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

Oregon Health Authority

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Quarterly Dental Pilot Project Meeting: DPP 100 Meeting Minutes

Date: Monday, December 16, 2019
Time: 9:00 AM – 11:30 AM
Location: OHA Public Health Division
800 NE Oregon Street
Portland, OR 97232
Conference Room 900 – Ninth Floor

Committee Members Present:
Rick Asai, Jennifer Clemens, Jonathan Hall, Paula Hendrix, Leslee Huggins, Connor McNulty

Committee Members Present Phone:
Bob Garcia, Jill Jones, Laura McKeane

Committee Members Absent:
Michael Costa, Kelli Swanson Jaecks, Carolyn Muckerheide

OHA Staff & Consultant to OHA:
Bruce Austin, Kelly Hansen, Fred King, Sarah Kowalski, John Putz, Rose McPharlin, Amy Umphlett

Project Attendees:
Azma Ahmed, Miranda Davis, Kari Douglass, Alistair Kok, Naomi Petrie, Sarah Rodgers, Gita Yitta

Signed in Public Attendees:
Toby Absher, Tanya Firemoon, Allison Lecatsas, Jamie Meyers, Christina Peters, Dove Spector

Summary of Meeting

Agenda Item: Review of Meeting Agenda and Introductions

Topic: Review of meeting agenda.

Summary of Discussion: Meetings are recorded for note taking purposes. Reviewed agenda.

Decision: No decisions made. Move to next agenda item.

Action: Meeting started.

Text in italics is intended to clarify or provide additional information not available in the meeting.

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Agenda Item: Review of Modification Request, Presentation by Northwest Portland Area Indian Health Board (NPAIHB)

Topic: Project Sponsor, DPP#100, Northwest Portland Area Indian Health Board (NPAIHB) Modification Request. Presentation by Gita Yitta, DMD, Dental Director for the pilot project.

Summary of Discussion: NPAIHB requested to modify project to expand CTCLUSI location to allow home visiting by trainees; modification request submitted to the Oregon Health Authority (OHA).

Modification Request Process: On November 4, 2019, the Oregon Health Authority's (OHA) Dental Pilot Project Program received a modification request from the Northwest Portland Area Indian Health Board (NPAIHB) to allow Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) dental health aide therapists (DHATs) to conduct home visits under general supervision as part of Dental Pilot Project (DPP) #100.

A copy of the presentation was included in materials packet disseminated to Advisory Committee.

Decision: No decisions made.

Action: Move on to discussion with Advisory Committee and NPAIHB project staff.

Agenda Item: Discussion, Role of Advisory Committee in Modification Request

Topic: Review modification request, feedback and recommendations submitted by committee members, review of OHA process to determine approval or denial of a modification request.

Summary of Discussion: From November 27 - December 4, 2019, OHA sought feedback and recommendations from Advisory Committee members. Members were given three options:

1. Recommend Approval of Modification Request
2. Recommend Denial of Modification Request
3. Need More Information

A summary of responses received was provided to the Advisory Committee. Memo with full comments included in materials packet disseminated to Advisory Committee.

OHA received recommendations and feedback from 10 members of the Advisory Committee for dental pilot project #100.

• Eight members recommended approval of the modification request.

• Zero members recommended denial of the modification request.

• Two members need more information before making a recommendation.

Discussion with committee members regarding the additional information required to make a recommendation for approval or denial.

Ms. Paula Hendrix indicated she felt comfortable with the information provided in the discussion and presentation by the NPAIHB. She indicated that she would like to change her decision from “need more information” to “recommend approval of modification request.”

Dr. Rick Asai highlighted several concerns with the modification request including concerns regarding data collection and long-term outcome measures. Discussion with Advisory Committee and NPAIHB project representatives on data measurements and expected outcomes. Discussion was had regarding whether adding a site or location at this point in the project compromised the data being collected. Project staff discussed the populations associated with the additional home visiting locations are the same individuals that would be seen at the CTCLUSI dental clinic however had barriers to being seen in the clinic. The data elements would be the same.

Comments included questions and discussion around the navigation component of the modification request. The Community Dental Health Coordinator model was developed to provide navigation support to underserved populations. [*More information about the Community Dental Health Coordinator Model*[i] *was requested and is available in the endnotes.]* The expansion of the CTCLUSI site will include system navigation by the DHAT trainee.

OHA discussed comments regarding the data and evaluation plans which were identified as more global questions regarding the evaluation plan itself and were beyond the specific feedback on the modification request. OHA indicated that the Evaluation Plan was reviewed and already approved by OHA. OHA stated that the onus rests with the project, not OHA, to see if the short-term objectives outlined in the Evaluation Plan are met. The project acknowledged that many of the long-term objectives will not be able to be demonstrated because the length of the pilot project is too short however the data collected and included in quarterly reports does cite progress towards meeting the long-term objectives.

NPAIHB referenced a paper published in 2017 in which over ten years of data was analyzed. [*More information on the paper “Dental Utilization for Communities Served by Dental Therapists in Alaska’s Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study”* [ii] *is available in the endnotes.]* NPAIHB stated that their project will only be operating 5 years. The project stated that attempting to determine the DHAT’s impact in the reduction of disease isn’t possible if the DHAT is only at the site for a few years.

Text in italics is intended to clarify or provide additional information not available in the meeting.

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Advisory Committee members are not asked to vote however OHA strongly considers the feedback submitted by committee members. Prior to the meeting, 80% of the responding committee members recommended approving the modification request; during meeting Ms. Hendrix recommended approval of the request so that 90% of responding committee members recommended approving the modification request.

Discussion regarding supervision distinctions in the Oregon Dental Practice Act: The project was authorized to operate under general supervision. The only exceptions are to two procedures which require indirect supervision, primary and permanent extractions. SB 738 intends for projects to operate under general supervision. The project was approved to operate under general supervision.

Under 4 (a) of Senate Bill 738: "(4)(a) Notwithstanding ORS 679.020 and 680.020, a person may practice dentistry or dental hygiene without a license as part of a pilot project approved under this section under the general supervision of a dentist licensed under ORS chapter 679 and in accordance with rules adopted by the authority."

Definitions of supervision were discussed.

- "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed. OAR 808-001-0002

- "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist. OAR 808-001-0002

- "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. OAR 808-001-0002

OHA process to determine if modification request is approved or denied:
1.OHA determines if the populations align with the approved pilot project's application. In this case, the populations served at the home visiting locations are the same individuals that would be eligible to be seen at the CTCLUSI clinic.

2. OHA determines if the modification meets the minimum standards in administrative rule.

3. OHA evaluates whether the modification is going to result in a substantial change to underlying purpose and scope of the pilot project as originally approved.

Decision: No decision made.

Action: OHA will review feedback received during the discussion and submitted to OHA. A determination whether to approve or deny the modification request will be made within the next few weeks. The committee will be notified of the decision.

Agenda Item: Purpose of Site Visits

Topic: The Authority's role in conducting site visits and their purpose.

Summary of Discussion: Site visits are part of the responsibilities of the Oregon Health Authority (OHA) and required under administrative rule.

Extracted portions of OAR 333-010-0790 Dental Pilot Projects: Authority Responsibilities relating to site visits:

(b) Periodic, but at least annual, site visits to one or more project offices, employment/utilizations sites, or other locations where trainees are being prepared or utilized;

(3) 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;

(C) Interviews with project participants and recipients of care; and

(D) Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application.

(b) If the Authority has convened an advisory committee, representatives of the committee may be invited by the Authority to participate in the site visit though the Authority may, at its discretion, limit the number of members who can participate;

OHA is required to conduct site visits, at a minimum annually as stated in OAR 333-010-0790 Dental Pilot Projects.

- *To date OHA has conducted 6 site visits in the three and half years the project has been operating. The first DHAT started seeing patients in Oregon in the 3rd quarter of 2017. Site Visits were conducted in September 2017(Alaska), February 2018(NARA Dental Clinic), May 2018(CTCLUSI Dental Clinic), September 2018 (NARA Residential Center), May 2019(CTCLUSI) and November 2019(the NARA Wellness Center and Youth Center).*

OHA described the primary purpose of site visits as to gain information from the pilot project and the progress being made by interviewing participants which may include trainees, project staff, other staff and clients or patients. OHA learns a great deal of information about the successes, opportunities, lessons learned and challenges that the projects face. Often, it is not until a site visit is conducted is it

made clear to OHA and other participants, such as members from the Advisory Committee, some of the nuances of the project until a first hand account is had by an individual

- Site visits are made up of two distinct components: the physical site visit and the chart review process.
- Site visits allow OHA to confirm that the project is complying with their approved or amended application and verification that safeguards are in place to protect patients
- OHA may invite members of the Advisory Committee to participate in the site visit. Invited Advisory Committee members that choose to participate in site visits do so with the understanding that their role is to aid OHA in fulfillment of its responsibilities under administrative rule.

In discussion with the committee, there was concern that the most recent site visit took place at a location that did not meet criteria in administrative rule. A committee member raised concerns that the trainee was not being prepared or utilized at the location the site visit occurred. The project indicated that the trainee was not providing care at the location at this time as the trainee is under direct supervision and in their preceptorship. The project plans to have the trainee eventually provide care at the NARA Wellness Center and Youth Center. OHA indicated that while no care is being currently provided by the trainee at the site, the trainee is being prepared by shadowing others providing dental care at the site. Dental care is provided on site by a dental hygienist in conjunction with a dental assistant. The project indicated that part of the preceptorship process is to have the DHAT visit all of the site locations where care will be provided and to become a familiar face at the location.

Discussion with the committee on whether OHA is following a checklist to attend locations or if there is a goal to selection sites or a process. OHA stated that site visits are based on where OHA has been before so that locations are minimally disturbed and there is less redundancy. OHA may go back to a location twice however, for example, CTCLUSI has one location where services are being provided. OHA has conducted two site visits to the CTCLUSI location. OHA is required to do site visits to the locations where trainee's are being prepared or utilized. Not all locations that were approved in the pilot project application are being utilized at this time.

Decision: No decisions made.

Action: OHA will schedule a site visit in the spring or early summer of 2020.The committee will be notified.

Agenda Item: Classification of Adverse Events

Topic: Presentation on the Classification of Adverse Events.

Summary of Discussion: Presentation by Rose McPharlin, DDS, Professor of Restorative Dentistry at the OHSU School of Dentistry. Dr. McPharlin has been contracted by OHA and serves as a consultant to the Dental Pilot Project Program.

Dr. McPharlin presented on classifications of adverse events (AE) in dentistry. A discussion occurred on what was considered an AE versus what is considered a quality of care event (non-AEs). Dr. McPharlin went through various examples with the committee and pilot project staff and participants on what is considering an AE, what is poor quality of care and how the decision is determined. An adverse event tree was discussed with the committee. Committee had questions on the process and how to determine if a potential AE was in fact an AE versus a quality of care concern. [*Several papers*[iii] *have been cited and linked in the endnotes on the Adverse Events in dentistry process being utilized to determine AE's in the pilot projects.]*

A copy of the presentation was included in materials packet disseminated to Advisory Committee.

Decision: No decisions made.

Action: OHA will discuss examples of charts in the calibration training this afternoon with chart reviewers on the committee.

Agenda Item: Review Site Visit Report, Native American Rehabilitation Association Site Visit September 2018

Topic: OHA published the final site visit report for the NARA Rehabilitation Association Site Visit in 2018.

Summary of Discussion: OHA gave a presentation and answered questions regarding the data elements outline in the slides. Presentation highlighted some of the data elements of the report. The report utilized the revised chart review document. The Advisory Committee reviewers will participate in a chart calibration training this afternoon. (12/16/2019) The chart review document is based on the Western Regional Examining Board. Concerns were raised the by the project that candidates who take WREB do so with materials and/or teeth or ideal patient candidates and question how those standards can apply to the chart review process. OHA discussed the goal was to find objective standards so that reviewers had clear information on what to base their determinations on whether the minimum standard of care has been met. The chart review tool includes a revised version of Adverse Event categories. The process for determination of when there is a tie between below minimum standard of care versus above minimum standard of care was explained. Committee members asked clarifying questions

A copy of the presentation and chart review document was included in the materials packet disseminated to Advisory Committee.

Decision: No decisions made.

Action: OHA will post the final site visit report on the OHA Oral Health website.[iv]

Agenda Item: Follow Up Items, Future Meeting Dates, Site Visit, Next Steps, Closing

Topic: Results of committee decision to change frequency of meetings from quarterly to semi-annually.

Summary of Discussion: Committee members have overwhelming chosen to move to meeting twice a year. OHA will cancel the meeting in March. OHA will look at extending the length of the meeting in June and possibly conducting another calibration training, if needed, on the same date. OHA will get that information out as soon as possible so that committee members can make arrangements. If needed, a conference call or email or even a webinar could be conducted instead of meeting in person in the event an issue arises.

Decision: Announcement of Advisory Committee's decision to move meetings to semi-annually.

Action: OHA will schedule meetings semi-annually going forward.

Public Comment Period: There were no public comments.

- Calibration Training: Monday, December 16th, 2019, Portland State Office Building – 12:30pm-4:00pm
- **Next Meeting: Monday, June 8, 2020 Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 900 and 9am-Noon.**
- Calibration Training: Monday, June 8, 2020, Portland State Office Building – 12:30pm-4:00pm, Room location to be determined.

