, Capital Dental.

Next Speaker: Kelly [Jaeks], Oregon Dental Hygienists Association.

Next Speaker: Annie **** for OJ.

Next Speaker: Uh, Mary Muller, um, OJ ****.

Next Speaker: And I guess it's ****.

Next Speaker: Jennifer [Lewis Goff], ****.

Next Speaker: [Azma] Ahmed, um, ****.

Next Speaker: Pam Johnson, Northwest ****.

Next Speaker: Christina Peters, ****.

Next Speaker: I'm Julietta Amad, ****.

Next Speaker: Thank you, everybody, and, uh, for those on the phone, you prob'ly couldn't hear the last introductions very well, but we have Dr. [Yitta]. We have Christina Peters, Pam Johnson, uh, Dr. Ahmed and Jen, uh, from the OJ. So, um, you've prob'ly seen the agenda. We have two hours for this meeting and a very full agenda, so we'll keep it moving. Um, the first, first part of this is, uh, what's up on the screen for those in the room, and for those on the phone, you, you got the PowerPoint, um, sometime before this week, but it's, it's the green background of the first slide titled Cultural ****, and part of this presentation also mentions a request to make some changes in the stipulated agreement, and, and we'll hear about that towards the end. And I just wanna say we're not making a, a decision on that today. We'll be sending out a, a survey so we get everybody's input after the meeting, so we don't need a long discussion about that today 'cause you'll have chances for input. So any questions before we start the presentation?

Next Speaker: Do you want me to stand?

Next Speaker: You can go wherever you're comfortable, and I have the **** right here.

Next Speaker: And for those on the phone, let us know if you can't hear Dr. Veta **** 'cause we're in kind of a big room.

Next Speaker: So if you can't hear me, I'll try to speak as loudly as I can. I'm Veta. I'm the pilot project director for, uh, Project 100, and I used to be on the dental advisory committee, um, so I have knowledge kinda of both sides, um, and so I just wanna talk a little bit about cultural competency, and I know for a majority this has sorta been a topic that keeps being addressed, and it's still **** really doesn't relate to me, and I wanna talk a little bit about how it relates to me when I didn't think it did. So I was asked about 6 months ago to help with, um, a nursing student survey about cultural competency, and I told the student on the phone, you know, I don't really feel like I need this training because I did my residency in the Bronx with primarily African-American, um, Hispanic population. Um, I've taken 6 years of Spanish. Some of my best friends are Indian, Asian and white, and so I was like, you know what? I think I'm culturally competent. I know everything there is I need to know, and little did I know as I started working in public health, things just completely changed for me. I was like there is so much that I did not know about my ****. So I really had to do a lot of, um, reading on my own about socioeconomic issues, poverty, um, underserved communities, um, to really educate myself about things and decisions, even my own training. And it's actually really helped me, um, in becoming a better clinician, and it's helped me in training my staff, because a lotta my staff does not have the background that I have, so, um, cultural competency is defined as the ability of providers' organizations to effectively deliver health care services that meet the social cultural needs **** the patients, and in that definition, it doesn't say underserved patients. It doesn't say a specific type of minority group. It's patients, and given how diverse a population we are in the United States right now, all those types of patients are coming into private practice. They're cash patients. They're PPO patients, so I think it's good for us as health care providers to have an understanding of the patient base that we are seeing. And part of cultural competency is understanding cultural language differences, and that's not meaning that we have to learn ten languages. It's just not practical. It's about, uh, knowing that cultural, uh, language barriers do exist and helping, um, to address those **** through interpretive services, um, and also acknowledging past history, history of discrimination of racism, and unfortunately in health care settings, it really is a problem, and I know it's really, it, it's very uncomfortable for me to talk about because I've been a victim of racism, you know, in school, um, and so I, I feel like patients, especially in our underserved communities, experience this quite a bit, and this can impact or influence their willingness to seek treatment, and I feel like as providers, we're not doing our job if our patients don't feel comfortable with us or they feel like we're judging them. And also a more current area is to, obtaining care. For instance, transportation issues, which I live in Southern Oregon, so transportation is a, a huge issue there. Mental health issues, and as we're seeing in these addiction issues, and with addiction, look, it, it's, it's affecting everyone from people with the highest socioeconomic background. Right? To people of the lowest socioeconomic background. And, um, in terms of the, um, Native American, Alaska Native population, they have higher rates of mental health problems than the rest of the U.S. population. Two to three higher rates of substance abuse disorders. Post-traumatic stress disorders. Suicide attachment disorders that have then led to intergenerational historical trauma forced upon them such as forced to move off of the land into government-operated boarding schools which separated children from their parents, spiritual practices and cultures, so it's pretty much like you put yourself in their position. It's someone coming to your house, telling you that you have to move to a different state, and you're just like why. Right? And that's really what this is, so I think it's a part, being a part of this tribal project that I learned more about the communities that they serve, and I thought this, um, this paragraph was pretty telling of the past trauma that these, these patients and these communities have endured. Um, culturally competent care fosters trust between patient and clinician. It really helps to relieve patient anxiety. It helps to provide better understanding of how a patient may respond to pain. It helps manage patient discomfort in a respectful, cultural, appropriate way. It **** with a patient's past traumatic experience. Unfavorable dental experience can influence patient retention and no-show rates,

and simply because a clinician is able to provide safe care does not mean that the patient feels safe. That's just a sad reality of just being in health care. Sometimes as much as I **** attention and I try to be as warm to my patients, sometimes there're still shakin' in the chair. Right? They're still nervous, and so my che, my safety checklist is always medical history. Right? Um, with the diabetes control and has their **** been checked? Do they need antibiotic, any sorta antibiotic medication? Is this gonna be a surgical versus a simple extraction? Am I prepared for this? Or have I done a thorough informed consent? And these are just a few of the, you know, safety checklist items, but these just stood out to me. Now a patient's perception of safety, I think when I go into my primary care doctor, I'm not, I'm not walkin' the same, I'm really worried I'm gonna have a latex allergy reaction. Right? Or I'm really worried I'm gonna go into cardiac arrest. Um, I would say a lotta patient perception of safety is am I in control of my health? Do I understand what's going on with my diagnosis and what's going on with treatment? Am I overwhelmed with dental terminology? Because I have to say dental treatment plans can be very confusing. Do I feel judged? And do I feel discriminated against? And this is actually a study taken by the Commonwealth Fund, and it's a portion of people who believe they would receive better health care if they were of a different race or ethnicity. I mean this is pretty disturbing. Um, if you look, predominantly African-Americans felt like if they were of a different race, they would've been treated better in all care settings. Then with Latinos, Asian Americans, and lastly, 1 percent white. I mean I, I think that if, if I were to get a survey of my office and a patient wrote had I've been white, I think if would've been treated better, I feel like I would feel, you know, my stomach would really turn with that type of feedback. So, and a lot of our patients won't be honest. Right? At the end of the visit they're not gonna tell the front desk I think if I was different skin color, a different race or maybe if I wore different clothes or, um, appeared to be wealthier than I am that I would've been treated better. Patients don't always tell you what they feel at the end of an appointment. And this is from Alex Jones who, she lives in Southern Oregon so I've gotten to know her recently, and she wrote something that I felt was really nice. Um, she said growing up on the Coco Indian tribe reservation, I was taught at a young age to not only take care of my tribal family but to focus on my tribal elders and their health care needs. Um, I just think it's really cool that she has experienced living on a reservation and she wants to come back and serve her community. I mean regardless of anyone's opinions of the new types of health care providers that are coming out, it's nice to know that people wanna come back and help those who are underserved in our communities. I mean it really takes a selfless person to do that, so I just connect Alex and the other ****, you know, in the program who wanna help the people that they know, um, in their communities who need their help. Um, so in terms of primary extractions, the current guideline states that for primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, um, needs to be sectioned for removal, and I am a big stickler for scope of practice, staying within the scope of practice, and with this type of pilot project, everything needs to be very, very clear. Um, it helps us, it helps **** for notetaking, for charts. If there is any ambig, ambiguity or anything that's not clear, it just makes it harder to communicate and it's also harder for chart reviews, so I will **** just more clarity on the topic of mobile primary teeth, um, for instance, the degree of mobility required because it says some. Also the **** obviously excluding to the gum line anything that would even be close to going surgical. Um, is **** allowable? For instance like large **** restorations or large **** decay. Um, the amount of clinical cro, crown extending that's required, um, and being as specific as possible and be sure that the **** stays in their scope of practice and again, **** thorough charting and notetaking, and obviously it's the safety component as well. Right? Stay within your scope of practice. Make sure that this is just a much safer execution of treatment. So that is – I tried to keep it short 'cause I know we don't have a whole lotta time, but that's it.

Next Speaker: ****.

Next Speaker: I think you gave a great summary of the cultural competency, and I just wanna say that, that that topic and, and the training report are gonna be a, a more visible part of what we take **** I think because, um, I think in CCO2.O, it's gonna have a lot more visibility so, um, there will be urging of all providers to be more aware of it and, and obviously trainings.

Next Speaker: So if you guys have questions for Dr. Veta, go for it.

Next Speaker: So are you asking for feedback regarding this?

Next Speaker: Well, I had proposed this to the OHA and I think that he was **** clear that we'll be discussing this.

Next Speaker: Later or now?

Next Speaker: Well –

Next Speaker: Now and li, and –

Next Speaker: Yeah, I, we –

Next Speaker: – follow up.

Next Speaker: We've got a little time now for –

Next Speaker: And then OHA presents a formal –

Next Speaker: Right. We'll –

Next Speaker: – re, response. Right?

Next Speaker: – we'll send out a questionnaire. Yeah.

Next Speaker: Uh, some of you guys **** training.

Next Speaker: Right.

Next Speaker: And, um, and as you know, there's all kinds of ways, uh, a primary extraction goes south pretty quick, and, um, and it's not just a, uh, a risk for what the final outcome would be, but what kinda duration that child has to endure if things aren't done properly in terms of pain and, and ****, you know, trauma sitting in the chair. Um, my, my own personal opinion to add to that list would be, uh, prior pulp therapy. That makes a tooth much more fragile to fracture and leaving root tips behind. Um, I would, I would say that much more so than fracture or restorations or what not, 'cause that's the most likely scenario, particularly with pulpectomies, um, if you're lookin' for a reduced risk of adverse outcomes. Um, and for a mobility perspective, every tooth has mobility, as you know. Um, but if we're lookin' for a, um, uh, a metric to, to make for a decision-making tool to decrease that negative outcome, I would say a one plus would be, uh, a more of a pathologic amount of mobility, and that's where you could have a, a greater, uh, chance of not having a fracture, so a root fracture, that is. Because by definition, they can't go diggin' with, um, takin' a handpiece to a, to –

Next Speaker: ****.

Next Speaker: – bone or do that kinda thing. Are they allowed to use root picks when something like this happens?

Next Speaker: Yes.

Next Speaker: 'Cause it's inevitable.

Next Speaker: Yeah, I mean preferred not to for –

Next Speaker: Right. Uh –

Next Speaker: **** symbol. Right.

Next Speaker: Well, I, I think it's, if, if we're goin' down this road of primary extractions, um, they fracture, um, at, more at this age group than permanent teeth do, and so I think that should be defined at this point whether or not ro, root picks are gonna be needed or used or not for east, west or what not, so, um, I think both those points should be brought up in discussion if we're gonna have one later.

Next Speaker: No, I think that's valid.

Next Speaker: Yeah.

Next Speaker: Discussing instruments and ****.

Next Speaker: I mean it's like what line do, do you not cross? Just have it from a safety perspective, 'cause once you open, once you bring out root picks and things, then all kinds of things can go bad in terms of, you know, nerve trauma or whatever if it's not done the right way, if there's not training done to, to do it. Yeah.

Next Speaker: Are we talking about primary teeth?

Next Speaker: Yes.

Next Speaker: Yeah.

Next Speaker: Or like damage to developing permanent ****.

Next Speaker: Right. Exactly.

Next Speaker: Yeah. Good morning, Carol. We just started this conversation when you walked in ****.

Next Speaker: On the phone, are there any comments or questions on the phone?

Next Speaker: I don't think they really hear me.

Next Speaker: In, in the clinics that you –

Next Speaker: This is Kyle Johnstone on the phone.

Next Speaker: Hi, Kyle.

Next Speaker: I would say, I would say I would definitely advocate for having, uh, some contingency so if they do get in, into trouble during that extraction **** so I'm an advocate for that 'cause **** something will break off in the socket even **** the ability to take care of that I think is kinda shooting the, the clinician in the foot personally. That's all I have to say. Thank you.

Next Speaker: Kyle, it sounds like you're doing pediatric ****.

Next Speaker: Yeah.

Next Speaker: Yeah, sorta multitasking. I apologize.

Next Speaker: That's good ****.

Next Speaker: Um, well, it's all, so the le, so are – I just wanna clarify. What're you asking from us? You want clarification or you want us to change –

Next Speaker: I do want, yeah. I want my clarification.

Next Speaker: Okay. 'Cause right now, it says that the trainee will not extract a tooth if it's unerupted, impacted, fractured or decayed to the gum line or needs to be sections for removal, and that's from –

Next Speaker: **** mobility –

Next Speaker: – that's on that front page.

Next Speaker: – **** one plus. Right? I mean **** more specification.

Next Speaker: Okay.

Next Speaker: Because if, if the extraction was done and there's a chart review, there might be a question of what type of mobility was this. Right? Or does that fall within – I think with these type of thing, it just needs to be very specific, just like how with the permanent extractions are specific.

Next Speaker: Yeah. What about if the tooth is a, um, tooth remnant? If it's a remnant –

Next Speaker: If, if that's –

Next Speaker: – then it's –

Next Speaker: – if it stays specifically **** remnant is allowed as well.

Next Speaker: Okay.

Next Speaker: You have the same mobility, uh –

Next Speaker: Would you – well, yeah. It would have.

Next Speaker: Yeah.

Next Speaker: And mobility's ****.

Next Speaker: I, I think mobility's important just 'cause it excludes, um, uh, attempting a **** removal which is super hard. There's a lotta folks out there won't touch those, much less a DI.

Next Speaker: Okay, well, thanks for this, and we'll, we'll follow up with the questionnaire, like I said. Um, so we're right on schedule. Um, Kelly's, um, uh, presentation is the next big part of ours, and, uh, but as you know, the, the **** of this report is **** after lots and lots of work, and we, we weren't planning on discussing that today since we have a full agenda with, with Kelly's presentation coming up next, so if – and I know that, uh, there's been some concerns and comments on that, and if you have more concerns, comments, just get ahold of me outside of the meeting and talk about it.

Next Speaker: Okay. so, um, that board is driving me nuts. I'm gonna move it. so as you think back to June, um, we started –

Next Speaker: Is, is this being recorded ****?

Next Speaker: This is ****.

Next Speaker: This is being recorded as well?

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Yeah, it's ****.

Next Speaker: Okay.

Next Speaker: Driving me nuts.

Next Speaker: Thank you. **** too.

Next Speaker: All right. I'm gonna stand up here so I can read my notes. Um, let me know if you can't hear me. Um, so back in June after the last advisory committee meeting, we had some feedback. Some people were having trouble being, feeling very hurt and very **** on, being on the phone, um, so we thank you to everyone who responded to the survey, the survey –

Next Speaker: I have to interrupt you for a second.

Next Speaker: Yeah.

Next Speaker: So people know that I, um, printed this super weird. Apparently I just printed the second part of your presentation. Not this first on these PowerPoint things.

Next Speaker: Oh –

Next Speaker: ****.

Next Speaker: **** and then we'll get going.

Next Speaker: Yeah, exactly.

Next Speaker: So don't –

Next Speaker: So don't think that you're like, your thing's ****. That's why.

Next Speaker: Um –

Next Speaker: Sorry.

Next Speaker: These aren't the important slides anyway, uh, because it's more feedback for us about how you feel about, uh, these meetings and it's a chance for all of you to weigh in on all the topics that we discuss during the meetings after you've had a chance to go home and sorta digest stuff and think about it. Um, so we will have another set of these surveys after each, um, of our meetings. Um, and then I just kinda have so **** for a minute, and, um, the, uh, on here you can see most people, as we go from very unproductive around to, at the top is very productive, um, and I'm sorry for the people on the phone. I don't know if – I, if the –

Next Speaker: If they got the packet –

Next Speaker: They, they should be in the PowerPoint.

Next Speaker: It's on PowerPoint.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Okay. We're on Slide 12, and remind me if I forget to say next slide for the people on the phone.

Next Speaker: It's on their first slide 'cause Dr. Veta's presentation was in the video.

Next Speaker: It says 12 on the slide.

Next Speaker: Okay.

Next Speaker: So most people, 43 percent of people, um, found that the, um, meeting was somewhat productive, but we have a, a range, um, so we, we do need to, we do have a, quite a bit of opinions. Um, there are, so here are a couple of the, uh, representative comments from those opinions. Um, and, uh, I guess we, I didn't understand why we had the guest speakers at the beginning, uh, until much later in the day. Um, let me interject that the guest speaker we were talking about last time, um, was a presentation on trauma informed care, um, as our continuing, uh – I just lost the word.

Next Speaker: Efforts.

Next Speaker: Efforts. Thank you. Towards, um, having more cultural competency and trauma informed care approaches to public health industry. Um, it would've been much more useful to have been, have introduced why they were there so I could've got more out of it. Also, it's too bad that more members weren't there. So, um, while the meetings are open to the, on the phone, it is unfortunate that it's harder to interact with everyone, um, here. Um, and then on the more negative side, it consis, perhaps, it would consistently feel like concerns were brought up, were addressed in a way that indicated the project plan to do things, how they would like to, which may or may not address the actual concern. So maybe that's an indica that we need, indication that we need to be a little more clear and direct in our, uh, work. Uh, the good news. Uh, most, on the next slide, No. 14, um, most people feel comfortable sharing their opinions. So this is sort of a, I just want to gauge and see how comfortable advisory committees are, members are and if we're providing a safe space for everyone to speak at it. Um, no one said they were uncomfortable. So I'm gonna keep moving like this. And then as part of our, um, task is to, um, develop a final report on, on subject matter expert, um, opinions based of the model that we're exploring right here. Um, so we're gonna start by talking about different, um, topics that we **** back to June, uh, that we brainstormed is the most important topics to talk about, um, and explore in terms of dental ****. Um, there's an overwhelming, uh, consensus that we really need to start with scope of practice. So those of you that received the scope of practice **** survey, that is why we did that one first. So any questions on the feedback surveys for the advisory committee meetings before I move on to the bulk of today's presentation? No? Okay. Uh, any question on the phone? All right, we are on – oh, this slide doesn't have a number. It's No. 16. It's the title slide. Uh, Delphi survey, an introduction. Does anybody here know what a Delphi survey, a Delphi technique, a Delphi method means? Ooh, naïve audience, yay. Okay.

Next Speaker: I **** only one person here knows what they mean.

Next Speaker: Huh? This just got stapled weird. I don't know. It's the copy machine's fault.

Next Speaker: Oh.

Next Speaker: That's why I don't like the copy machine. It's like a –

Next Speaker: We're on Slide 17.

Next Speaker: – **** kind of stupid thing, so. I'm sorry. So you now you can, like, page around.

Next Speaker: All right. We're on Slide 17. Before we look at the aims, it's just the aims of our particular Delphi method, I'll just give you a brief, brief introduction. The Delphi method is a, um, qualitative research method of trying to find, uh, an aiming a group towards consensus, especially on controversial topics. It's a method of surveying a group and then rethinking and re, uh, defining different elements until you come to a consensus. So our aim with this Delphi process is to explore views among dental subject matter experts, you and the advisory committee, um, relating to the potential use of Dental Health Aide Therapist, DHATs in Oregon. This process intended to consider DHATs under the general model currently being piloted by the **** area ****. They are, are multiple versions of dental therapists. We are right now just thinking about DHATS, but we're thinking about 'em in a hypothetical function. Yes.

Next Speaker: I have a question.

Next Speaker: Quick question.

Next Speaker: So –

Next Speaker: We don't have a lot of time for long questions, just quick questions.

Next Speaker: I've got a quick one then. Um, so just so I understand what you're saying here, –

Next Speaker: Mm hmm.

Next Speaker: – we're talkin' about hypothetic or hypothetical scenarios –

Next Speaker: We're talking about the model.

Next Speaker: – or hypothetical model.

Next Speaker: We're not talking about changing things on the ground.

Next Speaker: I understand.

Next Speaker: Okay.

Next Speaker: But, so when, when tho, when, I can see for myself, when I filled out this survey, –

Next Speaker: Mm hmm.

Next Speaker: – there was a lot of questions of how do you feel about X, Y and Z, and that I think everyone in this room can agree that this whole, not, not model, but the actual, the, our data that we're getting from this is in its infancy. Right?

Next Speaker: Yes. And –

Next Speaker: So what, what we're really, what you're really asking me I felt like was just my opinion that I'm stepping on the table with that time zero almost.

Next Speaker: It's exactly what I'm asking for.

Next Speaker: Okay. I think we need to be clear about that.

Next Speaker: Okay.

Next Speaker: Because you can't, if we're, if we have a job to do as a committee, it's to take the measurements that we take and the assessments that we do and apply them towards, based on those assessments, as individuals around this table, to, to make a conclusion. If we weight the – I'm assuming we'll do these, these surveys throughout the process. I think we need to weight those at the end more than with the beginning because the beginning is just our own personal biases, which is the opposite of what you do with the study.

Next Speaker: Yeah.

Next Speaker: Right?

Next Speaker: Let me get more into the methodology of these surveys.

Next Speaker: Okay.

Next Speaker: And that might answer some of your questions.

Next Speaker: Great.

Next Speaker: I didn't want to get too in detail about the methodology when I sent out the survey 'cause I really wanted your just gut initial reactions.

Next Speaker: Okay.

Next Speaker: Does that make sense? Okay.

Next Speaker: Yes.

Next Speaker: Um, and then just reiterating here that these are the, the general topics that we'll discuss. So when I, um, say we're gonna go through this method, we're actually gonna do five versions of this method 'cause we're gonna do it each time for each of these big topics. So the Delphi method. Um, this is literally stealing from Wikipedia. I know it's not necessarily good practice to copy Wikipedia, but it's a good definition. Um, so on Page 18, uh, the Delphi method is a structured communication **** method, um, originally developed as a systematic interactive forecasting method which relies on a panel of experts. Um, and then the main method, main thing that makes this method interesting is that we go back to this issue multiple times after we learn more and more information and so that our opinions get, uh, honed towards the end. And so it's the final survey that really matters the most. Um, so you're really trying to get yourself to that final survey, but really thinking about it in a systematic way the whole time. Um, so the goals are to determine a ra, or develop a range of possible program alternatives. Um, so here in for ****, we'll look at the alternative method to scope of practice. For example, that if there are issues that the committee has with scope of practice, what are some alternative hypotheticals that we would consider? Um, to explore or expose underlying assumptions or information leading to different judgments? That's why we always ask for, uh, free text comments and why I wanted your gut reactions on that initial survey. To seek out information which may generate a consensus on the part of the respondent group. We understand that this is a very controversial topic, and consensus can mean different things. Where unanimous consensus may not be likely in this group, um, one important part of this method is that we will highlight key dissenting factors in the end. Um, so we will say 90 percent of the group, and we'll give out the statistics about how many people agree with this topic, but here are some key, key takeaways that are, uh, dissenting but are still within the, uh, subject matter expert group.

Next Speaker: Will that be broken down into, um, uh, basically practitioners as well?

Next Speaker: That's why I asked for –

Next Speaker: **** –

Next Speaker: – information about your, um, – in, in the survey, for those who didn't partake, um, I ask about your credentials and your area of employment, um, even if you don't put your name so that, um, I can say okay, all the people with this opinion are in this area ****.

Next Speaker: I see. So not just a numbers-based thing? It's –

Next Speaker: Mm hmm.

Next Speaker: – parceled out.

Next Speaker: For the most, uh, and it's right now 'cause they only have one set. It's **** numbers. But it's not, it's not parceled out yet, but that is the goal. Um, and then one last one is to educate the responding group as to the diverse and interrelated aspects of the topic. We really want to think about oh, why was I, did I have this opinion. Let me listen to the, the responses back from other people, uh, that, that may have a different opinion. And I don't know why I put No. Slide 20, which is unfortunately not visible. Uh, huh. It's somewhere in your note packet.

Next Speaker: Which you can't read. But you can read this little tiny, little pieces if you will.

Next Speaker: Okay. I will read it to you. Um, but it should've been after the pros and cons. Um, one of the biggest pros is that it's, um, encourages participants to reassess your initial judgments over time. And then anon, anonymity, um, you may, you're afraid to put your name in on the surveys. When you enter that, that actually makes my job in sort of parsing out, uh, those subgroups that can help that. But you're not required to. You are welcome to just put it in anonymously. Um, that reduces the effect of dominant individuals that are speaking. Some people are just a lot more comfortable saying their mind in a room and saying it with their name. Some people are not. So this is a chance for everybody to, um, to speak to their comfort level. The problem, the cons, it can be very time intensive, as some of you might've noticed. And so it's very easy to lose people over time as they don't want to participate in the survey. So I really want to stress that it is, it may, if it takes some time, I appreciate it that it takes some time, um, but we really, really, really appreciate the number of you that do respond to these surveys. So going back to the que, um, No. 20, so the, actually, how this is gonna work, um, the first bubble, the facilitator seeks out, uh, individuals from a pool of experts. We've already done that. We have our advisory committee. And then the Step 1, oh, geez, um, the experts respond to those requests, receive feedback and revise the responses. So we send out the survey about scope of practice, and you respond, and then today I'm bringing back some of this feedback. But we're gonna do the same thing multiple times and that's – oh ****. So Step 2, 4, 6, ideally, you'll redo a survey at least three times to see how opinions change and see – it, usually, in these processes, opinions will guide, tend toward, um, a central opinion. One of the cons that can tend toward the middle, even if the middle is not necessarily where it should go, but it will, hopefully, tend towards, uh, where the true consensus is in the group. Um, but we will do it as many times as we need to reach a certain level of consensus. I am not going to aim for 100 percent. It's just not gonna happen. Let's move on. Um, and then in the end, the facilitator, OJ, will, um, compile all of those into a final report that says this is the **** opinions. And then the final opinion, um, to ans, speak to, uh, Dr. Schwinn's point, um, are the ones that really, really matter. Um, I mean, they all matter, but they – yes, Kelly.

Next Speaker: So will the subsequent surveys be the same questions, or will ****?

Next Speaker: That's – oh, thank you for reminding me a key thing. So each time we do the survey, the questions are adjusted slightly based on the results of the previous ****. So they will be slightly different to try and tease out different spec, specific differences. So one of the questions was asking about definition. Um, we might adjust that definiti, definition to, uh, account for all the comments we re, we received, and then see if that definition has a higher degree of acceptance.

Next Speaker: I have a second question.

Next Speaker: Yes.

Next Speaker: Thank you. Um, and so the reason, the 30,000-foot –

Next Speaker: Mm hmm.

Next Speaker: – level reason why we are doing all this amongst the committee, –

Next Speaker: Mm hmm.

Next Speaker: – because at the end of the day, you want to know the consensus feeling of the committee, for example, on scope of practice.

Next Speaker: Correct.

Next Speaker: And you then, so you think us knowing the consensus of each other is going to help us make better, informed decisions on the pilot project? That's my question. Why do, how do these –

Next Speaker: I'm not sure I understand the question.

Next Speaker: – at the end of the day, relate to what we are doing here as far as oversight of the pilot project?

Next Speaker: What we're doing here –

Next Speaker: I imagine this –

Next Speaker: – is overtime, –

Next Speaker: **** I like that.

Next Speaker: – overtime, I guess that's a, a good way to frame that that I haven't really done yet. Um, it's understanding the consensus here, but it's also a chance for you to change your opinion as you learn more about how the project is moving on the ground. So it's not just your peers that will change opinions, change your opinions. It is the data that comes from the project. And we're interested to see how the, uh, project movement over time, uh, and the, the use of a pilot project system changes opinions of subject matter experts on these types of topics, if that makes sense.

Next Speaker: Yes. So it's not just this pilot project. We are also testing, we're using this pilot project to test how pilot projects work –

Next Speaker: In a way, yes.

Next Speaker: – and still work ****.

Next Speaker: In a very **** way.

Next Speaker: Okay.

Next Speaker: But we have a responsibility to draw conclusions about what you're looking at, ultimate conclusions that'll go in a final report.

Next Speaker: Right.

Next Speaker: I understand that.

Next Speaker: So yeah.

Next Speaker: Yeah. And it's a, it's a, we also want to make sure we get everybody's voices heard, not just people who like to talk at meetings. Like, I like to talk at meetings, and that doesn't mean I should be the loudest voice in everything.

Next Speaker: Thank you.

Next Speaker: Okay.

Next Speaker: So to state it in a different way, –

Next Speaker: Mm hmm.

Next Speaker: – these, this tool **** obviously **** some type of consensus **** move discussions forward, but it's meant to inform as part of the final report?

Next Speaker: Yes.

Next Speaker: Okay.

Next Speaker: Yes. Any other questions on the phone?

Next Speaker: How has participation been?

Next Speaker: Uh, –

Next Speaker: I think it's ten.

Next Speaker: Get, get to that. Ten respondents.

Next Speaker: So I, I guess the reason I ask is because the **** I think we've discussed this a couple times in the last few meetings just with participation levels varying in person, on phone, but it's hard to measure accurately over time if you don't have the same participation count really. How, how are you taking that into account, I guess?

Next Speaker: That's very difficult in an anonymous survey.

Next Speaker: Uh huh.

Next Speaker: That's why I have the optional to leave your name. Um, I will also say when I compile comments, I will not share people's names to make you feel more comfortable. But if you want to leave your name – thank you to everyone who did. Um, if you want to leave your name, I will not attach your name to any comments.

Next Speaker: I'm just curious **** –

Next Speaker: Just as an, an aside, um, I can't require you to respond to surveys. That's the researchers' vain of existence. I mean, –

Next Speaker: Ten out of how many? How many are on this committee officially?

Next Speaker: I want to say six –

Next Speaker: Twelve or 13, I don't know.

Next Speaker: I, it was sent to 16 people.

Next Speaker: I'd have to go back and look ****.

Next Speaker: So I would love to have 12 next time. Uh, –

Next Speaker: Is there any way you can change, maybe, the time of the meetings to make it – I don't know. 'Cause sometimes I think a Monday morning might be **** –

Next Speaker: Oh, that's a thing that I forgot to put in the presentation is part of our, um, survey after the last meeting, we asked what days were best for people, and it was overwhelmingly Mondays.

Next Speaker: Oh, okay, never mind.

Next Speaker: **** –

Next Speaker: Much ****.

Next Speaker: Can we, can, can we, can we ring up, uh, the next survey, uh, time of day?

Next Speaker: Yes.

Next Speaker: Oh, the time of the meetings?

Next Speaker: Yeah.

Next Speaker: Yeah, yeah, sure.

Next Speaker: Don't think we put that in there. Let's put that in there.

Next Speaker: Sure.

Next Speaker: Thank you.

Next Speaker: Yeah, that's fine. Uh, we will do that.

Next Speaker: All right. Um, on Slide 22, these are just things to keep in mind. Um, we are not making determinations about the project on the ground. We are not guiding their work through this process. We are using the information we get for them to just guide our opinions. Uh, we will revisit these topics throughout the life of the project. We are at the infancy right now. We are, this is baseline. We don't have information yet to make, uh, changes ****. Okay. Um, and then you have these slides. So if you want to look at some Delphi at work, here are some, some papers you can take a look at. Um, so the results from the first, the, the first survey was, I believe it was 28 questions. So, um, there are quite a few slides to get through. I am hoping we can get through them all. Um, but this is a chance for you to also give more feedback on the survey. Uh, and then maybe talk about why, what results surprised you, which maybe don't because each of you only know about your own, own responses so far really. So ten responses. Um, the, half of them, uh, were from dentist clinicians, which, um, is very useful because they're the only group for whom the entire scope of practice of a **** falls in theirs. So thank you to everyone who participates. We really want a wide range of backgrounds. But this is your, um, idea of who responded. Um, and the average that time it took was 25 minutes. So, um, I, that doesn't count offline time, obviously. That's just the amount of time the sys, Survey Monkey recorded is you taking to fill it in. Uh, so one thing, first thing I asked is how, um, knowledgeable do you feel about the DHAT model. Do you feel like you really understand what the DHAT model is? Um, most people feel that they are pretty knowledgeable. This is a self-report. But at least, we're, we feel like we're talk, know what we're talking about. Um, and then I just had fun with word ****. Don't worry about this. This is just word **** more comments. I found some software, so. So, um, on Slide 28, uh, this is the DHAT definition we are workin' with. I don't really feel the need to read it. Um, presumably, everybody else has read it. Um, on to the next slide. Does this definition, um, – oh, the colors did not turn out beautifully. Oh, well. Um, did this definition match your understanding of the DHAT model? Interestingly, um, 30 percent of people did not think that matched their understanding of the DHAT model.

