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

Oregon Health Authority

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AGENDA

Dental Pilot Project #200

"Training Dental Hygienists to Place Interim Therapeutic Restorations"

Site Visit One
Independence, Oregon
April 5, 2017
10:00am – 4:00pm

Location: Independence Elementary		
10:00-11:00	**Independence Elementary** 150 South 4th Street Independence, Oregon 97351	DPP #200: Trainee Demonstration of Virtual Dental Home, Telehealth
11:00–12:00	**Lunch**	
Location: Central Health and Wellness Center 1601 Monmouth Street Independence, OR 97351		
12:00-12:10	Official Introductions, Agenda Review	Bruce Austin, DMD Sarah Kowalski, RDH
12:10-12:20	Site Visit Process and Overview	Sarah Kowalski, RDH
12:20-1:20	OHSU Project Update Review of Didactic & Clinical Course Materials Interviews with Project Staff, Supervising Dentist Utilize: Administrative/Operations Assessment Tool	Linda Mann, EPDH, RDH Eli Schwarz, DDS, MPH, PhD Richie Kohlie, BDS, MS
1:20-1:30	Break	
1:30-2:15	****Interview with Trainee:** Meagan Newton, EPDH Utilize: Interview with Trainee Tool	Program Staff, Advisory Committee Members*
2:15-3:00	****Interview with Supervising Dentist:** Jennifer Clemens, DMD Utilize: Interview with Supervising Dentist Tool	Program Staff, Advisory Committee Members*
3:00-4:00	Overview of Clinic Abstraction Records Process Electronic Interviews Patient Satisfaction Surveys Next Steps Closing	OHA Program Staff

** Interviews with the Trainees and Supervising Dentists are a closed door process. Only Advisory Committee members and OHA program staff are invited to participate in the interview process.

Site Visit Location and Attendees

Site Visit Program Location: School	Independence Elementary School 150 S 4th Street Independence, OR 97351
Site Visit Program Location: Meeting Facility	Central Health and Wellness Center 1601 Monmouth St, Independence, OR 97351
DPP #200 Representatives	Linda Mann, EPDH, RDH Edith Ibanez, Dental Assistant
Trainee	Meagan Newton, EPDH
Collaborating Dentists	Richie Kohlie, BDS, MS Eli Schwarz, DDS, MPH, PhD
Supervising Dentist	Jennifer Clemens, DMD
Advisory Committee Members	Kyle Johnstone, MHA, RDH, EPP *Virginia Garcia Memorial Health Center* Tony Finch, MA, MPH *Oregon Oral Health Coalition* Fred Bremner, DMD *Clackamas County Dental Society*
Oregon Health Authority Program Staff	Bruce Austin, DMD *Oregon Statewide Dental Director* Kelly Hansen Research Analyst *Dental Pilot Project Program* Sarah Kowalski, RDH, MS *Dental Pilot Project Program Coordinator* Mauri Mohler Administrative Support *Dental Pilot Project Program*

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Oregon Health Authority
Dental Pilot Project Program

Dental Pilot Project: Application #200

Abstract
Training Dental Hygienists to Place Interim Therapeutic Restorations
March 18, 2016

Applicant/Sponsor:	Oregon Health & Science University, School of Dentistry, 3181 SW Sam Jackson Park Road, Portland, OR 97239
Project Director:	Eli Schwarz, DDS, MPH, PhD Department of Community Dentistry, Oregon Health & Science University 3030 SW Moody Ave, Suite 135B Portland, OR 97201
Training Supervisor(s):	Eli Schwarz, DDS, MPH, PhD & Richie Kohli, BDS, MS

Sponsor Type:	Non-Profit Educational Institution

Oregon Health & Science University is a nationally prominent research university and Oregon's only public academic health center. It educates health professionals and scientists and provides leading-edge patient care, community service and biomedical research.

The OHSU School of Dentistry shares the mission of the Oregon Health & Science University to provide educational programs, basic and clinical research, and high quality care and community programs. We strive to foster an environment of mutual respect where the free exchange of ideas can flourish. The dental school prepares graduates in general dentistry and the dental specialties to deliver compassionate and ethical oro-facial health care.

The mission of the Department of Community Dentistry is to promote critical analysis of social, behavioral, and policy-influenced factors that affect oral health outcomes in both individual patients and the entire population. These goals are achieved through a comprehensive didactic and experiential learning curriculum that begins in year one of the pre-doctoral program and culminates with the DS4 clinical rotations in community based dental clinics. We strive to develop curricula that lay the foundation for the student's life-time professional

development, commitment to service and community collaboration, and ensure awareness and cultural competency of the comprehensive and complex nature of health care for vulnerable populations.

Purpose:	• Teaches new skills to existing categories of dental health care personnel.
	• To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place "Interim Therapeutic Restorations" (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Proposed Project Period:	11/1/2015 – 9/1/2020

Proposed Number of Sites:	Polk County**:** Central School District School: 5 School Sites

Site Locations:	
Training/Didactic Phase:	• Didactic training will be held via online management system called Sakai, webinars, and in-person meetings in the conference rooms at Capitol Dental Care. • Didactic resources are available through University of the Pacific (UoP). • Laboratory and clinical training will take place at Capitol Dental Care which has fully equipped dental clinics.
Utilization Phase:	• **Ash Creek Elementary**, Independence OR. 492 total student enrollment, 243 K-2nd grade students. 64% free and reduced lunch population • **Independence Elementary**, Independence, OR. 421 total student enrollment, 200 K-2nd grade students. 77.7% free and reduced lunch population • **Monmouth Elementary**, Monmouth OR. 547 total student enrollment. 266 K-2nd grade students. 55.9% free and reduced lunch population. • **Falls City Elementary**, Falls City, OR. 97 total school enrollment. 31 K-2nd grade students. 70.1% free and reduced lunch population.

	• **Community Action Head Start**-Independence Site. 40 children, age 3-5. OCDC Head Start-Independence Site. • In addition, we have also been meeting regularly with a Steering Group of those likely to participate in the pilot project, now and at a future time. These include representatives from: • Capitol Dental Care • Virginia Garcia Memorial Health Center • Advantage Dental • Kemple Memorial Children's Dental Clinic

Proposed Number of Trainees:	**10-12**
Proposed Number of Supervisors:	**4**
Number of Collaborating Dentists:	**4**
Proposed Number of Sites:	**5**

Application Chronology:

Application Submitted:	November 2, 2015
Application Approved for Completeness:	November 30, 2015
Application Received by Technical Review Board:	December 11, 2015
TRB Application Review Comments Due:	January 28, 2016
MOA Received by Program:	February 5, 2016
Applicants Notified of Intent to Approve:	February 19, 2016
Application Under 10 Day Period of Public Comment:	February 22, 2016 – March 4, 2016
Project Approved by Director:	March 8, 2016
Oregon Board of Dentistry Notified of Approval Status:	March 10, 2016

Estimated Cost and Funding Source(s):

Estimated Cost:	$111,797.01
Funding Source(s) Committed:	Three sources of funding have been identified: 1) Oregon Health Plan (OHP) covers dental care for Medicaid members through capitated payments to the Dental Care Organization (DCO) to which the CCO has assigned the members; 2) The training, technical assistance, and evaluation will be funded in the initial year through a telehealth grant from the Oregon Health Authority through September 2016; 3) A group of funders of Oregon Oral Health Funders Collaborative that has supported the planning grant to

	develop the present application has expressed an interest to fund ongoing support of the evaluation and testing of the pilot project.
Total Committed:	$111,797.01 for first 18 months

Background and History of the Project:
Selected Passages from the DPP #200 Application

Need for the Project:

Numerous reports within the last ten years have addressed workforce shortages in the dental field, lack of access to oral health care among low-income, rural, and other disadvantaged population groups, and the resulting profound oral health disparities experienced by these groups. Recent reports document that very slow progress is being made in improving the access to oral health care for these population groups. The health transformation process underway in Oregon has recently expanded access to the Oregon Health Plan for around 250,000 additional members. However, since the workforce situation has not been addressed, the existing dental workforce is under additional pressure and overall, access to dental care may further deteriorate. According to an Oregon Healthcare Workforce Institute analysis, the number of dentists practicing in Oregon decreased by 8% from 2010 to 2012 which may indicate a continuous trend. The traditional dental care delivery model of stationary dental offices or community health centers with dental practitioners and auxiliaries needs to be expanded to test alternative and sustainable models.