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[i] American Dental Association. Action for Dental Health. "Solutions: About CDHCs." Accessed January 17, 2020. Materials available at American Dental Association – Action for Dental Health – Community Dental Health Coordinators.

National Rural Health Association. (2019) Community Dental Health Worker "Community Dental Health Coordinators." North Carolina Medical Journal. Copy of full article available at National Rural Health Association.

[ii] Chi, D., Lenaker, D., Mancl, L., Dunbar, M. and Babb, M. (2018). Dental therapists linked to improved dental outcomes for Alaska Native communities in the Yukon-Kuskokwim Delta. Journal of Public Health Dentistry, 78(2), pp.175-182. Abstract available at Journal of Public Health Dentistry. Copy of full article available at University of Washington-School of Dentistry Faculty page, Don Chi, DDS, PhD.

[iii] Kalenderian, Elsbeth DDS, MPH, PhD et al. (2017) Classifying Adverse Events in the Dental Office. Abstract available at Journal of Patient Safety. Full article available to Advisory Committee members for Dental Pilot Project #100.

Elsbeth Kalenderian, DDS, MPH; Muhammad F. Walji, PhD; Anamaria Tavares, DDS; Rachel B. Ramoni, DMD, ScD. (2013) An adverse event trigger tool in dentistry: A new methodology for measuring harm in the dental office. Abstract available at Journal of the American Dental Association. Full article available to Advisory Committee members for Dental Pilot Project #100.

[iv] Oregon Health Authority, Dental Pilot Project #100, NARA Residential Site Visit Report 2018, (2019). Copy of full report available at Oregon Health Authority, Dental Pilot Project #100, Site Visits.

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AGENDA

Dental Pilot Project #100 “Oregon Tribes Dental Health Aide Therapist Pilot Project"
Quarterly Dental Pilot Project Program Advisory Committee Meeting DPP #100
December 16th, 2019, 9:00am – 11:30am

Location: Portland State Office Building, 800 NE Oregon Street, Room 900, Portland **Conference Line: Dial-In Number: 1-888-273-3658 Participant Code: 76 64 09**		
9:00am-9:10am	Official Introductions, Agenda Review	Sarah Kowalski, RDH, MS
9:10am-9:30am	Review of Modification Request, Presentation by NPAIHB	NPAIHB
9:30am-10:00am	Discussion, Role of Advisory Committee in Modification Request	Advisory Committee NPAIHB OHA
10:00am-10:10am	Purpose of Site Visits	OHA
10:10am-10:50am	Classification of Adverse Events	Rose McPharlin, DDS
10:50am-11:15am	Review Site Visit Report, Native American Rehabilitation Association Site Visit September 2018	Kelly Hansen, Research Analyst Assessment & Evaluation Team
11:15am-11:20am	Follow Up Items, Future Meeting Dates, Site Visit, Next Steps, Closing	Sarah Kowalski, RDH, MS
11:20am-11:30am	Public Comment Period	Public comments are limited to 2 minutes per individual; Public comments are accepted via in-person oral testimony or submission of written comments via email to oral.health@state.or.us or US Mail.

Calibration Training: December 16th, 2019: 11:30am-4:00pm, Room 900

Next Meeting: June 8th, 2020 Length and Time TBD
Location 800 NE Oregon Street, Portland, Oregon

Dental Pilot Project Program

Dental Pilot Project #100

"Oregon Tribes Dental Health Aide Therapist Pilot Project"

DPP#100 Advisory Committee Meeting

December 16, 2019

Pilot Project #100 Modifications: Community Outreach

December 16th, 2019

- Pilot Project #100 requests a modification to add the option for CTCLUSI Dental Therapists to conduct home visits under general supervision
- There is no request for modification of current approved scope of practice
- The patient population to benefit will be tribal members who are eligible for treatment at CTCLUSI dental clinic

OUTREACH MODIFICATION

Partnering Departments:

Confederated Tribes of Coos, Lower Umpqua, Siuslaw Indians Family Services

Naomi Petrie, Dental Health Aide Therapist

CTCLUSI Elders

CTCLUSI new mothers and their children

Target Groups

Planned services for new mothers and children

Mothers

- Limited exam
- Visual exam
- Record PSR
- OHI
- Nutritional counseling
- Toothbrush prophy and flossing
- Dispense OH products
- Recommended treatment
- Your baby's teeth brochure
- Motivational interviewing (MI)

Children

- Oral evaluation for patients under 13
- Toothbrush prophy and flossing
- OHI for mother regarding baby's teeth
- Nutritional counseling for mother regarding baby teeth
- Counseling, education, motivational interviewing for mother about baby teeth
- SDF treatment, if needed

Elders

- Limited exam
- Visual exam
- Record PSR
- OHI
- Nutritional counseling
- Toothbrush prophy and flossing
- Dispense OH products
- SDF treatment, if needed
- Recommended treatment

Planned services for Elders

Locations:

- CTCLUSI Elder's homes
- CTCLUSI New Mothers homes

Population:

- 12: CLUSI elders (55+ years of age), may increase later
- 12: CTCLUSI new mothers/tribal spouses (18+ years of age)
- 12: CTCLUSI newborns (0-3years of age)
- CTCLUSI children residing in a new mother's home between the age of 3-18 years old

Frequency of visits:

- CTCLUSI Elder's homes: 3 times a week
- CTCLUSI new mother home: pending need
- Certified childcare provider facilities and homes: a maximum of every 3 months per facility

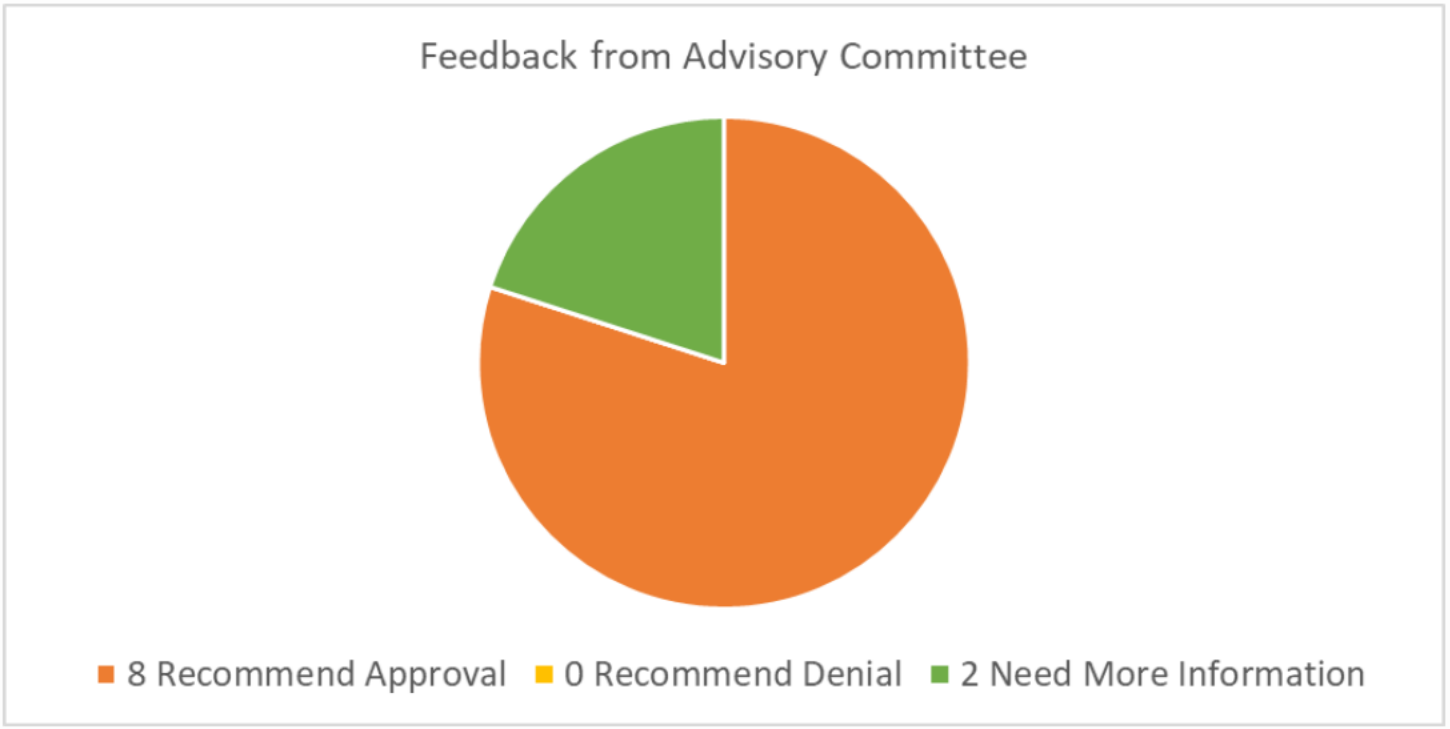
Thank you!

Dental Pilot Project Program

Advisory Committee: Synopsis of Recommendations & Feedback Received for Home Visits Modification Request

- From November 27 - December 4, 2019, OHA sought feedback and recommendations from Advisory Committee members. Members were given three options:
  - 1. Recommend Approval of Modification Request
  - 2. Recommend Denial of Modification Request
  - 3. Need More Information

Dental Pilot Project Program



Dental Pilot Project Program

Advisory Committee Members

Synopsis of Feedback (Materials Packet Pages 10-11)

- Need More Information and Feedback

Dental Pilot Project Program

- DHAT Trainees operating under the Dental Pilot Project Program are authorized to provide services under "**general supervision**" once they have completed their preceptorship and receive standing orders from their supervising dentist. The only exception to this is that extraction procedures must be performed under "direct supervision" or "indirect supervision." (Materials Packet Page 9)

- Application was approved to allow full scope of practice

- Senate Bill 738 (4)(a) Notwithstanding ORS 679.020 and 680.020, a person may practice dentistry or dental hygiene without a license as part of a pilot project approved under this section under the **general supervision** of a dentist licensed under ORS chapter 679 and in accordance with rules adopted by the authority. (Materials Packet Pages 12-13)

Dental Pilot Project Program

Purpose of Site Visits

- Oregon Health Authority Responsibilities
- Role of Advisory Committee Members

Adverse Events in Dentistry

- Collaborative study by
- University of Texas Health Science Center, Houston
- Harvard School of Dental Medicine
- Oregon Health & Science University
- University of California San Francisco
- **Rose McPharlin, DDS**

Project Objectives

- Describe the process for defining, identifying and classifying Adverse Events in dental patient charts
- Provide examples of AEs (determined by consensus)
- Provide examples of Quality of Care events (non-AEs)

Background

- Medicine has well established record of adverse events
- Institute of Medicine Report: "To Err is Human" 2000 reported that AEs caused by medical errors are the 8th leading cause of death in US
- There is little to no understanding about the type or frequency of patient safety issues in Dentistry
- Only the grossest of dental care AEs have been documented
- Critical need to define and identify AEs in dental settings

Reported Dental Adverse Events from FDA Maude Database

- AEs involving dental devices: 1.4% of reports between 1996-2011
- Aspiration
- Edema due to sodium hypochlorite extrusion
- Sublingual thrombosed vein (laceration)
- Death

What is not an AE?

- Causes or precursors to AEs
  - Errors
  - Near misses
  - Poor/unacceptable quality of care
- Natural course of disease

Not Adverse Events

- Hazards or potential harm are not AEs
- In the absence of harm, these are not AEs: errors, negligence, blame, accusations, or malpractice
- Omissions are not AEs
- Quality of care issues in the absence of harm are not AEs
- Repeated treatment attempts with poor prognosis (heroic dentistry) without harm is not an AE (e.g. repeated attempt to restore teeth)
- Incidents that occur as result of disease or condition (carious pulp exposure); are common occurrence or expected or within a reasonable range of the standard of care (denture sore spots) are not AEs

Definition of "Adverse Event"

- Institute of Medicine: an injury resulting from a medical intervention (not due to the underlying clinical condition of the patient)
- AHRQ: Injury cause by medical care
- Institute for Healthcare Improvement: Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization or results in death
- FDA: Undesirable experience associated with the use of a medical product

What is an AE?

- Adverse events are incidents of
- "**physical harm** that is due to treatment within a timeframe relevant to the clinical scenario"
- Note: panel regarded the harm without blame

Examples of Dental Adverse Events

- Painful dry socket
- Peri-implantitis
- Perforation of tooth due to endodontic treatment
- Pain following extraction/RCT without proper pain management
- Wrong tooth extraction
- RCT on wrong tooth
- Paresthesia following a dental procedure
- Death due to overdose of anesthesia
- Tissue necrosis due to bleaching or rubber dam clamp
- Allergic reactions to dental materials
- Laceration of lip/tongue/cheek during dental procedure

Adverse Event Classifications

- Allergy/Toxicity/Foreign Body (FB)response
- Aspiration/Ingestion of FB
- Infections
- Wrong site/wrong procedure/wrong patient
- Bleeding
- Pain (**)
- Hard Tissue Damage (tooth or bone, implant damage resulting in bone loss)
- Soft Tissue injury/inflammation (intra/extra oral)
- Nerve injury (paresthesias)
- Other systemic complications (anaphylaxis, asthma attack, diabetic episode)
- Other oro-facial complications (sinus perforations, trismus)
- Other harm (psychological stress was not included in the scope of study)

Definition and Classification

Table 1 Definition and classification system used to identify dental AEs

AE definition	Physical harm that is moderate or severe due to treatment within a specific time frame
AE type	1. Allergy/toxicity/foreign body response
	2. Aspiration/ingestion of foreign bodies
	3. Infections
	4. Wrong-site, wrong-procedure, and wrong-patient errors
	5. Bleeding
	6. Pain
	7. Hard tissue injury
	8. Soft tissue injury
	9. Nerve injury
	10. Other systemic complications
	11. Other orofacial complications
	12. Other harm
AE severity	E1: temporary minimal harm E2: temporary moderate-to-severe harm G1: permanent minimal harm G2: permanent moderate-to-severe harm

Abbreviation: AE, adverse event.