Next Speaker: Was the question specific this particular DHAT model we are –

Next Speaker: Yes.

Next Speaker: – looking at for the pilot project?

Next Speaker: Yes.

Next Speaker: Okay. That's, of course, **** DHAT wants.

Next Speaker: Yes. Well, this is the only DHAT model. There are other dental therapy models.

Next Speaker: And that's what I think maybe, perhaps, –

Next Speaker: Yeah.

Next Speaker: – would've been confusing for some people ****.

Next Speaker: That's, that's a good note. Um, and something that I think we continuously need to stress that we're talking about the DHAT model because it does get confusing when there are multiple dental therapy boxes. Um, so there are some interesting comments, and this is a chance, um, the, the theme that came back in the comments when we're asking about definition is a lot of people took issue with the term intense, um, when talking about the training program for dental, for DHATs. Um, so the term intense is subjective and potentially misleading. Uh, significant number of comments mentioned that. Um, and then there was confusion between, uh, DHAT program practicing in Alaska with certification and in Oregon under the pilot project. So for the Delphi method survey, don't get hung up on whether or not they're certified because that's a technicality that that cannot be certified here. If this were to be a thing in Oregon, they would have to have a certified body. So let's imagine that there is one.

Next Speaker: Would, would it be reasonable, let's say, at some point, being certified then because –

Next Speaker: Yeah.

Next Speaker: – that, it's a different ballgame here.

Next Speaker: Yeah.

Next Speaker: I mean, –

Next Speaker: So –

Next Speaker: – 'cause right now, we're talking about an uncertified practitioner, and I think there's some pe –

Next Speaker: But I think we're talking about on the ground. What we're talking about is the hypothetical, the 30,000-foot level.

Next Speaker: Okay. So –

Next Speaker: But we really need to make **** –

Next Speaker: I think I would include that in the definition. Should there be a certification –

Next Speaker: Mm hmm.

Next Speaker: – body and then the definition.

Next Speaker: Okay.

Next Speaker: Because, 'cause as you're describing it now, –

Next Speaker: Uh huh.

Next Speaker: – it's not the same in terms of comfort level for some people.

Next Speaker: Okay.

Next Speaker: If that makes sense.

Next Speaker: All right. Um, and then on here I have, um, two, two, I asked you to provide a, a different definition that worked better for you. Um, and these were two **** well, well-written comments that might, uh, be informative. And I'll just read the short one, 'cause the long is long, and my throat's already sore. Uh, a dental therapist is a mid-level dental provider who does not necessarily have a dental background before a 2-year training program. These providers can be an adjunct to a dental team by providing preventive emergency and restorative treatment ****. So that's a really short, simple definition of what a DHAT is. I know we have a longer, uh, more **** definition as well. So we'll, what we'll do is we'll take these, all these comments together, adjust that definition and then ask what you think of that new one. Make sense?

Next Speaker: Mm hmm.

Next Speaker: Okay. Do you think that the DHAT model as currently **** by the pilot project should be implemented in Oregon? This one, it looks like it, overwhelming, people either said, were, said no or weren't, unsure. This is not surprising to me. We are in the infancy. This is why we do pilot projects.

Next Speaker: And I can imagine that OHA employees might have answered unsure since we're officially neutral on all of our projects. I'm serious about that. I don't remember what I answered on this one, but, –

Next Speaker: Okay.

Next Speaker: – um, –

Next Speaker: I will say, obviously, I did not take the survey. I made the survey.

Next Speaker: I did not take the survey.

Next Speaker: Just, you know.

Next Speaker: Just as an aside, methodologically, um, –

Next Speaker: So just besides you, who else from OHA would've, would have taken it?

Next Speaker: No one.

Next Speaker: Okay.

Next Speaker: He's ****.

Next Speaker: And I'm **** entered on this ****.

Next Speaker: Okay.

Next Speaker: I shouldn't have. I think.

Next Speaker: Um, **** okay. Uh, do you think a modified version of the pilot project, the DMO, should be **** in Oregon? And here, more people were unsure than had an opinion. Um, I think the term modified was confusing. We're not talking about making modifications to the project as is. We're talking about oh, with it, when it goes to legislature, should it be exactly as envisioned by the project or should there be some tweaks to it when it goes to legislature? That's the idea there. So we'll try to make that a little more clear the next round. So the scope of practice, um, I had Sara, who is, – uh, I'm not clinician, so I didn't break this down. Um, I had Sara break down the entire DHAT scope of practice into, um, these different categories, and then we asked about categories and then specific procedures within each of these categories. Patient evaluation assessment and diagnosing, quite a split on whether or not, um, – okay, uh, sorry for the people on the phone. We are on Slide 34. I always get ahead of myself. Um, we, quite a split on whether or not patient evaluation assessment and diagnosing as a category should be included in the scope of practice. Um, but when you start looking at the comments, it looks like it's almost an even split, 40/60. Um, the comments start to show you that there's actually a consensus on patient evalunition, evaluation and assessment. It's, uh, diagnosement, diagnosing, uh, the diagnostic capabilities is, uh, really where the group is split half and half. Uh, so they are just a couple represented comments that I've pulled out for, um, whether some believe that it is an essential component, um, to the DHAT scope of practice and some that, um, disagree. Does anyone have any comments they want to say after people want to read that?

Next Speaker: Well, I just, –

Next Speaker: Yes.

Next Speaker: – I'm not sure if everyone, you know, in Oregon –

Next Speaker: Mm hmm.

Next Speaker: – our rules, de, the dental hygienists diagnose. So some people get caught up on this word diagnose.

Next Speaker: Yes.

Next Speaker: Can't diagnose.

Next Speaker: We diagnose dental hygiene wi, within our scope.

Next Speaker: I thought we assessed.

Next Speaker: We diagnose. We are, there's only two states in the country –

Next Speaker: Oh, we diagnose.

Next Speaker: – where the word diagnosis is **** hygiene rules.

Next Speaker: Really?

Next Speaker: Yes, we are one of those states. So, but I, so this word diagnosing is inflammatory all across the country. But in our state, we already have law and rules that the dental hygiene, hygienist can diagnose within the dental hygiene scope of practice.

Next Speaker: Okay.

Next Speaker: We don't, dental hygienists diagnose into the dental scope only what is allowed within the **** dental hygienist.

Next Speaker: That's a very good, uh, clarification, and as a clinician ****.

Next Speaker: Thank you.

Next Speaker: Any comments or questions so far on the phone? All right, next slide. Um, **** this is for, not as important right now. Um, I asked how important you feel it is, um, that this, uh, category is in the scope and practice. Um, really, this just is another way to show as you move left, from left to right on the slide from very important to not very important. Um, how **** you are as this being a part of the scope and practice. You look like you have another comment.

Next Speaker: I just, in, in –

Next Speaker: Yeah.

Next Speaker: – fu, in future surveys, you might want to consider –

Next Speaker: Mm hmm.

Next Speaker: – taking the diagnosing as a separate question.

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: So –

Next Speaker: And then –

Next Speaker: And, and see **** –

Next Speaker: Just ****.

Next Speaker: – over time.

Next Speaker: This is **** –

Next Speaker: And, and, and, and, and defining the diagnosis as the diagnosis that the DHAT would do only into the –

Next Speaker: In scope.

Next Speaker: – DHAT scope. That would make it more clear I think.

Next Speaker: Yeah. Um, and as we go to the, when we go each of the different procedures ****, uh, within, uh, assessment, evaluation, diagnosing, um, uh, the blue, so on all of these procedure charts as you go left to right, it says percent of people who think, who say

either yes in blue, uh, do not, yes, in blue, um, it's sort of like mottled greenish ****. I don't know what to call that color. No, do not include on the screen. And then it should be orange, red on the actual PDF for the people on the phone for no's, and then the unsure's are grey. So where you see predominance of blue, that's people just thinking these things should clearly be, uh, included in the DHAT scope of practice. So, uh, exposing dental radiographic images, pulp vitality testing carries risk assessment, periodontal charting, interestingly enough, um, oral health assessment not including diagnosis, all those were very comfortably within the scope of practice. Um, it's when we get too comprehensive, comprehensive dental examination including diagnosis and treatment planning is where the group is literally split 50/50. So, uh, next, we are going to break that out into its own category. Uh, so any other comments on diagnosing or, and assessment before we move on? All right. So next is preventive procedures. Um, this is actually the most clear category. Yes, it should be included. That's, um, – and, and if we remember back to the definition is when **** into the definition is one of the key aspects of the, uh, uh, dental therapists DHAT is that they, um, work on preventive procedures, procedures. So I think this really speaks for itself that, um, nobody thought it wasn't important or should not be included. Um, Part 1, so the, unfortunate is it includes a wide variety of procedures. Um, but once again, predominantly, everyone there's a lot of consensus already on this, uh, type of work, uh preventive procedures. Pardon me. Um, uh, there is a little bit of unconcern about ****. I'm not sure what we do with that, so we'll see how that goes over time. Uh, Slide 41, they're just broken into two slides. Um, let me – is, and is everybody, can everybody read that first? Yes? Okay. All right. Any comments or thoughts on preventive procedures? I love that it's straightforward. All right. We are moving along.

Next Speaker: Do, can I, –

Next Speaker: Yes.

Next Speaker: – can I ask you a question? When somebody says no on something, do, is, is there a comment field on this part –

Next Speaker: So my, um, –

Next Speaker: –for them to clarify why they don't want sil, like, silver diamine fluoride or?

Next Speaker: My understanding of programming these things into Survey Monkey would not let me do a comment field for each of the procedures.

Next Speaker: Okay.

Next Speaker: I'm gonna keep trying to fi, make that so they can make it very clear what procedure people are talking about. Um, and if there are other, uh, comments about the actual, like, logistics of this survey that are confusing or anything, let me know, and I'm still workin' to make the best out of the, um, the **** application as I can. Um, there is a text box at the end of the whole section for procedures. So there's, there's a chance to provide comments at the end of each question. Um, all of these are within one question.

Next Speaker: Okay.

Next Speaker: Okay? Uh, periodontal procedures, uh, is another, uh, is a three-way split, um, between yes, no and undecided. And most of the concern and comments there is around the level of training, um, around, uh, periodontal procedures. Uh, and some people were not sure whether they are trained at all, did not know what the level of training was and did not

know if the level of training was appropriate. Um, it's also us split as to whether it would be an important avenue to, um, continue down in terms of including in the scope of practice. Does anybody have any further comments about periodontal procedures? Does this surprise anyone?

Next Speaker: **** surprised.

Next Speaker: Yeah.

Next Speaker: Because of what this community is still dealing with what they're changing in the program **** Alaska, so –

Next Speaker: Yeah.

Next Speaker: – ****. So it's not surprising.

Next Speaker: Yep. Um, so we broke it down into, uh, full be, full off ****, periodontal scaning, scaling and root planning and then localized **** anti-microbial agents. Um, there really wasn't much consensus in any of these, so we'll have to, um, take those comments and explore further why. Um, I didn't see – the, the main, uh, the brunt of comments was more clearly around levels of training and, um, clarification around levels of training. Does anybody want to speak to why they, they say yes or no, or you don't have to if you don't want to? I'm just gonna give you a chance. Okay. Uh, then we get to another one that, um, is a very, very broad category; restorative or slash endodontic procedures. Um, this is another almost 50/50 split. 40 percent yes included, 40 percent no included, not included. Um, this one, because of the comments, we will break it out into restorative, one group, **** endodontic another group. Um, oh, there was a lot more consensus on, uh, on, to go to que, uh, Slide 48. There is a lot more, um, consensus towards including, um, restorations, than there is endodontic procedures. There's a lot more concern about, um, levels of training and, um, capability for endodontic procedures. So if we go back to, uh, Page 47, there's, here's some nice, uh, representative comments that help, um, talk about why these should and should not be included. The takeaway for me for the next survey is these need to be broken out into separate different categories before we can really, uh, speak to them. Any comments? The main thing is that **** that the people who are, uh, supportive of including these really wanted to help, um, I think alleviate emergent acute concerns and also provide long-term relief. Um, that counterbalances people who are concerned about level of training and decision-making abilities. So here we are, most people, I mean, we're actually very close to consensus on agreeing, um, that endodontic, or excuse me, that restorative procedures should be included. But then we, the group gets very split when we start talking about, uh, pulp caps, uh, or, um, stainless steel crowns or even pre-fab **** resin crowns. Primary teeth, less so, but – and then when we start talk about pulp therapy, there is actually consensus leaning towards non, non-inclusion in the scope of practice.

Next Speaker: Just **** –

Next Speaker: Yes, yes.

Next Speaker: – **** some people thought that, um, **** would be appropriate to include in the scope **** only ****. I mean, do you have more people thinking that ****.

Next Speaker: Uh, what?

Next Speaker: So the therapeutic pulp, uh, the first one ****. 60 percent of people thought that it should be included – no.

Next Speaker: No, that's backwards. Blue is included. That weird greenish color is not included.

Next Speaker: All right.

Next Speaker: Yes. It's supposed to be, there were, on my computer, that was a red ****.

Next Speaker: Oh.

Next Speaker: And it was a lot more clear. So my apologies for ****, uh, the projector. So on the PDF you received, it will be more of an orangey, red color, which is a little – I'm sorry for those who are color blind, but it's, uh, – yeah.

Next Speaker: This must be what it's like to be color blind.

Next Speaker: Oh, I, I need to, I, I think in the next round, I might also do some other visual clarifications maybe. 'Cause it, it's, you can't rely on color. Um, and then we get to what I thought would be the most stickler; surgical procedures. If you think, uh, and 60 percent, so just over half, uh, did not think that **** included in the DHAT scope of practice. Um, and then the relative of importance is actually leaning towards, um, not as important as part, as part of the scope of practice. Uh, so it'll be interesting to see how this may change as we look at more information from the pilot project. I want to emphasize here that we are not doing, your responses here are your opinions of the project, you're not changing the project in any way from these comments. So, some of the representative comments, um, are around, uh, not enough training, but some people woulda struck criterion, make sure their scope is on the conservative side of scope of surgical procedures, um, presumably that person would include them. Um, which is, you know, as we, really speaks to the, uh, request to, um, clarify those surgical procedures. Yes?

Next Speaker: ****.

Next Speaker: Okay. So when we break down to what the surgical procedures should be included, um, interestingly coronal ****, uh, fairly good consensus there that it should be included. 70 percent. Um, and then, fairly evenly split, um, on the other, the other three components. Primarily, simple extraction, **** and suturing. Does anybody have any comments or questions on these? And then, we move to, uh, adjunctive procedures, which is literally just all the other stuff that we couldn't categorize, uh, so –

Next Speaker: Kelly, can I ask a question?

Next Speaker: Yes, please.

Next Speaker: So the, those of us who were takin' this survey were getting our information again from how we learned about the program, about the, the training and whatnot –

Next Speaker: Mm hmm.

Next Speaker: – and now just starting on the chart reviews. Um, with that data set of chart reviews, um, I guess I either don't remember hearing or forgot how those charts are sampled. Are they decided at the site or are they random or are they consecutive or how's that done?

Next Speaker: It's randomized from our, we randomize ****.

Next Speaker: Okay, so like number thing. You go and you –

Next Speaker: Yeah.

Next Speaker: – pick out those ones? Okay.

Next Speaker: It's a random selection.

Next Speaker: Good. That helps. Thank you.

Next Speaker: Um, the, this level of information is supposed to be from your understanding of the project, from the materials that been provi, been provided in the past year that they've undergone, been in, in practice and especially since they've been in the training phase for, um, most of the time so far. Uh, so this is just based on your initial understandings of the model, we're, we haven't presented nearly enou, we don't have enough, uh, chart review data to make generalizable comments yet, so as we have those, we'll start releasing them, and that, you know, will for, inform opinions as we go along.

Next Speaker: Can I ask one final question?

Next Speaker: Mm hmm.

Next Speaker: Sorry.

Next Speaker: Um, **** –

Next Speaker: Careful with your word final.

Next Speaker: Final final. Uh, ****, um, so when we, we answer questions like this, extremely important, not important or we're not sure, that kinda thing.

Next Speaker: Yeah.

Next Speaker: Um, I think, at least from my perspective, I would e, unsure or not enough information to answer –

Next Speaker: Yeah.

Next Speaker: – is a, be a more comfortable box to check for me.

Next Speaker: Not enough information to answer?

Next Speaker: Right. Like, right, because, because, um, I, I'm not against something, for instance, I just don't have enough information to give at least, at least an opinion that I think's gonna be judged by someone else.

Next Speaker: That's a good ****.

Next Speaker: Does that make sense?

Next Speaker: Yeah. I'll put that in there next time, um, this is just the traditional **** scale, so.

Next Speaker: No, that's good ****.

Next Speaker: That's why I did that, but –

Next Speaker: Because it'd just be more ****, yeah.

Next Speaker: Yeah.

Next Speaker: Uh –

Next Speaker: And usually adjunctive procedures are defined as things that don't have a CDT code, like doing antecedent **** as part of a –

Next Speaker: Yeah.

Next Speaker: – two-surface amalgam on a primary tooth or, or whatever it, it's the, the, the procedures we do in the process of doing a code, codable procedure, like, um –

Next Speaker: Except for nitrous. You code that.

Next Speaker: Yeah, that's right.

Next Speaker: It just didn't fit elsewhere.

Next Speaker: Uh, I don't know if they do adjustments and repairs on removable prosthesis.

Next Speaker: ****.

Next Speaker: Okay.

Next Speaker: ****.

Next Speaker: Mm hmm.

Next Speaker: So that's very interesting that most people would think it should be.

Next Speaker: But you know, that's actually an interesting conversation that they've been having about that specific issue as well. It's a –

Next Speaker: Interesting.

Next Speaker: It's apparently a hole everywhere. So.

Next Speaker: Nitrous oxide. Um, a lot –

Next Speaker: I'm sorry, I didn't hear what you said. It's a hole everywhere?

Next Speaker: Uh, it's a discussion that they're having in Alaska and other places as well, as to whether or not that should be part of the scope of practice. It's a hole in available services in other places.

Next Speaker: And along those lines, Oregon is one of five states that allows denturists to work.

Next Speaker: Uh, and then the comments around nitrous oxide, um, were actually concerned that the current training program does not include nitrous oxide. So, uh, this is a nice, uh, comment from one respondent about, uh, the importance of nitrous oxide, um, uh, to reduce situational anxiety and reduce pain and, and concern among, especially among pediatric patients. All right. So in summary, on Slide 59, and I'm shocked at the time. Um, uh, the consesa, consensus of the group so far is that patient assessment and evaluation, um, procedures should be included but there is, there is a split on diagnosis abilities and, um, we really need to think back on what, what that means, uh, diagnosis and what criteria **** the scope of practice and how that compares to other, uh, workforce models within Oregon already. Uh, preventive procedures, um, that one is, it's a very clear consensus that preventative procedures are a very important part of the DHAT scope of practice. Uh, restorative, endodontic procedures, we really need to address these as separate categories before we can say there's a whole lot of, uh, consensus. Um, surgical procedures, there was a fairly good consensus that extraction of coronal remnants of deciduous teeth, uh, should be included and, and are, uh, safely included, um, and, and there was a wide split on the others and then adjunctive procedures, it was just an interesting, uh, mix of people, uh, should not be inclu, nitrous oxide should be included but most comments were in support of nitrous oxide being included, therefore being included in the training program. So, the next step is the next survey is coming soon, um, we might do the next survey as, um, the initial survey on a different subject area. Um, **** we have more information about the scope of practice and how it's going on the ground before we, we really bring in the next set of opinions. That make sense? Um, so you want to be able to have some feedback from each of these, um, at, or each of the advisory committee meetings so when I send it out, please complete by November 15th, um, so that I have time to put it all together for the next meeting. Uh, and thank you very much for your presentation. We really appreciate it. And, I, my goal is 12 people by November 15th. ****, okay.

Next Speaker: So obviously we're ahead of schedule.

Next Speaker: Yeah.

Next Speaker: Any more conversation about the survey, the meanings or the purpose of the survey or –

Next Speaker: And does anybody –

Next Speaker: – **** details?

Next Speaker: I want to open it up, um, in this section to the project, if they have any responses or comments they'd like to make about the, the results from that survey. I know, put you on the spot. It's okay.

Next Speaker: I think it's very interesting and I, um, I would be interested in the, kind of over the life –

Next Speaker: Mm hmm.

Next Speaker: – of, as more of the advisory committee has the opportunity to do chart reviews and as more of our providers are providing services –

Next Speaker: Mm hmm.

Next Speaker: – um, I'd be interested, you know, how it changes over time.

Next Speaker: Yeah, that is the **** part about it, our due process is we really get to see the change in opinion over time, and people aren't married to their opinion, or they shouldn't be. Yes.

Next Speaker: Have you guys decided how this is going to be used eventually? Is this a formal part of the evaluation or is it just a tool for the committee to have a –

Next Speaker: It's a tool for our committee to, to develop a final consensus that will be put into the final evaluation report, but it's only a part of that report.

Next Speaker: **** I'll just start by not evaluation of the project, but –

Next Speaker: It's not an evaluation of the product, yes, no.

Next Speaker: – what you mean is really the final report to the legislature.

Next Speaker: Yes.

Next Speaker: Gotcha.

Next Speaker: Thank you for that clarification.

Next Speaker: Yeah.

Next Speaker: I, I knew that's what you were saying, but –

Next Speaker: Yeah.

Next Speaker: – maybe didn't say it out loud.

Next Speaker: Okay.

Next Speaker: Any comments on the other side of the room? I feel like I'm neglecting – all right? Nothing.

Next Speaker: All right, well, Sara, uh, anything else you want to cover with our extra time?

Next Speaker: My throat ****.

Next Speaker: Sorry, Sara.

Next Speaker: Um, we're doing a site visit next week or 2 weeks from now.

Next Speaker: The 20th.

Next Speaker: That's doing your thing.

Next Speaker: Yeah, next day is the 20th, oh my god, um, in Saint Helen's, Oregon at the outpatient –

Next Speaker: Well, halfway to Saint Helen.

Next Speaker: – whatever, it's somewhere north.

Next Speaker: Be in the north though.

Next Speaker: I don't know, I haven't got the address, so.

Next Speaker: ****.

Next Speaker: Um, it'll be a relatively short site visit, um, and that's under the NARA umbrella 'cause that's one of the, um, places you go. Um, what else related to any of that?

Next Speaker: **** said they would do a report ****.

Next Speaker: So the, so the, CT **** has met all of the, so in this, um, so this is a little confusing, but we're doing a, um, a format that is more sustainable to our program. Um, so going through this site visit report at, you know, the initial site visit report from like a year ago when we went last September was more of a narrative, um, and it was probably appropriate for that visit because it, there's not a lot of the, um, administrative rules, but this is going to be kind of the format that we are going to be using, um, going forward. Do they meet this, do they meet this rule? They do not, and, um, so for the purposes CT Cluvy, yes, the site did pass. Now, there is a whole separate part that they do, you know, with the chart reviews, which is, um, you know, a separate component of that. So yeah, yeah, um, and then as many of you know, we are rule making and that will be, that will change. The site visit report will make it even longer.

Next Speaker: Mm hmm.

Next Speaker: So yeah, does that answer your question?

Next Speaker: Mm hmm, thank you.

Next Speaker: I'm very excited about it. It took me forever to do that, so.

Next Speaker: Will there be a preliminary report released in the same way for CT Cluvy?

Next Speaker: Yeah, but I don't think it's gonna have, um, very –

Next Speaker: It'll be much shorter.

Next Speaker: – anything to say.

Next Speaker: That's fine.

Next Speaker: Because it's gonna say you passed, and then you'll get fuller version that looks more like this.

Next Speaker: But with that kind of a report.

Next Speaker: Yeah, I know exactly. No, I know they're, and it took a long time to, um, restructure how to do this because we are, um, as some of you may know, we did receive a third application to, um, the pilot project program. So we've got lots of little things going on, so good times.

Next Speaker: You want to give a short summary of that?

Next Speaker: Um, it's another dental therapy pilot project, but it's hygiene based. So you'd have to be a hygienist first, um, and it's going to go to, um, it well, it actually just went last Friday to the technical review board, which has six or seven people on it, um, and we'll be meeting in October to review that, so. So, uh, project was sponsored by Willamette General, um, in, how do you want to say, in partnership with, uh, Capitol. Who else is in that?

Next Speaker: Pacific.

Next Speaker: Pacific, who else?

Next Speaker: Garcia.

Next Speaker: Yeah, Virginia Garcia. It's a lot of people.

Next Speaker: A lot of people.

Next Speaker: It's probably a much larger project in terms of the number of people involved in it. So that'll be interesting and then at some, the, the way that it's structured now because we're in, we have to go by our current administrative rules, is that it will go, um, after the technical review board meets, then makes some recommendations to OHA, whether they recommend to approve it or not, it'll go out for public comment. Um, and during the middle of that public comment time is probably when the new rules take effect. So then it'll be an even longer public comment period and then some of the, it just gets really sticky. So, um, there's lots moving pieces to it, but that's kind of the nuts and bolts of it. It's just, it looks fairly similar to this other than the model of the education and training is obviously, you have to be a hygienist is different.

Next Speaker: Well, one more thing, um, could you let, let us know the, the timeline for the rule making and the completion of the RAF process?

Next Speaker: So, um, in the next, I think, 3 weeks, it goes out for public, it gets posted, goes out for public comment for I don't even know how many days. There's a whole bunch of rules about making rules, and then that gets, um, then OHA has to formally respond to any public comments, and then they may or may not change what's there based on the public

comments, and then ultimately, if they've, meet the criteria that they have to meet, then they get approved, and then officially, they would be December 1st.

Next Speaker: Yeah, they have to be approved by the Secretary of State.

Next Speaker: Yeah, I don't even know, yeah, yeah.

Next Speaker: They have to get legal ****.

Next Speaker: Exactly, so there's, there's all those –

Next Speaker: Yeah.

Next Speaker: – vetting processes that it has to go through.

Next Speaker: Mm hmm.

Next Speaker: Yep, so, yep.

Next Speaker: Um, since we have some extra time, and I know we can't simply talk about something else.

Next Speaker: We can talk about other things because it's 11:15.

Next Speaker: Yeah.

Next Speaker: Okay, so if you, uh, just for us without having to go back and pen through all this, do a summary, so from the site visit, um, in Southern passed.

Next Speaker: Yeah.

Next Speaker: But the site visit in NARA through all this year, has gone back and forth, back and forth without compliance, then was in compliance in certain things. So do we not talk about that or where are we today –

Next Speaker: No, we talked –

Next Speaker: – with the NARA site?

Next Speaker: – yeah, so in April, we talked at that meeting about the preliminary site visit report and, um, a little bit in June, and then this here basically took all of that information from the preliminary report and just organized it. There's nothing really new in here, um. What they have done and maybe Dr. Veta, you want to, so there's a couple things in the stipulated agreement that OHA signed between, um, OHA and Northwest Portland Area Indian Health Board –

Next Speaker: Yeah.

Next Speaker: – and one of them was, um, contracting, um –

Next Speaker: Mm hmm.

Next Speaker: – with Dr. [Yitta] our, our dentist, so there you are, and then there's this other piece that, um, you guys had to write.

Next Speaker: Standard Operating Procedures Manual which I submitted in August. It's really formal and it's, um, it's really organized in terms of intraoral photos, um, documentation, chart use and I'm actually training the staff this week on it, kinda my expectations of what a good quality intraoral photo is, um, isolation, um, getting weights for children and things like that.

Next Speaker: And new cameras.

Next Speaker: And you bought new cameras.

Next Speaker: We did, **** 2.0. Very, very expensive high quality cameras.

Next Speaker: Oh, I think it'll help.

Next Speaker: **** Rogers emailed me yesterday and said they're great and you can't see bubbles. I actually tested the old cameras myself and they were not diagnostic. They're very blurry and I said, I'm, like, don't even use these as all. So, um, the new cameras **** the images will be significantly better. And I'm also gonna go through how, you know, the angulations and the types of shots that need to be taken.

Next Speaker: Mm hmm.

Next Speaker: To really make it easy for a chart reviewer to see and the labeling is also going to be much better. The clinic's already started labeling past photos as well.

Next Speaker: Okay.

Next Speaker: Like a pre-op, mid-op, post-op and the date and tooth number are gonna be very clear.

Next Speaker: That is, um, very important and, and, and will make the chart reviews actually a, um, usable in the future. So.

Next Speaker: But **** I think you're gonna notice significant changes in organization and quality and presentation. That's really what I'm stressing.

Next Speaker: And we already saw changes in the **** after, after the **** , um, and then the next part is that we are doing the follow up site visit to NARA, uh, in two weeks which is part of the ****.

Next Speaker: I'm, I'm glad to hear that things are gonna be a bit more organized. Um, I think, I'm sure I'm not alone in here but I might be but, um, the chart review was excruciating. It was some of the worst dentistry I've seen and I've sat on the board for eight years and, um, it's important that everyone in this room know that had those cases came up for some other minor infraction and we opened those up to the Board of Dentistry, um, reprimands, restitution for re, for things being redone, like, it's not a small thing. Um, and it's my job to report back to the state agency that oversees standard of care and explain what happened to this chart review. I'm glad things are gonna be better but we can only really judge based on what we see and what I'm lookin' forward to seeing better stuff. Um, I want whatever notes are put up in

this meeting that I strongly disagree with there were no instances of patient harm. Um, I mean, if, if we're defining harm in terms of things that are gonna not work or pathology labs or things done outside of, of a scope of practice or in terms of standard of care I think harm was done. And I think that's, um, um, it's this member's opinion that, that, that be instances in terms of there were no medical emergencies. There was no, there was no adverse outcomes regarding lacerations. But there was certainly inadequate care which by definition is harm. So, I'm gonna be writing a report myself and explaining this to the people who sit across the river and look at dental work in a different form, um, and I'm lookin' forward to seeing the new, um, uh, chart reviews and seeing how clear and better they are. I know they're looking forward to it. I know I am. Um, at some point I had to stop and get up from my computer and just take a walk 'cause it was, like, it was, as if I was lookin' at the worsts cases on the Board of Dentistry.

Next Speaker: Well –

Next Speaker: So it's important to know that.

Next Speaker: To clarify there was, there was a wide range of opinions on the, the quality aspect with ****.

Next Speaker: And if, and if I can give you a glimpse of what would have happened in a different setting, the eight to nine people giving opinions in that setting would have had a similar one to mine.

Next Speaker: Okay.

Next Speaker: All right.

Next Speaker: Well, can we, since we're talking about this, so patient harm, we need to, we need to clarify what we mean by patient harm –

Next Speaker: Mm hmm.

Next Speaker: – to describe in here, so if you have something specific that you just, what you just said, it would be helpful if you could send that so that we know –

Next Speaker: To email to you?

Next Speaker: – that we are talking about the same things.

Next Speaker: Sure.

Next Speaker: Yeah, patient **** versus –

Next Speaker: Quality –

Next Speaker: – quality ****.

Next Speaker: ****.

Next Speaker: **** wants it all.

Next Speaker: **** post-meeting ****.

Next Speaker: Okay, I think it's important to clarify –

Next Speaker: I'm happy to write ****.

Next Speaker: – what that means because there are –

Next Speaker: It's a broad –

Next Speaker: Well, that's the pro-, problem with it, so maybe we need to be more specific about what that means so that it's clear. Um, and then, um, Kelly, you sent out an email, so in, at some point we summarize initial data –

Next Speaker: Mm hmm. So, right now, I mean –

Next Speaker: One chart ****.

Next Speaker: – **** chart with you of just a couple, I mean, it was only charged through last December, it was extremely limited, uh, and then after taking out the charts that you had the correct photos or any photos, let alone diagnostic photos, um, or other required **** illness, we just do not have anywhere close to a, uh, sample size of vague generalizable comments, so we can't from these comments, generalizable statements about chart reviews until we've done at least **** chart reviews. Um, so, after we've done two or three sets of chart reviews it's gonna start making, um, releasing some of that information.

Next Speaker: Okay.