Studies in other states have shown that a remotely located dentist, working with an Expanded Practice Dentist Hygienist (EPDH), who is seeing a patient at a different location, can collaboratively deliver quality dental care. Led by an EPDH, Capitol Dental Care will implement telehealth-connected oral health teams to reach children who have not been receiving dental care on a regular basis and to provide community-based dental diagnostic, prevention and early intervention services, including ITR placement when indicated by the dentist.

Description of patients:

Demographic Data about Availability of Health Care Services
Polk County continues to show an increase in diversity, especially within the Hispanic population. 11.2% of the population considers themselves Hispanic compared to 10% in 2007. The Caucasian population has grown from 86% to 87.9% while the American Indian/Alaskan Native population has remained consistent at 1.9%. There were slight increases in the African American population from .4% to .5% and in the Asian/Pacific Islander population from 1.6% to 1.9% in 2009. According to the 2005-2009 US Census Bureau data, 11.4% of Polk County residents speak a language other than English in their home compared to 14% of Oregon residents and 19.6% of US residents.

Oral Health needs assessment suggested that 34.3% of the Polk County residents had no dental visit in the last 12 months. Currently, only about 20% of Oregon dentists accept Oregon Health Plan (OHP) members. In Marion and Polk Counties, there are 122 OHP enrolled dentists. This is approximately 1 dentist for every 550 members of the Willamette Valley Community Health (WVCH) Coordinated Care Organization. Although this may be considered an acceptable ratio issues remain of provider timely availability, appointment timing, and

insurance coverage; thus, there are still barriers for OHP members' access.

Oregon 2012 Smile Survey: This statewide survey gauges the health of the Oregon dental system by looking at the oral health, access, and overall quality of dental care for school children, aged 6 to 9. The survey examines the percentage of children who need urgent dental care, have any tooth decay, have rampant tooth decay (7 or more cavities), and have received dental sealants. The survey showed those with lower incomes, non-English speaking, and Hispanic background generally have worse dental health outcomes than those who have higher incomes, speak only English, and are white.

Purpose of the Project:

To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place "Interim Therapeutic Restorations" (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Oregon is in the midst of a dental health care crisis with more than 91 areas in the state designated as dental care health professional shortage areas (Kaiser Family Foundation study, April 28, 2014). This level of "deficiency" translates to more than 61% of Oregon residents not having their dental care needs met. One county where the need is particularly great is Polk County, and it is within this county - and the Polk County School District that a collaborative consisting of OHSU School of Dentistry, University of the Pacific Center for Special Care, and Capitol Dental Care (CDC) will implement its pilot project to train Expanded Dental Hygienists to place interim therapeutic restorations (ITR) within the context of a telehealth connected dental team.

This OHSU project has been planned and developed in collaboration with the University of the Pacific, Arthur A. Dugoni School of Dentistry (UoP) and Capitol Dental Care (CDC).

Project Description:

Under the dental pilot project program [Capitol Dental Care] CDC will build upon existing community outreach programs in Polk County by adding the telehealth model to existing preventive services, which include assessment, radiographs, intra-oral photographs, cleanings, sealants, fluorides, oral health instruction, and ITR if indicated. CDC's telehealth connected dental team of Expanded Practice Dental Hygienists, dental assistants, and supervising dentist, will visit three schools within the District, serving approximately 10 children per day~75 per month with a total expected population of 1200-1500 measurable encounters over the life of the 15-month project.

Those children with advanced disease in need of additional care will be referred for care either through CDC's mobile van operatory, or directed to a dental clinic for restorative care, as needed.

This Dental Workforce Pilot Project (DWPP) will add one new duty to those currently permitted for Expanded Practice Dental Hygienists (EPDHs) that are part of a community-based telehealth connected team system of care already under way.

The Oregon Health and Science University will train Expanded Practice Dental Hygienists (EPDH) to perform a new duty in community settings to improve the oral health of underserved populations and demonstrate their ability to carry out this duty.

Project Objectives:

Short-Term Objectives:	• Train EPDHs and evaluate their competence to place ITRs.
Long-Term Objectives:	• Through the performance of these duties to allow EPDHs working in community settings with underserved populations to facilitate collaboration with a dentist and to develop an appropriate plan of care for the patient. The placement of ITRs when directed to do so by a collaborating dentist will allow EPDHs to stabilize patients' oral health from further deterioration until they can be seen by a dentist in an appropriate setting. • To facilitate the development of new models of care designed to improve the oral health status of underserved populations.

Laws and Regulations Pertinent to the Proposed Project:	The Dental Practice Act governs the scope of practice for both dentists and dental hygienists operating in the state of Oregon. The key provisions can be found at Oregon Revised Statutes, Chapter 680 (680.010 – 680.210 and 680.990 (Dental Hygienists). Currently, an Expanded Practice Dental Hygienist (EPDH) may only perform the placement and finishing of direct alloy and direct composite restorations after the supervising dentist has prepared the tooth (teeth) for restorations (ORS 818-035-0072).

DPP 200 – Steering Group Information

OHSU's original application proposed both an Advisory Board to engage external stakeholders to advise the project, as well as a Steering Group to regularly convene partners involved directly in implementation or oversight of project activities. During project implementation, it became clear that it would better serve the project and time of those involved to have one body that is responsible for oversight and planning. The core of this Steering Group consists of OHSU, Capitol Dental Care, and University of the Pacific, and engages representatives from external organizations, such as the Oregon Health Authority, as needed.

Regular participants include:

- OHSU – Dr. Eli Schwarz, PI; Dr. Richie Kohli, Co-PI; and the project manager, currently Elizabeth Palumbo.
- Capitol Dental Care – Linda Mann, Director of Community Outreach; Meagan Kintz, EPDH; and Dr. Jennifer Clemens, supervising dentist.
- University of Pacific – Dr. Paul Glassman and UoP's project manager, currently Chaula Patel, join remotely or in person as needed

In 2017, the project began engaging the Virginia Garcia Memorial Health Center and Advantage Dental in the group, as we plan to bring these two providers on as additional implementing partners to expand the pilot project to additional sites.

Frequency of Meetings:
The core group has convened regularly via teleconference (once or twice per month on average), and in person when possible, since the start of the pilot. Topics covered at the meetings include reporting deadlines and requirements for OHA and funders, IRB requirements and updates, ITR training, and implementing challenges that need to be addressed.

In-person Steering Group-only meetings:

- **June 17, 2016**: The Steering Group met to discuss preparations for ITR training to be held in July
- **July 14-15 2016**: ITR training for implementing staff was held with Capitol and UoP, during which the core Steering Group also conducting planning for the ITR phase of the telehealth project.
- **January 3, 2017**: OHSU and Capitol held an in person meeting to discuss the 2016 quarterly report to OHA, planning for the external evaluator, and planning for implementing the satisfaction survey
- **March 8, 2017**: OHSU and Capitol with OHA in preparation for the site visit

Additional meetings to engage external stakeholders:

- **May 6, 2016**: Capitol Dental presented on the project to the OHSU Office of Rural Health
- **May 18, 2016**: OHSU and Capitol Dental conducted a site visit at Independence Elementary School for researchers from the School of Public Health at SUNY – Albany who were interested in looking at the funding, infrastructure, and workforce needs of the project, as well as patient experience with telehealth.
- **March 2017**: OHSU reported preliminary outcomes at the International Association for Dental Research Annual meeting in San Francisco.
- **April 2017** - OHSU reported preliminary outcomes at the National Oral Health Conference in New Mexico

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

Oregon Health Authority

Dental Pilot Project Program
Administrative/Operations Assessment Tool
DPP #200

Date:_____ Site:_____

Reviewer's Name & Organization: _____

Patient Population: (Circle all that are served at this site)

A. Head Start – Early Childhood
B. Elementary School Children
C. Developmentally Disabled Child or Teen
D. Others (Identify) _____

Elements of Implementation:
OAR Minimum Standards 333-010-0410, OAR (a) Patient Safety 333-010-0435, OAR Program Responsibilities 333-010-0455

Curriculum and Clinical Protocols OAR 333-010-0430	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
Curriculum: 1. Please comment on the curriculum that is being used for the pilot project.				
2. Location of Curriculum Electronic In-Person Both				
3. Is the curriculum available for trainee or supervising dentist's use for later reference?				