Classification of Harm

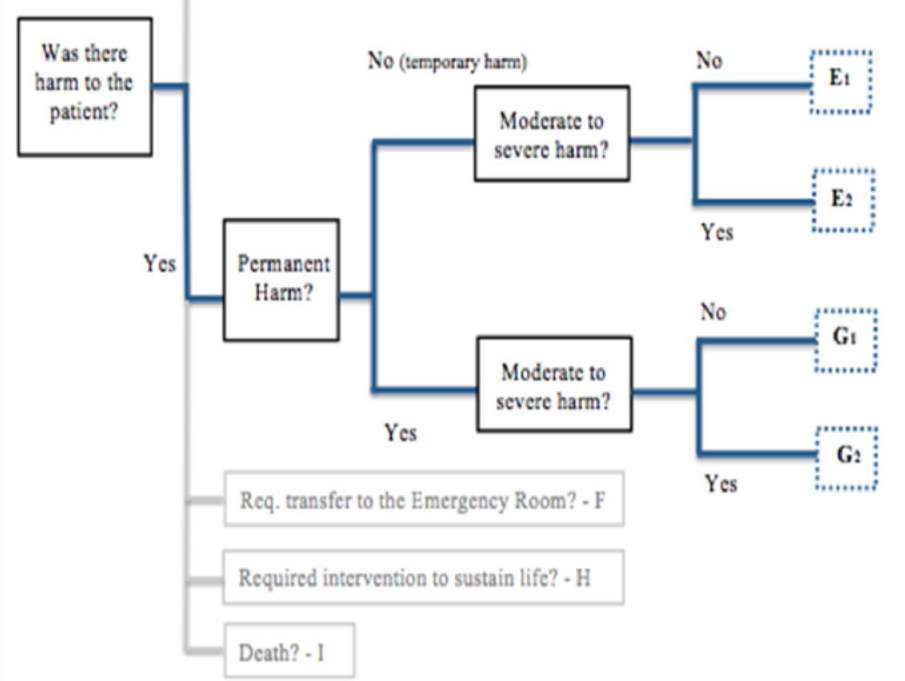
Temporary

- E1: mild
- E2: moderate to severe

Permanent

- G1: mild
- G2: moderate to severe

Severity Tree



Allergy/Toxicity/Foreign Body Response

- Administration of any substance, medicament that results in allergic rxn
- Administration of medication, anesthetic, chemical that is in a dosage that results in a reaction
- Foreign Body Response: object retained at site of treatment—file separation, overhang

Aspiration/Ingestion of Foreign Body

- Aspirated objects: crowns, fragments of restorations, impression material
- Ingested objects: swallowed materials

Infections

- Infections that escalate after treatment or arise post-operatively
- Sinus infections (resulting from perforations or communications with oral cavity)
- Space infections: submandibular
- Cellulitis
- Infections with fluctuant swelling requiring I & D = E2

Wrong Site/Procedure/Patient

- Anesthetizing the wrong site is an **error,** not an AE unless harm occurs
- Wrong procedure is an AE, which is why safety protocols are followed in the operating suite
- Wrong Patient occurrences is why hospitals have cross checks

Bleeding

- Bleeding that is expected to occur with the procedure and is of short duration is not an AE
- Bleeding that is uncontrolled or prolonged and requires intervention is an AE

Pain

- Pain can be expected; if the pain is slight, manageable or temporary, then **no harm** has occurred. **No Adverse Event**

- If a patient quantifies the pain using a pain scale (0-10) and states the pain is
  - 1-3 Slight = no harm, no AE
  - 4-6 Moderate = E1 (temporary mild-moderate)
  - 7-10 Severe = E2 (temporary severe)

Pain Scale

- Scale of 1-10
- 1-3 = Slight pain = No Harm (expected or considered commonly occurring within the standard of care)
- 4-6 = Moderate pain = E1
- 7-10 = Severe pain = E2

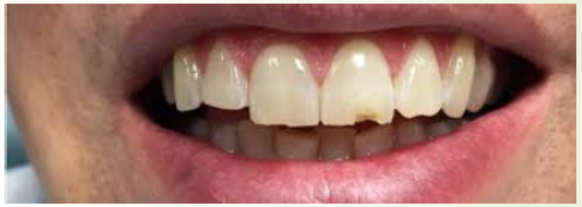
Pain

- In the absence of a pain scale, if the pain is described as

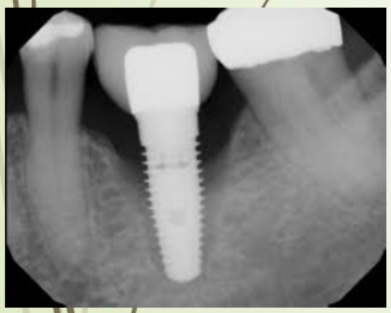
- "Can't sleep, Killing me, throbbing, stabbing, jabbing, pounding, pulsing
  it is an AE =E2
  If the patient goes in for an emergency dental visit for pain
  it is an AE =E2
  If a representative calls with the complaint and requests and Rx for pain management, it is an AE = E2

Hard Tissue Damage

- Damage to tooth or bone.

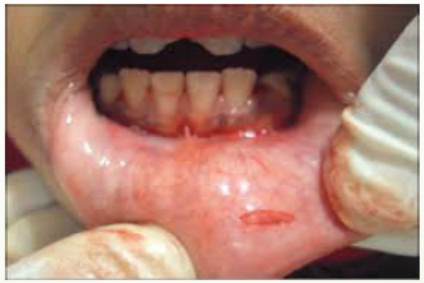


- Include implants that are failing and have resultant bone loss



Soft Tissue Injury/Inflammation

- Intra- and Extra- oral soft tissue injuries to lips, tongue, oral mucosa, gingiva, floor of the mouth
- Include lacerations, punctures, burns, nicks, cuts,

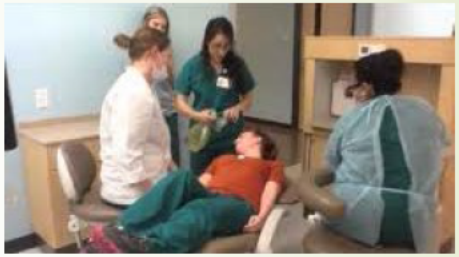


Nerve Injury

- Paresthesia that presents with numbness with or without pain
- Triggered by report of tingling, paresthesia, dysesthesia, numbness, palsy
- Between 0-30 days after a treatment/procedure

Other Systemic Complications (potential AE)

- Anaphylaxis
- Asthma
- Anxiety attack/fainting
- Behavioral complications
- Diabetic episode
- Trip, fall, bump head
- Transfer to ER without a specific diagnosis



Other Oro-facial Complications

- Sinus related issues: perforation
- Trismus
- Sinus Infection
- Extra-oral inflammation

Other Harm

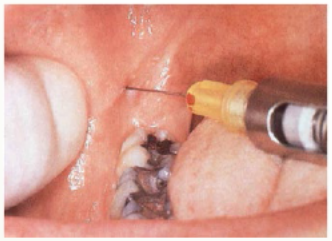
- Eye injuries resulting from incident during procedure

What is not an AE?

- Causes or precursors to AEs (Underlying conditions)
- Errors
- Near Misses
- Poor/unacceptable quality of Care
- Natural course of disease

What are errors?

- Errors are unintended incidents that did not cause physical harm
- Example: anesthetizing the wrong side



Poor Quality of Care

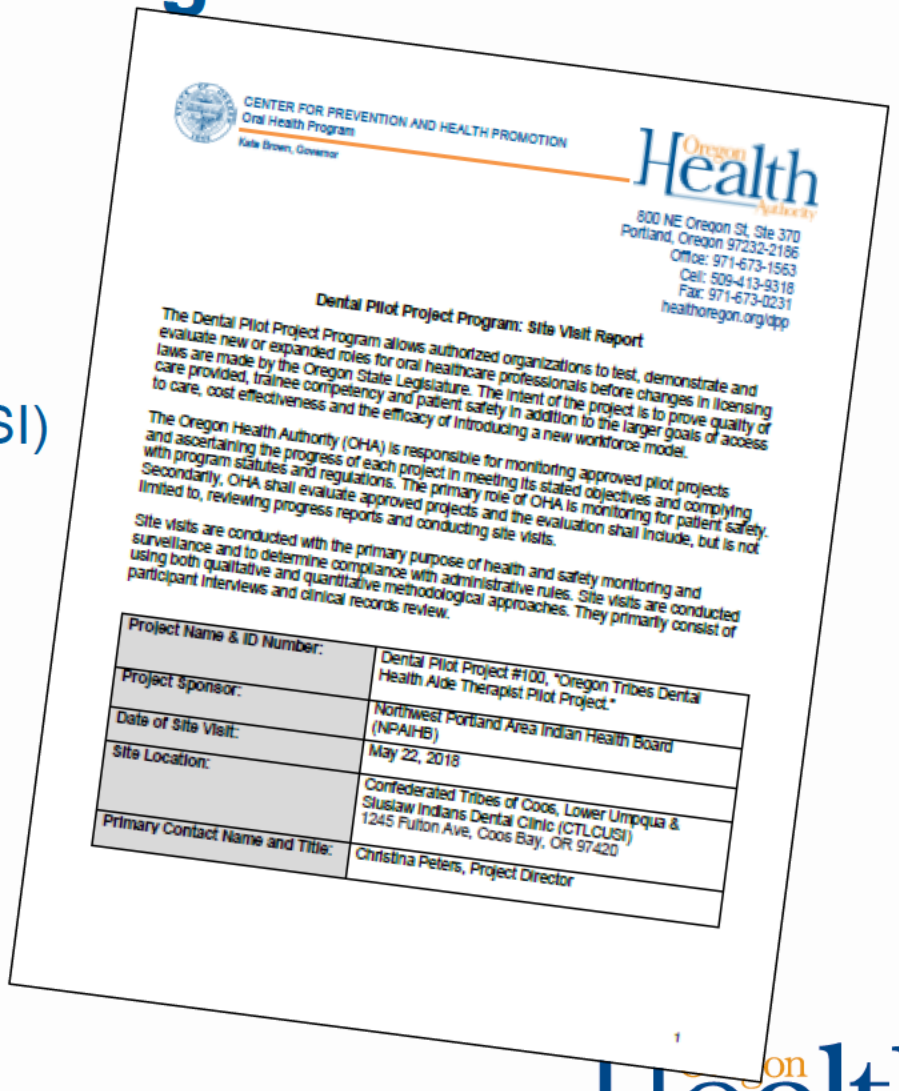
- Chart Omissions/inadequate documentation
- Poor or no images
- Bad margins, overhangs that do not cause ST damage
- Porous material
- Non-retentive restorations
- Open contacts
- Caries remains
- Heroic Dentistry (dentistry that has poor prognosis for longevity)
- Errors

?Questions?

Dental Pilot Project Program

Site Visit Report

- Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians Dental Clinic (CTLCUSI)
- May 22, 2018
- Materials Packet Pages 14-46



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

Oregon Health Authority

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Office: 971-673-1563
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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.