Next Speaker: I have a technical question. So, on the chart reviews, was there equal amounts per clinician **** this information but ****.

Next Speaker: Uh, they were not, they were all given the opportunity to, to do all of them but nobody except Bruce did all of them, but there were 22 –

Next Speaker: Twenty –

Next Speaker: – 22, yeah, and there was six dentists, only dentists.

Next Speaker: Yeah.

Next Speaker: I think most were –

Next Speaker: On average, four per chart.

Next Speaker: Yeah.

Next Speaker: 'Cause they were, sorry, maybe this is old information but there's supposed to be clarified that they could, working and compare groups, correct **** or –

Next Speaker: So, if it came and –

Next Speaker: Um –

Next Speaker: Uh, the clinicians that, that did the chart reviews –

Next Speaker: Yes.

Next Speaker: – **** and then in, uh, they all should have had the equal number of charts, just, he asked a question earlier about how many, how they were randomly selected and ****.

Next Speaker: Oh, all the charts that were randomly selected from NARA were made available to the chart reviewers –

Next Speaker: Yeah.

Next Speaker: – um, it was made clear to me that that was a bit overwhelming in number to go through for each reviewer, so we're, and it was an overwhelming number for us to work on. Um, **** has got it, so we will work on that process going forward. This, the first chart review was also a chance for us to pilot our project, our process –

Next Speaker: ****.

Next Speaker: – while the, the, um, doing a chart review on when, on a period when the, um, trainee was still in, um, the preceptorship phase. So, it's still not in the, the real true on the ground scope of practice of the DHAT, it's their preceptorship phase. So, we wanted to iron out –

Next Speaker: ****.

Next Speaker: – some of those kinks before we get to that, the, the, the next ****.

Next Speaker: But the attendants they have similar workload for each clinician ****.

Next Speaker: Yes, the attendants have a similar workload to each clinician except for Bruce who has to do it all.

Next Speaker: Oh, we don't care about Bruce ****.

Next Speaker: Uh –

Next Speaker: Each chart was taking, I mean, I think 30 minutes, 40 minutes –

Next Speaker: ****.

Next Speaker: – it was too much.

Next Speaker: It was taking longer than we anticipated –

Next Speaker: Yeah.

Next Speaker: – so we're working on some of our processes to make that a little more clear and really focus on the important parts of the chart review –

Next Speaker: Yeah.

Next Speaker: – and we're not expecting the clinicians to do the **** the objective parts, the, the clinician part of the chart review is really the subjective –

Next Speaker: Yeah.

Next Speaker: So you don't have to dig, dig, dig for things.

Next Speaker: Right, but does it also ensure **** everybody **** the clinician so that because also they tend to be able to pair up and compare, you know, opinions.

Next Speaker: If they wanted –

Next Speaker: ****.

Next Speaker: What I can do, well, you can pair up and work on them together if you want. What I do, statistically, is when I get enough of them, I compare **** comparisons between clinicians who look at the same chart and see how well they agree and then I come up with a metric called a Kappa Score of how well the group agrees overall and to see that we're all looking through the same lens, um, at the chart reviews. So far, the Kappa Scores, the preliminary Kappa Scores I'm getting, um, test scores go from 0 to 1, anything above a .8 is considered reliable, I'm getting around .4, .5 right now.

Next Speaker: Which basically means people don't necessarily agree.

Next Speaker: People do not agree.

Next Speaker: Yeah, so there was one chart, like, we were looking and somebody, like if it was a rating of 1 to 5, okay.

Next Speaker: An overall –

Next Speaker: Like your overall impression of the procedure 1 to 5, there was one person that marked 1 and the other three people marked a 4. I mean, there's a, that's a wide variety, you know, so what does that mean? You know, are they looking at exactly the same thing? Why would this person, you know, there's a lot of –

Next Speaker: So, until –

Next Speaker: – variation.

Next Speaker: Until we have that variation really looked at and we can really make assessments around that variation, we're relying on Bruce's as the final auditor of, of the final project, relying on his expertise.

Next Speaker: So, I guess the –

Next Speaker: Kelly, just to clarify, one of the reasons you have them all available to all of the clinicians is so that opinions versus fact can kind of get weeded out –

Next Speaker: Yes.

Next Speaker: – a little bit so that you can then have four people looking at the same chart –

Next Speaker: Yeah.

Next Speaker: – and at one person –

Next Speaker: Until, until we get that Kappa Score near 1, I'm not comfortable having one reviewer look at a chart and say this is the committee's opinion.

Next Speaker: Okay.

Next Speaker: ****.

Next Speaker: Well, that's something to, and I wonder too then if the clinicians are pairing up to go through if that would throw off your score as well. Shouldn't they all be independently reviewing them so that you're getting the independent opinion of the reviewers?

Next Speaker: I, methodologically, ideally, yes, but as I'm also trying to make people think about things in a critical manner and talk them through, I think talking through things is really helpful –

Next Speaker: ****.

Next Speaker: – and the people who came in together who, that I helped, uh, coach through some of them in person, like **** so, I don't, I don't s-, I think that's still a useful thing to do. I just want to make sure that the loudest voices aren't the loudest just 'cause they're the loudest.

Next Speaker: I think, you know, when we were, I did a chart review **** across and you were looking at different charts.

Next Speaker: But they were talk, you were talking about what –

Next Speaker: You were asking questions like for this, for this question –

Next Speaker: Mm hmm.

Next Speaker: – right, what, is it referring to this or are you referring to that? It was, it was **** because we were doing our own pilot project of how we were doing our chart review.

Next Speaker: Yeah, that's exactly, exactly **** first round ****.

Next Speaker: **** is this, is it, is this valid, we **** this information when we already addressed it –

Next Speaker: Yeah.

Next Speaker: Right.

Next Speaker: – over here?

Next Speaker: Exactly.

Next Speaker: ****.

Next Speaker: So, yeah, so that's a chance for us all to also to pare down the whole thing, make it a little more streamlined.

Next Speaker: I also **** about the chart review form in terms of cleaning it up and making it less redundant, right –

Next Speaker: Yeah, we have wonderful guidelines, you know that.

Next Speaker: – because I, I feel like it's very daunting. By the end you're just like, wow, **** right, so.

Next Speaker: Yeah.

Next Speaker: Like, we need to make it, you know –

Next Speaker: Yeah.

Next Speaker: – just to make sure that, like, people aren't getting fatigued or, um –

Next Speaker: And like you said –

Next Speaker: And we're really ****.

Next Speaker: – your images will be better labeled, the charts will be more organized, like Kelly said, um, non-clinicians can go through and see if some of the boxes are checked –

Next Speaker: Like, I'll do the boxes checking.

Next Speaker: – so we don't have to go through every form. Yeah.

Next Speaker: I mean, I'm not a clinician, I can't **** anything about quality, things like that, but I can say yes **** there.

Next Speaker: All right.

Next Speaker: So can I ask a question ****? Understanding that, that the, the whole process is made up, you know, in the very beginning with ****, I believe there was a discussion that came up a number of times in the rule making that the Board of Dentistry's involvement in this would be very important and helpful, especially in terms of standardizing and helping to calibrate ****. I'm not a clinician but I know some people **** you know, have, probably haven't done chart reviews on others, you know, for a number of years. Is that something that is still valid that could be explored and have greater involvement?

Next Speaker: Um, I can't speak to –

Next Speaker: It depends on our process, right?

Next Speaker: Yeah.

Next Speaker: I mean, I don't really know what they're, I mean, is that your pro-, what is your process when you do, I mean, you're all getting together and –

Next Speaker: Right.

Next Speaker: – you're doing it as a group.

Next Speaker: It, after independent reviewing. So, what happens is, uh, data's gathered in terms of a chart, and then someone who's either, has some degree of clinical experience or a full-blown doctor, um, does, um, does essentially highlighting of that same data, okay. So, for instance, like –

Next Speaker: So, it is extracted or –

Next Speaker: Well, it's not –

Next Speaker: – pared.

Next Speaker: – it's not distilled, it's not like things taken out.

Next Speaker: Okay, so you go through and find –

Next Speaker: So you see –

Next Speaker: – the important things.

Next Speaker: – I mean, every Board book is 500 pages.

Next Speaker: Yeah, okay.

Next Speaker: So, everything is in there, and then things are highlighted in terms of what the reviewer, the initial reviewer sees, just to kind of catch your eye to it, so there's kind of a storyline you could follow, and all nine, ten, whatever members see it by themselves separately, but then, and then the, then the, a meeting happens where it's all discussed and invariably just with that much data lookin' at, sifting through that much data with that many different perspectives and backgrounds are just individuals, there's gonna be one or two people or more, like I saw it this way, I saw it that way, and then a consensus is made about what is the reality.

Next Speaker: Mm hmm.

Next Speaker: Right? And so –

Next Speaker: It sounds like a ****.

Next Speaker: Right, it is, right? And so, and so, um, the, in terms of how it's here, it's obviously a different, a different goal and a different purpose, but, um, having, having, having at least the information, part of it was just the difficulty in just reading the whole thing. I think, I'm sure I no-, notated some things, just out of frustration, like I don't think it's even here. In reality it was on the next one or whatever.

Next Speaker: That's, yeah.

Next Speaker: You know what I mean?

Next Speaker: And that's the biggest theme was concern about –

Next Speaker: ****.

Next Speaker: – readability of charts.

Next Speaker: So, if it's, if it's something where someone can go through that and if it's possible to go through and just kinda like the things that are typically done, or omissions, if you're looking for a box to check or uncheck –

Next Speaker: Yeah.

Next Speaker: – and then get presented to the clinicians just to streamline it a little bit that way –

Next Speaker: That is what we were thinking –

Next Speaker: – with or without the consensus.

Next Speaker: – of doing.

Next Speaker: So that's what, that's what I started.

Next Speaker: We started doing that, um –

Next Speaker: And trimming out things that are redundant so you don't have you're not looking at two, two things that are like –

Next Speaker: The same thing.

Next Speaker: – similar.

Next Speaker: Yeah.

Next Speaker: Right.

Next Speaker: We've, um, yeah, so, we're going through that and we're also not gonna have **** three charts ****.

Next Speaker: The only concern that I have about your process is getting people together to do the second stage of that and getting together and having that conversation. That's been –

Next Speaker: No, and –

Next Speaker: – the hardest part –

Next Speaker: – logistically it's impossible.

Next Speaker: It's, it's basically impossible –

Next Speaker: Right.

Next Speaker: – for this, um, especially since this is an all volunteer Board –

Next Speaker: The only –

Next Speaker: – **** we're taking a lot of time out of your **** life and we understand that, so.

Next Speaker: The only comment I'll make about that is that if there is someone who, so back to the Board of Dentistry, like, they used to do this thing all the time where if there's a concern about a particular case, someone will, we call it stars. Like, I have two stars in this one, I want everyone to talk about this, I want to go to the front of the line. If there's a situation, and I think there's some ethical concerns in here too that if there's a, if there's a, a bad outcome that is, if we're supposed to be behind patient safety or, you know, quality of care for this person who consented for it, you can't consent to non-quality care, that's not possible. Right? That, um that if there's an ability for the clinicians reading these chart reviews say hey, I want this one brought up at a, at a consensus level or at least brought up with, you know, two or three different reviewers at minimum to be, like, hey, this seems like a big deal.

Next Speaker: That's a good idea.

Next Speaker: I, I like that.

Next Speaker: And then, and then that raises up the food chain, go back to whoever's doing –

Next Speaker: Okay.

Next Speaker: – doing it that way, but then –

Next Speaker: Just flag it.

Next Speaker: Flag it, yes.

Next Speaker: Okay.

Next Speaker: And then –

Next Speaker: ****.

Next Speaker: – not to whitewash it, but to say, like, let's be sure that what we're lookin' at is a real thing here ,and that's where I feel like, 'cause the, the challenge –

Next Speaker: That's a really good point.

Next Speaker: – I had was like I feel like I'm just lookin' at, no offense whoever did this, but like just a heaping pile of garbage and I can't do anything about it where in another setting I can go oh, we can do X, Y, and Z, follow up, get more information, consensus it, and then find

a solution. Here you're just like eh, it's one, it's two, whatever, and that's it. Does that make sense?

Next Speaker: Okay, I like that.

Next Speaker: Okay.

Next Speaker: And I think –

Next Speaker: ****.

Next Speaker: – I think that's **** next process.

Next Speaker: And I think we'll, we'll have a lot better gauge of quality just by having more clear images –

Next Speaker: Definitely.

Next Speaker: – ****.

Next Speaker: When does that, when does that start?

Next Speaker: So **** this week.

Next Speaker: Okay.

Next Speaker: But I have to give them enough time for them to absorb it and to reread the manuals, so September 24th.

Next Speaker: It's like, so that's when –

Next Speaker: A physical line –

Next Speaker: – good ****, no, good, they were –

Next Speaker: And they already started. I mean, I've given them emails and updates about, you know, what we need to be doing, so, but formally with, like, my presentation, September 24th is the day.

Next Speaker: Okay.

Next Speaker: ****.

Next Speaker: The unfortunate part about that is that the data, the chart reviews are always just lagged –

Next Speaker: Yeah.

Next Speaker: – I mean, because it's based on a sampling from the day that it's submitted from the previous quarter.

Next Speaker: But you need ****.

Next Speaker: **** is very different style of **** so, yeah, so huge differences there and you will when we, we're still doing that highlighting and cleaning that we clearly learned needed to happen. Uh, I mean, I do –

Next Speaker: How long should it take somebody to do a chart review, 10 minutes?

Next Speaker: It shouldn't take more than 10 minutes per chart ****.

Next Speaker: Okay, so that's where we really need to get our goal –

Next Speaker: Yeah.

Next Speaker: – down to so that you can actually be –

Next Speaker: We don't need to take everybody's **** like crazy.

Next Speaker: **** work with, um, **** coordination how we're organizing our presentation of the charts, like how do they ****?

Next Speaker: Yeah, we can –

Next Speaker: Yeah, I think that's probably better to make it a little bit easier, more efficient.

Next Speaker: So far, just so you know, we've taken everything you've put in, and I've merged them all to one .pdf document so that people aren't going between different files, so each chart is its own file and I do further redactions for the project's information.

Next Speaker: Yeah.

Next Speaker: Okay, so, what else do we have –

Next Speaker: Well, we've got this –

Next Speaker: I want to make one quick question.

Next Speaker: Yeah.

Next Speaker: If I can interrupt you. Um, since for the **** process **** if you notice I have people on the phone **** PowerPoint patient team, uh, everyone wants to talk about scope of practice, and then it's split on what other –

Next Speaker: Yeah.

Next Speaker: – uh –

Next Speaker: What to talk about next.

Next Speaker: – topics people would like to talk about. Has that changed for anybody? Anybody interested in talking about a different topic to start, uh, looking at a different topic

since we don't really have enough information to really delve further into scope of practice until we have learned more about the project.

Next Speaker: So, education and training, population served, supervision, or licensure and regulatory.

Next Speaker: And **** they're all just making executive decisions.

Next Speaker: **** licensure or education would be my vote.

Next Speaker: Okay, all right, it'll probably be education, that's what I was thinking. Okay.

Next Speaker: And we'll cover, we'll cover it all eventually.

Next Speaker: Oh yeah, it's just –

Next Speaker: Yeah.

Next Speaker: ****.

Next Speaker: Yeah, and some of these might make more sense when we get farther down the road too.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah, maybe **** later.

Next Speaker: Yeah, the population survey, I know that some of the, I don't know.

Next Speaker: **** education ****.

Next Speaker: Okay, yeah.

Next Speaker: **** jeopardy ****.

Next Speaker: Okay and the –

Next Speaker: Okay, we have a winner.

Next Speaker: The only other things on the agenda are upcoming meeting which are ****.

Next Speaker: Yes.

Next Speaker: **** like Sara said will be at the, the residential treatment center out on Highway 30 next week –

Next Speaker: Yeah.

Next Speaker: – and go from there. Um, and any other comments in the room before the public comment? All right, is there any public comment –

Next Speaker: Or on the phone?

Next Speaker: – on the phone or in the room?

Next Speaker: Okay.

Next Speaker: All right.

Next Speaker: All right, so our next meeting –

Next Speaker: **** not bad.

Next Speaker: Yeah, that's great, like, on December 3rd we'll have our next meeting in this room.

Next Speaker: Yeah, and thank you all very much for being here and being on the phone and reviewing everything.

Next Speaker: And I will send a meeting survey out, um, in a day or two so that you can, if you have any feedback on the meeting after you've had a chance to digest it.

Next Speaker: All right, thanks guys.

Next Speaker: Okay, thank you.

Next Speaker: Hang up on the phone.

Next Speaker: I know, uh ****.

Public Comment: No Public Comment

Meeting Adjourned at 11:48am

Meeting adjourned

Public Comments: No Public Comments

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

Oregon Health Authority

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

Language from Stipulated Agreement

Extraction Criteria

a. Only allow a DHAT trainee to perform extractions under the following conditions:

1. All extractions must be performed under the indirect supervision of the trainee's dentist. Indirect supervision is defined under ORS 679.010 as supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

2. For primary and permanent tooth extractions, the DHAT trainee will first receive and document authorization from the supervising dentist.

3. For **primary teeth**, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gumline, or needs to be sectioned for removal.

4. For **permanent teeth**, the trainee may perform non-surgical extractions of periodontally diseased teeth with evidence of bone loss and +2 degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gumline, or needs to be sectioned for removal.

5. Document all information related to extractions as specified above along with the criteria required for the project evaluation which include a recent radiograph of the tooth to be extracted, a pre-operative intra-oral image of the tooth to be extracted and a post-operative image of the extracted tooth.

CULTURAL COMPETENCY/ PRIMARY EXTRACTIONS

CULTURAL COMPETENCY

- "Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients"

  -CULTURAL COMPETENCE IN HEALTH CARE: IS IT IMPORTANT FOR PEOPLE WITH CHRONIC CONDITIONS. *Issue Brief Number 5, February 2004*

CULTURAL COMPETENCY

- Understanding cultural and language differences
- Acknowledging past history of discrimination or racism
- Knowing current barriers to obtaining care

PAST HISTORY OF TRAUMA

- "Research indicates that AI/AN populations have disproportionately higher rates of mental health problems than the rest of the US population. 2, 3 High rates of substance use disorders (SUDs), posttraumatic stress disorder (PTSD), suicide, and attachment disorders in many AI/AN communities have been directly linked to the intergenerational historical trauma forced upon them, such as forced removal off their land and government-operated boarding schools which separated AI/AN children from their parents, spiritual practices, and culture." -Mental Health Disparities: American Indians and Alaska Natives. American Psychiatric Association.

DENTAL VISIT

- Culturally competent care fosters trust between patient and clinician
  - Relieves patient anxiety
  - Provides better understanding of how a patient may respond to pain
  - Manage patient's discomfort in a respectful, culturally appropriate way
  - Empathize with a patient's past traumatic experience
  - Unfavorable dental experiences can influence patient retention and no show rates
  - Simply because a clinician is able to provide safe care does not mean the patient feels safe

CLINICIAN'S SAFETY CHECKLIST

- Risk of medical emergency
- Surgical vs simple extraction
- Informed consent

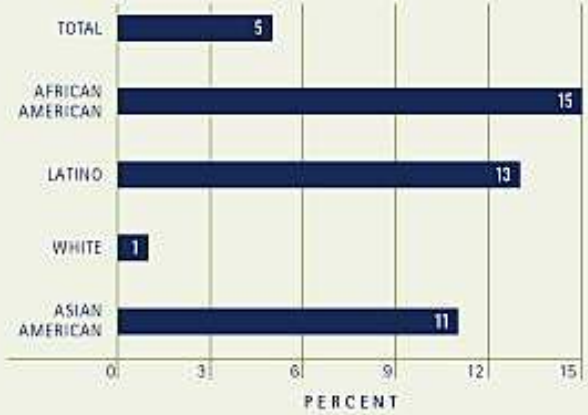
PATIENT'S PERCEPTION OF SAFETY

- Patient is in control of their health
- Patient understands their diagnosis and treatment
- Patient does not feel overwhelmed with dental terminology
- Patient does not feel judged
- Patient does not feel discriminated against

Racial and Ethnic Minorities are Less Satisfied with the Health Care They Receive

FIGURE 4

Proportion of people who believe they would receive better health care if they were of a different race and/or ethnicity, total and by race/ethnicity



SOURCE: Collins, K.S., Hughes, D.L., Doty, M.M., Ives, B.L., Edwards, J.N. & Tenney, K. 2002. *Diverse communities, common concerns: Assessing health care quality for minority Americans.* New York: The Commonwealth Fund.

CULTURAL COMPETENCE IN HEALTH CARE: IS IT IMPORTANT FOR PEOPLE WITH CHRONIC CONDITIONS. *Issue Brief Number 5, February 2004*

FIRSTHAND EXPERIENCE

- "Growing up on the Coquille Indian Tribe Reservation, I was taught at a young age to not only take care of my Tribal families but to focus on our Tribal Elders and their healthcare needs. "

-Alex Jones, recently graduated DHAT

PRIMARY EXTRACTIONS

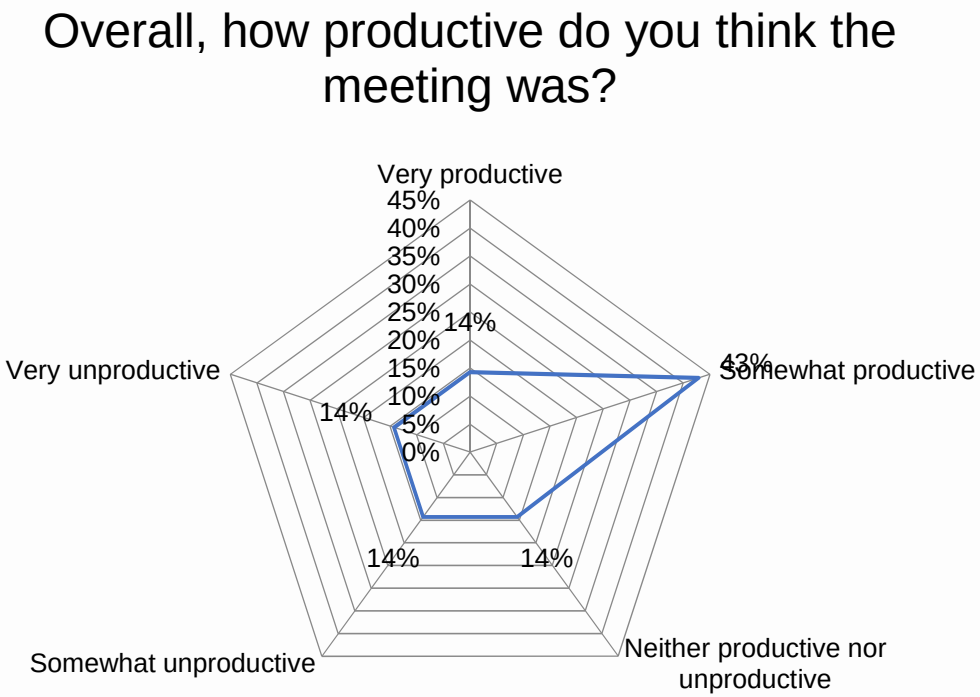
- The current guideline states: "For primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal."

PRIMARY EXTRACTIONS

- NPAIHB is asking for more clarity on the topic of mobile primary teeth:
  - Degree of mobility required
  - Degree of fracture permitted (excluding to the gumline)
  - Extent of decay allowable (failed class 2 restoration, class 5 decay)
  - Amount of clinical crown required (exfoliating with minimal crown left)
  - Being as specific as possible ensures DHAT stays within scope of practice and helps with thorough charting/note taking
  - Safety is the primary goal

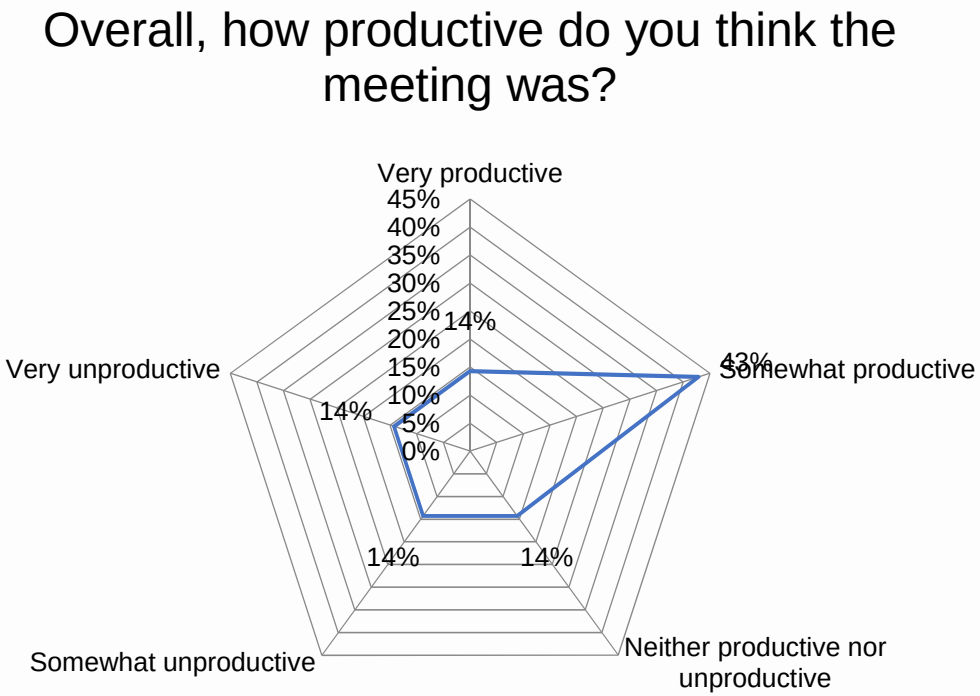
THANK YOU!

Meeting Feedback for June 18, 2018



Meeting Feedback for June 18, 2018

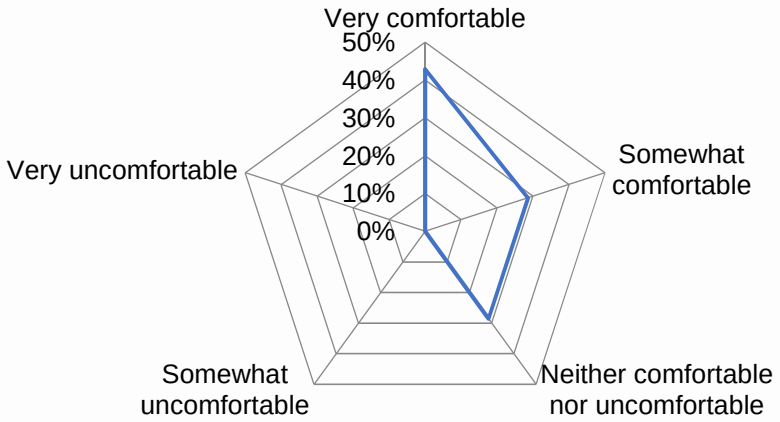
"I didn't understand why we had the guest speakers at the beginning until much later in the day. It would have been more useful to have introduced why they were there so I could have gotten more out of it. Also it was too bad that more members weren't there."



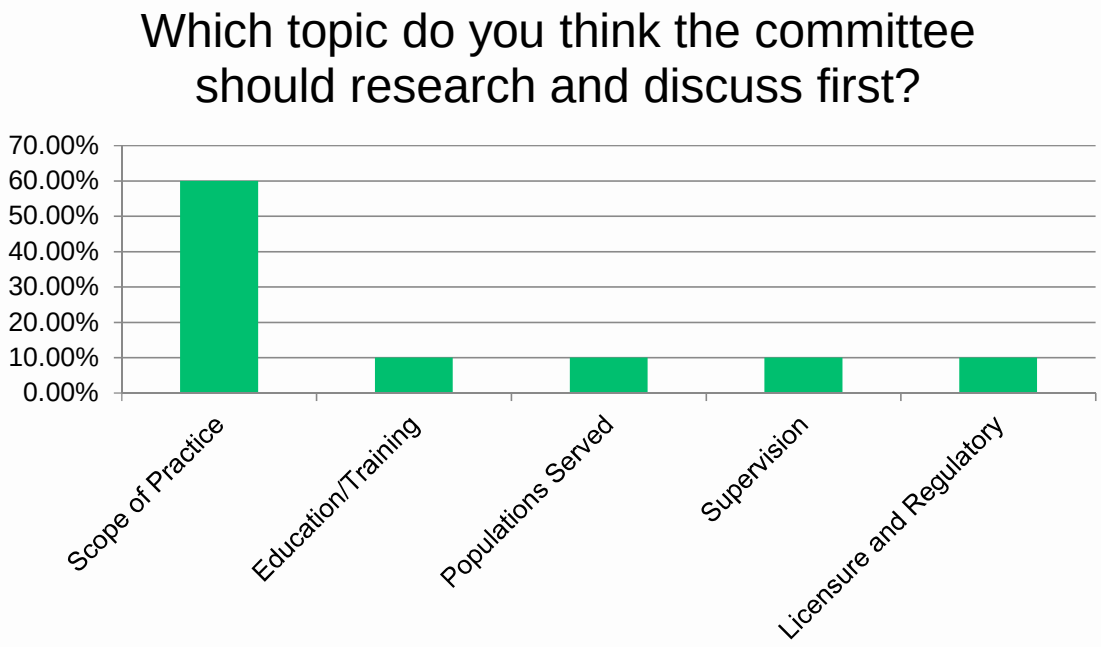
It consistently felt like concerns that were brought up were addressed in a way that indicated the project planned to do things how they would like to, which may or may not address the actual concern.

Meeting Feedback for June 18, 2018

How comfortable did you feel sharing your opinions in the meeting?



Meeting Feedback for June 18, 2018



Delphi Surveys:
An Introduction

Investigating Subject Matter Expert Opinions on DHATs

Oregon Dental Pilot Project Program

September 10, 2018

ORAL HEALTH PROGRAM
Public Health Division

- ***Aims***: To explore views among dental subject matter experts relating to the potential use of dental health aide therapists (DHATs) in Oregon. This process is intended to consider DHATs under the general model currently being piloted by the NAIHB. The following topics will be surveyed to develop a group consensus and policy recommendations while highlighting key areas of dissent:
  - Scope of Practice
  - Supervision
  - Populations Served
  - Education/Training
  - Licensure and Regulatory

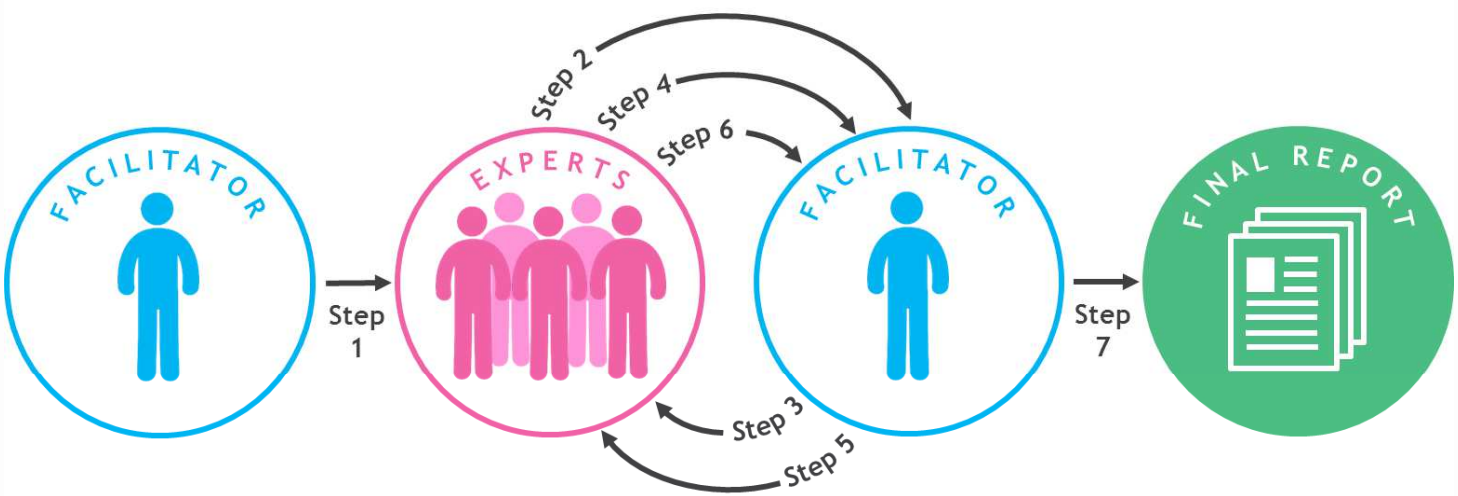
The Delphi Method

- The **Delphi method** is a structured communication technique or method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts.[1][2][3][4] The experts answer questionnaires in two or more rounds. After each round, a facilitator or change agent[5] provides an anonymised summary of the experts' forecasts from the previous round as well as the reasons they provided for their judgments. Thus, experts are encouraged to revise their earlier answers in light of the replies of other members of their panel. It is believed that during this process the range of the answers will decrease and the group will converge towards the "correct" answer. Finally, the process is stopped after a predefined stop criterion (e.g. number of rounds, achievement of consensus, stability of results) and the mean or median scores of the final rounds determine the results.[6]

Goals of a Delphi process:

- To determine or develop a range of possible program alternatives
- To explore or expose underlying assumptions or information leading to different judgements
- To seek out information which may generate a consensus on the part of the respondent group
- To correlate informed judgements on a topic spanning a wide range of disciplines
- To educate the respondent group as to the diverse and interrelated aspects of the topic

- Source: Hsu, Chia-Chien & A. Sandford, Brian. (2007). The Delphi Technique: Making Sense Of Consensus. Practical Assessment, Research and Evaluation. 12.