Clinical Protocols: 1. Location of Clinical Protocols: Electronic Hard Copy Both 2. What types of protocols have been developed for the pilot project? Examples of clinical protocol topics included patient selection and clinic scheduling, equipment utilization and standardization, record storage, retrieval and confidentiality, radiological/digital equipment usage etc.				
3. Are clinical protocols freely available to trainees?				
Trainee & Supervising Dentist Information OAR 333-010-0420, OAR 333-010-0425, OAR 333-010-0435	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
1. How many trainees do you have participating at the pilot project sites? How many trainees have completed the training course? How many trainees are actively placing ITRs at approved sites?				
2. Please comment on the selection of trainees.				
3. How are patients scheduled with the EPDH? Is there coordination required with classrooms?				
4. How many days or hours per week is the EPDH trainee scheduled at this site?				

5. Where is the licensing information for each trainee located? Has OHA been provided with the names of trainees in the dental pilot project?				
6. Are supervising dentists located onsite? What is the process if a trainee to contact a supervising dentist?				
7. What is the process for reviewing trainee records to assure adequate patient safeguards are being utilized?				
Competency Assessment, Documentation, OAR 333-010-0435, OAR 333-010-0430	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
1. Are there competency assessment records available for each trainee?				
2. Do the records reflect the status of the trainees? (i.e clinical training, employment/utilization phase.)				
3. What comments, if any, are documented A. About the level of training for the trainees? B. About the patient care rendered by the trainee? C. About the trainee's communication and interpersonal skills? D. About the trainees professionalism? E. About the trainees dental and medical knowledge?				
4. Is there a procedure log for each trainee?				
5. Does it reflect details about the procedures performed by the trainee, e.g. type of procedure, method used, steps performed by the trainee? Do you have comments about the data contained in the procedures log?				
6. Do records contain information: A. About the type(s) of complications incurred by the trainee and/or the supervising dentist?				

B. Findings about rate(s) of complications incurred by the trainee/supervising dentist at the site?				
Informed Consent OAR 333-010-0440, 333-010-0455	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
1. Is there a description of the method for obtaining the informed consent from patients to be treated by trainees or those legally able to give informed consent for the patients?				
2. Is there a copy of the informed consent form available for review?				
3. Is there documentation in the patient record that informed consent was been obtained prior to providing care to the patient? This is applicable when an evaluation team member is reviewing patient's dental records.				

Provide additional comments or additional questions that require clarification.

Comments:

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
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Dental Pilot Project Program
Interview with Trainee Tool
DPP #200

Date:_____ Site:_____

Reviewer's Name & Organization: _____

Name of Interviewee & Role: _____

Patient Population: (Circle all that are served at this site)

A. Head Start – Early Childhood
B. Elementary School Children
C. Developmentally Disabled Child or Teen
D. Others (Identify) _____

Elements of Implementation:
OAR Minimum Standards 333-010-0410, OAR (a) Patient Safety 333-010-0435, OAR Program Responsibilities 333-010-0455

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OAR 333-010-0455 (C) Interviews with project participants and recipients of care	OAR Compliance			Comments
	Yes	No	N/A	
Interview with Trainee: 1. How long have you been licensed as a Registered Dental Hygienist? When did you obtain your EPDH license?				
2. What inspired you to become a part of the pilot project?				
3. What new skills have you learned?				

4. How are you progressing with the new skills?				
5. How competent do you feel in performing the ITR procedure? Other skills you have learned?				
6. Are you expected to perform tasks that you were not trained to do?				
7. Please comment on the course content during your training phase. a) Didactic b) Clinical				
8. What was the time allocated for training?				
9. Was the time allocated for training sufficient for your comfort level/competency level?				
10. Is this your first experience with a distance learning model of training and provision of service? a) If so, describe your experience. b) If not, can you compare this experience with your other experiences?				
OAR 333-010-0435 (b) Trainee competency; (c) Supervisor fulfillment of role and responsibilities	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
Trainee Clinical Experience: 1. How are the patients selected or assigned to you?				
2. How many patients have you treated this school year in total between all schools in the project site?				

How many ITRs have you placed? Please comment on the placement of ITRs in the patient's mouth?(e.g. number placed per patient, errors in placement and contributing factors, success in placements, other) Have there been any discrepancies between your recommendations to treat a patient with an IRT and the supervising dentists recommendations to either not treat or refer on to a dentist for treatment? How often does this occur?				
3. Please comment on how appointments with patients are established? a) Describe the coordination process with the school nurse, school administrators, school principal or others. b) Coordination with the patient and parents. c) Barriers.				
4. Have you experienced any adverse events or complications in providing your service?				
OAR 333-010-0435 (c) Supervisor fulfillment of role and responsibilities	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
1. Please comment on the consultation process with the preceptor or supervising dentist? a) Real-time consultation b) If consultation is via store and forward transmission of images to supervising dentist, discuss how feedback is provided to you. c) Does store and forward transmission of images require you to set-up a second appointment for the patient? If so, discuss.				
2. After placement of ITRs in patients, do you provide referral information to a dentist for further services?				
3. Do you follow-up with the patient after the initial service provided and after you have made a referral?				

Is this documented in the patients chart?				
4. Please comment on the timeframe of patient referrals to the point-of-service by a dentist?				
5. Please comment on the setting for the clinical setting where the oral health services are provided? (e.g. room designated for clinical services, dentist office, other)				
6. What are your expectations regarding the outcome of this project?				
7. Are there any other comments, or information you would like to share with us?				

Provide additional comments or additional questions that require clarification.

Comments:

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Oregon Health Authority

Dental Pilot Project Program
Supervising Dentist Interview Tool
DPP #200

Date:_____ Site:_____

Reviewer's Name & Organization: _____

Supervising Dentist Name:_____

Patient Population: (Circle all that are served at this site)

A. Head Start – Early Childhood
B. Elementary School Children
C. Developmentally Disabled Child or Teen
D. Others (Identify) _____

Elements of Implementation:
OAR Minimum Standards 333-010-0410, OAR (a) Patient Safety 333-010-0435, OAR Program Responsibilities 333-010-0455

Instructor and Supervisor Information OAR 333-010-0425, Supervisor fulfillment of role and responsibilities, OAR 333-010-0435, Informed Consent 333-010-0440, Interviews with project participants and recipients of care OAR 333-010-0455	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
Supervising Dentist Interview: 1. What are your current professional responsibilities outside of this project?				
2. Please share some of your experiences with us in providing oral health care.				

3. What inspired you to participate in the pilot program?				
4. Describe your understanding of the supervising dentist's role.				
5. Do you feel comfortable in your role as a supervising dentist?				
Instructor and Supervisor Information OAR 333-010-0425, Supervisor fulfillment of role and responsibilities, OAR 333-010-0435, Informed Consent 333-010-0440, Interviews with project participants and recipients of care OAR 333-010-0455	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
Supervising Dentist/Trainee Process: 1. How frequently are you in contact with the trainee(s) assigned to you?				
2. If there are more than one trainee providing services at this site, who assigns the patients to the trainee?				
3. Have there been instances wherein patients (or parents/guardians) have withdrawn consent for participation in the pilot project? If so, did the patient provide a reason?				
Supervising Dentist's Evaluation of the Trainee: 1. Please comment on the trainee's performance of the following: a. The trainee's initial oral evaluation of the patient. b. The placement of an Interim Therapeutic Restoration (ITR) in the patient's mouth.				

2. Describe the method of communication and how information is shared regarding pilot project observations between: a) Trainee and supervising dentist Please comment on the process for transmission of radiological images and post-operative intra-oral images to you for review. How are orders received and documented? b) Supervising dentist to DPP #200 management				
3. Discuss the referral policy and procedures regarding patients seen by trainee(s) who are in need of more specialized care. Who makes the referral?				
4. Were there any unusual occurrences or incidents observed or reported regarding the oral health care services provided by the trainee?				
5. Are the trainees involved in any post-care or follow-up care of patients in the pilot project? Please describe.				
6. What performance strengths have you identified in the trainee's performance?				
7. Have you identified any performance weakness? If trainees exhibited performance weakness, what remedial activities were undertaken to improve the trainee's performance?				