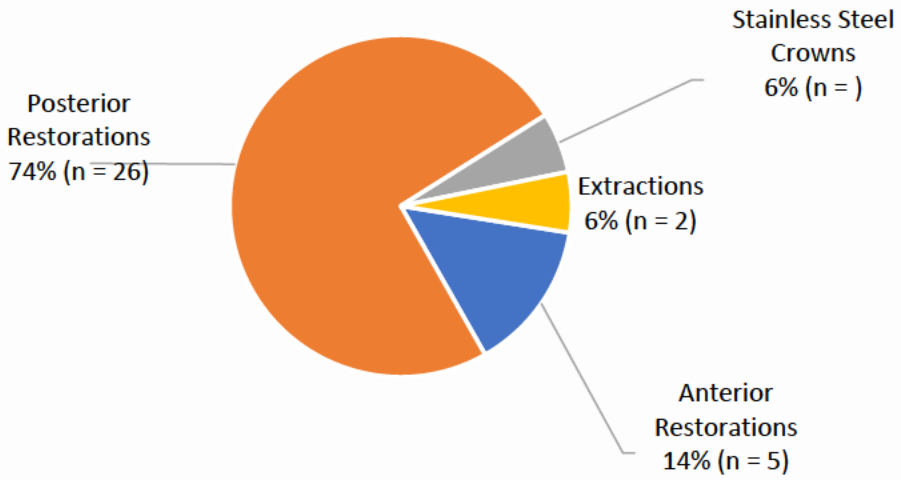
The Oregon Health Authority (OHA) is responsible for monitoring approved pilot projects and ascertaining the progress of each project in meeting its stated objectives and complying with program statutes and regulations. The primary role of OHA is monitoring for patient safety. Secondarily, OHA shall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

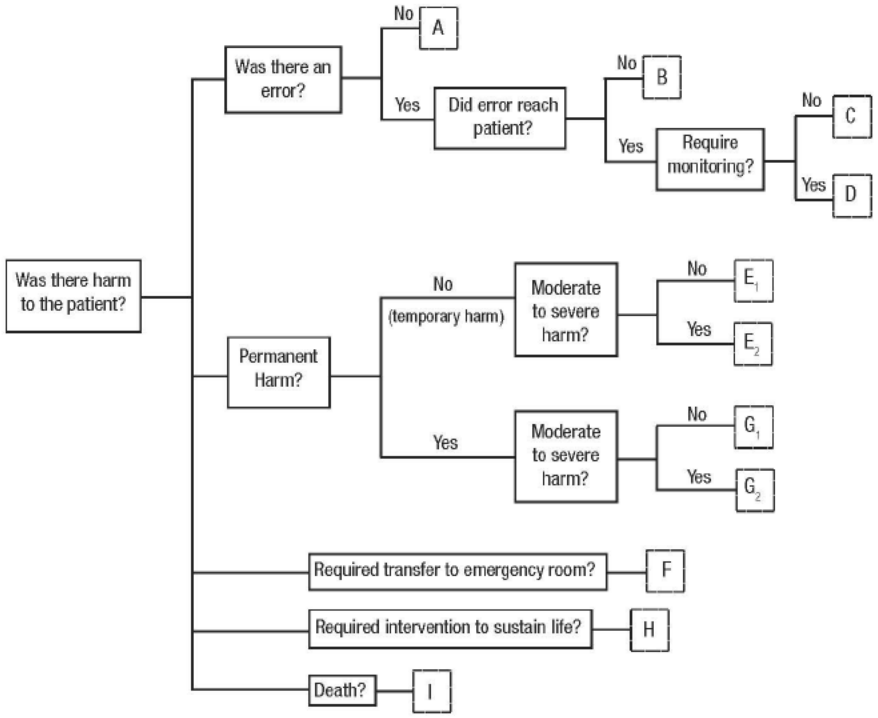
Site visits are conducted with the primary purpose of health and safety monitoring and surveillance and to determine compliance with administrative rules. Site visits are conducted using both qualitative and quantitative methodological approaches. They primarily consist of participant interviews and 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:	May 22, 2018
Site Location:	Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians Dental Clinic (CTLCUSI) 1245 Fulton Ave, Coos Bay, OR 97420
Primary Contact Name and Title:	Christina Peters, Project Director

1

Figure 1: Makeup of chart review sample by procedure type.





Category	Description of Dental Adverse Event Severity Categories using the Dental AE severity tree
A	No errors
B	Error with no impact on patient
C	Error with minimal/mild impact to patient; does not require monitoring
D	Error with moderate to severe impact to patient; requires monitoring
E_1	Temporary (reversible or transient) minimal/mild harm to the patient
E_2	Temporary (reversible or transient) moderate to severe harm to the patient
F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization
G_1	Permanent minimal/mild patient harm
G_2	Permanent moderate to severe patient harm
H	Intervention required to sustain life
I	Patient death

Figure 3: Percent of cases rated as treatment appropriate for diagnosis by a majority of reviewers.

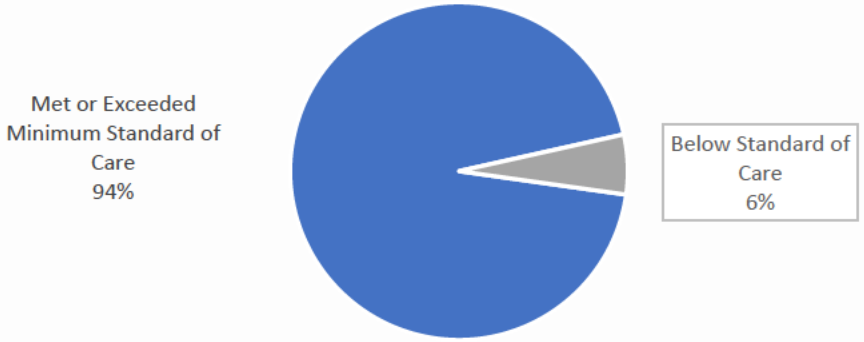


Figure 4: Percent of cases rated at or above minimum standard of care (Overall Impression).

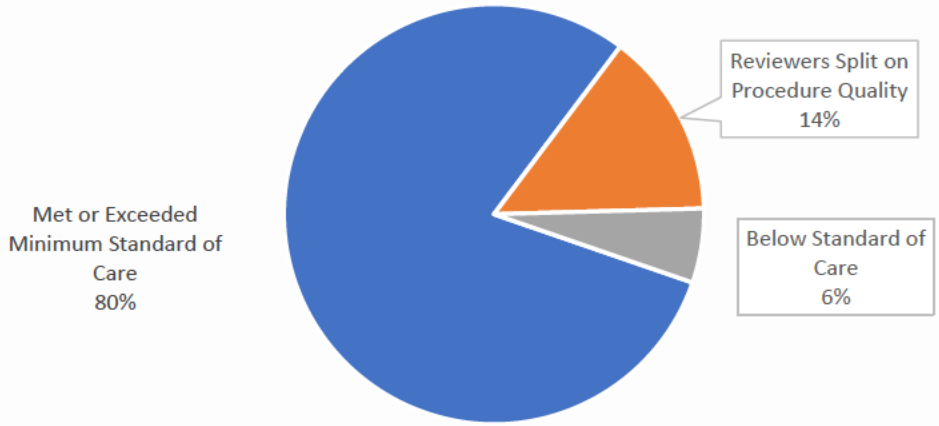


Figure 5: Median ratings for overall impression of procedure quality by procedure type.

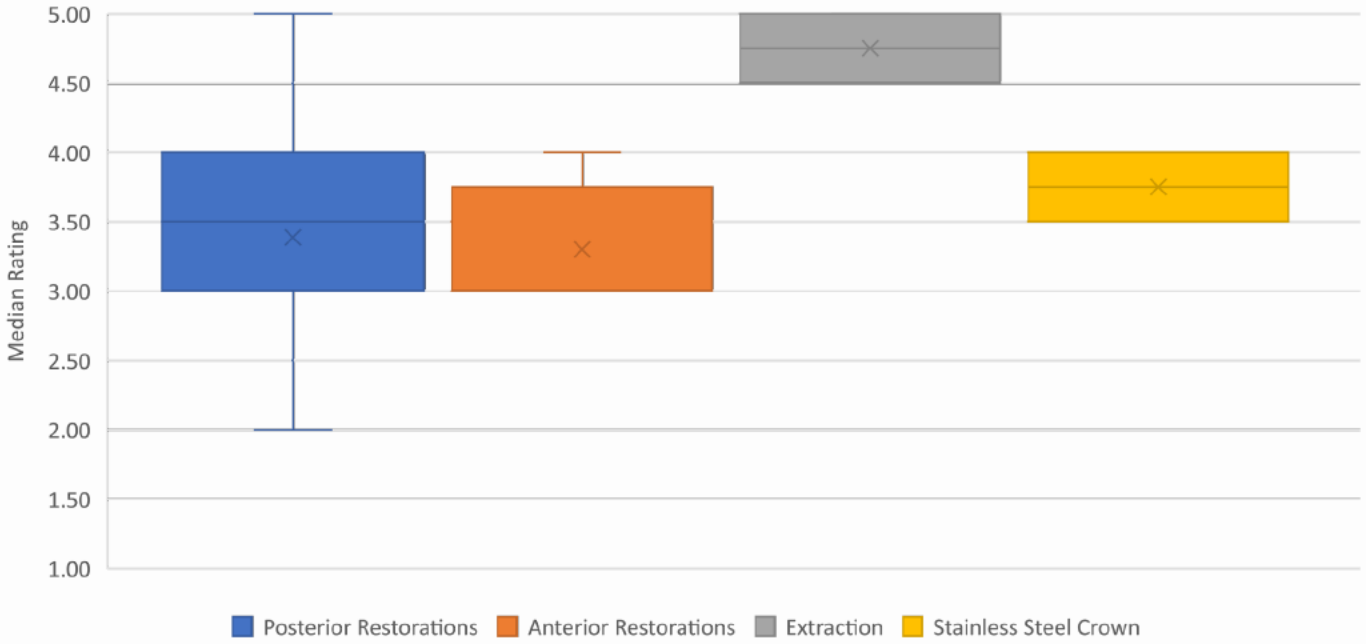


Figure 6: Median Ratings for Sub-Criteria in Posterior Amalgam/Composite Restorations