FACILITATOR
Step 1
EXPERTS
Step 2
Step 3
Step 4
Step 5
Step 6
FACILITATOR
Step 7
FINAL REPORT
Facilitator seeks individual assessments from a pool of experts.
Experts respond to the request, receive feedback and revise their responses.
Facilitator compiles the responses and sends a revised set of questions to each expert. Several cycles of feedback may be needed.
Facilitator produces report on experts' responses, noting key outliers.

- PROS
  - Allows and *encourages* participants to reassess initial judgements
  - Anonymity reduces effect of dominant individuals and opinions
  - Utilizes the tools of statistical analysis of objective insight

- CONS
  - Tends toward the median opinion
  - Time intensive
  - Difficulty maintaining response rates
  - Potential of molding opinions

Keep in mind…

- This is HYPOTHETICAL – we are not making any determinations about the current project at this time
- We will revisit these topics throughout the life of the project
- Opinions are expected to change over time

Examples of Delphi at work

- Mac Giolla Phadraig C, Nunn J, Dougall A, O'Neill E, McLoughlin J, et al. (2014) What Should Dental Services for People with Disabilities Be Like? Results of an Irish Delphi Panel Survey. PLOS ONE 9(11): e113393. https://doi.org/10.1371/journal.pone.0113393
- http://portal.healthworkforce.eu/pilot-study-experiences-in-belgium-using-horizon-scanning-and-delphi/
- Feo R, Conroy T, Jangland E, et al. Towards a standardised definition for fundamental care: A modified Delphi study. *J Clin Nurs*. 2018;27:2285–2299. https://doi.org/10.1111/jocn.14247
- Newman C., Patterson K., Eason M. & Short B. (2016) *Journal of Nursing Management* 24, 1130–1136. Defining the role of a forensic hospital registered nurse using the Delphi method
- Hsu, Chia-Chien & A. Sandford, Brian. (2007). The Delphi Technique: Making Sense Of Consensus. Practical Assessment, Research and Evaluation. 12.

Dental Health Aide Therapist Scope of Practice

Delphi Survey Round 1 Results

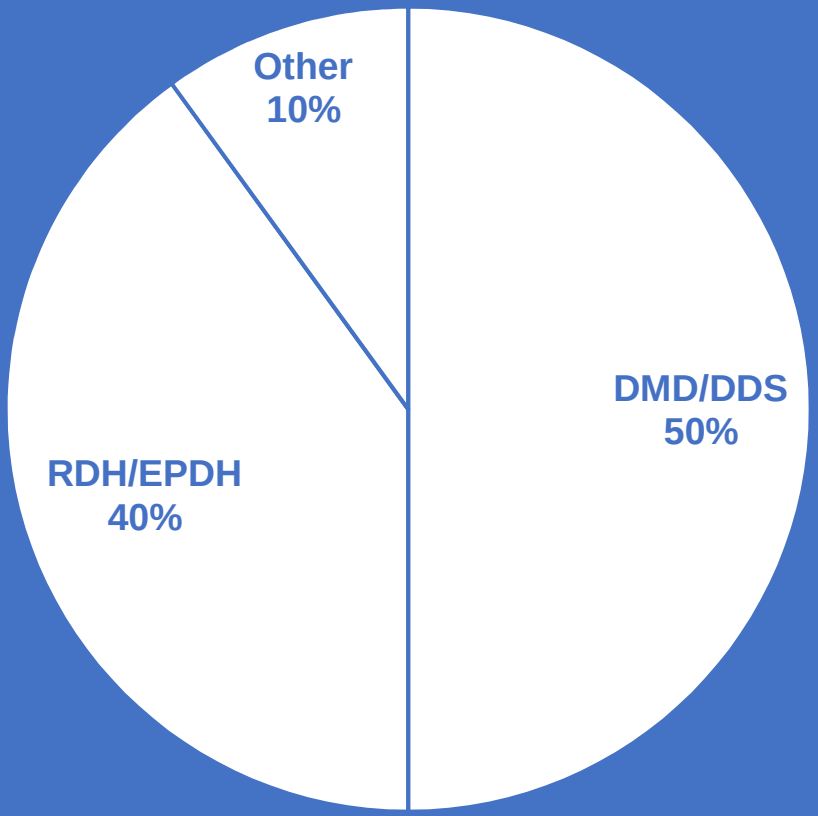
September 10, 2018

ORAL HEALTH PROGRAM
Public Health Division

Delphi Scope of Practice Round 1

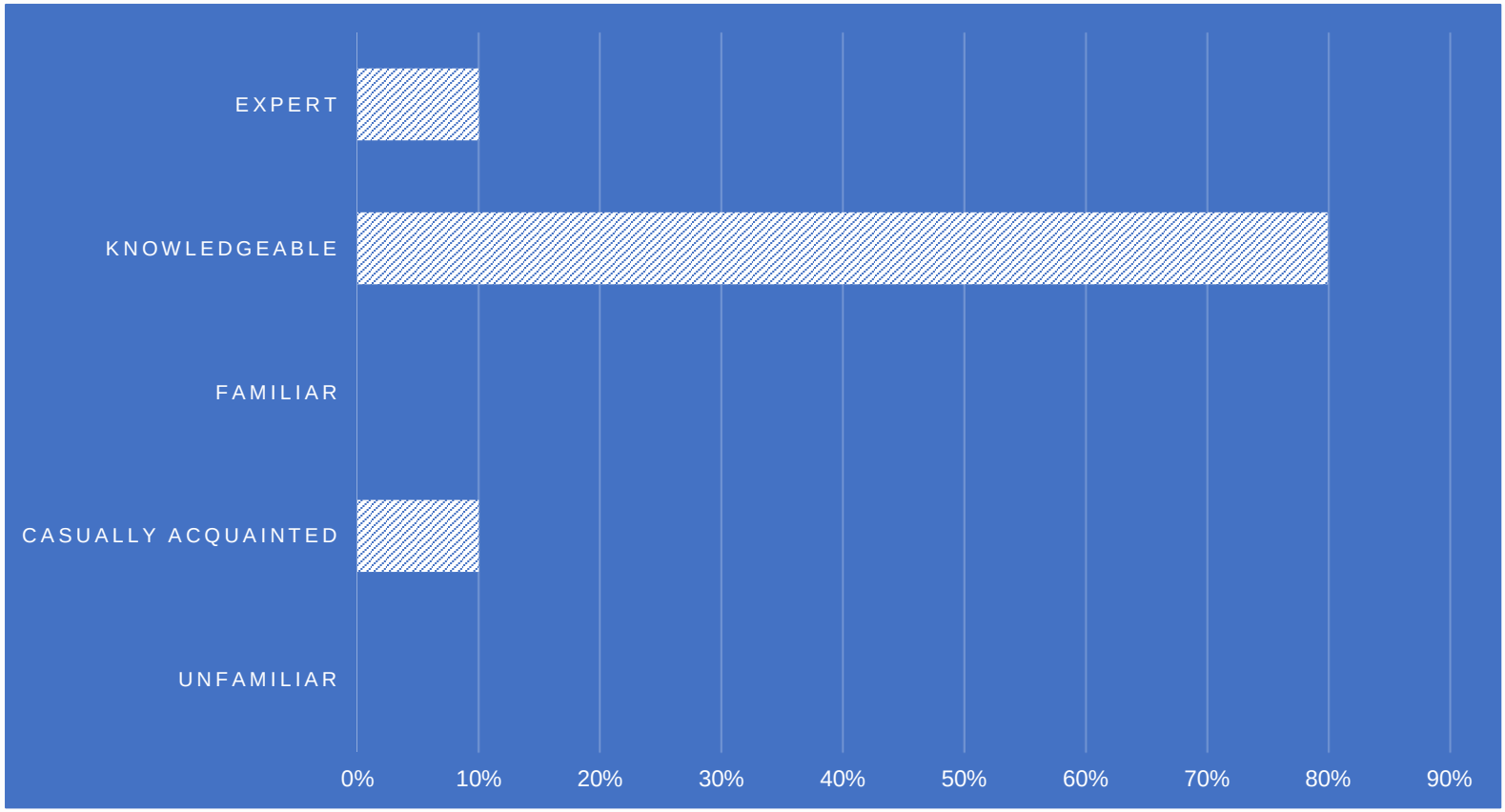
10 Respondents

Average time:
25 minutes



Survey 1:
August 2018

Please indicated your degree of expertise or familiarity with the DHAT model

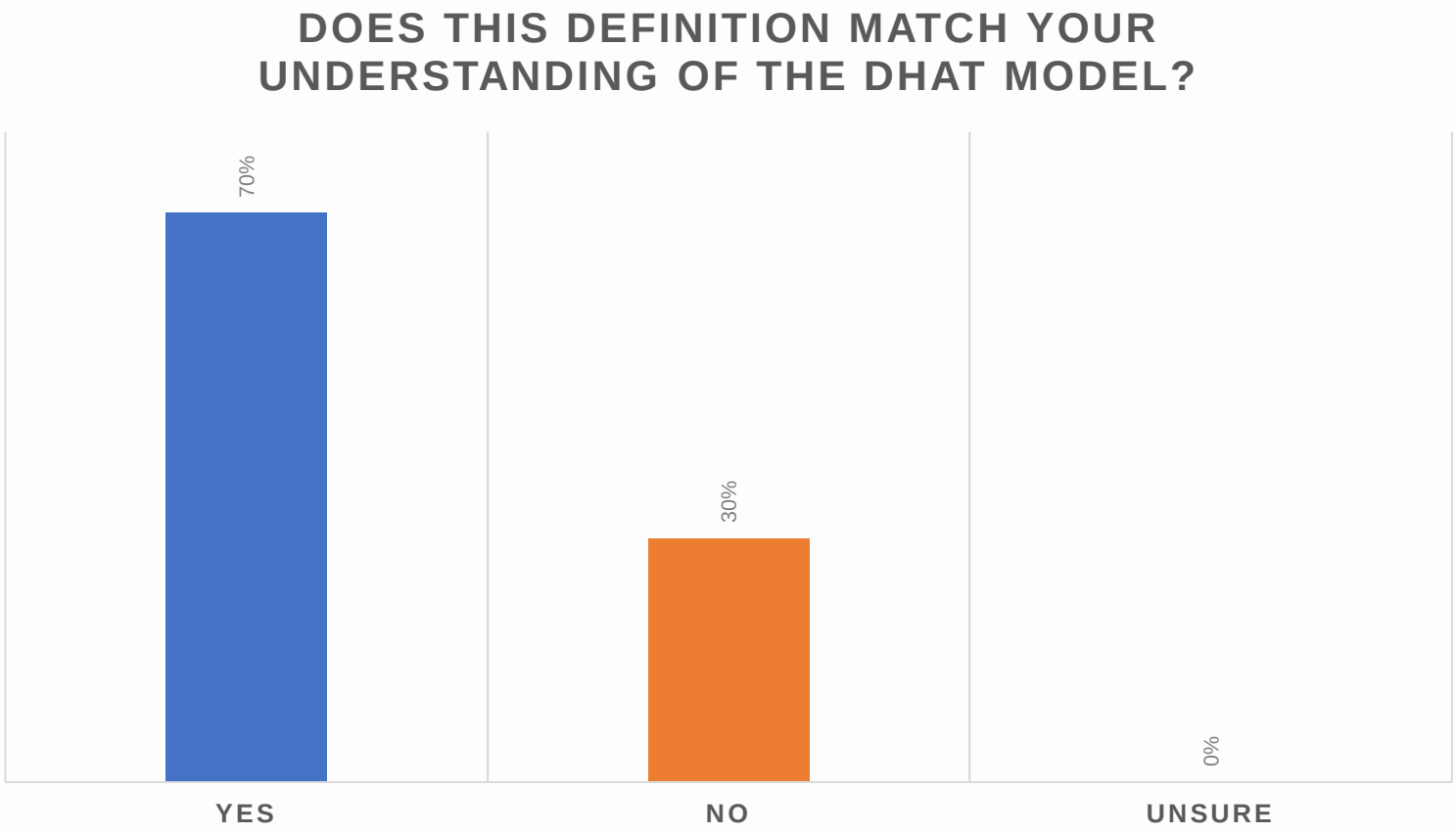


Oregon Health Authority

DHAT Definition

Dental Health Aide Therapists (DHAT) are individuals who are trained in an intense 2 year program operated jointly by the Alaska Native Tribal Health Consortium (ANTHC) and Iḷisaġvik College. There are no specific dental background or other healthcare provider prerequisites required for entry into the training program. Individuals are recruited from tribal communities with the expectation that they will return to their community to provide oral healthcare services. DHAT's are certified by Community Health Aide Program (CHAP) after completing a preceptorship with a supervising dentist. DHATs are not required to be licensed to operate in Alaska. CHAP does not require DHATs to take a written or clinical board examination by a third party to become certified. Once certified, they receive a set of standing orders and work offsite under general supervision.
They consult with their supervising dentists via email, phone or telemedicine. The goal is to keep the patient in the community and provide all services within the DHAT scope of practice.

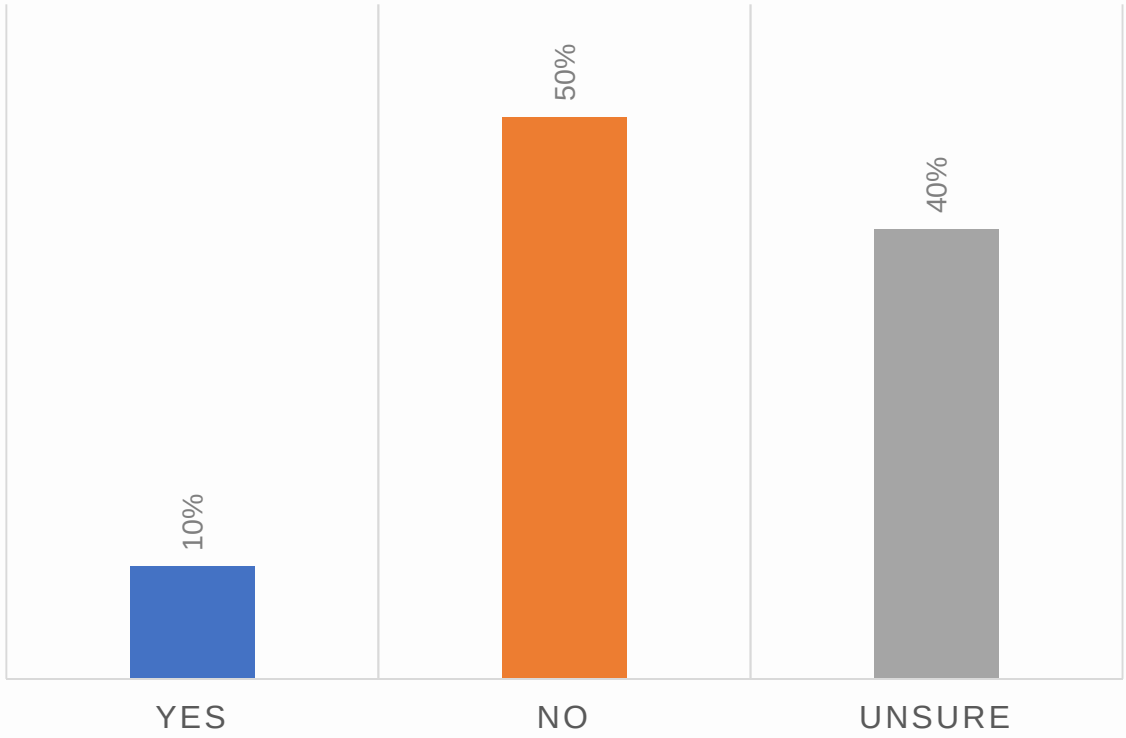
DHAT Definition



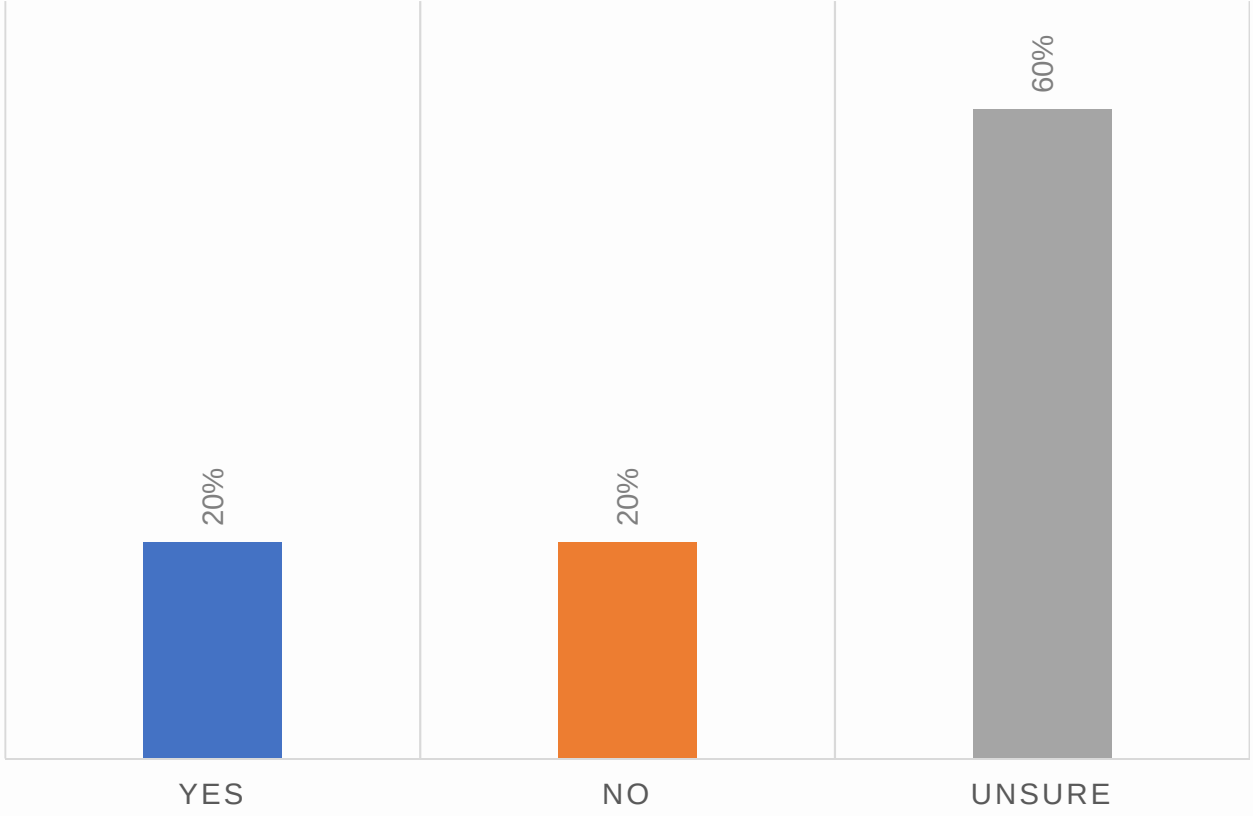
DHAT Definition Abstracted Comments

- The term ‘intense’ is subjective and potentially misleading
- Confusion between DHATs practicing in Alaska, and with certification, and in Oregon under the Pilot Project Program
  - For the Delphi Method Survey → imagine a hypothetical world where Oregon has a licensed DHAT
- “A dental therapist is a mid-level dental provider who does not necessarily have a dental background before the two-year training program. These providers can be an adjunct to a dental team by providing preventive, emergency, and restorative treatment as well as some extractions. “
- “The DHAT model provides a way for people who live in remote or underserved communities to receive oral health care within their community. The model also allows for these patients to receive culturally-appropriate care from members of their own community. In this model, a person (with or without previous dental training) participates in a two year DHAT training course sponsored by the Alaska Native Tribal Health Consortium (ANTHC) and Iḷisaġvik College. After completion of this course, the student must then participate in a preceptorship with a supervising dentist. After the preceptorship is complete, the student can be certified by the Community Health Aide Program. Once certified, DHATs work with a supervising dentist who will provide standing orders. DHATs communicate with their supervising dentist via phone, email, or telemedicine. The goal of the DHAT model is to provide increased access to oral health care for people who live in remote or underserved areas, provide culturally-appropriate care, and attempt to keep patients within the communities as much as possible while receiving this care.”

Do you think that the DHAT model as currently envisioned by the pilot project should be implemented in Oregon?



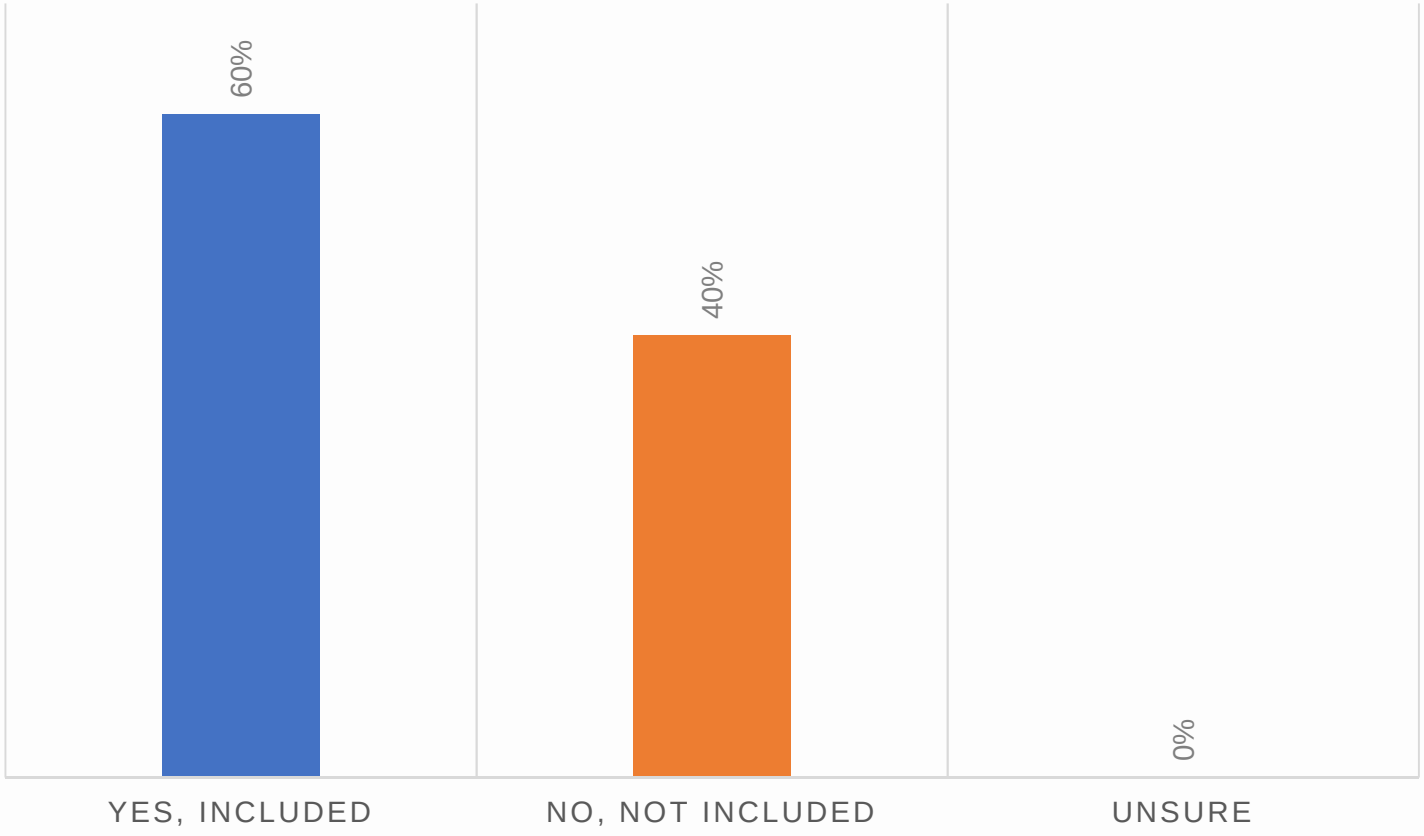
Do you think a *modified* version of the pilot project DHAT model should be implemented in Oregon?



DHAT Scope of Practice

- Patient Assessment and Evaluation
  - Preventive Procedures
- Restorative/Endodontic Procedures
  - Surgical Procedures
  - Adjunctive Procedures

Patient Evaluation, Assessment and Diagnosing

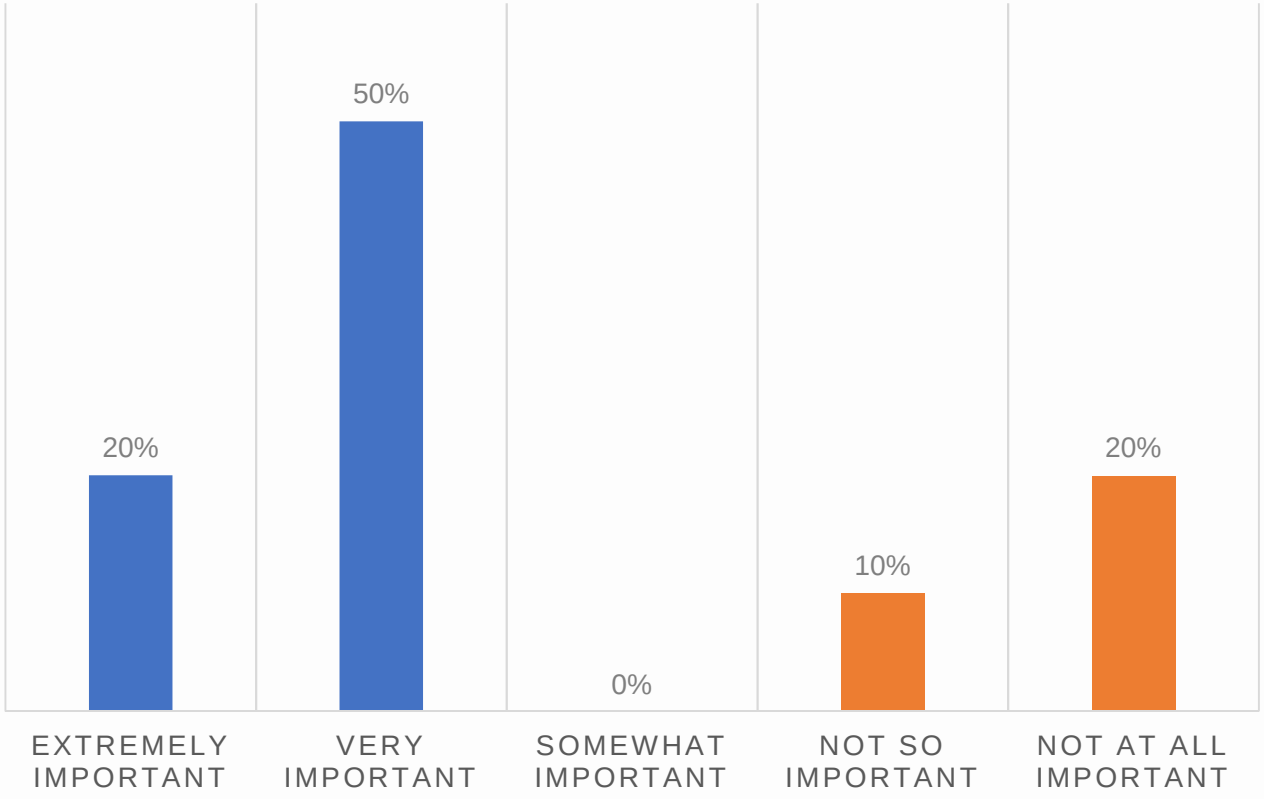


Comments

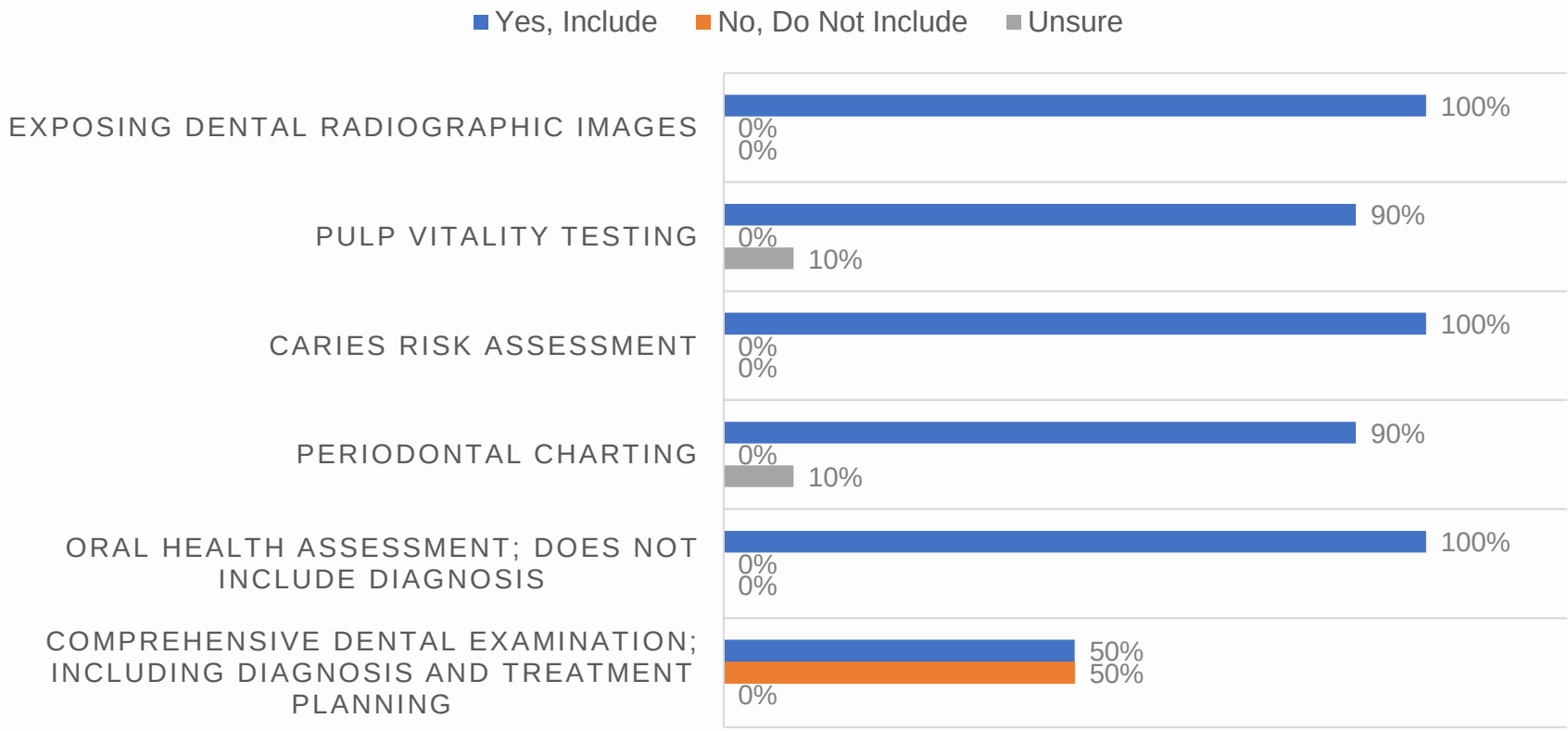
- Consensus on patient evaluation and assessment
- Wide split on diagnosing

- Representative comments:
  - "I think this is an essential component to removing the barriers to care. If the dentist has to provide the evaluation, assessment, and diagnosis, it makes it harder to deliver care to patients who live in remote and underserved areas."
  - To perform independent work, I believe a DHAT should be able to do these things. I would like to be in a profession where we can admit (what we all already know) that you don't have to have a DMD/DDS behind your name to be able to diagnose disease.
  - "Like all invasive procedures, the pre and post pop diagnosis has a tendency to change. Diagnosing is vital if someone is cutting or removing tissue. Hard or Soft."
  - "Diagnosing is the paramount purview of a dentist in my opinion as it involves so many other factors than procedure based treatment"

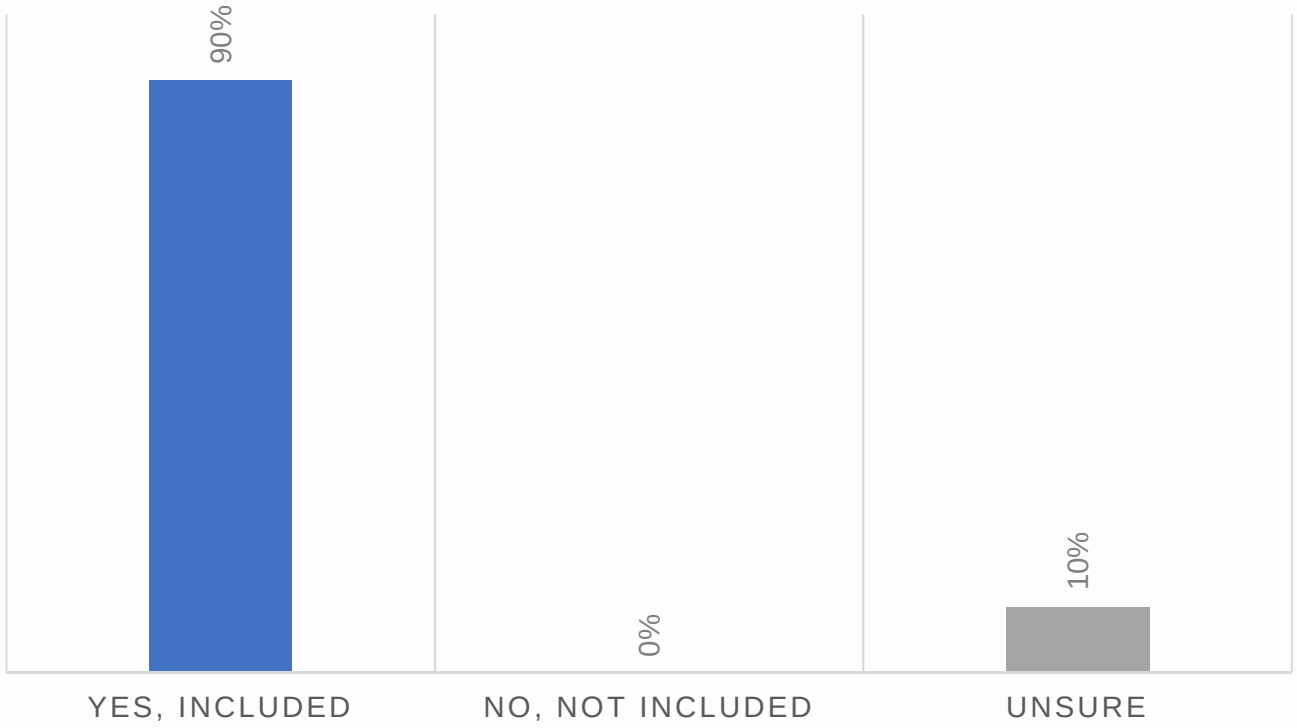
How important do you feel it is that the DHAT Scope of Practice include Patient Evaluation and Assessment and Diagnosing?