8. Do you feel the training and preparation for the employment/utilization phase was satisfactory or is there need for improvement?				
Satisfaction Surveys: 9. Have you had a chance to review the patient questionnaires (patient follow-up surveys or patient satisfaction surveys)? What were your findings?				

Provide additional comments or additional questions that require clarification.

Comments:

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Dental Pilot Project Program
Interview with School Staff, Administrators and School HealthCare Providers
DPP #200

Date:_____ School:_____

Name of Interviewee & Role:_____

Elements of Implementation: OAR Minimum Standards 333-010-0410, OAR (a) Patient Safety 333-010-0435, OAR Program Responsibilities 333-010-0455	
Questions:	**Answers:**
1. What is your role in the school?	
2. What type of health services are provided in your school? (e.g. school nurse, school based health center, dental clinic, etc.) How often are the providers on site? (e.g. 1 day per week, 1 day per month, etc.)	
3. Can you comment on any dental access issues the student population faces at your school? Access to dental care was defined by the Oregon Medicaid Advisory Committee in 2016. "Oral health care access is achieved when people* are able to seek out and receive the right care, from the right provider, in the right place, at the right time.[1]	

[1] Oregon Medicaid Advisory Committee: Oral Health Workgroup Available at http://www.oregon.gov/oha/OHPR/MAC/ Documents/ MAC-oralhealthframework-Oct2016.pdf

*Regardless of race, ethnicity, language spoken, culture, gender, age, disability status, income, education, or health	
4. How often do you have students who complain of dental pain?	
5. How are patients referred to see the Expanded Practice Dental Hygienist in the school? If the EPDH is not on site, is there a process for a student to obtain emergency dental care?	
6. How do the students in the elementary school access the dental services provided in the Central Health & Wellness Center - School Based Health Center? (e.g. school transportation is provided, parents are responsible for getting child to SBHC appointment, etc.)	
7. How long has dental care been provided in your school? Can you comment on the impact of dental care services being provided on site?	
8. What is your perception of what would occur if there were no longer dental services provided in the school?	

9. How have parents responded to having dental services provided on site at the school?	
10. The Dental Pilot Project Program has authorized the EPDH in your school to perform a procedure known as an Interim Therapeutic Restoration (ITR)* if ordered to do so by a supervising dentist. The EPDH sends the records to the supervising dentist via electronic methods. The supervising dentist reviews the records and makes a determination as to whether the student requires an ITR. Have you noticed an impact of the ITR procedure on the student population? (e.g. less complaints in school nurse office, reduced absenteeism, etc.) *An Interim Therapeutic Restoration (ITR) is a restoration placed on a tooth to prevent the progression of dental decay. The provider uses hand instruments to remove as much of the decay as possible and then places a restoration in the area. Local anesthetic is not required. Dental drills are not required.	
11. What is your perception of the professionalism exhibited by the EPDH in the pilot project?	

Provide additional comments or additional questions that require clarification.

Comments:

Guidelines for Placement of Interim Therapeutic Restorations

The Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry (Pacific) has developed the following guidelines for use in training for HWPP #172. These guidelines were developed to train allied dental personnel to place "Interim Therapeutic Restorations" (ITR) when directed to do so by a dentist. The ITR is a provisional restoration designed to stop the progression of dental caries until the patient can receive further evaluation of treatment for that tooth by a dentist.

In addition, these guidelines are designed to provide general guidance, not precise instructions that are applicable in all circumstances. This approach recognizes that providers delivering care will need to adapt to local circumstances and develop customized procedures for performance and follow---up for this duty. OHSU has adopted these guidelines for its ongoing pilot project.

Background and Rationale

An Interim Therapeutic Restoration (ITR) is a preventive technique that places carious teeth in a holding pattern to stop progression of decay until they can be seen by a dentist for follow---up or definitive care. [1] It is part of an approach referred to as "minimally invasive dentistry" where the objective is to preserve natural tooth structure and keep teeth healthy with minimal removal of tooth structure. [2] Some of the techniques and principles used in this approach include:

a) Non---cavitated lesions (white spots) can be remineralized by application of high dose fluoride or fluoride varnish.
b) Caries is detected using radiographs and visual examination. Care is taken <u>not</u> to use an explorer to poke at groves and pits in teeth to try to detect a "stick". If there is demineralized enamel present, poking it with an explorer could break off pieces of the enamel. In addition, if a hole small enough to catch the sharp end of an explorer were present that hole should be covered with a sealant or ITR, something that could be done without poking at the tooth with the explorer.
c) Small areas of radiolucency in the dentin of a tooth do not require a conventional filling. If there is a hole in the tooth or enamel groove adjacent to the area of radiolucency, it may be possible to place a sealant or ITR and remove the source of oxygen and food to the lesion and stop the progression of the decay.
d) A systematic review of the literature had demonstrated that children who have ITRs placed have less pain and are less afraid of subsequent dental work than children who have similar lesions treated with conventional fillings. Therefore an ITR can be considered a preferable treatment compared to a conventional restoration in an area where it is indicated. [3]

A full review of the literature supporting the use of Interim Therapeutic Restorations has been published. [4]

Criteria for ITR Placement

1. Patient factors:
   a. The patient's American Society of Anesthesiologists Physical Status Classification is Class III or less.
   b. The patient is cooperative enough to have the restoration placed without the need for special protocols, including sedation or physical support.
   c. The patient, or responsible party, has provided consent for the procedure.

2. Tooth factors:
   a. The cavity is accessible without the need for creating access using a dental handpiece.
   b. The margins of the cavity are accessible so that clean non---carious margins can be obtained around the entire periphery of the cavity with the use of hand instrumentation.
   c. The depth of the lesion is more than two millimeters from the pulp on radiographic examination or is judged by the dentist to be a shallow lesion such that the treatment does not endanger the pulp or require the use of local anesthetic.
   d. The tooth is restorable and does not have other significant pathology.
   e. The patient reports that the tooth is asymptomatic, or if there is mild sensitivity to sweet, hot, or cold that the sensation stops within a few seconds of the stimulus being removed.
3. In some circumstances the available records may not be ideal for making the decision to place an ITR. The collaborating dentist has the option to request further records or information. However, there will be circumstances where the existing records are the best that can be obtained for that patient. It is then up to the collaborating dentist to use his or her clinical judgment to determine the risks and benefits of placing the ITR and to make a decision about whether to treatment plan the ITR.

Criteria for Completion of an ITR

Criteria for evaluating successful completion of adhesive protective restorations includes all of the following:

1. The restorative material is not in hyper---occlusion.
2. There are no marginal voids.
3. There is minimal excess material.

Protocols for Follow---Up for an ITR

The following are protocols which are suggested for follow---up after the placement of an ITR.

1. One week follow---up
   a. All patients or caregivers of patients who have ITRs placed are provided with

contact information for the trainee who placed the ITR and told how they may be contacted for questions or if they have any problems.

2. Three month follow---up
   a. Trainees arrange for a three month follow---up visit with patients who have ITRs placed.
   b. At the initial three month follow---up visit, a visual inspection of the tooth is performed to determine if the ITR is intact. If the ITR is not intact at any visit subsequent to placement, and the cavitation is still present in the tooth, the EPDH will replace and also will take another intra-oral photo before and after replacing.
3. Six---month and 1 year follow---up
   a. Trainees arrange for continued three month follow---up visits with patients who have ITRs placed.
   b. At six months intervals, if the ITR is intact, the trainees complete the following procedures:
      i. Take an X---ray that includes the tooth/teeth with the ITR. (**if** patient is due for recall xrays at the time) and intra---oral photographs to include the tooth with the ITR.
      ii. Additional record collection for the patient that is appropriate for a periodic recall visit.
4. These follow---up protocols may be modified by the oral health providers involved based on local circumstances.

Protocols for Adverse Outcomes After Placement of an ITR

Below are several hypothetical adverse outcomes from ITR placement (none of these outcomes has occurred in the California pilots). The list contains suggested responses to each theoretical outcome.