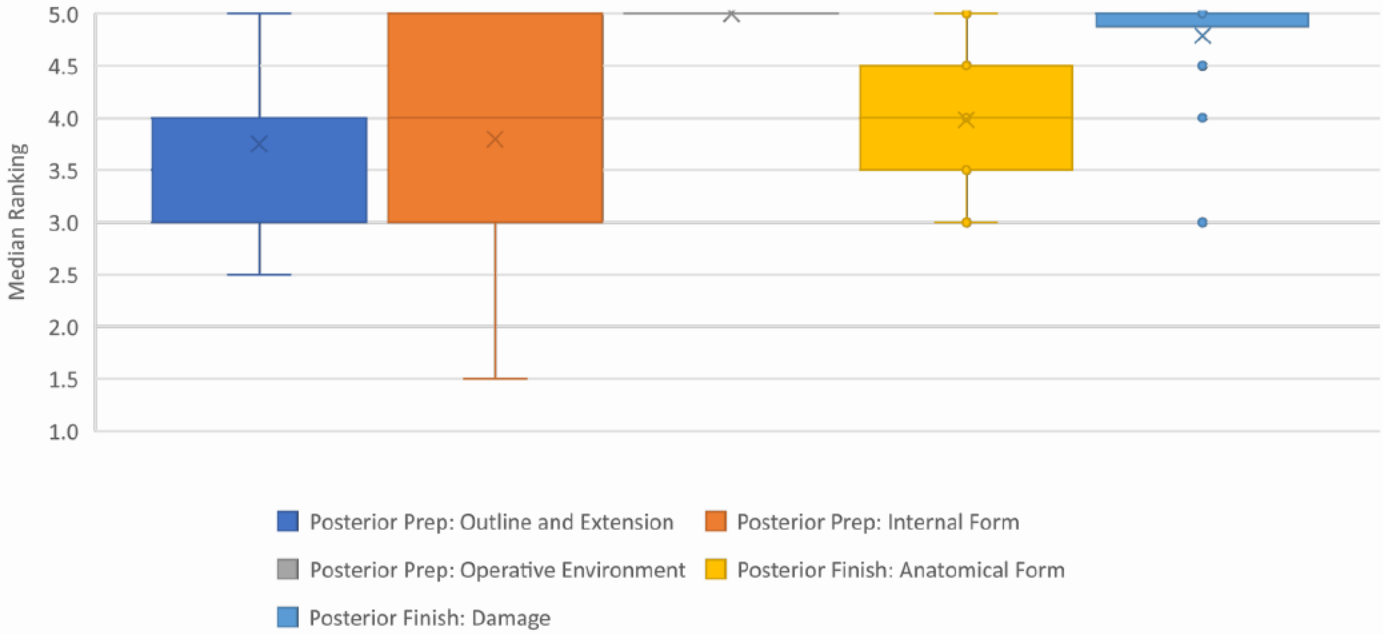


Figure 7: Median Ratings for Sub-Criteria in Anterior Composite Restorations

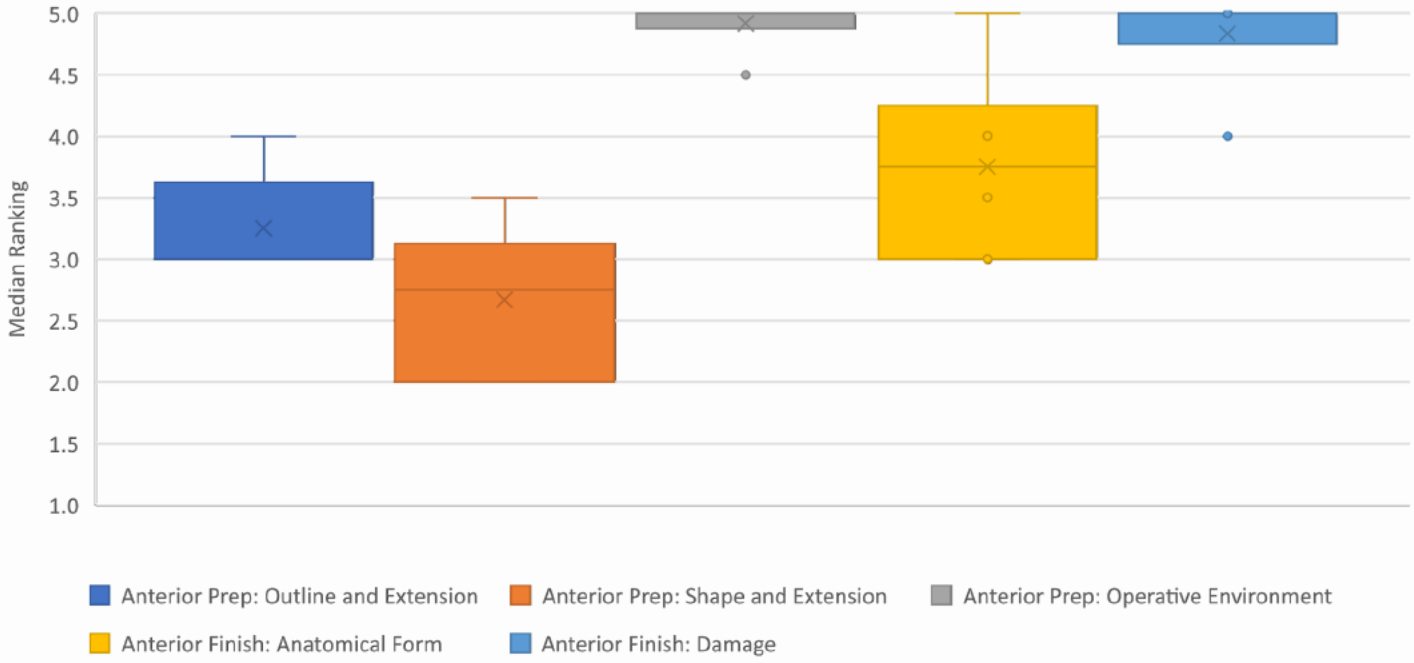
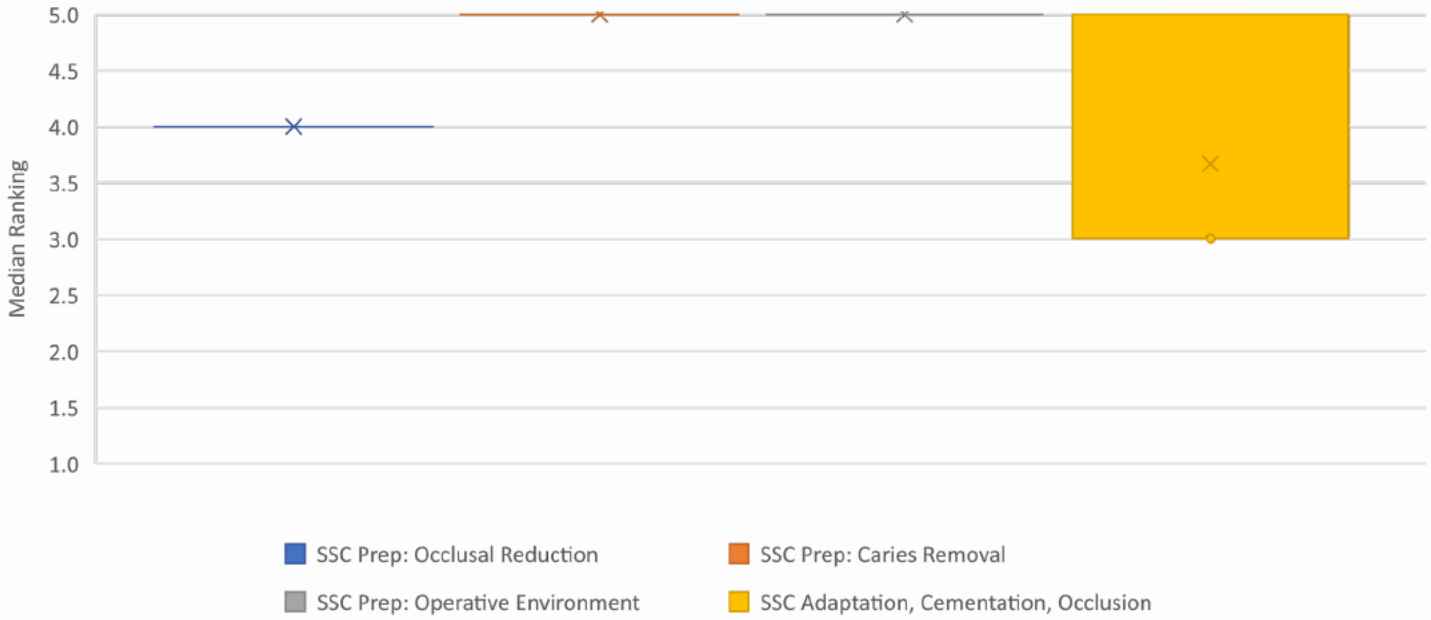
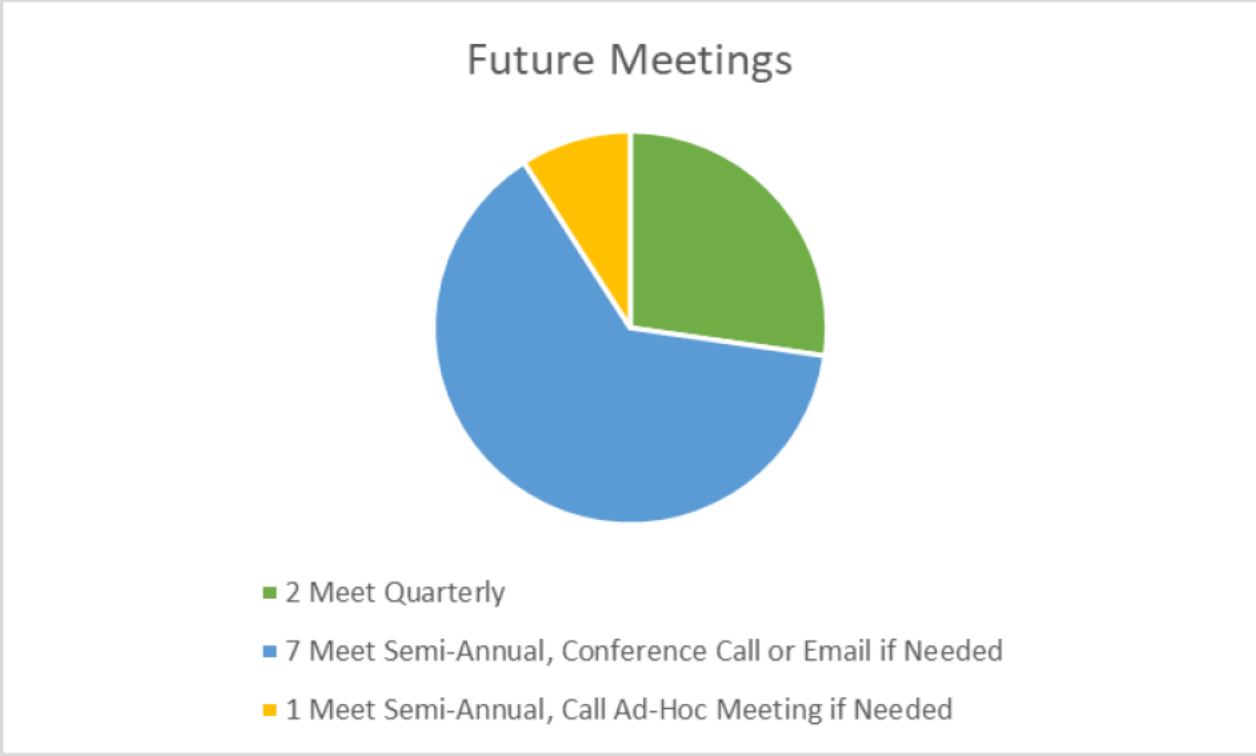


Figure 8: Median Ratings for Sub-Criteria in Stainless Steel Crowns



Dental Pilot Project Program

Future Meetings Doodle Poll Results



Dental Pilot Project Program

- Next Meeting:
  June 8th, 2020

- Site Visit:
  Currently determining a date, Spring 2020

Dental Pilot Project Program

- Public Comments:

- Please sign-up
- Limited to 2 minutes per individual

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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 State of Oregon Legislature. The intent of the project is to examine the quality of care provided, determine trainee competency, and demonstrate the new or revised practices do not harm patient safety. The project also seeks to offer solutions to improve 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 (OARs 333-010-0700 through 333-010-0820). The primary role of OHA is monitoring for patient safety. Secondarily, OHA evaluates approved projects and the evaluation includes, 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 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:	September 20, 2018
Site Location:	NARA Residential Treatment Center 17645 NW St Helens Rd, Portland, OR 97231
Description of Location:	NARA Residential Treatment Center[1] is a residential addiction treatment center located in Portland, Oregon. According to materials and information provided by NARA and available online at www.naranorthwest.org which provides information about the program, "Services are guided

[1] NARA Residential Treatment Center, https://www naranorthwest.org/projects/adult-residential-addictions-treatment/

	by [a] Cultural Director who trains and consults with staff on cultural competence and provides cultural programming for clients." "Our staff includes master's level Counselors, Clinical Supervisors, Certified Alcohol Drug Counselors (CADC), and Psychologists. Interns from local colleges and universities may also provide services. A Family Nurse Practitioner provides on-site physical health services. Access to other Mental Health Therapists, Psychiatrists, Psychiatric Nurses, Dental Professionals and Medical Providers is the key to our Integrated Care Model. NARA is licensed by the State of Oregon to provide mental health and residential addiction treatment services." "Our Residential Addiction Services provide a range of integrated services to offer recovering persons hope and support. Clients come to NARA from all over Oregon and the United States. Services are supplemented with community recovery support such as Good Medicine 12 Step Group to facilitate a positive transition when clients complete residential treatment." "Services: • Assessment and Evaluation • Individualized and Collaborative Service Planning • Individual and Group Counseling • Case Management Services • Cultural Groups and Activities • Parenting Support • Parent-Child Development Services • Childcare while participating in on-site treatment services • Oregon Health Plan Eligibility Assistance • Access to Peer Based, Recovery Support Services • Access to Physical Health and Mental Health Services • Access to Transitional Housing as needed" Please visit NARA at www.naranorthwest.org for more information about NARA and their programs.
Primary Contact Name and Title:	Christina Peters, Project Director

Site Visits

Oregon Administrative Rule (OAR) 333-010-0790: Dental Pilot Projects: Authority Responsibilities[2]

(1) Project monitoring. Program staff shall monitor and evaluate approved projects which shall include, but is not limited to:
(b) Periodic, but at least annual, site visits to one or more project offices, employment/utilizations sites, or other locations where trainees are being prepared or utilized;
(3) 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;
(C) Interviews with project participants and recipients of care; and
(D) Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application.
(b) If the Authority has convened an advisory committee, representatives of the committee may be invited by the Authority to participate in the site visit though the Authority may, at its discretion, limit the number of members who can participate;
(c) Written notification of the date, purpose and principal members of the site visit team shall be sent to the project director at least 90 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) The Authority will provide the project sponsor with at least 14 business days to submit to the Authority required patient records, data or other documents as required for the site visit; and
(g) Following a site visit the Authority will:
(A) Within 60 calendar days, issue a written preliminary report to the sponsor of findings of the site visit, any deficiencies that were found, and provide the sponsor with the opportunity to submit a plan of corrective action;
(i) A signed plan of correction must be received by the Authority within 30 calendar days from the date the preliminary report of findings was provided to the project sponsor;
(ii) The Authority shall determine if the written plan of correction is acceptable no later than 30 calendar days after receipt. If the plan of correction is not acceptable to the Authority, the Authority shall notify the project sponsor in writing and request that the plan of correction be modified and resubmitted no later than 10 business days from the date the letter of non-acceptance was mailed to the project sponsor;
(iii) The project sponsor shall correct all deficiencies within 30 calendar days from the date of correction provided by the Authority, unless an extension of time is requested from the Authority. A request for such an extension shall be submitted in writing and must accompany the plan of correction.
(iv) If the project sponsor does not come into compliance by the date of correction reflected on the approved plan of correction, the Authority may propose to suspend or terminate the project as defined under OAR 333-010-0820, Suspension or Termination of Project.

[2] Full Text of Oregon Administrative Rules 333-010-0700 through 333-010-0820, Oregon Secretary of State, Oregon Administrative Rules, Oregon Health Authority, Public Health Division, Chapter 333, Division 10, Health Promotion and Chronic Disease Prevention, Online at https://sos.oregon.gov/

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. OHA has determined that Dental Pilot Project #100 is in compliance with the requirements set forth in OARs 333-010-0400 through 333-010-0470, and therefore has **passed** the site visit. Please see Appendix A for a copy of the preliminary report of findings.

In 2018, Oregon Administrative Rules 333-010-0700 through 333-010-0820 were amended. Due to a significant amount of revision to the rule text, rules 333-010-0400 through 333-010-0470 were repealed and replaced with new rule language, OAR 333-010-0700 through 333-010-0820, which went into effect December 1, 2018.

The site visit conducted on September 20th, 2018 fell under administrative rules in effect at that time which required OHA to determine a pass or fail for the site visit. As of December 1, 2018, site visits no longer receive a determination of pass or failure. In the event deficiencies are found during a site visit, the project director will be notified and required to submit a corrective plan of action.