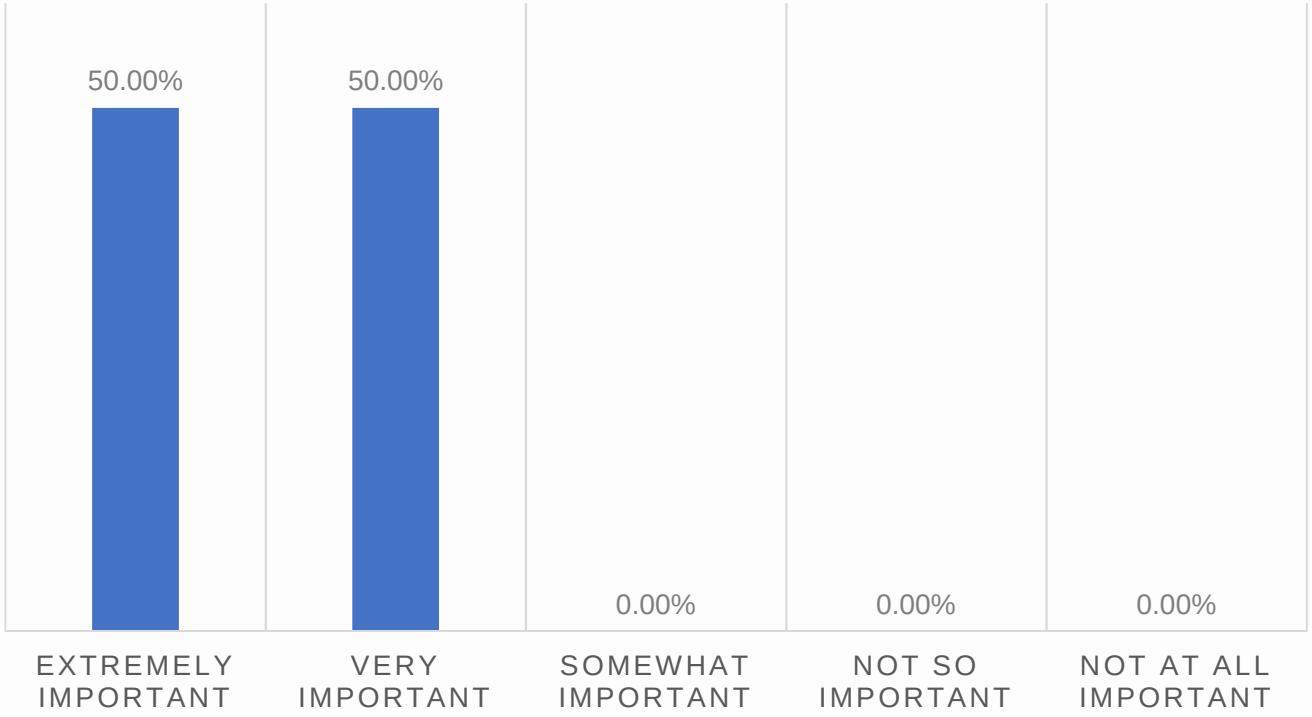
For Each Procedure, indicate whether you believe that the procedure should be included in the DHAT Scope of Practice, based on your understanding of the education and training model for DHATs.



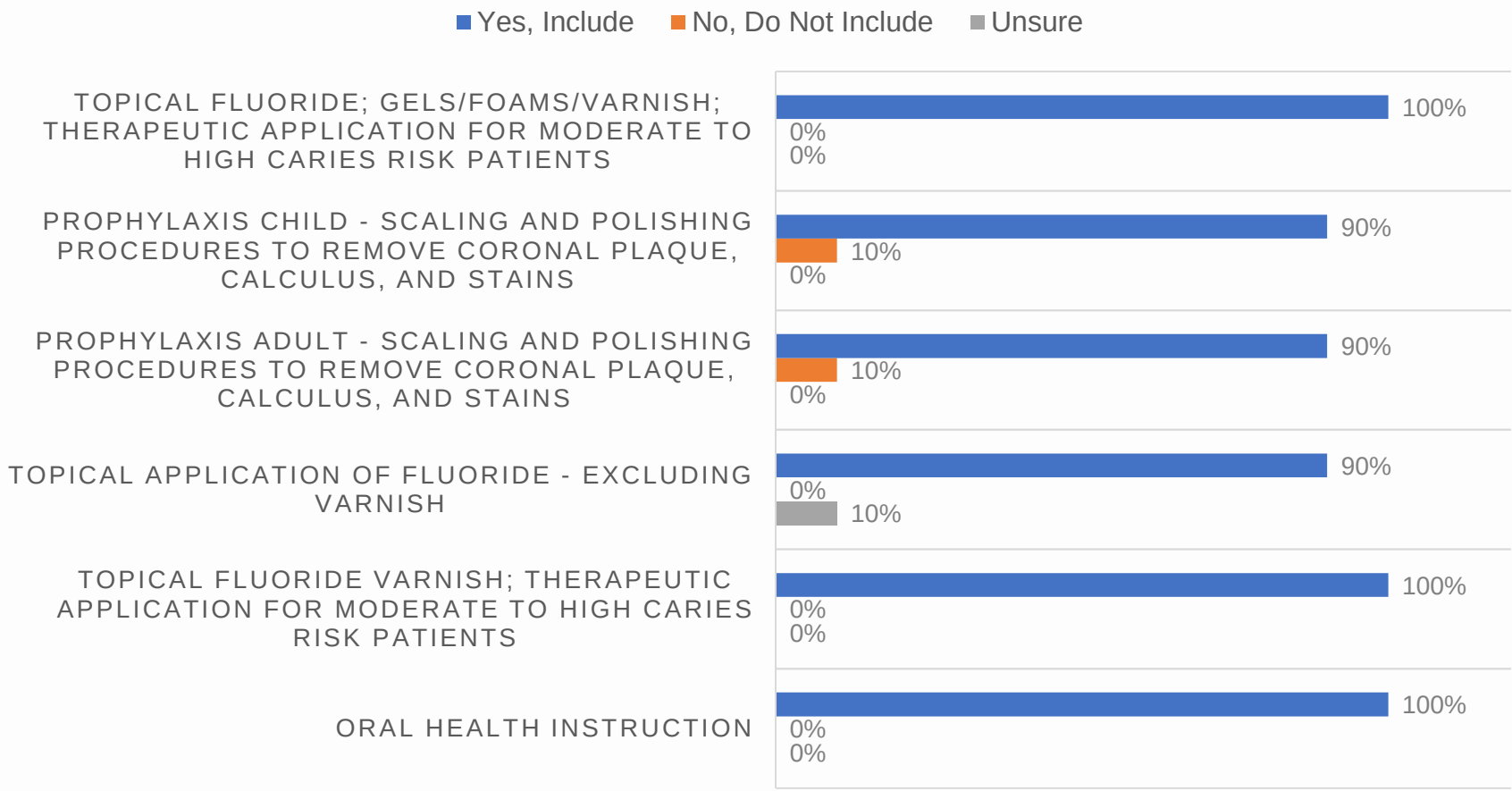
Should the DHAT Scope of Practice include Preventive Procedures?



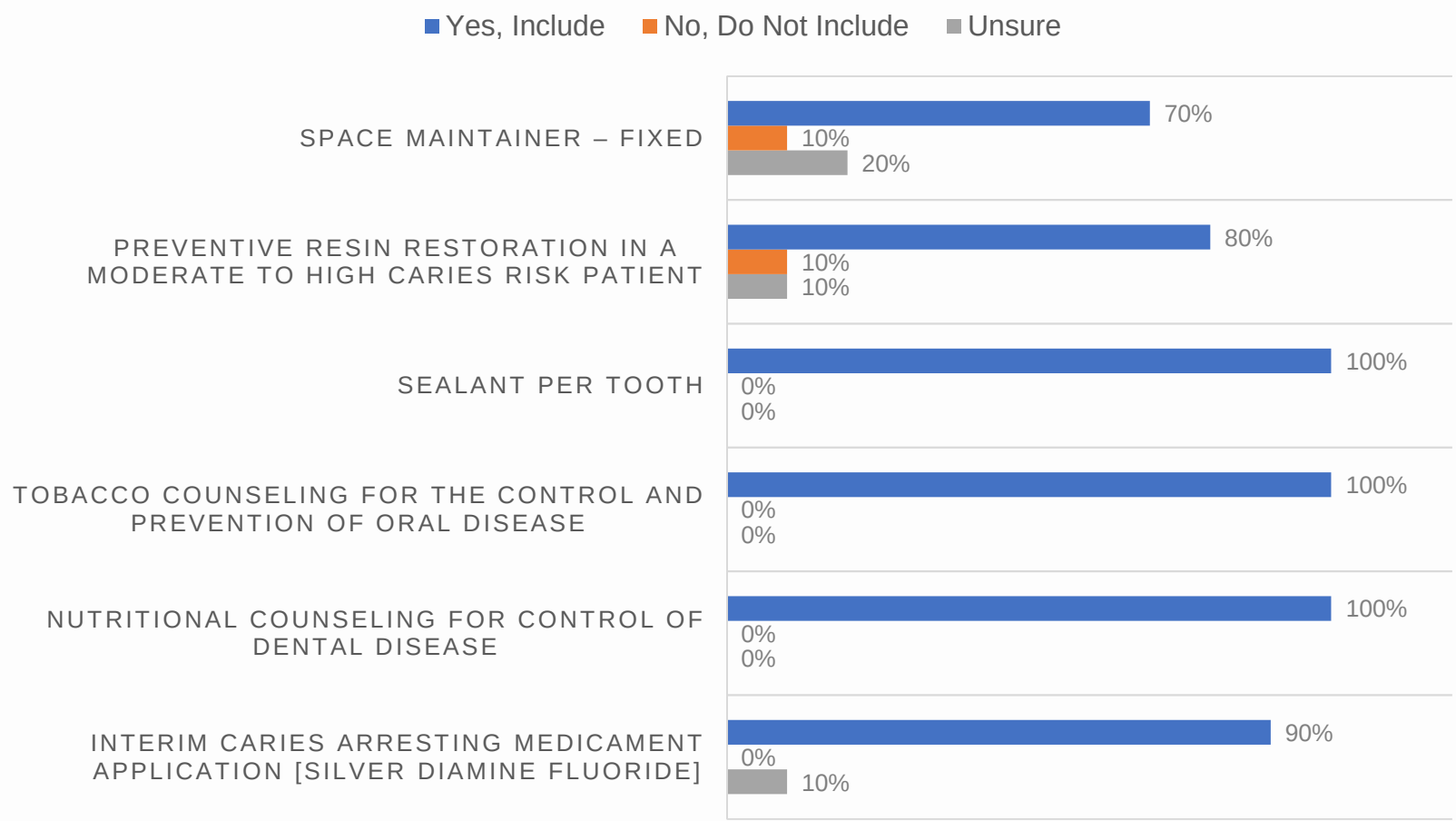
How important do you feel it is that the DHAT Scope of Practice include Preventive Procedures?



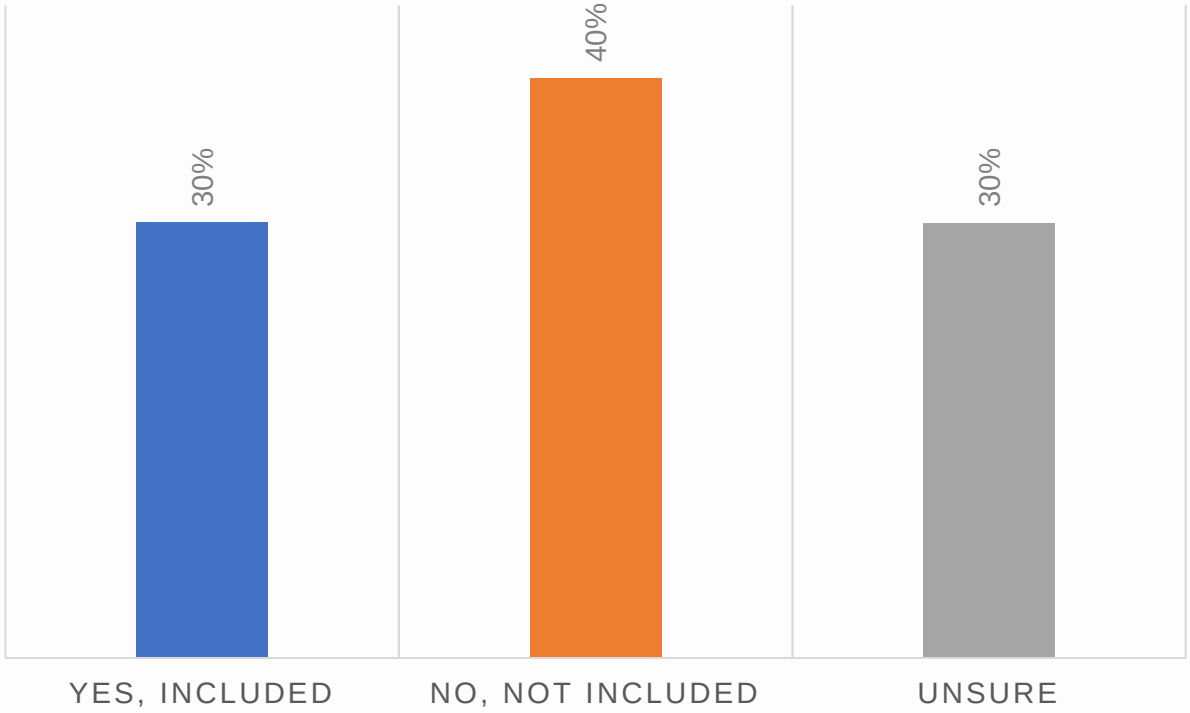
Preventive Procedures Part 1



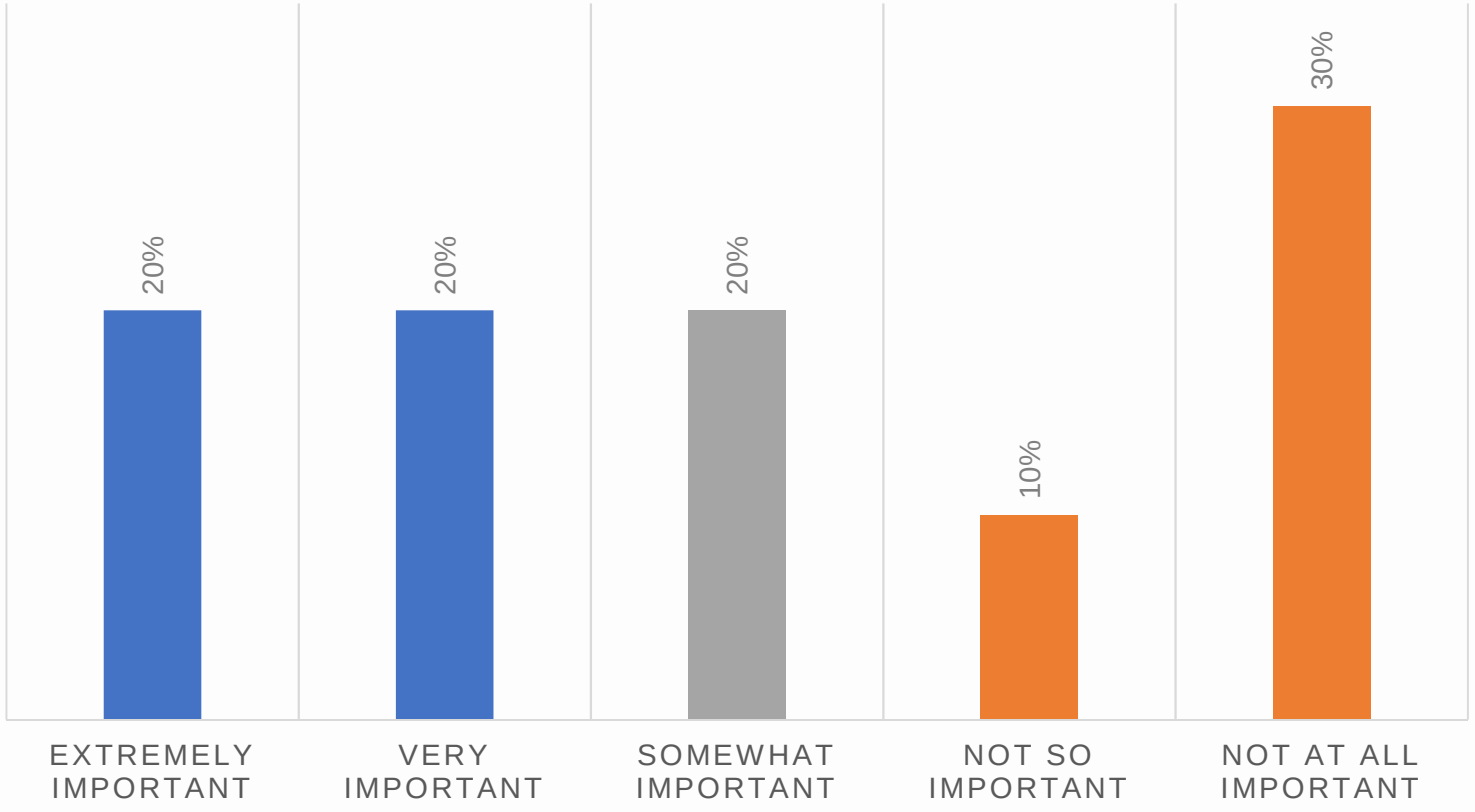
Preventive Procedures Part 2



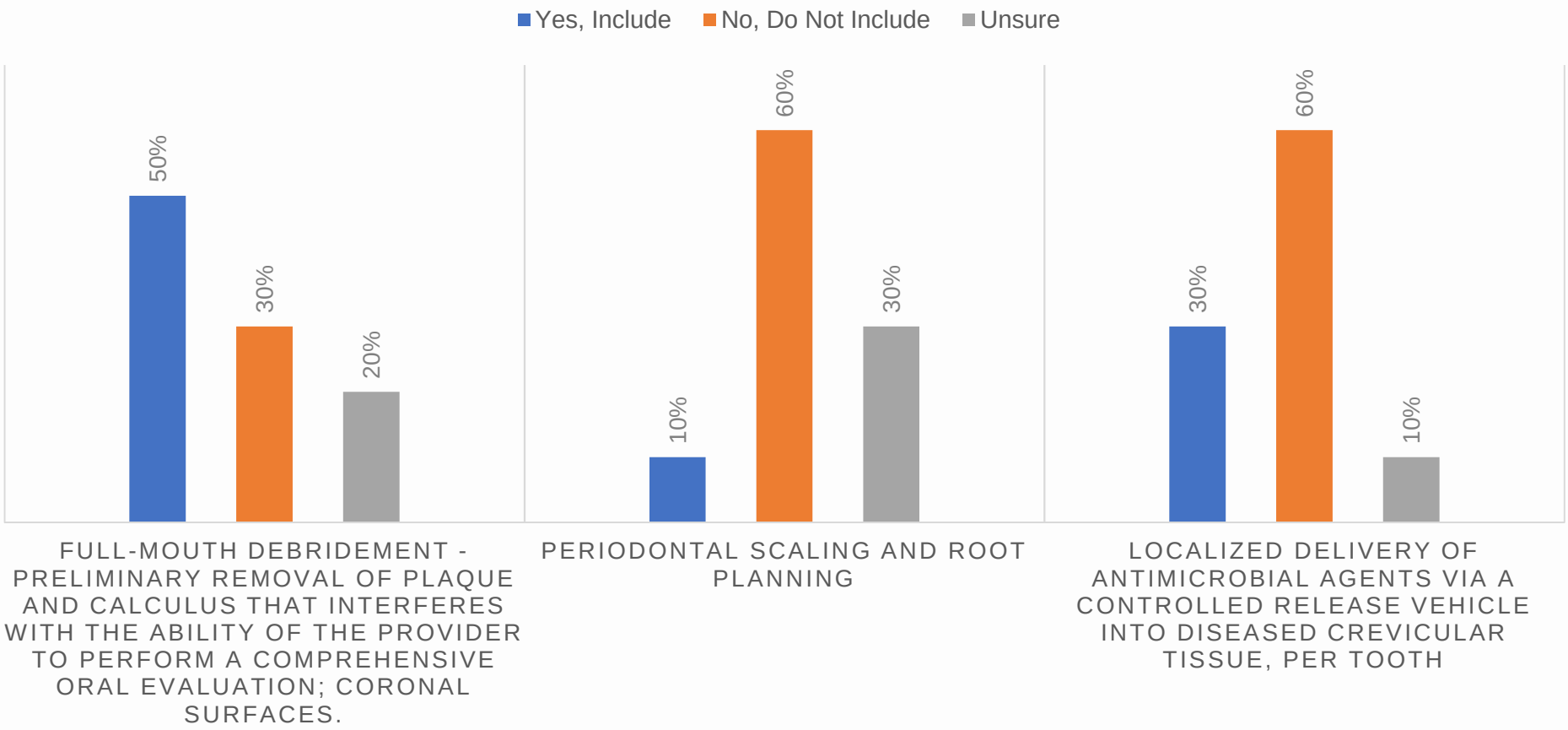
Should the DHAT Scope of Practice include Periodontal Procedures?



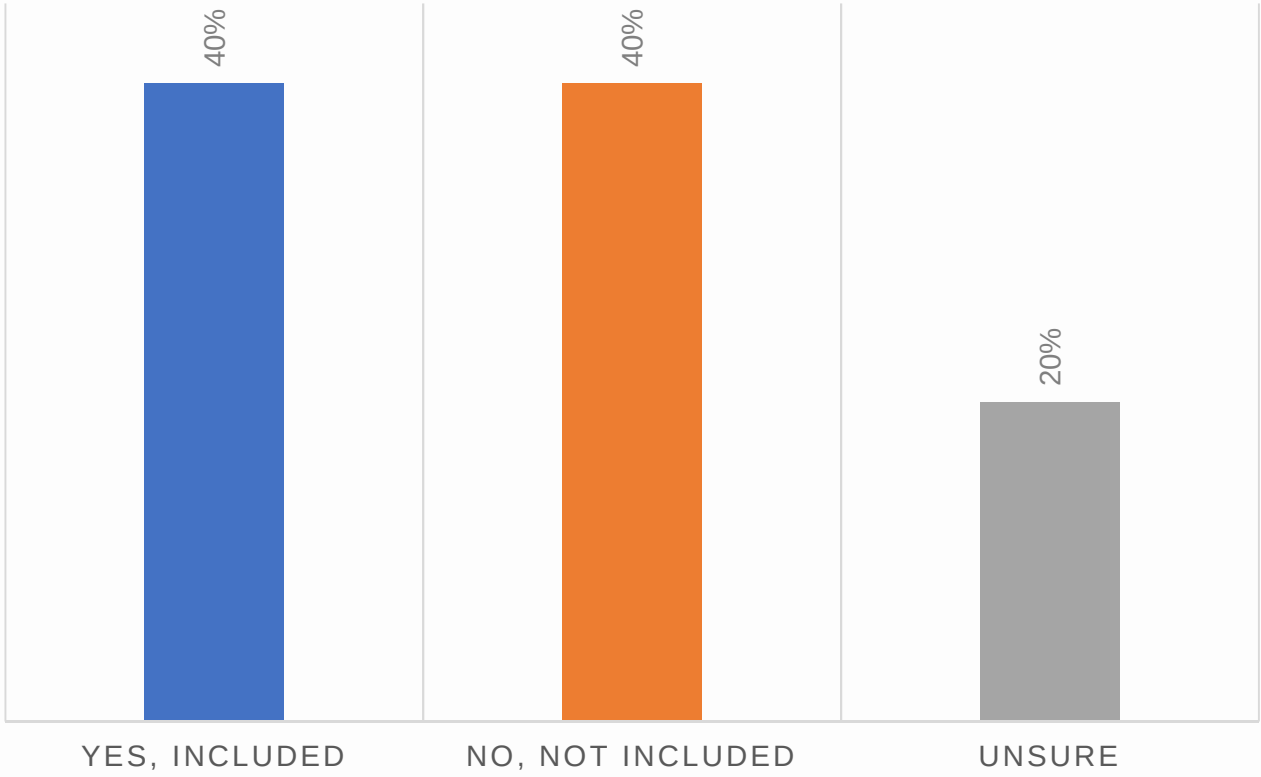
How important do you feel it is that the DHAT Scope of Practice include Periodontal Procedures?



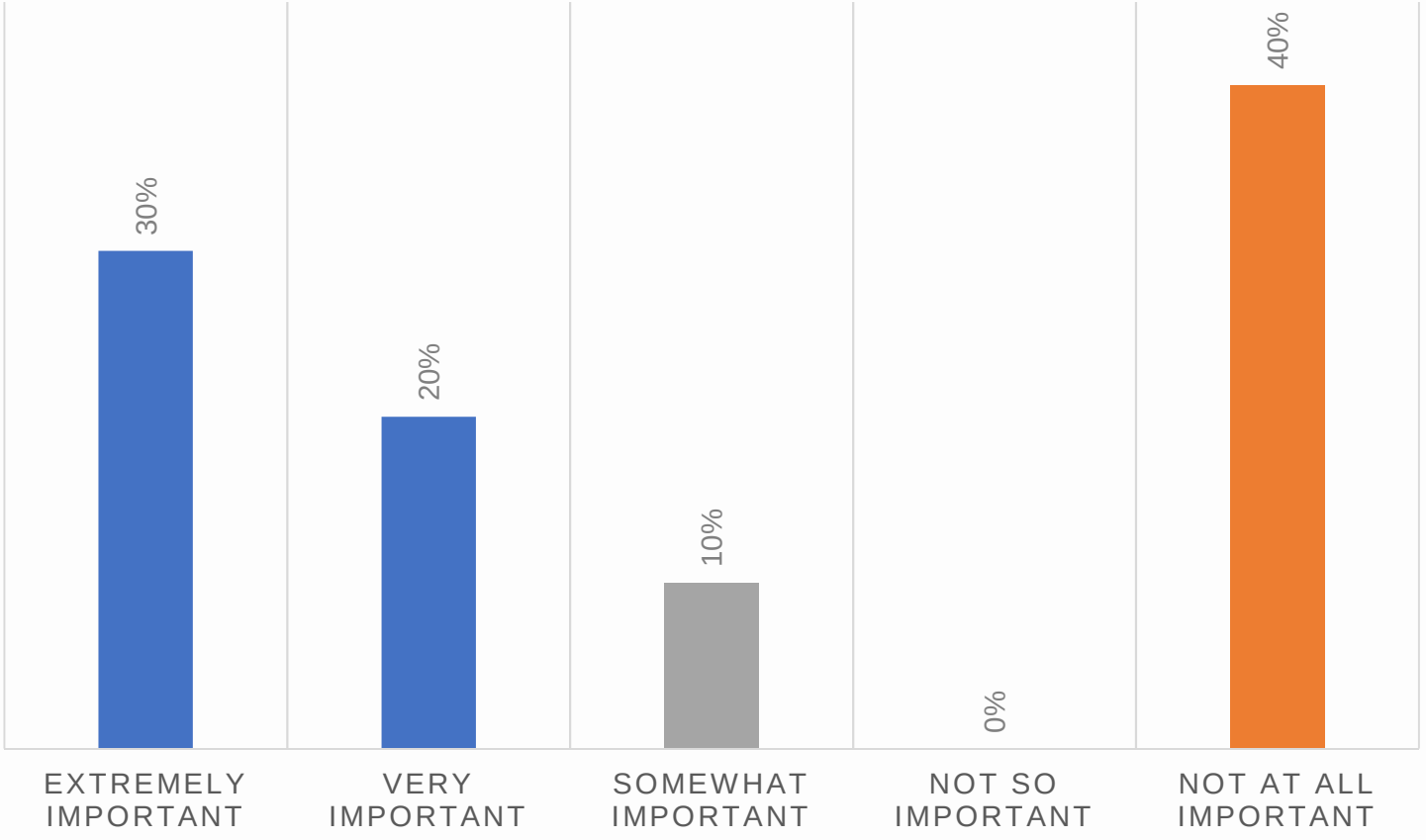
Periodontal Procedures



Should the DHAT Scope of Practice include Restorative/Endodontic Procedures?



How important do you feel it is that the DHAT Scope of Practice include Restorative/Endodontic Procedures?