1. During the placement of an ITR there is an exposure of the pulp
   a. Small area (pinpoint)
      i. Cover the exposure with a small amount of Glass Ionomer material, curethat increment of material and then complete the restoration.
      ii. The patient should receive a consultation by, or a referral to, a dentist for an appointment to take place within a week or two.
   b. Large area
      i. Hold a dry cotton pellet over the exposed area until bleedingstops.
      ii. Place a new cotton pellet over exposed area
      iii. Place a glass ionomer restoration on top of cotton pellet.
      iv. The patient should receive a consultation by, or a referral to, a dentist for an appointment to take place within a few days.
2. During or after the placement of an ITR part of the tooth breaks
   a. Repair the area with glass ionomer if it is a small area.
   b. If it cannot be repaired, then the patient should receive a consultation by, or a referral to, a dentist.

3. During the placement of an ITR the gingival tissue is injured

a. For a small area of injury, the gingival tissue usually heals quickly. There may be no specific treatment or follow---up required.
b. For a larger area of injury the patient should receive a consultation by, or a referral to, a dentist.

4. During the placement of an ITR or at a subsequent visit the ITR is determined to be too high
   a. The patient may or may not experience pain.
   b. If possible, reduce the height of the ITR so it is no longer too high. If the tooth is not sensitive it should continue to be monitored using the follow---up protocols listed above.
   c. If the tooth is sensitive see "The Tooth is Sensitive" below.

5. The margins are not sealed
   a. Add additional material to seal the margin if possible.
   b. If the margin cannot be sealed, the patient should be referred to a dentist for an appointment within a few weeks.

6. The tooth is sensitive
   a. If the tooth becomes sensitive post---ITR placement, the ITR should be checked to see if it is too high. See "The ITR is too high" above.
   b. For mild initial sensitivity the patient should wait to see if it gets better. Mild sensitivity may resolve over several weeks or months.
   c. If the tooth becomes sensitive post---ITR placement and continues for some time or the patient is experiencing more than mild sensitivity, then the patient should receive consultation by, or a referral to, a dentist.

References

[1] American Academy of Pediatric Dentistry (AAPD). Policy on Interim Therapeutic Restorations. 2001, revised 2008.
[2] Murdoch-Kinch, CA, McLean ME. Minimally Invasive Dentistry. JADA 2003:134:87-95.
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[4] Glassman P, Subar P, Budenz A. Managing Caries in Virtual Dental Homes Using Interim Therapeutic Restorations. CDA Journal 2013:41(10):745-752.

Appendix C

Policy on Interim Therapeutic Restorations (ITR)

Review Council

Council on Clinical Affairs

Latest Revision

2017

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that unique clinical circumstances can result in challenges in restorative care for infants, children, adolescents, and persons with special health care needs. When circumstances do not permit traditional cavity preparation and/or placement of traditional dental restorations or when caries control is necessary prior to placement of definitive restorations, interim therapeutic restorations (**ITR**)[1] may be beneficial and are best utilized as part of comprehensive care in the dental home.[2,3] This policy will differentiate ITR from atraumatic/alternative techniques (**ART**)[4] and describe the circumstances for its use.

Methods

This policy was originally developed by the Council on Clinical Affairs and adopted in 2001. This document is a revision of the previous version, revised in 2013. This updated policy is based upon electronic database and hand searches of medical and dental literature using the terms: dental caries, cavity, primary teeth, deciduous teeth, atraumatic restorative treatment, interim therapeutic restoration, AND glass ionomer. fields: all; limits: within the last 10 years, humans, English, birth through age 18. Additionally, websites for the AAPD and the American Dental Association were reviewed. Expert and/or consensus opinion by experienced researchers and clinicians was also considered.

Background

Atraumatic/alternative restorative technique (**ART**) has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care.[4-6] In many countries, practitioners provide treatment in non-traditional settings that restrict restorative care to placement of provisional restorations. Because circumstances do not allow for follow-up care, ART mistakenly has been interpreted as a definitive restoration. ITR utilizes similar techniques but has different therapeutic goals. Interim therapeutic restoration more accurately describes the procedure used in contemporary dental practice in the U.S.

ITR may be used to restore, arrest or prevent the progression of carious lesions in young patients, uncooperative patients, or patients with special health care needs or when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed.[7,8] Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth, in erupting molars when isolation conditions are not optimal for a definitive restoration, or for caries control in patients with active lesions prior to treatment performed under general anesthesia.[9,10] The use of ITR has been shown to reduce the levels of cariogenic oral bacteria (e.g., Mutans Streptococci, lactobacilli) in the oral cavity immediately following its placement.[11-13] However, this level may return to pretreatment counts over a period of six months after ITR placement if no other treatment is provided.[12]

The ITR procedure involves removal of caries using hand or rotary instruments with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as glass ionomer or resin-modified glass ionomer cement.[14] ITR has the greatest success when applied to single surface or small two surface restorations.[15,16] Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure.[16,17] Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations, especially when glass ionomers (which have fluoride releasing and recharging properties) are used.[18-20]

Policy statement

The AAPD recognizes ITR as a beneficial provisional technique in contemporary pediatric restorative dentistry. ITR may be used to restore and prevent the progression of dental caries in young patients, uncooperative patients, patients with special health care needs, and situations in which traditional cavity preparation and/or placement of traditional dental restorations are not feasible. ITR may be used for caries control in children with multiple carious lesions prior to definitive restoration of the teeth.

ABBREVIATIONS

AAPD: American Academy Pediatric Dentistry. **ART:** Atraumatic/alternative techniques. **ITR:** Interim therapeutic restorations.

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Dental Pilot Projects Compliance with Infection Control Procedures

Approved Dental Pilot Projects are required to follow infection control procedures as outlined under OAR 333-010-0410 Dental Pilot Projects: Minimum Standards, a dental pilot project shall: (f) Comply with the infection control procedures in OAR 818-012-0040.

Under the State of Oregon Board of Dentistry Dental Practice Act, Oregon Administrative Rules, Chapter 818:

DIVISION 12 STANDARDS OF PRACTICE: 818-012-0040 Infection Control Guidelines In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association. Additionally, licensees must comply with the following requirements:

(1) Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.

(2) Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.

(3) Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.

(4) Heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the licensee for the current calendar year and the two preceding calendar years.

(5) Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.

(6) Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.

(7) All contaminated wastes and sharps shall be disposed of according to any governmental requirements.

Stat. Auth.: ORS 679.120, 679.250(7), 680.075 & 680.150 Stats. Implemented: ORS 679.140, 679.140(4) & 680.100 Hist.: DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 127-89, cert. ef. 2-1-89; DE 2-1992, f. & cert. ef. 6-24-92; OBD 12004, f. 5-27-04, cert. ef. 6-1-04; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 62014, f. 7-2-14, cert. ef. 8-1-2014

Guiding Principles of Infection Control:

PRINCIPLE 1. TAKE ACTION TO STAY HEALTHY

PRINCIPLE 2. AVOID CONTACT WITH BLOOD AND OTHER POTENTIALLY INFECTIOUS BODY SUBSTANCES

PRINCIPLE 3. MAKE PATIENT CARE ITEMS (instruments, devices, equipment) SAFE FOR USE

PRINCIPLE 4. LIMIT THE SPREAD OF BLOOD AND OTHER INFECTIOUS BODY SUBSTANCES

Levels of Anticipated Contact between the dental health care professional (DHCP) or volunteer and the patient's mucous membranes, blood or saliva visibly contaminated with blood to determine the suggested elements for the infection control program. This checklist is designed to provide information for 3 levels of programs:

I. **Anticipated contact with the patient's mucous membranes, blood or saliva visibly contaminated with blood.**

II. **Anticipated contact with the patient's mucous membranes but not with blood or saliva visibly contaminated with blood.**

III. **No anticipated contact with the patient's mucous membranes, blood, or saliva visibly contaminated with blood.**

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ALL PROGRAMS SHOULD MEET THE MINIMUM REQUIREMENTS BASED ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S (CDC) GUIDING PRINCIPLES OF INFECTION CONTROL

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	X	X	**Infection Control Program Operating Procedures**			
			Is there a written infection control program?			
			Is there a designated person(s) responsible for program oversight?			
			Are there methods for monitoring and evaluating the program?			
			Is there a training program for dental health-care personnel (DHCP) (initial and ongoing) in infection control policies and practices?			
X	X	X	**Immunizations**			
			Are DHCP adequately immunized against vaccine-preventable diseases? Immunizations should meet or exceed federal, state and local guidelines. (May not be necessary for screenings)			
			Hepatitis B			
			Annual Influenza			
			Additional immunizations needed for program:			
X	X	X	**Hand Hygiene**			
			Are sinks available close to the area where care is provided?			
			If not, are alcohol-based hand sanitizers available?			
			Is staff properly trained in the use of alcohol handrub products?			
X	X		**Personal Protective Equipment (PPE) (e.g., gloves, masks, protective eyewear, protective clothing)**			
			Is there a protocol that outlines what PPE are worn for which procedures?			
			Is PPE storage available and close to care?			
			Are facilities available to disinfect PPE (DHCP evewear, patient eyewear, heavy duty utility gloves)?			