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 which may include trainees, patients, supervising dentists, project managers and/or project administrators 2. Clinical records review

Attendees:

Name	Title	Organization
Bruce Austin, DMD	Statewide Dental Director	OHA
Jennifer Clemens, DMD, MPH	Dental Director	Capitol Dental Care/Smile Keepers
Kelly Hansen	Research Analyst/Oral Health Program	OHA
Pam Johnson	Project Manager	NPAIHB
Sarah Kowalski, RDH, MS	Dental Pilot Project Program Coordinator	OHA
Christina Peters	Project Director	NPAIHB
Karen Shimada, MS	Executive Director, Oregon Oral Health Coalition	OHA Dental Pilot Project Advisory Committee

Project Sponsor Representatives and Interviewees:

Name	Title	Organization
Dawn Cram, RN, BSN	Residential Nurse Manager	NARA
Ben Steward, DHAT	Dental Health Aide Therapist	NARA

Record Reviewers:

Name	Title	Organization
Bruce Austin, DMD	Statewide Dental Director	Oregon Health Authority
Daniel Blickenstaff, DMD	Executive Director	Oregon Board of Dentistry
Jennifer Clemens, DMD, MPH	Dental Director	Capitol Dental Care/Smile Keepers
Rose McPharlin, DDS	General Dentist	OHSU-School of Dentistry
Caroline Muckerheide, DDS	Pediatric Dentist	Private Practice
Brandon Schwindt, DMD	Pediatric Dentist	Private Practice

Interviews:

OHA staff and members of the Advisory Committee for Dental Pilot Project #100 met with the Residential Nurse Manager and the Dental Health Aide Therapist (DHAT) Trainee at the facility.

The Residential Nurse Manager provided a broad overview of the facility, treatment program, and a description of the barriers and challenges to the population served by the program. NARA's goal is to integrate services into the program on site to reduce the number of hours or days a client is pulled out of treatment to see a dentist, physician, or other care provider. Many of the clients have not had adequate dental care in years, if ever. NARA has found that the individuals in their addiction treatment programs attain greater success when served in an integrated model of care—caring for the physical and mental needs of the clients. Families, including partners and children under the age of 5, are allowed to move in to the facility, staying in their own units.

The DHAT trainee is currently providing oral health education and oral health assessments at the NARA site. A grant was recently received by NARA's Dental Clinic to purchase the additional equipment needed to provide dental treatment on site at NARA Residential. The Residential Nurse Manager discussed the severe and acute dental needs experienced by most of their patients yet felt that most needs could likely be attended to by a DHAT. In the past, a dentist would attempt to come to NARA Residential, however staff indicate that dentist time has proved to be extremely difficult to schedule. The NARA Dental Clinic has an extensive wait list and a limited number of dentists. Multiple staff members emphasized that allowing a DHAT to provide services under their scope of practice allows clients to be seen on site at the residential facility in a timely manner and it is cost-effective because the DHAT is paid roughly half the salary of a dentist.

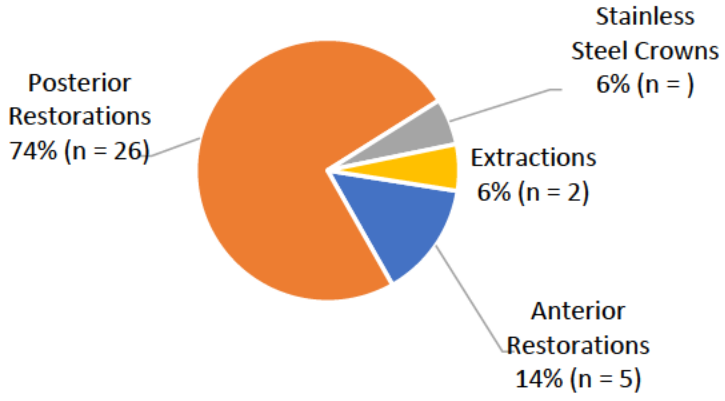
Clinical Records Review:

A rating form was developed based on the standards of the Western Regional Examining Board (*WREB*), a clinical testing agency, published literature on classifying dental adverse events, and Advisory Committee input.[3,4,5,6] However, while the Pilot Project chart reviews and subsequent analysis are in part designed using published materials and criteria from WREB, they are not meant to be a stand-in for a licensing test and should not be considered as such. The purpose of these chart reviews is to systematically monitor for patient safety in an approved project and to have a diverse panel of clinical reviewers assess that trainees meet project goals and provide the applicable minimum standard of care.

Charts were selected using a stratified random sampling method.[7] Using all procedures listed in the Quarterly Detailed Data Report after the Stipulated Agreement of April 3, 2018 as the initial sampling frame, procedures were limited to irreversible procedures (which include restorations, extractions and stainless steel crowns) and stratified by procedure category. Of 78 restorations, restorations were ordered by number of surfaces restored, age, and insurance status, 16 restorations from 13 patient charts were selected using a systematic sampling scheme. After removing duplicate chart numbers, 13 charts were selected. Thirty-five specific procedures were then abstracted from these 13 charts for review. All charts had personal identifying information such as name, specific age, date and location redacted before review.

Altogether, after including procedures not initially indicated in the sampling scheme, 35 procedures represent 13% (*n* = 31*)* of total restorations completed in the time frame and 66% (*n* = 2) of stainless steel crowns completed. were represented (*Figure 1*). Additionally, two extractions were reviewed, although both were completed before the Stipulated Agreement of April 3, 2018.

Figure 1: Makeup of chart review sample by procedure type.



Each of the resulting 35 procedures along with related X-ray and intraoral images were reviewed. Each procedure was reviewed by a minimum of three licensed

[3] WREB. (2019). *2019 Dental Exam Candidate Guide*. [Exam Criteria Documentation]. Retrieved from https://wreb.org/candidates/dental/dentalpdfs/Website_2019_Dental_Candidate_Guide.pdf
Additional information may also be found through the Commission on dental Competency Assessments Dental Therapy Exam guidelines https://www.cdcaexams.org/dental-therapy-exam/

[4] Kalenderian, E., Obadan-Udoh, E., Maramaldi, P., Etolue, J., Yansane, A., Stewart, D., … Walji, M. F. (2017). Classifying Adverse Events in the Dental Office. Journal of patient safety, 10.1097/PTS.0000000000000407. Advance online publication. doi:10.1097/PTS.0000000000000407

[5] Obadan, E. M., Ramoni, R. B., & Kalenderian, E. (2015). Lessons learned from dental patient safety case reports. *Journal of the American Dental Association (1939)*, *146*(5), 318–26.e2. doi:10.1016/j.adaj.2015.01.003

[6] Haladyna, T. (2010). *An Evaluation of the Western Region Examining Board Dental Examination*. [Report]. Retrieved November 14, 2019 from WREB https://wreb.org/resources/articles/2010_WREBDentalExam_Report.pdf

[7] Parsons, V.L. (2017). Stratified Sampling. In Wiley StatsRef: Statistics Reference Online (eds N. Balakrishnan, T. Colton, B. Everitt, W. Piegorsch, F. Ruggeri and J.L. Teugels). doi:10.1002/9781118445112.stat05999.pub2

dentists. The full panel of reviewers was comprised of a collaboration between the Advisory Committee, an external contracted expert from the OHSU-School of Dentistry and the Oregon Board of Dentistry, were required to attend a chart review training and calibration session before reviewing charts.

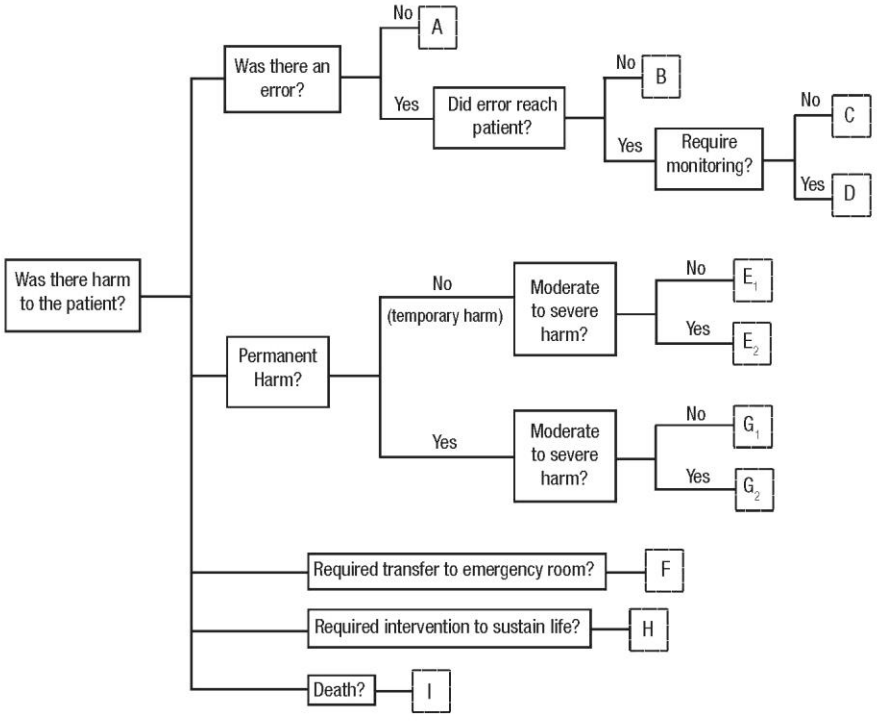
This report is primarily focused on objective measures of patient safety, administrative record keeping and compliance within the approved scope of practice for the pilot project. At the conclusion of the pilot project, OHA will publish a full report of findings as part of its overall evaluation and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

Clinical Record Review Results:

I. Adverse Events

If two or more reviewers identified an adverse event in their reviews, the procedure was evaluated by an external consultant, Dr. Rose McPharlin, Assistant Professor of Restorative Dentistry, OHSU School of Dentistry. Dr. McPharlin is an expert in the area of patient harm and quality of care. The review of patient records included a table for defining the severity of dental adverse events (*Figure 2*).

Figure 2: Adverse event severity categories.[8]



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F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization
G_1	Permanent minimal/mild patient harm
G_2	Permanent moderate to severe patient harm
H	Intervention required to sustain life
I	Patient death

Based on the external consultant's review, two procedures were identified as adverse events. Both were temporary in nature. In one case, cement was retained for one month before it was

[8] Adapted from: Kalenderian, E., Obadan-Udoh, E., Maramaldi, P., Etolue, J., Yansane, A., Stewart, D., … Walji, M. F. (2017). Classifying Adverse Events in the Dental Office. Journal of patient safety, 10.1097/PTS.0000000000000407. Advance online publication. doi:10.1097/PTS.0000000000000407

detected and removed. The duration of foreign matter retention was 1 month before it was removed, so severity was rated as E2--moderate to severe E2.

In the second case, Dr. McPharlin's final review notes that "the photo and the original diagnosis was for occlusal caries based on the clinical caries seen in the distal pit. The operator chose to open the mesial box for reasons that are not documented or can be seen radiographically as only incipient. The opening of the mesial box also resulted in hard tissue damage to the adjacent tooth, which will be shed soon: AE hard tissue damage of E1 nature."

II. Images and Radiographs

All reviews are conducted retrospectively using redacted chart notes, radiographs and intraoral photos. Reviewers were asked to indicate if both images and radiographs are were considered sufficient for evaluation. Of all procedures reviewed, 79% *(n* = 26*)* of charts included intra-oral images and 73% *(n* = 24*)* of charts included radiographs that reviewers felt were sufficient for evaluation.

Several reviewers reported difficulty with image quality in comment sections, including concerns that images were blurry and not of diagnostic quality, and whether the entire scope of work was visible in the photograph.

Effective September 2018, the NAIHB project implemented new intra-oral cameras to aid in further evaluation. Additionally, the since implemented Standard Operating Procedures Manual has the following stipulations for procedure photos:

> "Procedures requiring tooth preparation and final restoration require pre-op, mid-op, and post-op intraoral photos when appropriate. Images must be of high quality with no debris, blood, or excess restorative material present.
> Extractions: A recent radiograph of the tooth to be extracted is required including a pre-op intraoral photo. A post-op photo of the removed tooth must be taken including all residual coronal or root tip remnants. A post-op PA is not required.
> All photos require the following:
> • A label with correct tooth number
> • Correct dates attached to each photo to allow for easy retrievability
> Appendix C [of Evaluation & Monitoring Plan] lists all additional requirements for intraoral/extraoral photos and radiographs."

III. Anesthetic Notes

Reviewers were asked to evaluate the appropriateness of anesthetic provided and of clarity of documentation of any drug administration. A majority of reviewers rated 97% *(n* = 33*)* of cases as having appropriate anesthetic for the procedure. All cases were rated as having administered drug dosages within standard recommended limits and appropriately entered into chart notes. However, reviewers frequently commented that chart notes for seven patient charts did not provide a weight for pediatric patients so as to ensure an appropriate level of anesthesia is administered. The NAIHB has since instituted a set of standard operating procedures for all Pilot Project #100 trainees that include the documentation of weight for all patients under the age of 10 years who receive anesthetic treatment.

IV. Diagnosis

Based on the ratings provided by reviewers for the diagnosis description, 94% *(n* = 33*)* of procedures reviewed met or exceeded the minimum standard of care for diagnosis description. In the remaining 3% *(n* = 3*)* of cases, reviewers were evenly split on whether the listed diagnosis was appropriate.

V. Treatment

When determining if the treatment rendered is appropriate, there are several issues that must be addressed in drawing a conclusion. The dental provider must discuss the benefits, risks, costs of treatment, alternatives to treatment which may include a patient choosing to forgo treatment. Dental providers may encourage an optimal course of treatment however ultimately a patient has the right to choose whichever course of treatment they are most comfortable with. There are many barriers when choosing dental treatment, financial concerns are often a primary concern in addition to transportation barriers or missing additional work.