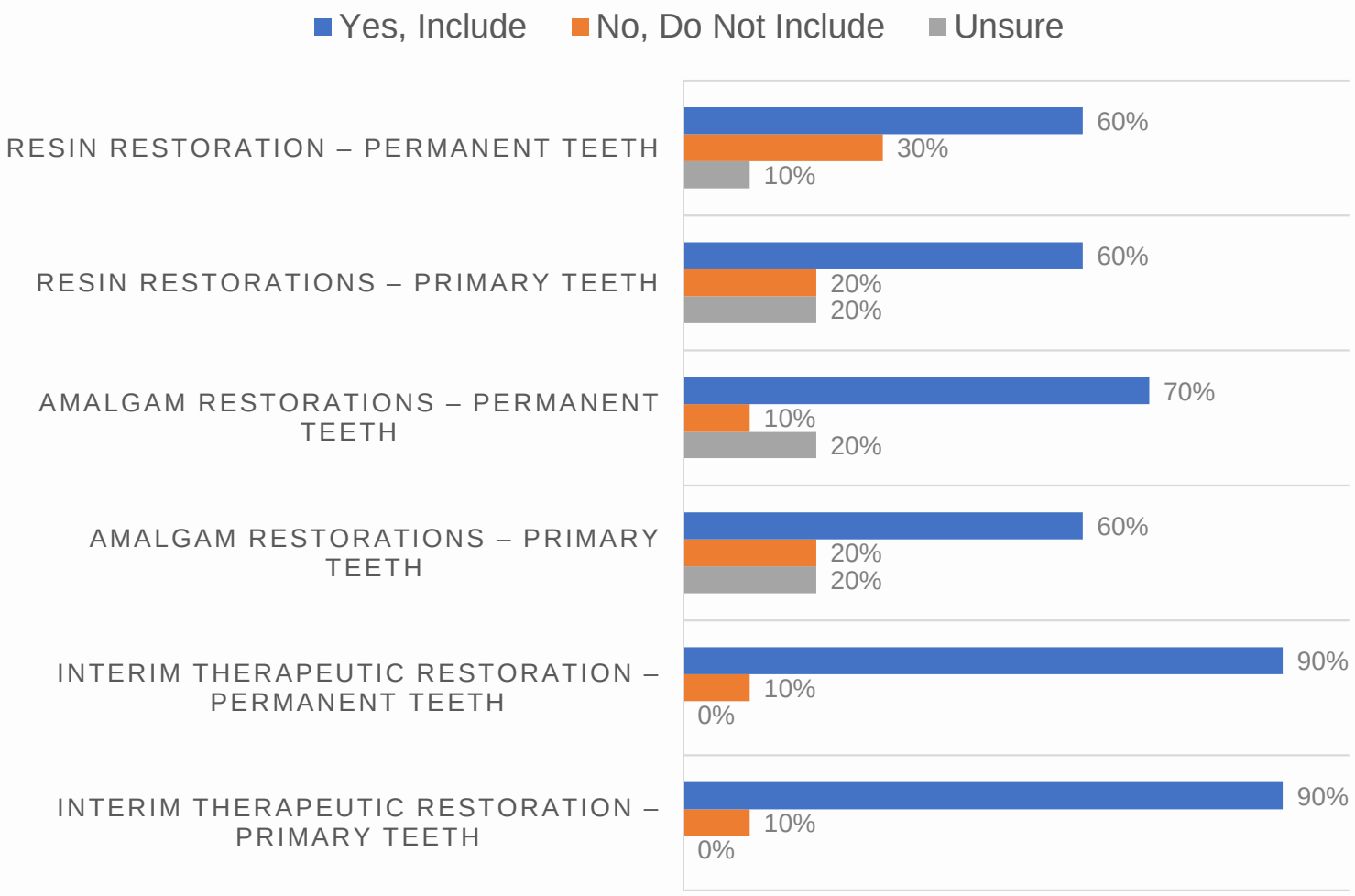


Representative Comments

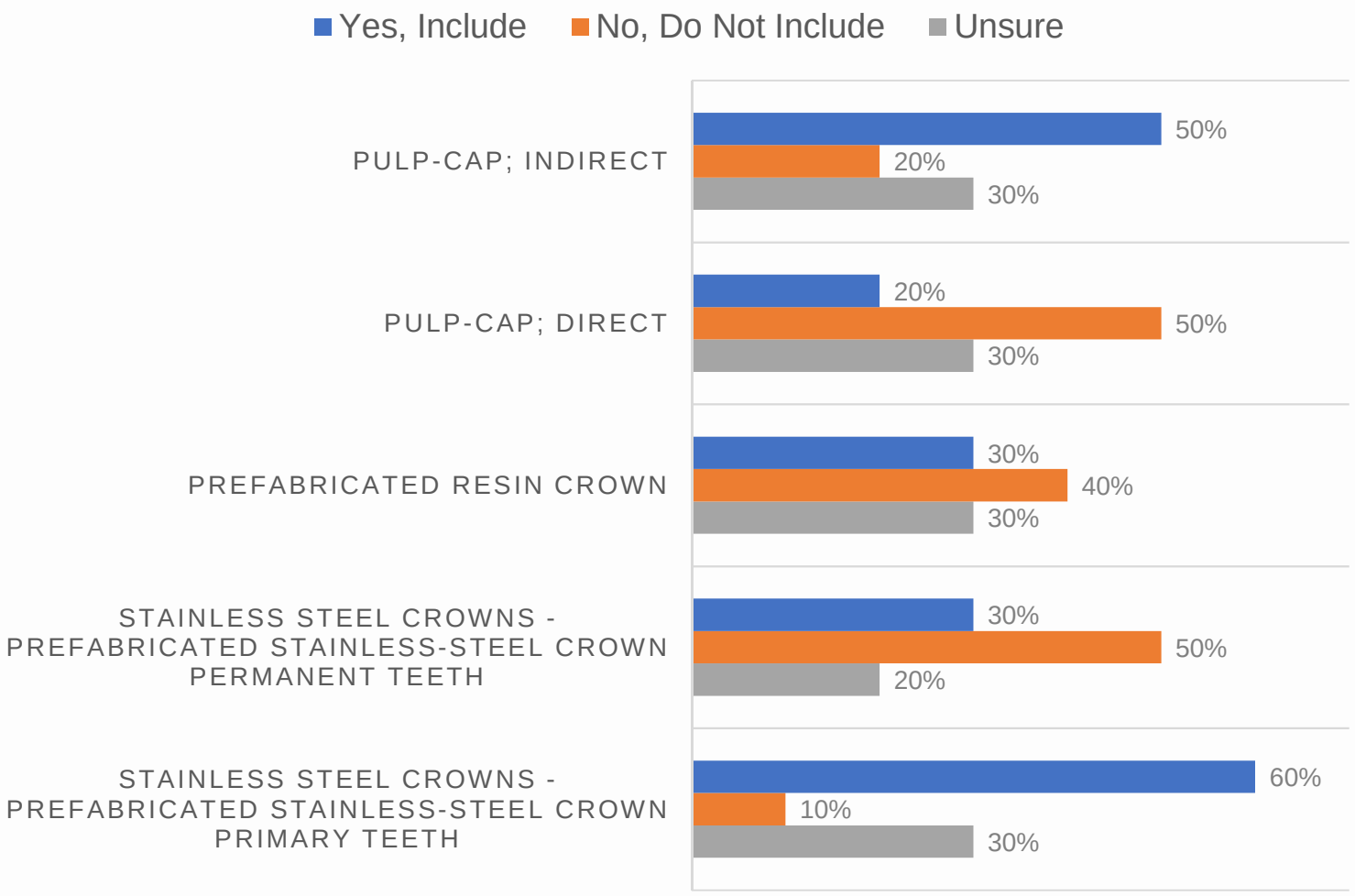
- “I think fillings and pulpotomies should be included. Not root canals or more complex endodontic procedures. This is important to deliver a full complement of services to patients that the DHAT serves. Otherwise, we are not providing care in their community and they will continue to not have access to care or have to travel to obtain care.”
- “DHATs may be capable of performing some restorative procedures but endodontic procedures are extremely technique sensitive and require advanced training for decision making throughout the procedure.”
- “These items are important to oral health and knowing how to perform these procedures could alleviate emergent, acute concerns and also help provide long-term relief.”

- Take away:
  - “Restorative and endodontic procedures should not be included together.”

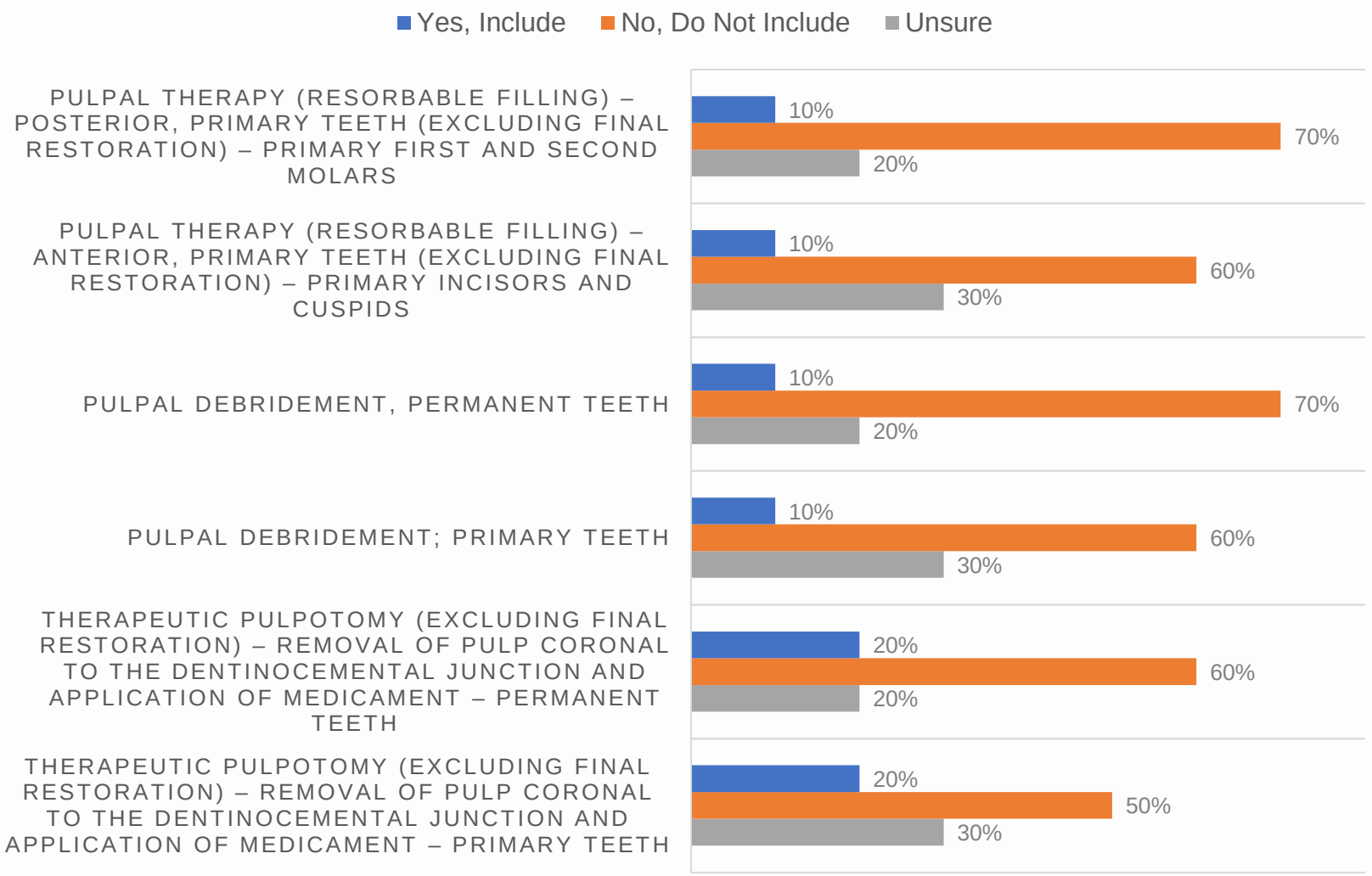
Restorative/Endodontic Procedures Part 1



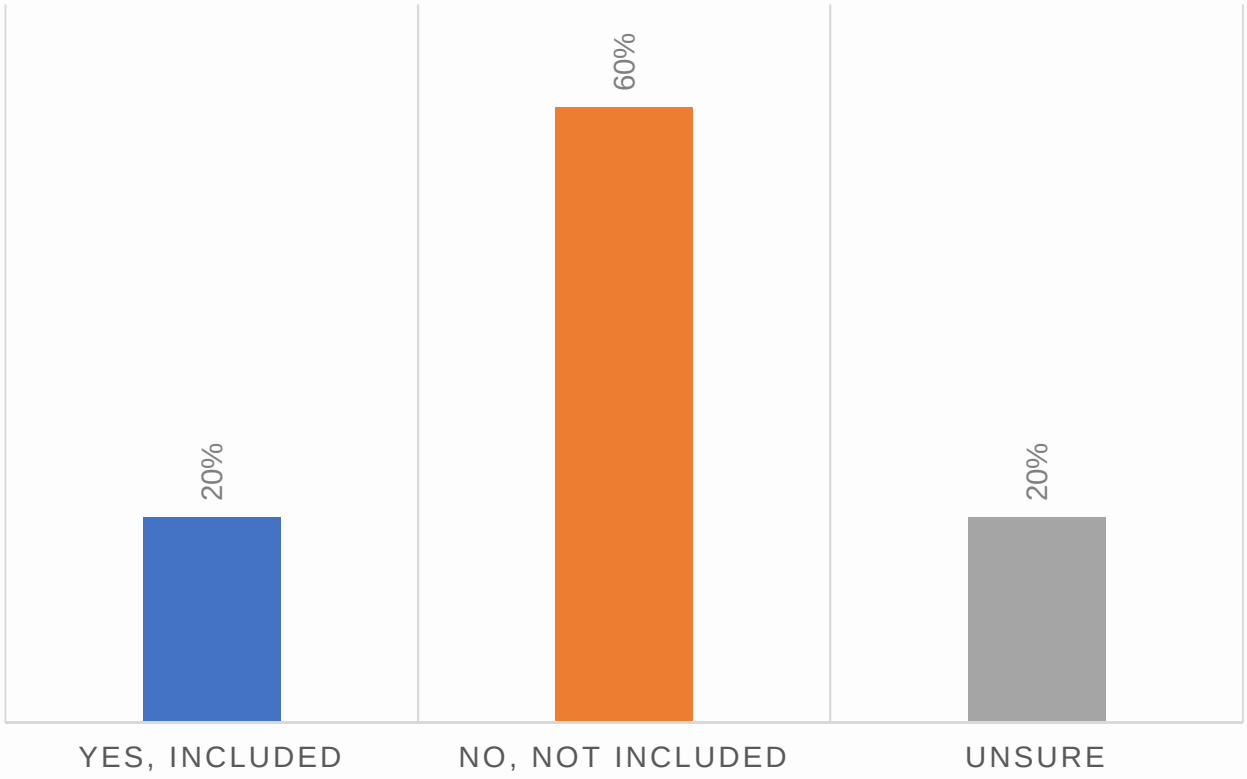
Restorative/Endodontic Procedures Part 2



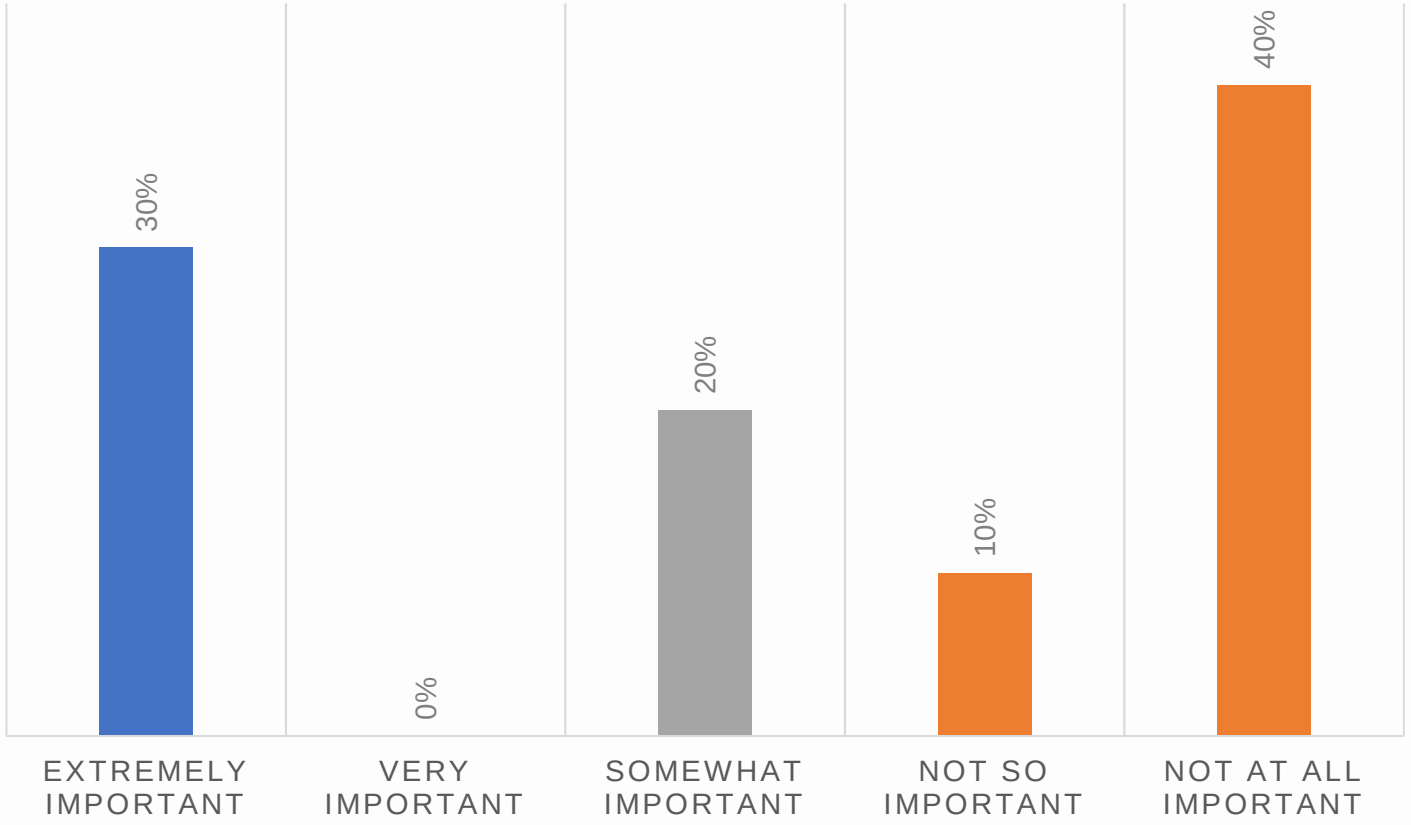
Restorative/Endodontic Procedures Part 3



Should the DHAT Scope of Practice include Surgical Procedures?



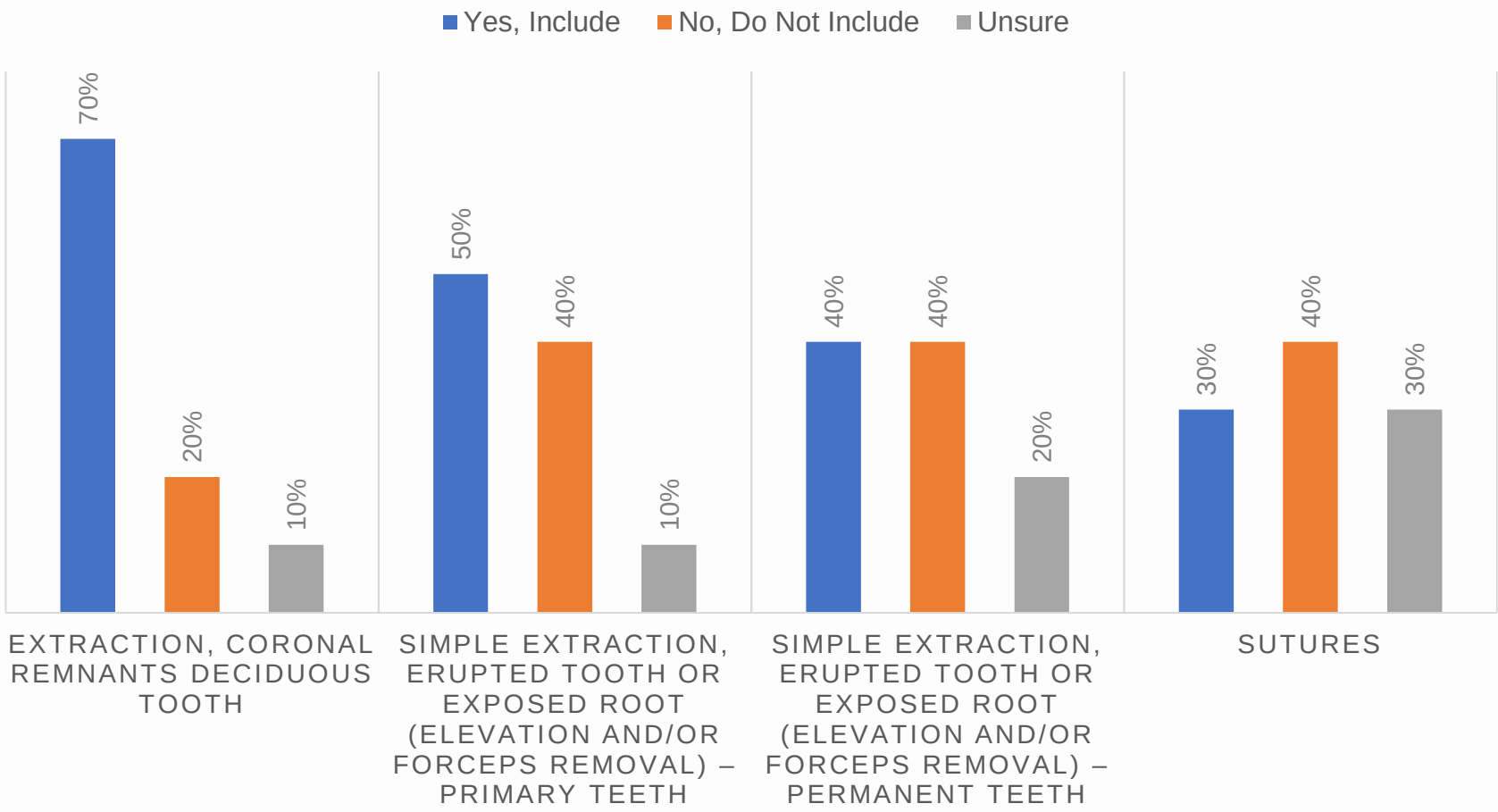
How important do you feel it is that the DHAT Scope of Practice include Surgical Procedures?



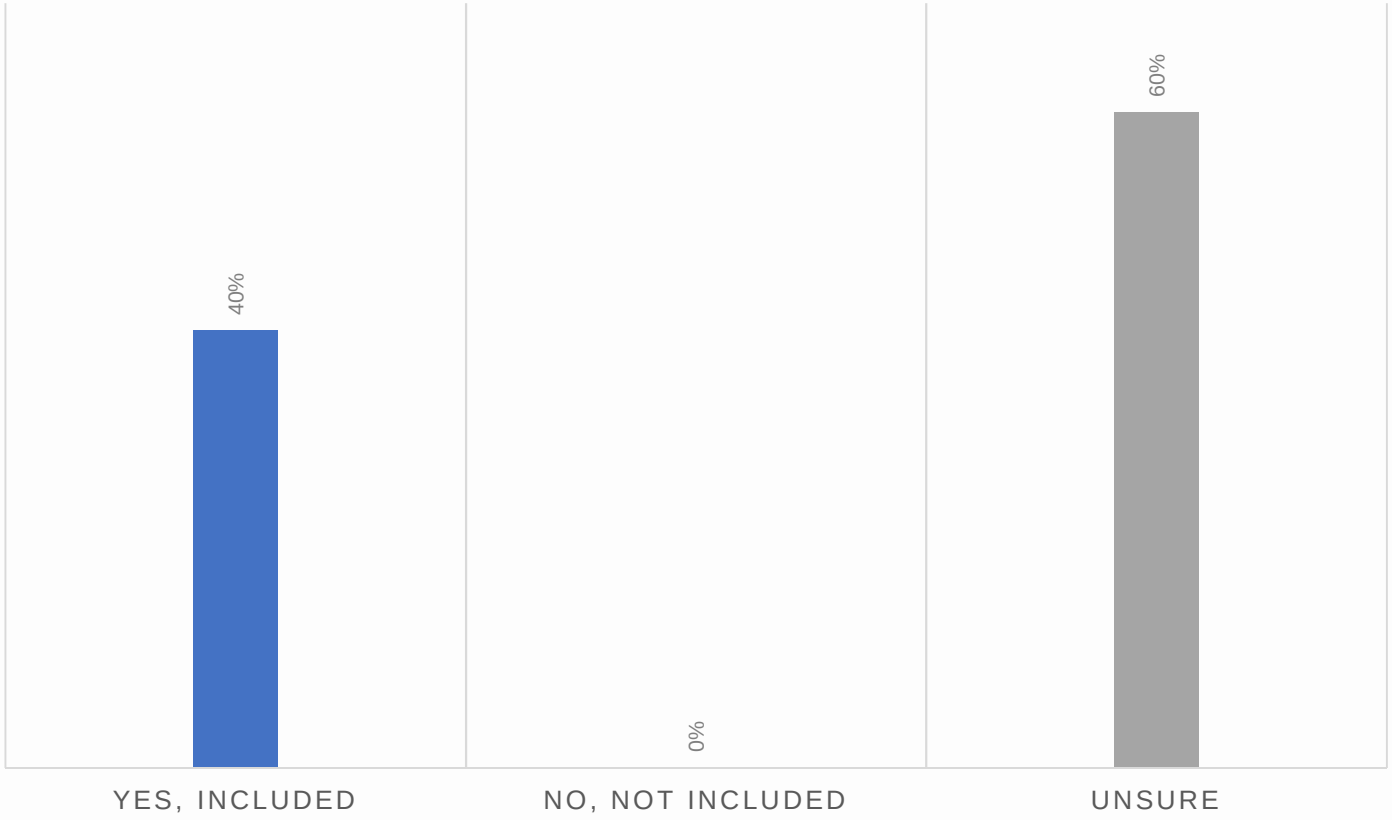
Representative Comments

- “I have not seen good evidence from the project to warrant including surgical procedures.”
- “I think it's somewhat important but I don't know if there's enough training or supervising dentist involvement/supervision in this procedure”
- “With strict criteria to make sure their scope is on the conservative side of surgical procedures.”
- “Not enough training”

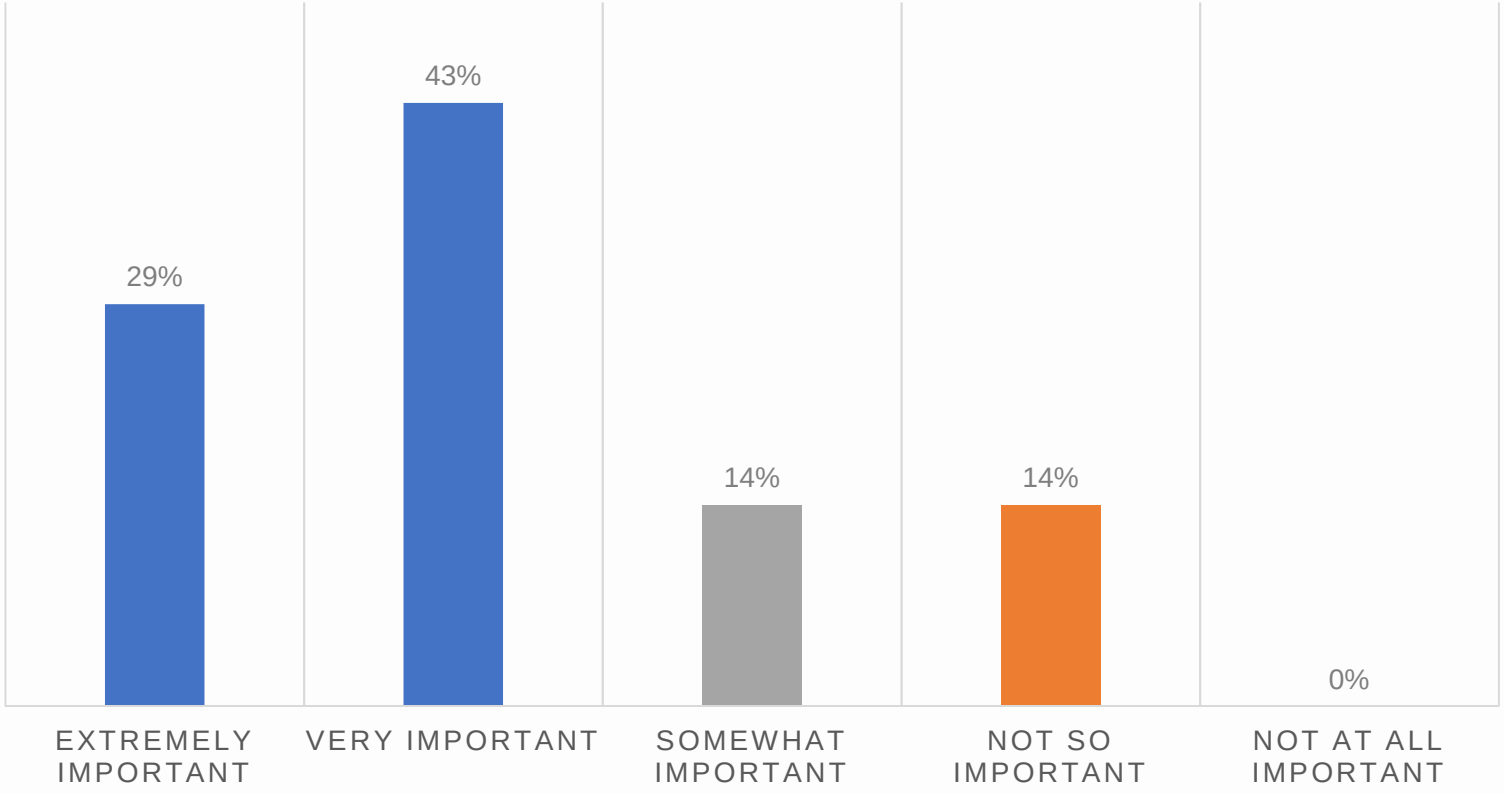
Surgical Procedures



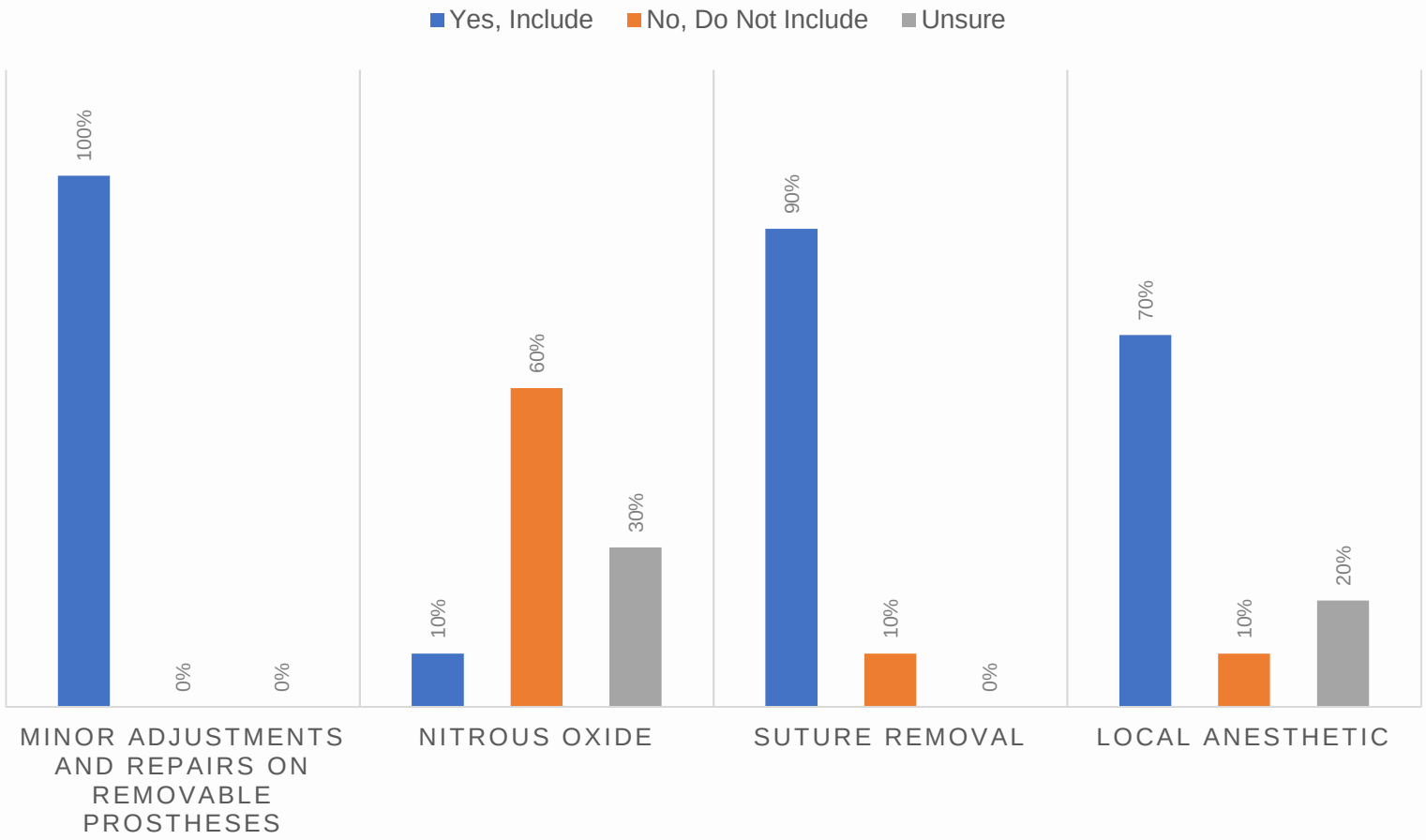
Should the DHAT Scope of Practice include Adjunctive Procedures?