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	**X**	**As necessary**	**Environmental Surfaces: Clinical Contact Surfaces (e.g., light handles and countertops)**			
			Is there a list of what surfaces will be cleaned, disinfected or barrier protected and the process and products to be used?			
			If chemical disinfectants are used, is there a protocol for how they are managed, stored and disposed?			
X	**X**		**Housekeeping Surfaces (e.g., floors, walls)**			
			Is there a list of which housekeeping surfaces will need to be cleaned and disinfected and how often?			
X	**X**		**Safe Handling of Sharp Instruments and Devices**			
			Are DHCP trained in the safe handling and management of sharps?			
			Are sharps containers safely located as close as possible to the user?			
			Is there a written protocol for transporting and disposing of sharps and sharps containers?			
X	**X**		**Management and Follow-Up of Occupational Exposures**			
			Is there a written procedures manual for post-exposure management?			
			Is there a designated person responsible for post-exposure management?			
			Is there a mechanism to document the exposure incident?			
			Where is the closest medical facility for wound care and post-exposure management?			
			Is there a mechanism to refer the source and DHCP for testing and follow-up?			
			Is there a mechanism for expert consultation by phone?			
			Are post-exposure prophylaxis medications readily available onsite, at an emergent care facility or nearby pharmacy?			
			Who is the responsible party for post-exposure care costs?			
			Does Workers' Compensation apply?			
			Have DHCP been trained in post-exposure management procedures?			

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	X	If used	**Reusable Patient Items**			
			Are reusable patient items processed onsite?			
			IF YES:			
			Is there a protocol for how and where contaminated instruments are cleaned and processed?			
X	X	If used	**Reusable Patient Items, continued**			
			Is there adequate space for the processing area to be divided into clean and dirty areas?			
			Has the person who is performing the processing been adequately trained?			
			Is the sterilizer(s) spore tested at least weekly?			
			Are protocols in place to handle positive tests?			
			Can dental equipment and patient items be safely stored and secured if left on site?			
			IF NO:			
			Is there an adequate inventory of instruments for the number of patients to be treated?			
			Are containers for holding or transporting contaminated instruments puncture-proof, secured, & labeled as a biohazard?			
X	X	X	**Single-Use (Disposable) Items and Devices**			
			Is there a protocol for which single-use, disposable items will be used and how they will be disposed? e.g., gloves, tongue depressors			
			Are disposable items unit-dosed for each patient?			
			Are syringes that deliver sealant and composite material barrier-protected if they aren't single-use, disposable syringes?			
X	X	X	**Management of Dental Unit Water Quality**			
			Is there a protocol for how dental unit water quality will be maintained and monitored?			

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	**X**	**X**	**Management of Regulated and Non-Regulated Medical Waste**			
			Is there a protocol and designated person responsible for proper disposal of regulated waste (e.g., sharps containers, extracted teeth) and non-regulated waste (regular trash)?			

CONSENT TO PERFORM
SPECIFIC PROCEDURES

Patient Name:_____Chart Number: _____

Dental Professional's Name:
Dental Professional License Category:
❒ Expanded Practice Dental Hygienist (EPDH)

PURPOSE. The purpose of this form is to obtain your consent to have procedures performed that are recommended for you.

I understand that the dental treatment that may be performed by the dental professional listed above is part of an educational training. The training is designed to teach dental professionals a new procedure. As a participant in the training, I understand the following:

1. The new duty being taught is:
   - Place an "**Interim Therapeutic Restoration" (ITR),** which is a temporary filling that will stabilize my tooth or teeth until I can have further evaluation or treatment by a dentist.
2. An ITR may prevent more decay or slow down tooth decay.
   a. Loose, food, debris or soft decay will be removed with a hand instrument.
   b. Some decay may be left in the tooth.
   c. A filling will be placed in my tooth or teeth to fill the hole in the tooth until I am able to have further evaluation or treatment by a dentist.
   d. Covering any decay left in the tooth will slow down the progression of decay and reduce the chance of having a toothache or infection.
   e. This procedure is generally comfortable and pain free.
   f. No local anesthetic is necessary. However, there may be some minor discomfort during the procedure.
   g. There is a small possibility of feeling pain in my tooth after the procedure.
   h. I may have an uncomfortable bite, or the filling may not last.
   i. If I experience problems with the filling, I may need additional dental work.
3. The services listed above are not a substitute for a complete dental examination, diagnosis and treatment by a dentist. I can choose not to have the procedure performed. If I decide not to have this procedure performed on me, it will not affect my right to future care or treatment.
4. No warranty or guarantee has been made to me regarding any treatment or procedure that I receive.

5. If a problem occurs during or after the dental professional places an ITR, I understand that I can notify the Central Health and Wellness Center for any follow up required. The dental clinic will arrange for evaluation of the problem and may arrange for follow-up care.
6. My identity will not be disclosed without my separate consent, except as specifically described in this form or allowed or required by law.

I have been given full opportunity to ask questions about this training, the procedure that will be performed, and any risks involved. I voluntarily consent to authorize this procedure to be performed should they be recommended for me. I certify that I have read this form and that I understand its contents.

_____

Name of Patient (PRINT) **Signature of Patient**

_____

Name of Patient's Parent/Legal Guardian (PRINT) **Signature of Patient's Parent/Legal Guardian**

Date:_____

REFUSAL: I refuse to participate in this training as described above and I refuse to have the procedure described in this form performed on me.

Signature: _____

For more information contact:
Linda Mann
Director of Community Outreach, Capitol Dental Care 503-587-7162

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Chart Review Process: DPP #200

Advisory committee members participating in the review of dental abstraction records.*

Todd Beck, DMD, *Private Practice,* Oregon Board of Dentistry member
Fred Bremner, DMD, *Executive Director,* Clackamas County Dental Association
Tony Finch, MA, MPH, *Executive Director,* Oregon Oral Health Coalition
Karen Hall, RDH, EPDH, *Oral Health Educator,* Oregon Oral Health Coalition
Lesley Harbison, BSDH, RDH, *Owner/Practitioner,* Gentle Touch Dental Hygiene
Kelli Swanson Jaecks, MA, RDH, *Past President* ADHA & ODHA
Kyle Johnstone, MHA, RDH, EPP, *Clinic Operations Manager,* Virginia Garcia Memorial Health Center
Kenneth R Wright, DDS, MPH, *Vice-President, Dental Services,* Kaiser Foundation Health Plan of the Northwest

*The ITR is currently only performed by licensed dentists in Oregon. Only dentists on the advisory committee completed portions of the Clinical Records Review Form that required the committee member to make an assessment as to whether the ITR was acceptable or unacceptable.

ACCEPTABLE

Patient 1:

- Informed consent documented; copy of signed form in chart
- ITRs were placed on teeth #T and #S.
- Intra-oral documentation present; Pre-operative, post-operative, retention images
- Radiographs documented, present, recent.
- Radiographs, intraoral photographs and ITR placements are acceptable by all reviewers.
- Documentation of preparation and placement of ITRs are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: Three-month follow-up by provider and supervising dentist is documented well; ITRs are retained and quality is still good.
- Complications: None
- Adverse Outcomes: None

ACCEPTABLE

Patient 2:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #K.
- Intra-oral documentation present; Pre-operative and post-operative images
- Radiographs documented, present, recent.