Based on the ratings provided by reviewers for the appropriateness of treatment, most procedures, 94% *(n* = 33*),* met or exceeded the standard of care for appropriate treatment according to a majority of reviewers.

Figure 3: Percent of cases rated as treatment appropriate for diagnosis by a majority of reviewers.

VI. Overall impression of procedure quality

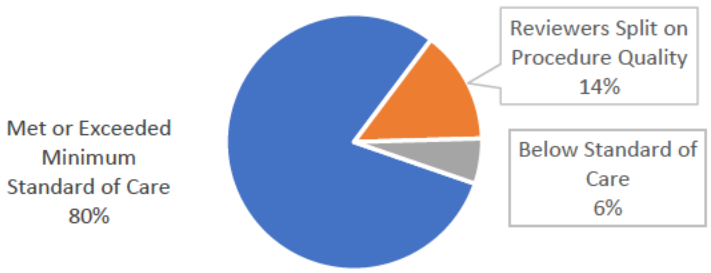
The measure entitled “overall impression of procedure quality” was scored by reviewers on a 1-5 scale as follows:

1: Significant deficiencies exist. Procedure can be considered a failure
2: Significant deficiencies exist, procedure falls under absolute minimum standard of care
3: Minimum standard of care. Only minor deficiencies present.
4: Procedure quality is adequate to good. Only minor deficiencies present.
5: Procedure is highly successful, no deficiencies present.

A rating of three is the minimum standard of care. Each procedure is rated by at least three but as many as six licensed dentists trained. However, there is a high degree of variation within reviewer responses. Therefore, the “overall impression” rating was converted from a five-point scale to a binary measure (whether or not the minimum standard of care was met according to a majority of reviews).

Based on the ratings provided by reviewers for the overall impression of procedure quality, most procedures (80%) *(n = 28)* were rated at or above the minimum standard of care by the majority of reviewers. In 14% *(n = 5)* of cases (four posterior restorations and one anterior restoration), reviewers were evenly split in their assessment of procedure quality as being above or below minimum standard of care. 6% *(n = 2)* of cases (two posterior restorations) were rated below the minimum standard of care by a majority of reviewers.

Figure 4: Percent of cases rated at or above minimum standard of care.



To demonstrate the range of quality of care provided, median score for each procedure was used as a measure of the central tendency of reviewers. Mean (average) scores at the case level are easily skewed by wide ranges in reviewer scores. Therefore, median scores are used similarly to the methodology used by WREB for these types of dental procedures.[9]

The average median score for all procedures on a scale of 1 to 5 was 3.50 (SD = 0.79), above the previously set cut point of minimum standard of care.[10] See *Figure 5* for box plots of median overall impression of procedure quality scores averaged across reviewers for each chart and broken down by procedure type. As seen in Figure 5, interquartile ranges (boxes) are all at or above minimum standard of care.

[9] For context, WREB uses the median score of three reviewers in their methodology so as to more accurately represent the central tendency in the case of small numbers.
From page 48 of the 2019 Dental Exam Candidate Guide:
"The Operative Exam is graded by three independent Grading Examiners. Grading Examiners grade according to the Operative Scoring Criteria Rating Scale on pgs. 50-53 and 61-62. The recorded score for each category is based on the median (middle) score of the three (3) scores assigned by the Grading Examiners. The median grades are then weighted and summed for the preparation and finish respectively, then averaged for the total procedure score."
[10] For the subjective measure of Overall Impression of Procedure Quality, the Intraclass Correlation Coefficient (ICC) as a measure of interrater reliability was 0.529, indicating moderate reliability.

Figure 5: Median ratings for overall impression of procedure quality by procedure type.

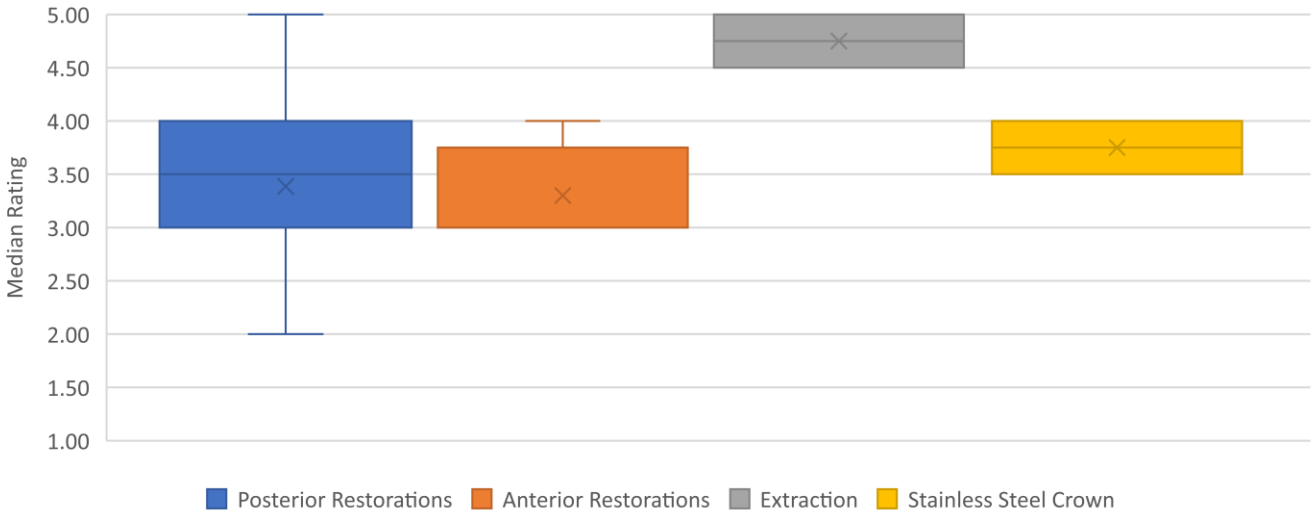


Table 1: Statistics for median rankings of overall impression of procedure quality by procedure type

	Median	Mean	Std. Deviation	Range	N
Posterior Restorations	3.5	3.42	0.82	3	26
Anterior Restorations	3	3.3	0.45	1	5
Extractions	4.75	4.75	0.35	0.5	2
SSCs	3.75	3.75	0.35	0.5	2

VII. Amalgam/Composite Restorations – Posterior

Amalgam/composite restorations were scored as Unacceptable (1), Inadequate (2), Acceptable – Minimum Standard of Care (3), Appropriate (4), or Optimal (5) on the following criteria:

Posterior Restorations Sub-Criteria	Minimum standard of care (see Appendix B for the full rating criteria)
Preparation: Outline and Extension	• Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.
Preparation: Internal Form	• Pulpal floor and/or axial wall is moderately shallow or deep.
Preparation: Operative Environment	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Management of any damage is appropriate • Documentation of difficult behavior if necessary to explain excessive damage
Finish: Anatomical Form	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped.

	• There is moderate variation of proximal contour and shape.
Finish: Margins	• Moderate marginal excesses and/or deficiencies are present.
Finish: Damage	• Moderate damage to hard or soft tissue is evident.

The ratings for each category were indexed by averaging the scores across these 6 criteria to create an overall rating. This overall rating was then converted from a five-point scale to a binary measure as previously described. There were 26 posterior restorations reviewed and based on the ratings provided by reviewers for Amalgam/Composite Restorations – Posterior, all of the procedures were rated as meeting or exceeding the standard of care for this category by a majority of reviewers.

Table 2: Percent and number of Posterior Restorations rated above or below standard of care in specific sub-criteria.

Posterior Restorations Sub-Criteria	Cases at or above minimum standard of care	Cases below minimum standard of care	Cases with reviewers evenly split
Preparation: Outline and Extension	85% (*n* = 22)	0% (*n* = *0*)	15% (*n* = *4*)
Preparation: Internal Form	81% (*n* = *21)*	8% (*n* = *2*)	12% (*n* = *3*)
Preparation: Operative Environment	100% (*n* = *26)*	0% (*n* = *0)*	0% (*n* = *0)*
Finish: Anatomical Form	100% (*n* = *26)*	0% (*n* = *0)*	0% (*n* = *0)*
Finish: Margins	85% (*n* = *22)*	0% (*n* = *0)*	15% (*n* = *4)*
Finish: Damage	100% (*n* = *26)*	0% (*n* = *0)*	0% (*n* = *0)*

On a scale of 1 to 5, the average overall median score for Posterior Restorations was 4.16 (SD = 0.77), above the previously set cut point of minimum standard of care. See *Figure 6* for box plots of median Posterior Restoration scores broken down by rating sub-criteria.

Figure 6: Median Ratings for Sub-Criteria in Posterior Amalgam/Composite Restorations

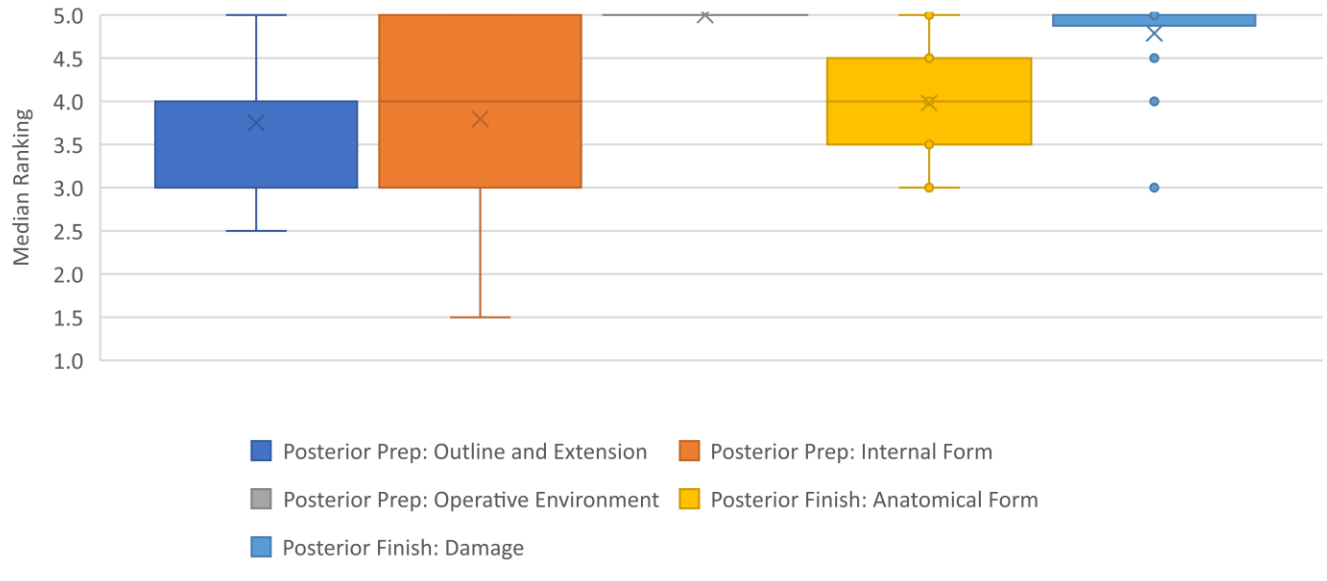


Table 3: Statistics for median rankings of Posterior Amalgam/Composite Restorations by sub-criteria.

	Median	Mean	Std. Deviation	Range	N
Preparation: Outline and Extension	4.00	3.75	0.75	2.50	26
Preparation: Internal Form	4.00	3.88	1.02	3.50	26
Preparation: Operative Environment	5.00	4.92	0.39	2.00	26
Finish: Anatomical Form	4.00	3.98	0.56	2.00	26
Finish: Margins	4.25	4.15	0.82	2.50	26
Finish: Damage	5.00	4.79	0.47	2.00	26

VIII. Anterior Composite Restorations

Anterior composite restorations were scored as Unacceptable (1), Inadequate (2), Acceptable – Minimum Standard of Care (3), Appropriate (4), or Optimal (5) on the following criteria:

Anterior Restorations Sub-Criteria	Minimum standard of care (see Appendix B for the full rating criteria)
Preparation: Outline and Extension	• Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration. • Cavosurface angles possibly compromise the integrity of the tooth or restoration.
Preparation: Shape and Extension	• Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth. • Gingival margin is moderately overextended. • Any overextension that severely weakens tooth is properly documented
Preparation: Operative Environment	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.
Finish: Anatomical Form	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.
Finish: Margins	• Moderate marginal excesses and/or deficiencies are present.
Finish: Damage	• Moderate damage to hard or soft tissue is evident.

All 5 procedures reviewed met or exceeded the standard of care for this category indexed across these criteria, using the same methodology as Posterior Restorations. On a scale of 1 to 5, the average median score for Posterior Restorations was 4.12 (SD = 0.45), above the previously set cut point of minimum standard of care. See *Figure 7* for box plots of median Anterior Restoration scores broken down by rating sub-criteria.