How important do you feel it is that the DHAT Scope of Practice include Adjunctive Procedures?



Adjunctive Procedures



Comments

- “It may be important to consider training and certifying DHATs to provide nitrous oxide. As one of the stated purposes of the DPP 100 is to reduce fear in tribal populations to receive timely dental care, I am concerned that psychological trauma may inadvertently occur if procedures are performed on pediatric populations without the benefit of nitrous oxide to attempt to reduce situational anxiety. Dental procedures are painful. Dental anxiety is a very important factor affecting the efficacy of prevention, diagnosis and treatment of dental diseases, both in patients in the developmental age and in young adults. As a pediatric dentist, I can attest to the reality that children who experience a painful and traumatic dental procedure often require more advanced and expensive behavior management approaches (such as sedation that must be performed by a specially trained professional) to complete necessary treatment. In addition, many children who experience traumatic dental experiences grow up to become adults with dental phobia who avoid necessary medical and dental care (this is supported by research).”

In Summary

- Patient Assessment and Evaluation
  - Consensus: patient assessment and evaluation
  - Group split on diagnosis abilities
- Preventive Procedures
  - Consensus: Preventive procedures are an important part of the DHAT scope of practice
- Restorative/Endodontic Procedures
  - Group split, need to address as separate categories
- Surgical Procedures
  - Consensus: Extraction of coronal remnants of deciduous tooth
  - Group split on others
- Adjunctive Procedures
  - Nitrous oxide?

NEXT STEPS

- Next survey is coming soon
  - We will revisit this subject area again after a sufficient number of chart reviews have been completed
- Please complete by November 15th

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program

Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Ste 370
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
Fax: 971-673-0231
healthoregon.org/dpp

Dental Pilot Project Program: Site Visit Report

The Dental Pilot Project Program allows authorized organizations to test, demonstrate and evaluate new or expanded roles for oral healthcare professionals before changes in licensing laws are made by the Oregon State Legislature. The intent of the project is to prove quality of care provided, trainee competency and patient safety in addition to the larger goals of access to care, cost effectiveness and the efficacy of introducing a new workforce model.

The Oregon Health Authority (OHA) is responsible for monitoring approved pilot projects and ascertaining the progress of each project in meeting its stated objectives and complying with program statutes and regulations. The primary role of OHA is monitoring for patient safety. Secondarily, OHA shall evaluate approved projects and the evaluation shall include, but is not limited to, reviewing progress reports and conducting site visits.

Site visits are conducted with the primary purpose of health and safety monitoring and surveillance and to determine compliance with administrative rules. Site visits are conducted using both qualitative and quantitative methodological approaches. They primarily consist of participant interviews and clinical records review.

Project Name & ID Number:	Dental Pilot Project #100, “Oregon Tribes Dental Health Aide Therapist Pilot Project.”
Project Sponsor:	Northwest Portland Area Indian Health Board (NPAIHB)
Date of Site Visit:	February 26, 2018
Site Location:	Native American Rehabilitation Association (NARA) Dental Clinic 12750 S.E. Stark St. Building E Portland, OR 97233
Primary Contact Name and Title:	Christina Peters, Project Director

Pass or Fail Site Visit

Per Oregon Administrative Rule (OAR) 333-010-0455, a report of findings and an indication of pass or fail for site visits shall be provided to the project director in written format within 60 calendar days following a site visit. The Oregon Health Authority has determined that Dental Pilot Project #100 is in non-compliance with the requirements set forth in OARs 333-010-0400 through 333-010-0470, and therefore has **failed** the site visit. Please see Appendix A for a copy of the preliminary report of findings.

The preliminary report reflects the OHA Dental Pilot Project Program's findings at the time of the site visit. Any improvements or changes made subsequent to a site visit may be described and documented in the program's response to the preliminary draft report, which becomes part of OHA's formal record of the pilot project. Such improvements or changes represent progress made by the project sponsor and are considered by OHA, although the preliminary site visit report and determination of passage or failure is not revised to reflect these changes.

As a result of the preliminary report, a Stipulated Agreement was signed on April 3, 2018 between the Oregon Health Authority (OHA) and the Northwest Portland Area Indian Health Board (NPAIHB) to take corrective action on some of the findings of the site visit.

Objectives of the Site Visit:	Methodology:
1. Determination that adequate patient safeguards are being utilized. 2. Validation that the project is complying with the approved or amended application **3.** Compliance with OARs 333-010-0400 – 333-010-0470.	1. Interviews with project participants 2. Clinical records review

Attendees:

Name	Title	Organization
Bruce Austin, DMD	Statewide Dental Director	OHA
Kelly Hansen	Research Analyst/Oral Health Program	OHA
Sarah Kowalski, RDH, MS	Dental Pilot Project Program Coordinator	OHA
Christina Peters	Project Director	NPAIHB
Pam Johnson	Project Manager	NPAIHB
Kelli Swanson Jaecks, RDH, MS	Dental Hygienist	OHA Dental Pilot Project Advisory Committee
Richie Kohli, BDS, MS, DPH	Dentist	OHA Dental Pilot Project Advisory Committee
Paula Hendrix	Dental Hygienist	OHA Dental Pilot Project Advisory Committee
Caroline Tydings, MPH	Administrative Support	OHA

Project Sponsor Representatives and Interviewees:

Name	Title	Organization
Azma Ahmed, DDS	Dental Director	NARA Dental Clinic
Sally Beach, RDH	Dental Hygienist	NARA Dental Clinic
April Geisler	DHAT Project Coordinator	NARA Dental Clinic
Allyson Lecatsas, MS	Health Director	NARA
Christina Peters	Project Director	NPAIHB
Pam Johnson	Project Manager	NPAIHB
Ben Steward	DHAT Trainee	NARA Dental Clinic
Michael Watkins	Chief Operating Officer	NARA

Advisory Committee Record Reviewers:

Name	Title	Organization
Bruce Austin, DMD	Statewide Dental Director	Oregon Health Authority
Len Barozzini, DDS	Director of Dental Services	Multnomah County
Jennifer Clemens, DMD, MPH	Dental Director	Capitol Dental/Smile Keepers
Richie Kohli, BDS, MS, DPH	Dentist, Assistant Professor	OHSU
Caroline Muckerheide, DDS	Pediatric Dentist	Private Practice
Brandon Schwindt, DMD	Pediatric Dentist	Private Practice

Clinical Records Review:
The purpose of the chart review is to allow Advisory Committee members who are subject-matter experts the opportunity to review and make assessments and determinations of the quality of care provided by the DHAT trainee within the constraints and limitations of a chart auditing review. Clinical records were selected from quarterly reporting data using a stratified random sampling scheme to ensure that all procedure categories were included.

Twenty-three unique records were reviewed, representing 50% of patients reported being seen by the DHAT through December 2017. Records were then reviewed by licensed clinical providers for objective and subjective measures of patient safety and quality of care. Chart reviews are inherently subjective in nature, and many of the elements characterized within the chart review are beyond the regulatory scope of the Authority for purposes of this report. Additionally, it is not appropriate to draw larger conclusions about DHAT quality of care from the extremely small sample size involved in one site visit. Each site visit includes a sample of patient record reviews that will be pooled for analysis in the final report and the end of the pilot project period.

This report is primarily focused on objective measures of patient safety, administrative record keeping and compliance within the approved scope of practice for the pilot project. At the conclusion of the pilot project, the Authority will publish a full report of findings as part of its overall evaluation and programmatic responsibilities.

Summary of Findings:

- There were no instances of patient harm that were revealed during the site visit.
- There were no adverse events reported to the Authority by the project sponsor as required under OAR 333-010-0435.
- Integration of a new type of provider is not expected to be a seamless process. Challenges and lessons learned have been provided on a quarterly basis by the project sponsor.
- The site visit illustrated significant gaps in communications between the project sponsor and the pilot sites, as well as between OHA and the project sponsor.
- New protocols have been adopted to remove potential barriers to communication including a bi-weekly phone call between the project sponsor and OHA program staff. Subsequent conversations have illustrated significant improvements in the project management protocols by the project sponsor.
- NPAIHB has implemented a monthly conference call between project sites clinical staff, clinic leadership, NPAIHB staff and DHAT coordinators.
- NPAIHB submitted an amended version of their original application to OHA for review. The amended application incorporated approved modifications to the original application. The amended application is under review for accuracy.

- Preliminary findings by OHA included a finding that NPAIHB was not in compliance with the Authority's understanding of Appendix C, intra-oral image and radiographic collection requirements, in the approved Evaluation and Monitoring Plan. Conflicting statements within the approved plan have created confusion regarding when the intra-oral imaging process was to go into effect. Due to the misunderstanding, OHA has not cited the project specifically for this issue in the final report. Since adequate patient safety and procedural quality cannot be determined without proper image documentation, OHA will require the project to adhere to the language on page one of the Appendix C document. From April 3, 2018 and on forward, intra-oral images will be taken at all required points of the procedure as outlined in Appendix C. Images are only required for irreversible procedures. A copy of Appendix C can be found in the appendix to this report under Appendix B.

- Chart reviewers indicated that charts were difficult to follow. In one instance, it was unclear to reviewers on what tooth a stainless-steel crown was placed and irregular entry of CDT codes was noted. Clinical photos were not consistently present and clearly labeled for irreversible procedures. Multiple reviewers commented that diagnosis, tooth surface, medication and allergy changes, reason for tooth non-restorability and other clinical findings were unclear based on progress notes. Additionally, several reviewers disagreed with documentation of diagnoses based on clinical findings.

- The pilot site has failed to maintain accurate patient records in accordance with OAR 818-012-0070. Examples include incorrectly recording treatment rendered, incorrectly coding for one procedure when a different procedure was performed, and not recording patient weight when administering analgesics to minors.

- In one instance, the trainee completed an extraction that was coded as D7210, which falls outside the scope of DHAT practice. D7210 is defined as surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Project managers indicated that this was coded in error, which indicates a failure to accurately document patient treatment.

- The preliminary report of findings required the project sponsor to respond to specific areas of concern, and NPAIHB responded by the due date indicated.

- A Stipulated Agreement was signed on April 3, 2018 between the Oregon Health Authority and the Northwest Portland Area Indian Health Board (NPAIHB). The agreement required NPAIHB to hire or contract with an Oregon-licensed dentist actively practicing in the State of Oregon to provide clinical technical expertise and project oversight, no later than June 21, 2018. On May 17, 2018, NPAIHB entered into a contract with Dr. Gita Yitta, a general dentist. Dr. Yitta is responsible for developing the standing operating procedures for use at the pilot sites, conducting trainings at pilot sites, and providing clinical dental project oversight and technical expertise as needed.

- OHA will conduct a follow-up site visit on September 20, 2018 to assure that the corrective actions have been implemented.

Report of Findings

333-010-0410: Dental Pilot Projects: Minimum Standards A dental pilot project shall: (1) Provide for patient safety as follows: (a) Provide treatment which does not expose a patient to risk of harm when equivalent or better treatment with less risk to the patient is available;	**ID Number** **MS1A**

Program Requirements	**Met** ☐	**Not Met** ☒

Observations and/or Identified Deficiencies:	*Rule 333-010-0410 is not met as evidenced by*: Based on interviews with project participants and review of chart records, it was determined that the trainee practiced outside the scope of approved practice. Review of the chart records indicate that on three separate occasions the trainee completed extractions or attempted to complete extractions, which are outside of the trainees approved scope of practice as outlined in the approved application: Project trainees are only authorized to complete simple uncomplicated extractions and only in a case of a medical emergency. Each extraction fell outside of the approved scope of practice as none of them were considered a medical emergency. In the 23 submitted cases, 8 charts included a total of 10 extraction procedures. In two of these instances, the procedure became surgical in nature in order to complete the procedure. DHAT trainees are not authorized to complete surgical extractions. In the one instance, the DHAT trainee was authorized to extract teeth #15 and #16. Chart notes state that after the teeth were extracted by the DHAT trainee, buccal bone was attached to the extracted teeth. The supervising dentist was required to take over the procedure and used a bone file to reshape the bone in the extraction site and suture the area. OHA is concerned that the DHAT trainee was authorized to complete procedures that fell outside of their scope of practice according to the approved project application. DHAT trainees do not have the scope of practice to cut soft tissue or resolve extractions that become surgical in nature. It is not uncommon for buccal bone to become partially removed and attached to extracted teeth. The primary concern is that the DHAT trainee does not possess the scope of practice to address an issue that requires the use of a bone file to smooth the socket. There are discrepancies on whether suturing is part of a DHAT scope of practice and curriculum.

	The DHAT trainee acted appropriately in conferring immediately with his supervising dentist. There is concern that third-molar extractions may be more problematic and are more likely to fall out of scope for a DHAT trainee. OHA has not limited DHAT trainees in the pilot project to extractions for particular teeth. Continued monitoring and further site visits will be conducted to evaluate the safety of allowing DHAT trainees to complete extractions of third-molars.
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB must only allow a DHAT trainee to perform extractions under the following conditions: 1. All extractions must be performed under the indirect supervision of the DHAT trainee's supervising dentist. Indirect supervision is defined under ORS 679.010 as supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. 2. For primary and permanent tooth extractions, the DHAT trainee will first receive and document authorization from the supervising dentist. 3. For primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal. 4. For permanent teeth, the trainee may perform non-surgical extractions of periodontally diseased teeth with evidence of bone loss and +2 degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal. 5. Document all information related to extractions as specified above along with the criteria required for the project evaluation which include a recent radiograph of the tooth to be extracted, a pre-operative intra-oral image of the tooth to be extracted, and a post-operative image of the extracted tooth.
Required Next Steps	The project is required to clarify the scope of practice concerns around intra-oral suturing. The DHAT trainee indicated in their interview during the site visit that they are specifically taught that intra-oral suturing is outside of their scope of authorized practice. This was confirmed in statements by the supervising dentist. Each stated that DHAT's are not taught suturing in the training program and are prohibited from suturing. This is of concern as NPAIHB

	contradicts the statements of both the trainee and supervising dentist. NPAIHB provided information to OHA stating that DHAT's are in fact authorized to perform suturing and are taught this as part of their training. Clarification as to the contradicting statements is required. • NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. In response to the confusion regarding suturing and the DHAT scope of practice, NPAIHB indicated that they have completed a gap analysis to determine if the DHAT trainee, Mr. Steward, needs to receive additional training. The curriculum has changed since he completed his training in 2009. Please see Appendix C for more details. NPAIHB has confirmed that this training will take place in September 2018.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority has approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. NPAIHB requested specific clinical criteria that must be documented in the chart prior to the dentist authorizing the procedure. OHA consulted with members of the Advisory Committee to recommend specific clinical criteria which may indicate that the tooth recommended for extraction by the DHAT trainee is part of their approved scope of practice as a simple and uncomplicated extraction include the following: • For primary teeth, chart notes and documentation must indicate the diagnosis and degree of mobility in addition to other supporting diagnostic information including presence of purulence (suppuration) and other supporting diagnostic criteria including degree of odontaglia. All diagnostic radiographic and photographic documentation must be documented in the chart

	record. The DHAT trainee will not extract teeth that are ankylosed. Chart notes, including radiographic images and intra-oral images, must illustrate that the tooth is erupted, not impacted, not fractured below the gumline, not decayed to the gumline, and does not require sectioning for removal. In addition, chart notes must illustrate the absence of associated sepsis, facial swelling, trismus or dysphagia. Chart notes must indicate the absence of dilacerations of the root(s), no proximity to vital structures including maxillary sinus and inferior alveolar nerve, adequate clinical crown, no tori or other need for alveoplasty. Documentation must include any hemostasis required or other interventions. Documentation of post-operative instructions provided both verbally and in writing. Approved dental pilot projects are required to be in compliance with OARs 333-010-0400 through 333-010-0470. • For permanent teeth, chart notes must indicate percentage of bone loss, degree of mobility in addition to other supporting diagnostic information including probing depths, bleeding on probing, clinical attachment levels, presence and severity of gingival recession, presence of purulence (suppuration) in addition to other supporting diagnostic criteria including degree of odontalgia. Chart notes, including radiographic images and intra-oral images, must illustrate that the tooth is erupted, not impacted, not fractured below the gumline, not decayed to the gumline and does not require sectioning for removal. In addition, chart notes must illustrate the absence of associated sepsis, facial swelling, trismus or dysphagia. Chart notes must indicate the absence of dilacerations of the root(s), no proximity to vital structures including maxillary sinus and inferior alveolar nerve, adequate clinical crown, no tori or other need for alveoplasty. Documentation must include any hemostasis required or other interventions. Documentation of post-operative instructions provided both verbally and in writing. Approved dental pilot projects are required to be in compliance with OARs 333-010-0400 through 333-010-0470. Standard of care for non-surgical uncomplicated dental extractions must be followed by both the supervising dentist and the DHAT trainee. The DHAT trainee does not have the scope of practice to cut soft tissue or resolve extractions that become surgical in nature. While the DHAT trainee is required to complete non-surgical uncomplicated extractions under indirect or direct supervision, the extraction procedure authorized by the dentist must fall within the scope of approved practice for a DHAT trainee. To this end, DHAT trainees are expected to perform procedures independently from initiation of the treatment to completion both during preceptorship and upon receipt of standing orders. Intervention by the supervising dentist should be a rare occurrence. A root cause analysis should always be performed when the supervising dentist is required to

	intervene in all treatment cases that have been initiated by the DHAT trainee. Documentation of analysis results should be included in chart notes. NPAIHB has indicated that they are developing a template in their electronic health record software "Dentrix" to ensure that sufficient documentation is noted in the patient chart prior to treatment.
Name and title of individual responsible to implement CAP.	Gita Yitta, DMD NPAIHB Project Dental Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0410: Dental Pilot Projects: Minimum Standards A dental pilot project shall: (1) Provide for patient safety as follows: (b) Seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience;		**ID Number** **MS1B**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and/or Identified Deficiencies:	No deficiencies identified. Trainee immediately conferred with the supervising dentist in response to issues identified in ID Number MS1A.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0410: Dental Pilot Projects: Minimum Standards A dental pilot project shall: (1) Provide for patient safety as follows: (c) Provide or arrange for emergency treatment for a patient currently receiving treatment;		**ID Number** **MS1C**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and/or Identified Deficiencies:	No deficiencies identified. There were no instances of emergencies.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0410: Dental Pilot Projects: Minimum Standards A dental pilot project shall: (1) Provide for patient safety as follows: (d) Comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines;		**ID Number** **MS1D**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and/or Identified Deficiencies:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0410: Dental Pilot Projects: Minimum Standards A dental pilot project shall: (1) Provide for patient safety as follows: (f) Comply with the infection control procedures in OAR 818-012-0040		**ID Number** **MS1F**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and/or Identified Deficiencies:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0410: Dental Pilot Projects: Minimum Standards (3) Assure that trainees have achieved a minimal level of competence before they enter the employment/utilization phase;		**ID Number** **MS3**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and/or Identified Deficiencies:	No deficiencies identified. *Comments*: The DHAT trainee was under their preceptorship phase, as outlined in the approved and amended application. The supervising dentist is responsible for making assessments and determination of competency for the trainee's approved scope of practice. Monitoring records and chart records indicate that the supervising dentist supervised the DHAT trainee under direct supervision and made appropriate documentation in determining competency for the purposes of completing the trainee's preceptorship.	
Corrective Action	Not applicable.	

Required Next Steps	Not applicable.

333-010-0420: Dental Pilot Projects: Trainees (1) A dental pilot project must have a plan to inform trainees of their responsibilities and limitations under Oregon Laws 2011, chapter 716 and these rules.		**ID Number** **T1**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0420 is not met as evidenced by:* Based on interviews with project participants and review of chart records, it was determined that the DHAT trainees at the pilot sites provided services to patients who were under the use of nitrous oxide. Nitrous oxide was administered by the supervising dentist under direct supervision. On November 21, 2017, OHA informed the NPAIHB in writing of the following requirements: • 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 OARs 818-026-0000 through 818-026-0120. • 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. • If it is the intention of the project trainees to utilize nitrous oxide or work on patients under nitrous oxide, then the project must apply for a modification to their application. A copy of the administrative rules for nitrous oxide OARs 818-026-0000 through 818-026-0130 was supplied to the NPAIHB. On November 30, 2017, OHA received a memo from NPAIHB stating: "After further review of the Oregon Dental Practices Act, we agree that our DHATs are not, and will not be authorized to administer Nitrous Oxide, or work on patients that have received Nitrous Oxide from someone who has a valid Nitrous Oxide permit." NPAIHB failed to inform the project sites of the directives issued	

	by OHA. The DHAT trainees at both pilot sites provided services to patients who were under the use of nitrous oxide. Nitrous oxide is not part of the approved scope of practice as outlined in the approved and amended application.
Corrective Action	On February 28, 2018, OHA informed both the NPAIHB and clinic sites verbally of the concerns discovered in the oral interviews with the NARA clinicians. A commitment to cease procedures that are not allowed under the approved application was obtained from both the NPAIHB and the pilot site. On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will prohibit DHAT trainees from treating patients who are receiving nitrous oxide.
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. The current DHAT training curriculum does not include training or education on the administration of nitrous oxide. NPAIHB is exploring the option of applying for a modification to allow the DHAT trainee to administer nitrous oxide upon a modification approval from OHA.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority has approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • NPAIHB has implemented a monthly conference call between clinical staff, clinic leadership, NPAIHB staff and DHAT coordinators.

identified	• A communications plan between the NPAIHB project manager, NPAIHB project dental director and OHA has been implemented via a bi-weekly conference call.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0425: Dental Pilot Projects: Instructor and Supervisor Information A dental pilot project must have: (2) A plan to orient supervisors to their roles and responsibilities.	**ID Number** **S2**

Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒

Observations and Identified Deficiencies:	*Rule 333-010-0425 is not met as evidenced by*: Based on interviews with project participants and review of chart records, it was determined that the supervising dentists at the pilot sites were not made aware of the limitations on the scope of practice for the DHAT or of directives issued by OHA around nitrous oxide and extractions. For complete narrative, please see section ID Numbers MS1A and T1.
Corrective Action	See section ID Numbers MS1A and T1 for details.
Required Next Steps	See section ID Numbers MS1A and T1 for details.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	See section ID Numbers MS1A and T1 for details.
Timeline to implement the CAP.	See section ID Numbers MS1A and T1 for details.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence	See section ID Numbers MS1A and T1 for details.

of the specific deficiency identified	
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan approved by the Authority that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure: (a) Patient safety;		**ID Number** **EM2A**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No observed deficiencies. Comments: Trainee was under their preceptorship phase, as outlined in the approved and amended application. The supervising dentist is responsible for making assessments and determination of competency for the trainee's approved scope of practice. Monitoring records and chart records indicate that the supervising dentist supervised the DHAT trainee under direct supervision and made appropriate documentation in determining competency.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan approved by the Authority that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure: (b) Trainee competency;		**ID Number** **EM2B**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No deficiencies. *Comments*: Trainee was under their preceptorship phase, as outlined in the approved and amended application. The supervising dentist is responsible for making assessments	

	and determination of competency for the trainee's approved scope of practice. Monitoring records and chart records indicate that the supervising dentist supervised the DHAT trainee under direct supervision and made appropriate documentation in determining competency.
Corrective Action	Not applicable.
Required Next Steps	Not applicable.

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan approved by the Authority that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure: (c) Supervisor fulfillment of role and responsibilities;	**ID Number** **EM2C**

Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒

Observations and Identified Deficiencies:	*Rule 333-010-0425 is not met as evidenced by*: Based on interviews with project participants and review of chart records, it was determined that the supervising dentists at the pilot sites were not made aware of the limitations on the scope of practice for the DHAT or of directives issued by OHA around nitrous oxide and extractions. For complete narrative, please see section ID Numbers MS1A, T1 and S2.
Corrective Action	See section ID Numbers MS1A, T1 and S2 for details.
Required Next Steps	See section ID Numbers MS1A, T1 and S2 for details.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	See section ID Numbers MS1A, T1 and S2 for details.
Timeline to implement the CAP.	See section ID Numbers MS1A, T1 and S2 for details.
Description of monitoring procedure(s) that the project sponsor will perform to	See section ID Numbers MS1A, T1 and S2 for details.

prevent a recurrence of the specific deficiency identified	
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan approved by the Authority that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure: (d) Employment/utilization site compliance.	**ID Number** **EM2D**

Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒

Observations and Identified Deficiencies:	*Rule 333-010-0435 is not met as evidenced by:* Based on interviews with project participants and review of chart records, it was determined that the supervising dentists and trainees at the pilot sites were not made aware of the limitations on the scope of practice for the DHAT or of directives issued by OHA around nitrous oxide and extractions. For complete narrative, see section ID Numbers MS1A, T1, S2 and EM2C for details.
Corrective Action	See section ID Numbers MS1A, T1, S2 and EM2C for details.
Required Next Steps	See section ID Numbers MS1A, T1, S2 and EM2C for details.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	See section ID Numbers MS1A, T1, S2 and EM2C for details.
Timeline to implement the CAP.	See section ID Numbers MS1A, T1, S2 and EM2C for details.
Description of monitoring procedure(s) that the project sponsor will perform to	NPAIHB has stated that the intent of their approved Evaluation and Monitoring Plan was to require intra-oral imaging after conclusion of the preceptorship. OHA interpreted language outlined in the project's Evaluation and Monitoring Plan Appendix C that this was happening during

prevent a recurrence of the specific deficiency identified	all points in the utilization phase, once the DHAT trainee was providing care to patients in Oregon. OHA has clarified that all irreversible procedures completed by the DHAT trainee require adherence to the process outlined in Appendix C of the approved Evaluation and Monitoring Plan.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (3) Data. A sponsor's evaluation and monitoring plans must describe: (b) How data will be monitored for completeness;		**ID Number** **EM3B**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0435 is not met as evidenced by:* The project was required to submit a full and complete detailed data report (DDR) to OHA quarterly. Upon review of the DDR and comparison of the chart records, numerous procedures were omitted on the detailed data report. Instructions for submission of the DDR indicate that every service provided by the trainee must be included as a separate entry. Stratified random samples are selected from the information contained in the DDR, so accuracy of the DDR is critical to the required evaluation by OHA. Based upon the submitted DDR, there were an expected 41 unique procedures (defined by ADA CDT codes) completed by the trainee on 23 unique patients. After review, there were 102 unique procedures identified as being completed by the trainee. Of the 23 charts reviewed, only 35% were accurately represented in the DDR. The procedures omitted in the DDR include one completed extraction, as well as many preventive and restorative services. This is an indication of severe data validity issues in the detailed data reports as submitted. Without a complete data set in the DDR, conclusions cannot be drawn as to the representative nature of the charts submitted. It is unknown how many other procedures have been completed by the trainee that were not included on the DDR for charts not selected in the randomized sample.	

Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the approved and amended Evaluation and Monitoring Plan.
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. NPAIHB agrees to follow its approved Evaluation and Monitoring plan. In response to the preliminary site visit report, NPAIHB requested technical assistance from OHA regarding compliance with the DDR.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	Clarification and requirements outlined in the DDR occurred on June 15, 2018 at a joint meeting between both organizations. • NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • NPAIHB has implemented a monthly conference call between clinical staff, clinic leadership, NPAIHB staff and DHAT coordinators. • A communications plan between the NPAIHB project manager, NPAIHB project dental director and OHA has been implemented via a bi-weekly conference call.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring 5) A sponsor must provide a report of information requested by the program in a format and timeframe requested.		**ID Number** **EM5**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0435 is not met as evidenced by:* As part of the site visit, the project was required to submit a randomized sample of charts to OHA by February 27, 2018 based upon quarterly data submitted in the Detailed Data Report. Upon review, it was determined that a significant portion of these charts were incomplete and were missing significant components required for review and assessment of quality. These included pre-operative intra-oral images, prep intra-oral images, post-operative intra-oral images, pre-operative radiographs and informed consent forms. Reviewers were unable to adequately assess several of these charts as required for evaluation of patient safety. Of the 24 charts requested, 63% were missing one or more element. OHA further requested the missing components of the charts and received most of the required materials on March 16, 2018. Project managers indicated on that date that one chart number had been included in the Detailed Data Report in error, and was not a patient seen by the trainee.	
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the approved and amended Evaluation and Monitoring Plan.	
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.	
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board.	

	NPAIHB agrees to follow its approved Evaluation and Monitoring plan.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • NPAIHB has implemented a monthly conference call between clinical staff, clinic leadership, NPAIHB staff and DHAT coordinators. • A communications plan between the NPAIHB project manager, NPAIHB project dental director and OHA has been implemented via a bi-weekly conference call.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (6) A sponsor must report adverse events to the program the day they occur.		**ID Number** **EM6**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No deficiencies. There were no instances of adverse events.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0440: Dental Pilot Projects: Informed Consent (1) A sponsor must ensure that informed consent for treatment is obtained from each patient or a person legally authorized to consent to treatment on behalf of the patient.		**ID Number** **IC1**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒

Observations and Identified Deficiencies:	*Rule 333-010-0440 is not met as evidenced by*: Based on review of randomized sample of charts, 87.5% of charts were missing the required signed and dated informed consent for treatment form for oral surgery.
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the informed consent process required by administrative rule and approved by OHA.
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. NPAIHB agrees to ensure that all required consent forms are completed and placed in charts prior to services being performed OHA will continue to require that written informed consent to see the DHAT trainee be obtained on a physical paper form approved for use in the pilot project. This form may not be electronic. Signed informed consent for treatment by the DHAT trainee must be scanned and uploaded into the patient record. Electronic forms are sufficient for use by pilot sites to consent to the treatment being provided, i.e. oral surgery, etc.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • NPAIHB has implemented a monthly conference call

will perform to prevent a recurrence of the specific deficiency identified	between clinical staff, clinic leadership, NPAIHB staff and DHAT coordinators. • A communications plan between the NPAIHB project manager, NPAIHB project dental director and OHA has been implemented via a bi-weekly conference call.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0440: Dental Pilot Projects: Informed Consent (4) Dental pilot project staff or trainees must document informed consent in the patient record prior to providing care to the patient.		**ID Number** **IC4**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0440 is not met as evidenced by:* All charts reviewed contained documentation in written format in the form of "PARQ". This was determined insufficient for consent to be treated by a trainee and for extraction procedures. Documentation of informed consent includes a copy of the signed forms required of each patient to consent to treatment by the DHAT trainee and signed consent for treatment forms. Scanned copies of these documents are part of the patient record. Documentation of PARQ in the chart notes is insufficient for purposes of meeting the administrative rules around Informed Consent.	
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the informed consent process required by administrative rule and approved by OHA.	
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.	

Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. • NPAIHB agrees to ensure that all required consent forms are completed and placed in charts prior to services being performed. • NPAIHB indicates that upon receiving a copy of the preliminary report, they implemented protocols at both sites to make certain that informed consent documents are completed. • The project will adhere to the standard operating procedures document (SOPs).
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • Individuals at each pilot site will receive training on procedure to follow. • A monitoring process will be developed to ensure compliance at each pilot site for adherence to the SOPs.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0440: Dental Pilot Projects: Informed Consent (5) Informed consent needs to be obtained specifically for those tasks, services, or functions to be provided by a pilot project trainee.		**ID Number** **IC5**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒

Observations and Identified Deficiencies:	*Rule 333-010-0440 is not met as evidenced by:* Of the sampled charts, 9% (n=2) were missing signed informed consent to be treated by the trainee. Additionally, 26% of charts were either missing signed consent entirely, were not obtained on or before the first date of service, or were otherwise missing elements. Chart reviewers noted that several charts had included a signed consent form that was not dated or did not include the printed patient name. A notation of "PARQ" was observed in most charts in lieu of written informed consent. Overall, only 74% of the 23 charts reviewed in the randomized sample had a signed form consenting to treatment by the DHAT trainee on the initial date of service.
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the informed consent process required by administrative rule and approved by OHA.
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. NPAIHB agrees to ensure that all required consent forms are completed and placed in charts prior to services being performed.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot

procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	project site. • Individuals at each pilot site will receive training on procedure to follow. • A monitoring process will be developed to ensure compliance at each pilot site for adherence to the SOPs.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0455 Dental Pilot Projects: Program Responsibilities (2) Site visits. (A) Determination that adequate patient safeguards are being utilized;		**ID Number** **PR2A**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No deficiencies observed. *Comments*: There were no concerns related to patient safety in terms of data storage, infection control, HIPPA violations or gross negligence. Several reviewers noted that weights were not recorded for any charts wherein the DHAT was administering local anesthetics to minor patients. Weight must be recorded to determine maximum allowable dosage for local anesthetic on patients under age 10.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0455 Dental Pilot Projects: Program Responsibilities (2) Site visits. (B) Validation that the project is complying with the approved or amended application		**ID Number** **PR2B**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0455 is not met as evidenced by:* The approved application provided that the scope of practice for a DHAT was that extractions are completed in cases of a medical emergency.	

	Review of charts indicate that extractions were often treatment planned, appointments scheduled in advance, and patients returned for treatment. Planned extractions do not meet the definition of a medical emergency. Pain scales on the majority of charts indicate there was no medical emergency occurring at the time of the procedure. Extractions by DHATs must only be performed in cases of medical emergencies, as defined by ORS 682.025 and OAR 141-120-0000, after documentation of supervising dentist authorization, completed informed consent form, recent pre-op radiographs, and pre-op photograph have been filed in the patient chart (prior to services being performed). Post-extraction photograph of the extracted tooth must be filed in the patient chart. On November 27, 2017, OHA issued a letter of concern to the project sponsor requiring the project to issue a request for modification to the approved application. The project sponsor was apprised of the concerns that the DHAT trainee was operating outside of the scope of approved practice. The project sponsor failed to communicate the directives issued by OHA to the pilot sites. DHAT trainees continued to provide extractions outside of the requirement stipulated in the approved application that they only be completed in cases of a medical emergency. NPAIHB submitted a request for modification to amend their approved application to OHA on January 1, 2018. OHA apprised NPAIHB that the request for modification was under review. Projects are prohibited from implementing modifications to their application until they receive approval from OHA.
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the informed consent process required by administrative rule and approved by OHA.
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. NPAIHB agrees to comply with its approved and amended application.
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.
Description of monitoring procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. • Prior to the implementation of an approved modification, NPAIHB and pilot sites will meet to discuss changes via conference call or in-person. • Individuals at each pilot site will receive training on procedure to follow. • A monitoring process will be developed to ensure compliance at each pilot site for adherence to the SOPs.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

333-010-0460 Dental Pilot Projects: Modifications (1) Any modifications or additions to an approved project shall be submitted in writing to program staff.		**ID Number** **M1**
Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No deficiencies identified. A written request for project modification was received by OHA on January 1, 2018.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0460 Dental Pilot Projects: Modifications (3) All other modifications require program staff approval prior to implementation.		**ID Number** **M3**
Dental Pilot Project Program Requirements	**Met** ☐	**Not Met** ☒
Observations and Identified Deficiencies:	*Rule 333-010-0460 is not met as evidenced by:* See section ID Number P2B for complete narrative of observations and identified deficiencies. NPAIHB did not receive approval prior to implementation of project modifications proposed in their January 1, 2018 project modification request.	
Corrective Action	On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will follow the informed consent process required by administrative rule and approved by OHA.	
Required Next Steps	NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.	
Corrective Action Plan (CAP) submitted by project sponsor and procedure for implementation	In lieu of a Corrective Action Plan submitted by the project sponsor, a Stipulated Agreement was signed by both the Oregon Health Authority and the project sponsor, the Northwest Portland Area Indian Health Board. NPAIHB agrees to comply with its approved and amended application. On March 28, 2018, OHA approved some of the project modifications requested by NPAIHB on January 1, 2018.	
Timeline to implement the CAP.	NPAIHB will conduct a joint training session with both pilot sites on September 12, 2018. The Authority approved the date change that was originally required in the preliminary report of findings.	
Description of monitoring	• NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot	

procedure(s) that the project sponsor will perform to prevent a recurrence of the specific deficiency identified	project site. • Prior to the implementation of an approved modification, NPAIHB and pilot sites will meet to discuss changes via conference call or in-person. • Individuals at each pilot site will receive training on procedure to follow. • A monitoring process will be developed to ensure compliance at each pilot site for adherence to the SOPs.
Name and title of individual responsible to implement CAP.	Christina Peters NPAIHB Project Director
Authority Approval	Signed Stipulated Agreement on April 3, 2018

REPORT END

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

Oregon Health Authority

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

DATE: April 9, 2018

TO: Joe Finkbonner
Northwest Portland Area Indian Health Board

FROM: Bruce Austin, Statewide Dental Director
Oregon Health Authority

RE: Status of February 26, 2018 Site Visit
Findings & Further Clarification Needed on Dental Pilot Project #100

SITE VISIT

On February 26, 2018, the Oregon Health Authority (OHA) conducted the second required site visit for Dental Pilot Project #100, "Oregon Tribes Dental Health Aide Therapist Pilot Project."

The OHA Dental Pilot Projects Program is responsible for monitoring approved pilot projects. The primary role of the Oregon Health Authority is monitoring for patient safety. Secondarily, program staff shall evaluate approved projects and the evaluation shall include, but is not limited to, reviewing progress reports and conducting site visits. OHA is responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations.

Per Oregon Administrative Rule (OAR) 333-010-0455, a report of findings and an indication of pass or fail for site visits shall be provided to the project director in written format within 60 calendar days following a site visit. The Oregon Health Authority has determined that Dental Pilot Project #100 is in non-compliance with the requirements set forth in OARs 333-010-0400 through 333-010-0470, and therefore has **failed** the site visit.

As outlined in OARs 333-010-0400 – 333-010-0470, dental pilot projects are required to operate according to their approved applications and modifications. Projects that operate outside of the approved provisions in their application or modifications are in violation of the OARs. A pilot project may be suspended or terminated during the term of approval for violation of 2011 Oregon Laws, chapter 716 or any of the OARs 333-010-0400 through 333-010-0470.

STIPULATED AGREEMENT

On April 3, 2018, the Northwest Portland Area Indian Health Board (NPAIHB) entered into a signed Stipulated Agreement which states that the NPAIHB and OHA agree that OHA has

adequate grounds to issue a Notice of Proposed Suspension to NPAIHB. In lieu of OHA issuing a Notice of Suspension to the project, NPAIHB agreed to the terms outlined in the agreement. NPAIHB agrees that if they violate the terms of the agreement, OHA may suspend its approval of the project until such time as it can come into compliance with its approved plan and OARs 333-010-0400 to 333-010-0470.

SITE VISIT FINDINGS & ITEMS NEEDING FURTHER CLARIFICATION

As part of the site visit, there are several items that need to be addressed or require further clarification from NPAIHB:

1. **Failure to Follow OHA Directives**: On November 27, 2018, OHA issued a notice to NPAIHB requiring the project to cease providing planned extractions by dental health aide therapist (DHAT) trainees since it is outside of the scope of practice requirements as outlined in the approved application. NPAIHB failed to inform the project sites of the directives issued by OHA. DHAT trainees at the pilot project sites continued to perform planned extractions outside of the requirements that they be a medical emergency. Medical emergencies are defined under ORS 682.025 and OAR 141-120-0000.

   Corrective Action: On February 28, 2018, OHA informed both the NPAIHB and clinic sites verbally of the concerns discovered in the oral interviews with the Native American Rehabilitation Association (NARA) clinicians. A commitment to cease procedures that are not allowed under the approved application was obtained from both the NPAIHB and pilot sites. On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will agree to follow clinical parameter criteria for extractions outlined in the agreement.

2. **Nitrous Oxide**: DHAT trainees at the pilot sites provided services to patients who were under the use of nitrous oxide. Nitrous oxide was administered by the supervising dentist under direct supervision.

   In an addendum to their approved application, NPAIHB states “The DHATs are not trained to use it; they will not be using Nitrous Oxide.” At subsequent Advisory Committee meetings, the NPAIHB was questioned as to the methodology and logic of excluding DHAT trainees from receiving training on nitrous oxide when it is used at each pilot site.

   On October 31, 2017, the NPAIHB 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.”

   On November 21, 2017, OHA informed the NPAIHB in writing of the following requirements:

   I. 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 OARs 818-026-0000 through 818-026-0120.

II. 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.

III. If it is the intention of the project trainees to utilize nitrous oxide or work on patients under nitrous oxide, then the project must apply for a modification to their application.

A copy of the administrative rules for nitrous oxide OARs 818-026-0000 through 818-026-0130 was supplied to the NPAIHB.

On November 30, 2017, OHA received a memo from NPAIHB stating: “After further review of the Oregon Dental Practices Act, we agree that our DHATs are not, and will not be authorized to administer Nitrous Oxide, or work on patients that have received Nitrous Oxide from someone who has a valid Nitrous Oxide permit.”

NPAIHB failed to inform the project sites of the directives issued by OHA. The DHAT trainees at both pilot sites provided services to patients who were under the use of nitrous oxide.

Corrective Action: On February 28, 2018, OHA informed both the NPAIHB and clinic sites verbally of the concerns discovered in the oral interviews with the NARA clinicians. A commitment to cease procedures that are not allowed under the approved application was obtained from both the NPAIHB and the pilot site. On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will prohibit DHAT trainees from treating patients who are receiving nitrous oxide.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

3. **Practicing Outside the Scope of Approved Practice**: Review of the chart records indicate that on three separate occasions the trainee completed extractions or attempted to complete extractions, which are outside of the trainees approved scope of practice as outlined in the Community Health Aide Programs Board (CHAP) Standards and approved application:

   As stated in the approved application under CHAP Standard 2.30.610, in addition to the requirement that extractions must be completed by DHAT trainees in the event of a medical emergency, DHAT trainees are authorized to complete uncomplicated extractions with prior evaluation of the x-ray and consultation when appropriate for proximity to the mandibular canal; proximity to the maxillary sinus, root fractures or dilacerations; multiple roots; a well-defined periodontal ligament space; and enough

clinical crown to luxate the tooth.

Project trainees are only authorized to complete simple uncomplicated extractions. In two of these instances, the procedure became surgical in nature in order to complete the procedure.

A. In the first instance, the trainee attempted to extract tooth #20 with no clinical crown above the gingival level. Radiographs demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was unable to extract the tooth and required intervention by the supervising dentist. The dentist was required to cut a flap in order to extract the tooth.

B. In the second instance, the trainee extracted teeth #15 and #16. Chart notes state that after the teeth were extracted by the DHAT trainee, buccal bone was attached to the extracted teeth. The supervising dentist was required to take over the procedure and used a bone file to reshape the bone in the extraction site and suture the area.

C. In the third instance, the trainee extracted teeth #18 and #19. Tooth #18 had no clinical crown. The two remaining roots of #18 were embedded in the soft tissue. Both radiographs and intra-oral images demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was successfully able to extract the teeth.

OHA is concerned that the DHAT trainee was authorized to complete procedures that fell outside of their scope of practice according to the approved project application. DHAT trainees do not have the scope of practice to cut soft tissue or resolve extractions that become surgical in nature. The NPAIHB has stated on several occasions that the DHAT trainees are taught the limitations of their scope of practice and are aware of those limitations. Of particular concern is that the DHAT trainee at the NARA site has been practicing for over 8 years.

There is considerable concern that the project's intention is to have the DHAT trainee complete extraction procedures under general supervision. Had the DHAT trainee been authorized to complete these procedures under general supervision, with no dentist on-site, the DHAT trainee would have lacked the necessary skills to complete the procedure. This would have resulted in undo pain for the patient and would have necessitated a referral to a dentist to complete the procedure.

Corrective Action: On April 2, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB must only allow a DHAT trainee to perform extractions under the following conditions:

1. All extractions must be performed under the indirect supervision of the DHAT trainee's supervising dentist. Indirect supervision is defined under ORS 679.010 as supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

2. For primary and permanent tooth extractions, the DHAT trainee will first receive and document authorization from the supervising dentist.

3. For primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal.

4. For permanent teeth, the trainee may perform non-surgical extractions of periodontally diseased teeth with evidence of bone loss and +2 degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal.

5. Document all information related to extractions as specified above along with the criteria required for the project evaluation which include a recent radiograph of the tooth to be extracted, a pre-operative intra-oral image of the tooth to be extracted, and a post-operative image of the extracted tooth.

Required Next Steps: The project is required to clarify the scope of practice concerns around intra-oral suturing. The DHAT trainee indicated in their interview during the site visit that they are specifically taught that intra-oral suturing is outside of their scope of authorized practice. This was confirmed in statements by the supervising dentist. Each stated that DHAT's are not taught suturing in the training program and are prohibited from suturing. This is of concern as NPAIHB contradicts the statements of both the trainee and supervising dentist. NPAIHB provided information to OHA stating that DHAT's are in fact authorized to perform suturing and are taught this as part of their training. Clarification as to the contradicting statements is required.

NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

4. **Informed Consent**: The project failed to obtain written informed consent for services by the trainee on the date of service, as required in OAR 333-010-0440 and OAR 123-456-7890, on multiple occasions in charts provided for review – including treatment of 3 minors. On four occasions, the signed consent to be treated by a trainee was obtained after the initial date of service. On two occasions, the printed patient name is not listed on the signed informed consent form. On one occasion, informed consent to be treated by the trainee was absent entirely. Overall, only 74% of the 23 charts reviewed in the randomized sample had a signed form consenting to treatment by the DHAT trainee on the initial date of service.

   Additionally, an approved oral surgery consent form is required for all extractions. Of the 9 charts reviewed for which an oral surgery consent form is required, only 1 chart had a signed oral surgery consent form that matches the form approved for the pilot project. For the remaining charts, 7 charts included a different oral surgery consent form. Written consent for oral surgery is missing entirely for one chart.

Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB must ensure that all required consent forms are completed and placed in charts prior to services being performed.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

5. **Non-Adherence to Approved Evaluation & Monitoring Plan**: Based on review of the 23 submitted charts, the project is not in compliance with Appendix C intra-oral image and radiographic collection requirements of the approved Evaluation and Monitoring Plan.

   In the 23 charts submitted, there were 42 unique procedures identified that required a pre- and post-operative intraoral image. Of these, 12 procedures (29%) were missing a pre-operative and/or post-operative intraoral image. Additionally, restoration procedures require an intraoral image of the tooth prep, which was missing in 5 of the 31 identified procedures requiring a prep image. Adequate patient safety and procedure quality cannot be determined without proper image documentation.

   Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

   Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

6. **Failure to Submit Required Information to OHA as Required**: As part of the site visit, the project was required to submit a randomized sample of charts to OHA by February 27, 2018 based upon quarterly data submitted in the Detailed Data Report. Upon review, it was determined that a significant portion of these charts were incomplete and were missing significant components required for review and assessment of quality. These include pre-operative intra-oral images, prep intra-oral images, post-operative intra-oral images, pre-operative radiographs and informed consent forms.

   Reviewers were unable to adequately assess several of these charts as required for evaluation of patient safety. Of the 24 charts requested, 63% were missing one or more element. OHA further requested the missing components of the charts and received most of the required materials on March 16, 2018. Project managers indicated on that

date that one chart number had been included in the Detailed Data Report in error, and was not a patient seen by the trainee.

Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

7. **Detailed Data**: The project is required to submit a full and complete detailed data report (DDR) to OHA quarterly. Upon review of the DDR and comparison of the chart records, numerous procedures were omitted on the detailed data report. Instructions for submission of the DDR indicate that every service provided by the trainee must be included as a separate entry. Stratified random samples are selected from the information contained in the DDR, so accuracy of the DDR is critical to the required evaluation by OHA.

   Based upon the submitted DDR, there were an expected 41 unique procedures (defined by ADA CDT codes) completed by the trainee on 23 unique patients. After review, there were 102 unique procedures identified as being completed by the trainee. Of the 23 charts reviewed, only 35% were accurately represented in the DDR. The procedures omitted in the DDR include one completed extraction, as well as many preventive and restorative services. This is an indication of severe data validity issues in the detailed data reports as submitted. Without a complete data set in the DDR, conclusions cannot be drawn as to the representative nature of the charts submitted. It is unknown how many other procedures have been completed by the trainee that were not included on the DDR for charts not selected in the randomized sample.

   Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

   Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

   The next detailed data report is due to OHA by April 30, 2018 and must include every procedure completed by the trainee.

8. **Failure to Document**: The pilot site has failed to maintain accurate patient records in accordance with OAR 818-012-0070. Examples include incorrectly recording treatment

rendered, incorrectly coding for one procedure when a different procedure was performed, and not recording patient weight when administering analgesics to minors.

Additionally, in one instance, the trainee completed an extraction that was coded as D7210, which falls outside the scope of DHAT practice. D7210 is defined as surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Project managers indicated that this was coded in error, which indicates a failure to accurately document patient treatment.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

9. **Advisory Committee**: The project failed to meet with their own advisory committee in the two years since approval of the dental pilot project. The approved application includes details of the project assembling an Advisory Committee of their own and meeting regularly. The project has not met once in two years since the approval of the project in February 2016.

   Corrective Action: OHA will require the project adhere to their approved application. OHA will require that the NPAIHB conduct quarterly meetings with their own Advisory Committee. The NPAIHB will submit dates and attendees of these meetings in their quarterly progress report to OHA.

10. **Project Management:** There is considerable concern that the NPAIHB is failing to adequately communicate clinical concerns with the project sites. Supervising dentists at each pilot site have indicated frustration with a lack of communication on issues which are highly relevant and time sensitive. Concerns remain that the NPAIHB does not have a clinical dental subject matter expertise in the project manager role. There remains ambiguity and inconsistencies regarding clinical questions and concerns raised by both OHA and the Advisory Committee around extractions, nitrous and suturing. Several statements received by OHA from the project have contradicted each other and have caused concern regarding patient safety and the provision of quality care.

    Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will hire or contract for an Oregon-licensed dentist actively practicing in the State of Oregon, to provide clinical technical expertise and project oversight by **June 21, 2018**.

RESPONSE REQUIRED

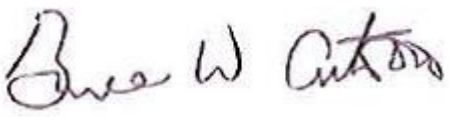
The project will respond to all concerns outlined above that are not addressed in the Stipulated Agreement. OHA will conduct a follow-up site visit to the NARA pilot site within

the next 6 months to assure that the corrective actions outlined above have been performed.

The Northwest Portland Area Indian Health Board must respond to any findings or requests for clarification by **Wednesday, May 16, 2018**.

A full report of findings will be issued by OHA by August 1, 2018.

Sincerely,



Bruce Austin, DMD
Statewide Dental Director

CC: Dental Pilot Project Advisory Committee #100

Appendix C

Guide to Radiography and Intra Oral Images for Irreversible Procedures Performed by Dental Therapists

REVISED APRIL 29, 2017

PREPARED BY DANE LENAKER, DMD, MPH
Lenaker Consulting

Introduction:

This purpose of this document is to provide guidance for the records necessary for irreversible procedures completed by dental therapists. This is to be used by dental therapists during direct, indirect, and external supervision while working in association with the Northwest Portland Area Indian Health Board.

Overview:

Dental therapists participate in procedures that are at times, irreversible. Examples of such procedures include fillings, stainless steel crowns (SSC's), pulpal therapy such as pulpotomies, and extractions. Each procedure may require different levels of documentation to adequately facilitate general supervision. This guide has been created to aid both the practicing dental therapist and supervising dentist with such requirements. See the table below:

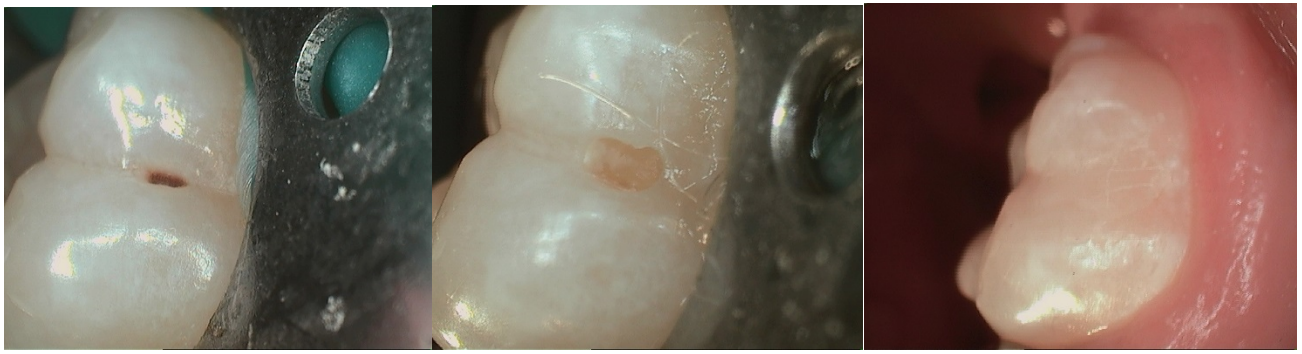
Description	Code(s)	Irreversible	FMX	Pano	BW's	PA's	Tooth Based Imaging	General Notes
Restorations (Composite, Amalgam, Protective)	2140, 2150, 2160, 2161, 2391, 2330, 2331, 2332, 2335, 2392, 2393, 2394, 2940, 2941,	Y	NA	NA	Y	Y	Y	**Radiographic Considerations:** 1) Pre-operative: new bitewing, PA, and/or tooth-level images **may** be required if patient has not had a comprehensive or periodic exam within the last year, OR if the tooth of the tooth has changed since the last evaluation. Radiographs should only be made when deemed clinically necessary, see references. 2) Post-operative: A post-operative radiograph is not indicated after the procedure. While it may provide additional insights on the quality of the restoration at the interproximal contact, the additional radiation exposure to the patient is typically not warranted. The contact maybe be evaluated at subsequent examinations when new radiographs are made. **Intra Oral Images Considerations:** 1) Pre-Op image from the occlusal view - should demonstrate cavitation of ICDAS 2 or greater if visible. 2) Preparation image: should demonstrate the completed preparation. If infected dentin and/or decalcification remains, note should reflect clinical reason for partial removal. Isolation should be appropriate for the choice of restoration. 3) OPTIONAL: if liner/base is used, occlusal image should be used to reflect the placement of such material. If pulpal therapy is initiated, reference requirements for said procedure below. 4) Finished restoration: Image should demonstrate all surfaces of finished restoration, primarily from the occlusal view. If restoration extends to other surfaces of the tooth, the images should reflect this, EG: MODBL restoration may require an occlusal image, and buccal image, and a lingual images. A buccal restoration may only require a buccal image.

Stainless Steel Crowns	2930, 2931,	Y	NA	NA	Y	Y	Y	**Radiographic Considerations:** 1) Pre-operative: new bitewing, PA, and/or tooth-level images **may** be required if patient has not had a comprehensive or periodic exam within the last year, OR if the tooth of the tooth has changed since the last evaluation. Radiographs should only be made when deemed clinically necessary, see references. 2) Post-operative: A post-operative radiograph is not indicated after the procedure. While it may provide additional insights on the quality of the restoration at the interproximal contact, the additional radiation exposure to the patient is typically not warranted. The contact maybe be evaluated at subsequent examinations when new radiographs are made. **Intra Oral Images Considerations:** 1) Pre-Op image from the occlusal view - should demonstrate cavitation of ICDAS 2 or greater if visible. 2) Preparation image: should demonstrate the completed preparation. If infected dentin and/or decalcification remains, note should reflect clinical reason for partial removal. Isolation should be appropriate for the choice of restoration. 3) OPTIONAL: if liner/base is used, occlusal image should be used to reflect the placement of such material. If pulpal therapy is initiated, reference requirements for said procedure below. 4) Finished restoration: Image should demonstrate all surfaces of finished restoration, demonstrating the occlusal, buccal, and lingual views to determine marginal seal, crown fit, and to assess the plane of occlusion.

Pulp Therapy	3110, 3120 3220, 3221	Y	NA	NA	N	Y	Y	**Radiographic Considerations:** 1) Pre-operative: new bitewing, PA, and/or tooth-level images may be required if patient has not had a comprehensive or periodic exam within the last year, OR if the tooth of the tooth has changed since the last evaluation. 2) Post-operative: A post-operative radiograph is not indicated after the procedure. **Intra Oral Images Considerations:** 1) Pre-op and preparation images should be consistent with that of restorative intra oral images. 2a) If completing a pulpotomy or pulpectomy, one image should be made of the completed access prior to build up and/or placement of IRM. 2b) if liner/base is used, image should be used to reflect the placement of liner/base when clinically indicated. If pulpal therapy was initiated, reference requirements for said procedure. 3) Additional images should follow that over the restorative requirements.
Extractions	7111, 7140	Y	NA	NA	N	Y	Y	**Radiographic Considerations:** 1) Pre-operative: new bitewing, PA, and/or tooth-level images are recommended for extraction procedures. 2) Post-operative: A post-operative radiograph may be indicated if the tooth to be removed is extracted n pieces, or the root tips appear blunted or indistinct post removal. **For this pilot project, all extractions should have a pre and post-op radiograph.** **Intra Oral Images Considerations:** 1) Pre-Op image from the occlusal view. Other views may be used for large, multi-surface cavitation. 2) Post-Op Image should show extracted tooth plus all root surfaces. This may include an image made apically to demonstrate root structure.

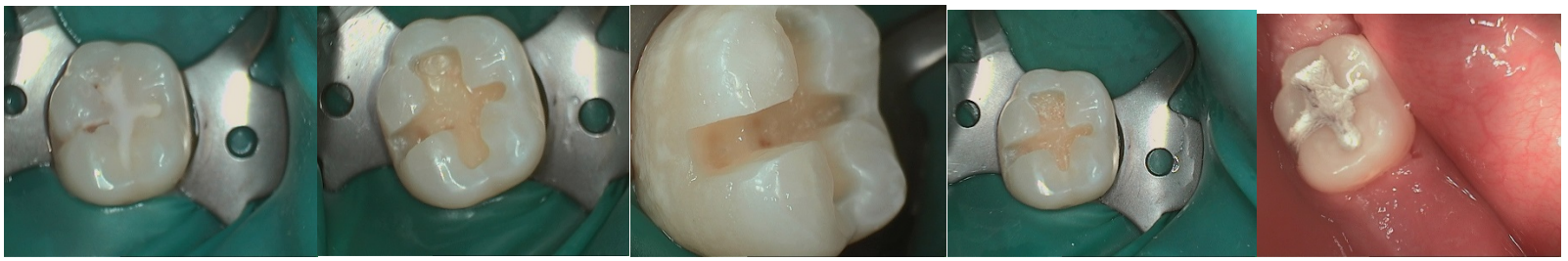
Example, Simple Restorative:

Below is an example of an image progression for buccal caries. Images were made of the buccal surface of the tooth pre-operatively, demonstrating an ICDAS class 2 or greater lesion. Restoration was prepared, an image was made of the final preparation. The image was then restored with a composite material, and final image was captured. Radiographs: not shown.



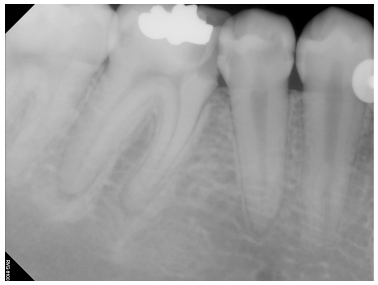
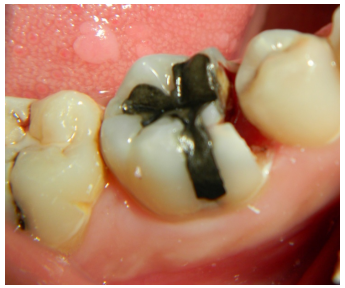
Example, Complex Restorative:

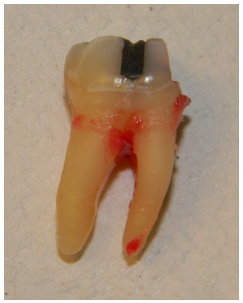
Below is an example of an image progression for recurrent caries on the occlusal and buccal surfaces. Images were made of the buccal pre-operatively, demonstrating an ICDAS class 2 or greater lesion from the occlusal. Restoration was prepared, additional images were made to show the cavitation extending to the buccal. A final image was made of the completed preparation. Lastly, the tooth restored with an amalgam material, and final image was captured. Radiographs: not shown.



Example, Complex Extraction

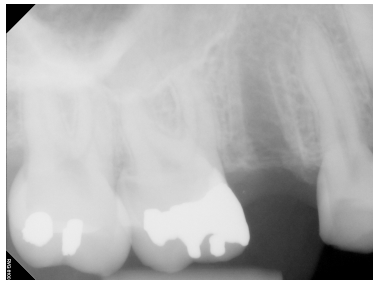
Below is an example of an image progression for a tooth requiring emergency extraction. This case has patient to be more complicated due to the root structure and space loss. As a result, a post op image was required of the tooth in question. Because roots and tooth were removed in whole, a post op radiograph was not ordered.



Example, Extraction with Tooth Fracture:

Below is an example of an image progression for a tooth that was delivered in multiple pieces. As a result, the supervising dentist requested a post op radiograph and an image of all tooth pieces. Not shown: Pre-op intra oral image of pre-op radiograph.




References:

1. American Academy of Pediatric Dentistry. Guideline on prescribing dental radiographs for infants, children, adolescents, and persons with special health care needs. http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf. Last accessed January 16, 2017. (**Guideline**)

2. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure (2012) n. pag. AMERICAN DENTAL ASSOCIATION. http://www.ada.org/~/media/ADA/Publications/ADA%20News/Files/Dental_Radiographic_Examinations_2012.pdf?la=en Last accessed January 16, 2017. (**Guideline**)

3. **Welcome to ICDAS 2017. (n.d.). Retrieved January 16, 2017, from https://www.icdas.org/**

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Christina Peters
Native Dental Therapy Initiative

4/30/18

RE: Gap Analysis for Ben Steward, DHAT

Dear Ms. Peters,

Ben Steward attending the Dental Health Aide Therapist (DHAT) Educational Program in Alaska January 2008 through December 2009. He successfully completed the program and became certified as a DHAT with the Alaska Community Health Aide Program Certification Board. The DHAT Educational Program as administered by the Alaska Native Tribal Health Consortium has largely remained consistent in the educational topics covered, with a few exceptions. One notable change was the shift of our academic affiliation from the University of Washington School of Medicine, MEDEX Physician Assistant Training Program to Iḷisaġvik College. Iḷisaġvik College is Alaska's only tribal college located in Utqiaġvik, Alaska. I have reviewed the curriculum from 2008 and cross walked it with the current curriculum to determine where there might be any gaps between the education Mr. Steward received and the current educational program. Please find the list of subjects/skills that Mr. Steward would need to get additional training in to bring him current with the curriculum of the Alaska Dental Therapy Educational Program (ADTEP) at Iḷisaġvik College.

Education needed to bring Mr. Steward current with the 2018 ADTEP curriculum.

1. Suturing for DHAT, to include suturing for hemostatis post extraction.
2. Changing periodontal dressings.
3. Minor adjustments and repairs on removable prostheses.
4. Dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider

The ADTEP faculty and staff will create a gap closing curriculum for Mr. Steward to be administered as soon as possible. A written statement of completion will be provided upon successful completion of the required coursework.

Please feel free to contact me with any questions.

Very respectfully,

Mary E. Williard, DDS

Mary E. Williard, DDS
Director, ADTEP Ilisagvik College
Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, Alaska 99508
Main: (907) 729-1900 | Fax: (907) 729-1901 | anthc.org