- Radiographs, intraoral photographs and ITR placements are acceptable by all reviewers.
- Documentation of preparation and placement of ITR is are acceptable.

- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: A three-month follow-up was not possible because the student had changed schools.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 3:

- Informed consent documented; copy of signed form in chart
- ITRs were placed on teeth #K and #T.
- Intra-oral documentation present; Pre-operative and post-operative images
- Radiographs documented, present, recent.
- Radiographs are deemed diagnostic but blurry by several reviewers.
- Intraoral photographs and ITR placements are acceptable by all reviewers.
- Documentation of preparation and placement of ITRs are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: A three-month follow-up appointment is planned.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 4:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #K.
- Radiographs documented, present, recent.
- Intra-oral documentation present; Pre-operative and post-operative images
- Radiographs are deemed diagnostic but one BWX was deemed of poor diagnostic quality due to lack of patient cooperation.
- Intraoral photographs and ITR placements are acceptable by all reviewers.
- Documentation of preparation and placement of ITRs are acceptable.
- Material is not in hyperocclusion.
- No marginal voids, finish is good with little or no excess material.
- Case management: A three-month follow-up appointment is planned.
- Complications: Repair of fractured ITR required.
- Adverse outcomes: None

Comments: One reviewer showed concern that the restoration is missing in part at the time of the follow-up appointment in March 2017, approximately six months after the initial placement. The ITR was replaced although a repair intraoral image was not furnished to OHA.

ACCEPTABLE

Patient 5:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #S.
- Radiographs documented, present, recent.
- Intra-oral documentation present; Pre-operative, post-operative and retention images
- Radiographs, intraoral photographs and ITR placement is acceptable by all reviewers.
- Documentation of preparation and placement of ITR is are acceptable.
- Material is not in hyperocclusion.

- No marginal voids; finish is good with little or no excess material.
- Case management: Three-month follow up by provider and supervising dentist is documented well; ITRs are retained and quality is still good.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 6:

- Informed consent documented; copy of signed form in chart
- ITRs were placed on teeth #J and #T.
- Intra-oral documentation present; Pre-operative, post-operative and retention images
- Radiographs documented, present, recent.
- Radiographs are deemed diagnostic but both BWXs were deemed of overall poor diagnostic quality due to lack of patient cooperation. Treated teeth were visible on the radiographs.
- Intraoral photographs and ITR placements were acceptable by all but one reviewers.
- Documentation of preparation and placement of ITRs are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: Six-month follow-up by provider and supervising dentist is documented well; ITRs are retained and quality is still good.
- Complications: None (Majority of reviewers rated ITR as acceptable with no complications.)
- Adverse Outcomes: None

Comments: One reviewer rated the voids on #T-O as unacceptable without further explanation.

ACCEPTABLE

Patient 7:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #T.
- Intra-oral documentation present; Pre-operative, post-operative and retention images
- Radiographs documented, present, recent.
- Radiographs, intraoral photographs and ITR placement is acceptable by all reviewers.
- Documentation of preparation and placement of ITR is are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: Three-month follow-up by provider and supervising dentist is documented well; ITRs are retained and quality is still good.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 8:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #A.
- Intra-oral documentation present; Pre-operative and post-operative images
- Radiographs documented, present, recent.

- Radiographs were deemed acceptable by all but one reviewer who deemed the radiograph non-diagnostic for the distal of #A.

- Intraoral photographs and ITR placement is acceptable by all reviewers.
- Documentation of preparation and placement of ITR is acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: A three-month follow-up appointment is planned.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 9:

- Informed consent documented; copy of signed form in chart
- ITRs were placed on teeth #K and #T.
- Intra-oral documentation present; Pre-operative and post-operative images.
- Radiographs documented, present, recent.
- Radiographs are deemed diagnostic but one BWX was deemed of overall poor diagnostic quality due to lack of patient cooperation.
- Patient was uncooperative for a BWX of #K.
- Intraoral photographs and ITR placements were acceptable by all but one reviewers.
- Documentation of preparation and placement of ITRs are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: A three-month follow-up appointment is planned.
- Complications: None
- Adverse outcomes: None

ACCEPTABLE

Patient 10:

- Informed consent documented; copy of signed form in chart
- A single ITR was placed on tooth #C.
- Intra-oral documentation present; Pre-operative and post-operative images.
- Radiographs documented, present, recent.
- Radiographs were deemed acceptable by all but one reviewer who deemed the radiograph non-diagnostic for the distal of #A.
- Intraoral photographs and ITR placement is acceptable by all reviewers.
- Documentation of preparation and placement of ITR is are acceptable.
- Material is not in hyperocclusion.
- No marginal voids; finish is good with little or no excess material.
- Case management: A three-month follow-up appointment is planned.
- Complications: None
- Adverse outcomes: None

Dental Pilot Project Program
Clinical Records Review Form
DPP #200

Date: _____ **Site:** _____ **Reviewer's Name, Organization:** _____

Oregon Administrative Rules: Minimum Standards 333-010-0410, (a) Patient Safety 333-010-0435, (2) Site Visits 333-010-0455, Description of Dental Pilot Projects 333-010-0400, Program Responsibilities 333-010-0455								
Dental Procedures and Nomenclature Code (CDT): Interim Therapeutic Restorations (ITR)								
Abstract Patient Record ID Number	Informed Consent Documented	Tooth Number(s), Surface(s) Restored	Indicate Patient Age	Reimbursement Type	Radiographs/ Intra-Oral Photographs	ITR Placements	Comments Comment on Quality of Care and Patient Safety Factors Which May Include the Following:	
		Indicate Class I, Class II, Class III or Class V Example: Tooth K – Class I Tooth C – Class V		• Medicaid • Private Insurance • Other • None	• Comments	• Number of Placements • Comments Regarding ITR Placements • Criteria for evaluating successful completion of Interim Therapeutic Restorations includes all of the following: 1. Restorative material is not in hyper-occlusion 2. There are no marginal voids. 3. There is minimal excess material. Record as Acceptable or Not Acceptable Example: Occlusion – Acceptable Margins – Acceptable Material – Acceptable Material: Material Used is the same product for all ITRs reviewed:	• Procedure Success • Incidents Or Unusual Occurrences • Type Of Complications, If Any _____ • Post-Treatment Evaluations/Follow-Up Care – Case Management: 3 Months, 6 Months • Trainee Records Indicate Follow-Up at 3-Months, 6-Months and 1 Year • Follow-Up consistent with ITR Protocols • Supervising Dentist reviewed ITR post-placement and deemed ITR acceptable based on ITR Placement Protocols.	• Other Comments

OREGON HEALTH & SCIENCE UNIVERSITY

School of Dentistry

Department of Pediatric Dentistry

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March 31, 2017

Sarah Kowalski, RDH
Dental Pilot Project Coordinator
Oral Health Program
The Oregon Health Authority
800 NE Oregon Street
Portland, Oregon 97023

To Whom It May Concern

Re: External Evaluator on Workforce Pilot Project #200: Training Dental Hygienists to Place Interim Therapeutic Restorations

The Dental Pilot Project #200 "Training Dental Hygienists to Place Interim Therapeutic Restorations" is being conducted by the School of Dentistry, Department of Community Dentistry at OHSU. I am serving as an external evaluator for this pilot project to evaluate the Interim Therapeutic Restorations (ITRs) placed by External Practice Dental Hygienists (EPDHs) during the training and utilization phase. I have specialization in Pediatric Dentistry and am an Assistant Professor at the School of Dentistry, Department of Pediatric Dentistry. I do not have any financial or commercial interest in the outcome of the project.

Please do not hesitate to contact me if you have any questions.

Sincerely,

John Engle, DDS
Assistant Professor, Department of Pediatric Dentistry
Oregon Health and Science University

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

Oregon Health Authority

Dental Pilot Project Program
External Evaluating Dentist Form
DPP #200

Date:____3-24-17_____
Site:_____

Reviewer's Name & Organization: ___John Engle, OHSU School of Dentistry_____

External Evaluating Dentist Name: _John Engle DDS_____

Patient Population: (Circle all that are served at this site)

A. Head Start – Early Childhood
B. Elementary School Children
C. Developmentally Disabled Child or Teen
D. Others (Identify) _____

Elements of Implementation:
OAR Definitions 333-010-0405, OAR Program Responsibilities 333-010-0455, OAR Minimum Standards 333-010-0410, OAR Evaluation & Monitoring 333-010-0435

OAR 333-010-0435 (e) Identification of an evaluator unaffiliated with the project and with no financial or commercial interest in the outcome of the project that will conduct the pilot project's evaluation. OAR 333-010-0435	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
External Evaluator Interview: 1. What are your current professional responsibilities outside of this project?				I am currently at OHSU in the Department of Pediatric Dentistry. My responsibilities include both clinical and didactic oversight of predoctoral dental students as well as residents in our pediatric dental residency program at both the School of Dentistry as well as at Doernbecher Children's Hospital.
2. Do you have a financial or commercial interest in the outcome of the pilot project?				No.
3. Describe your role as the external evaluator for the project.				I attended a clinical training day last fall, and subsequently have reviewed both x-ray films and clinical photos of selected

				patients. Both pre-operative and post-operative photos were included for review.
4. Did you attend the Pilot Project clinical training? In your opinion, is the clinical training curriculum sufficient?				Yes. It was a well - designed program, and was structured to allow for ample discussion and reflection. All aspects of the training allowed for integration and input of dentists, hygienists and support staff.
OAR 333-010-0410 (8) Quality of care	**OAR Compliance**			**Comments**
	Yes	**No**	**N/A**	
Evaluation of Trainee Competency 1. Describe the process for receiving records for review from the project? What types of records are you reviewing?				The records that I have reviewed have been uploaded for review by me. They have included both x-ray films as well as clinical photos.
2. Do you have any comments on the quality of the pre-operative radiographs taken for diagnosis?				While there were a couple of films that I would describe as “fuzzy” due to patient movement, they all fell within the range of clinically acceptable based on criteria that we would normally use in our school clinics.
3. Do you have any comments on the quality of the post-operative intraoral digital images taken for review of occlusion?				They were all excellent. I work with residents that take clinical photos, and I was impressed that the provided photos would rank alongside those of our residents.
Evaluation of Quality of Care Provided by Trainee 1. Describe the criteria for evaluating successful completion of Interim Therapeutic Restorations.				I look at the extent of changes in the enamel in the preoperative photo which will determine the expected outline form of the completed restoration. Once the ITR is placed I judge its outline form and compare that with the expected form. I judge contours of the ITR to ascertain that the form of the material approximates that of the morphology of the tooth. Finally I look at the surface characteristics of the ITR.

2. How many records have you reviewed for the project? How many records were deemed acceptable? How many records were deemed not-acceptable? Why?				Currently I have reviewed 24 records. All of the reviewed photos demonstrated acceptable results. I had listed comments on the provided spreadsheet. Two or three of the restorations were seen to have some surface roughness which would not impact clinical performance.
3. Were there any unusual occurrences or incidents observed or reported regarding the oral health care services provided by the trainee?				I did not observe any during the one day I was on site.
4. Based on the records reviewed, do you feel the preparation for the employment/utilization phase was satisfactory or is there need for change?				Simply based upon the fact that I have seen no significant issues with the quality of the post-operative photos I must assume that the preparation is acceptable.
5. What performance strengths have you identified in the trainee's performance?				N.A.
6. Have you identified any performance weakness? If trainees exhibited performance weakness, are you aware if any remedial activities were undertaken to improve the trainee's performance?				None identified. In all cases the oversight of the licensed dentist appears to have identified additional treatment needs, or the need for emergency services.

Provide additional comments or additional questions that require clarification.

Comments:

Dental Pilot Project: Adverse Event Reporting

ADVERSE EVENT REPORTING:
A sponsor must report adverse events to the Oregon Health Authority program staff the day they occur as outlined in OAR 333-010-0460.
Adverse Event reports are prepared by project sponsor personnel with the intent that such reports will not contain information regarding the patient's identity. The information will be prepared as a brief anecdotal account to be submitted to the Oregon Health Authority.

These guidelines serve only to describe some occurrence requiring a written anecdotal account. The examples serve as a minimal starting point for common reporting of incidents/occurrences so that project sponsors will be cognizant of trainee performances for the purposes of effective monitoring. Your judgment as to what constitutes a deviation from the usual norm of practice for your category of trainee is important.

Examples

1. A patient care error that has been identified by the trainee, supervising professional or other professional within the community or practice site.
2. Comments regarding the provision of health care by the trainees which reflect satisfaction or dissatisfaction with the services rendered. This information may originate from the following sources:
   A. Patients who have received services.
   B. Relatives or friends of patients receiving services.
   C. Community professionals such as physicians, pharmacists, dentists, nurses, health care administrators or others who may have knowledge of a trainee-patient interface.
   D. Other staff members who are employed by the employment/utilization site.
   E. Project sponsor staff having knowledge of trainee-patient interaction.

Instructions:

1. Contact Program Staff via telephone on the date of the incident at 971-673-1563.
2. Complete Adverse Event Reporting Form and follow submission instructions.

Title Dental Pilot Project:

Reporting Date:

Date of Incident:

Address of Incident:

Patients Gender: ◯ Male ◯ Female

Patients Age:

Incident Description: Be as specific as possible. Use separate sheets of paper if necessary.

Dental Pilot Project: Adverse Event Reporting

Provide a root cause analysis of the incident. Use separate sheets of paper if necessary.

Please identify actions that have been taken or plans of action to take to prevent similar adverse events from happening in the future.

Procedure Name(s) and CDT Code(s) Performed on involved patient:

Contact Name:

Email:

Project Manager Signature: Date:

Instructions:
Download and Complete the Adverse Event Form PDF.
Submit the Completed Form via email to sarah.e.kowalski@state.or.us.
Attachments must be in PDF format.

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

June 5, 2017

Eli Schwarz, DDS, MPH, PhD
Department of Community Dentistry
Oregon Health & Science University
3030 SW Moody Ave, Suite 135B
Portland, OR 97201

Re: Site Visit Pass

Dear Dr. Schwarz,

On April 5, 2017, the Oregon Health Authority conducted the first required site visit for Dental Pilot Project #200, "Training Dental Hygienists to Place Interim Therapeutic Restorations" in Independence, Oregon.

The OHA Dental Pilot Project 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.

The Oregon Health Authority is responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations.

The Oregon Health Authority has determined that Dental Pilot Project #200 is in compliance with the requirements set forth in the Oregon Administrative Rules 333-010-0400 through 333-010-0470 and therefor has **passed** the site visit.

ORS 333-010-0455 Program Responsibilities

(1) Project evaluation. Program staff shall evaluate approved projects and the evaluation shall include but is not limited to:
(a) Periodically requesting written information from the project, at least annually to ascertain the progress of the project in meeting its stated objectives and in complying with program statutes and regulations; and
(b) Periodic, but at least annual, site visits to project offices, locations, or both, where trainees are being prepared or utilized.
(2) Site visits.
(a) Site visits shall include, but are not limited to:
(A) Determination that adequate patient safeguards are being utilized;
(B) Validation that the project is complying with the approved or amended application; and
(C) Interviews with project participants and recipients of care.
(b) An interdisciplinary team composed of representatives of the dental boards,

professional organizations, and other state regulatory bodies may be invited to participate in the site visit.
(c) Written notification of the date, purpose, and principal members of the site visit team shall be sent to the project director at least 14 calendar days prior to the date of the site visit.
(d) Plans to interview trainees, supervisors, and patients or to review patient records shall be made in advance through the project director.
(e) An unannounced site visit may be conducted by program staff if program staff have concerns about patient or trainee safety.
(f) A report of findings and an indication of pass or fail for site visits shall be prepared by program staff and provided to the project director in written format within 60 calendar days following a site visit.

Sincerely,

Bruce Austin, DMD
Statewide Dental Director

Sarah Kowalski MS, RDH
Dental Pilot Project Coordinator

CC: Dental Pilot Project Advisory Committee #200
Linda Mann, RDH, EPDH