Figure 7: Median Ratings for Sub-Criteria in Anterior Composite Restorations

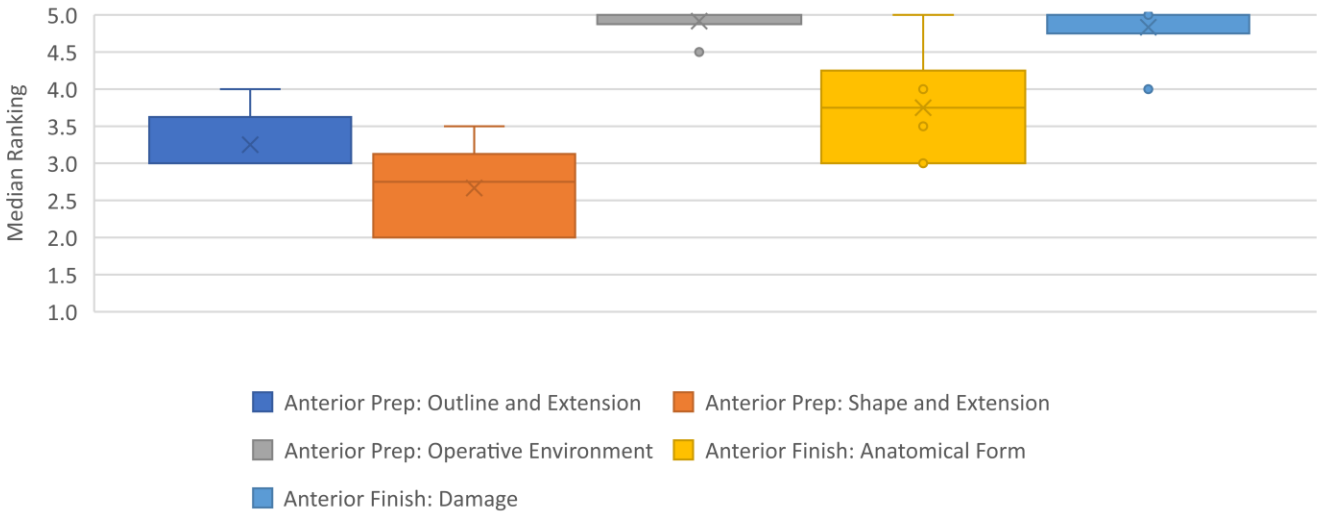


Table 4: Statistics for median rankings of Anterior Composite Restorations by sub-criteria.

	Median	Mean	Std. Deviation	Range	N
Preparation: Outline and Extension	3.00	3.30	0.45	1.00	5
Preparation: Shape and Extension	2.50	2.60	0.65	1.50	5
Preparation: Operative Environment	5.00	4.90	0.22	0.50	5
Finish: Anatomical Form	4.00	3.80	0.84	2.00	5
Finish: Margins	4.00	4.10	0.74	2.00	5
Finish: Damage	5.00	4.80	0.45	1.00	5

Within the sub-criteria, 40% (*n* =2) of anterior restorations were rated below standard of care on “Prep: Shape and Extension.” Reviewer comments indicate that remaining caries was the main area of concern. All other areas were rated on average at or above standard of care.

IX. Stainless Steel Crowns

Stainless steel crowns were scored as Unacceptable (1), Inadequate (2), Acceptable – Minimum Standard of Care (3), Appropriate (4), or Optimal (5) on the following criteria:

Stainless Steel Crowns Sub-Criteria	Minimum standard of care (see Appendix B for the full rating criteria)
Preparation: Occlusal Reduction/ Incisal Reduction /Proximal reduction	• Deviates up to 1.0 mm from optimal. • Sharp angles may affect the restoration.
Preparation: Caries Removal	• Complete Caries Removal
Preparation: Operative Environment	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Moderate damage to hard or soft tissue is evident.

Adaptation, Cementation, Occlusion	• Fit of crown is good (good contacts, length, and occlusion) • Correct position • Slight evidence of cement remaining radiographically • Occlusion appears good.
Finish: Function	• Occlusion is slightly in hyper-occlusion

All procedures reviewed met or exceeded the standard of care for this category and all sub criteria according to a majority of reviewers.

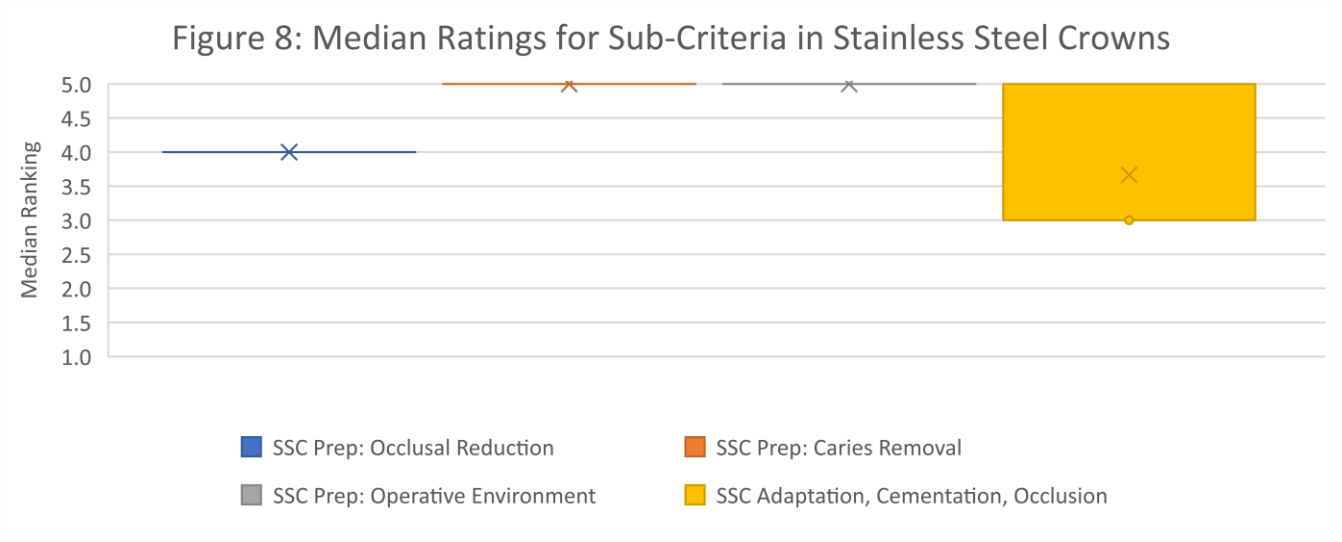


Table 5: Statistics for median rankings of Stainless Steel Crowns (SSC) by sub-criteria.

	Median	Mean	Std. Deviation	Range	N
SSC Prep: Occlusal Reduction	4.00	4.00	0.00	0.00	2
SSC Prep: Caries Removal	5.00	5.00	0.00	0.00	2
SSC Prep: Operative Environment	5.00	5.00	0.00	0.00	2
SSC Adaptation, Cementation, Occlusion	4.00	4.00	1.41	2.00	2
SSC Finish: Function	4.75	4.75	0.35	0.50	2

X. Extractions

Extractions were scored into two categories based upon specific project criteria for simple extractions

Yes: Minimum standard of care, tooth removed successfully with no complications
No: Extraction does not follow stipulated guidelines.

Both extractions reviewed met or exceeded the standard of care for this category according to a majority of reviewers.

Summary of Findings:

- There were two instances of temporary adverse events of E1 (Temporary minimal/mild harm to the patient) and E2 (Temporary moderate to severe harm to the patient) that were revealed during the site visit using the Dental Adverse Event Tree. Both of these were temporary adverse events in nature.
- DHAT trainees are operating under their approved scope of practice.
- The project is in full compliance with their approved amended application.
- Intra-oral cameras were implemented by October 1, 2018, after the date of the site visit in September 2018.
- Comments indicated in chart reviews that the reviewers had difficulty in determining many of the components of the chart review due to the lack of visibility in photos taken. Intra-oral cameras were not employed as of the date of this particular site visit.
- Weights were not recorded for a number of patients under age 10. Though not required in the Oregon Dental Practice Act, OHA requires weights to be recorded for patients age 10 and under who receive anesthetic. This is included in the standard operating procedures and was implemented as policy in both clinics after this site visit.

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:	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: (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.	
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.	
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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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:	No deficiencies identified.	
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: (a) Patient safety;	**ID Number** **EM2A**

Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No observed deficiencies.	
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 identified.	
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:	No deficiencies identified.	
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: (d) Employment/utilization site compliance.	**ID Number** **EM2D**

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

Observations and Identified Deficiencies:	No deficiencies identified.
Corrective Action	Not applicable.
Required Next Steps	Not applicable.

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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

333-010-0435: Dental Pilot Projects: Evaluation and Monitoring (6) A sponsor must report adverse events to the program the day they occur. Adverse Events determined E2(Severe Harm or greater), F, G, H, I must be reported to OHA the day they occur. See Appendix B Table 2 for Dental Adverse Event Severity Categories	**ID Number** **EM6**

Dental Pilot Project Program Requirements	**Met** ☒	**Not Met** ☐
Observations and Identified Deficiencies:	No deficiencies. There were no instances of adverse events of severe harm identified by the project. In final chart review, there were two instances of temporary adverse events of E1 (Temporary minimal/mild harm to the patient) and E2 (Temporary moderate to severe harm to the patient) that were revealed during the site visit using the Dental Adverse Event Tree. Both of these are temporary and reversible adverse events in nature.	

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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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.
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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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.	
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:	No deficiencies identified.	
Corrective Action	Not applicable.	
Required Next Steps	Not applicable.	

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
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www.healthoregon.org/dpp

December 17, 2018

Joe Finkbonner
NW Portland Area Indian Health Board
2121 SW Broadway STE 300
Portland, Oregon 97201

On September 20, 2018, the Oregon Health Authority conducted a required site visit for Dental Pilot Project #100, “Oregon Tribes Dental Health Aide Therapist Pilot Project” at the NARA Residential Treatment Center in Portland, Oregon.

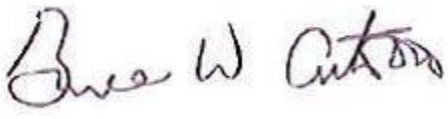
The OHA Dental Pilot Project Program is responsible for monitoring approved pilot projects. The primary role of the Oregon Health Authority is monitoring for patient safety. Secondarily, program staff shall evaluate approved projects and the evaluation shall include, but is not limited to, reviewing 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 #100 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.

A full report of findings will be issued to the project sponsor upon completion of the chart reviews.

Sincerely,



Bruce Austin, DMD
Statewide Dental Director

Kowalski Sarah E

From: Kowalski Sarah E
Sent: Monday, November 18, 2019 11:06 AM
To: Austin Bruce W <BRUCE.W.AUSTIN@dhsoha.state.or.us>; Bob Garcia <[redacted]>; cate.s.wilcox@dhsoha.state.or.us; Conor McNulty ([redacted]) <[redacted]>; [redacted]; Hansen Kelly <KELLY.HANSEN@dhsoha.state.or.us>; Jennifer Clemens <[redacted]>; Jennifer Clemens ([redacted]) [redacted]; Jill Jones [redacted]>; Jonathan Hall [redacted]>; Karen.Shimada [redacted]>; Kelli Swanson Jaecks[redacted]>; Laura McKeane [redacted]>; Leslee Huggins [redacted]; Michael Costa [redacted]>; Paula Hendrix [redacted]; Rick Asai [redacted]>; UMPHLETT Amy M <Amy.M.UMPHLETT@dhsoha.state.or.us>; BLICKENSTAFF Daniel <[redacted]>
Subject: Modification Request: Dental Pilot Project Program DPP#100 - Please Review
Importance: High

The Northwest Portland Area Indian Health Board (NPAIHB) has submitted a request to add two additional locations under the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians (CTCLUSI) Site.

- Under OAR 333-010-0800 Dental Pilot Projects: Project Modifications, the addition of a location constitutes a modification to the project.

Summary of Request: Add two locations under CTCLUSI Site: 1. Home-Visiting to Elder Populations 2. Home-Visiting to New-Mother Populations

Target Populations are described as follows:

- Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw
- Members who are eligible to be seen at CTCLUSI Dental Clinic
- Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe

Home visiting is an evidenced based approach that is widely used and there are a variety of service delivery models. The HRSA Maternal, Infant and Early Childhood Home Visiting program page contains a great deal of information about this concept.
The Confederated Tribes of Coos, Lower Umpqua & Siuslaw has an established Home Visiting Program in place.

Advisory Committee Role:
As outlined under OAR 333-010-0800, (3) If the Authority has convened an advisory committee for an approved project, the Authority may confer with the advisory committee regarding the proposed modification.

- The role of the Advisory Committee is to determine if the modification request meets the requirements of the OAR 333-010-0700 through 333-010-0820 and ultimately provide a recommendation for approval or denial based upon review of the modification request. The Advisory Committee does not authorize or approve modification requests, final authority rests with OHA.

1. Please review the attached request.
2. Please provide feedback to the Oregon Health Authority (OHA) Dental Pilot Project Program **no later than December 4th, 2019** by completing a **Doodle Poll**.
3. Additional feedback may be sent via email to sarah.e.kowalski@state.or.us.
4. All feedback will be shared with the Advisory Committee and is also subject to public record request.
5. Feedback from the Advisory Committee and the modification request will be discussed at the December 16th Advisory Committee meeting.

Public Comment:

- The modification request is not open to public comment, feedback is requested from current Advisory Committee members.
- There will be an opportunity for public comment at the conclusion of the December 16th Advisory Committee meeting.

Please let us know if you have any questions.
Your assistance is greatly appreciated,
Sarah

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Dental Pilot Project Coordinator
Oral Health Program
The Oregon Health Authority
800 NE Oregon Street
Portland, Oregon 97232
971-673-1563 (office)
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CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

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Memo

DATE: December 10, 2019

TO: Dental Pilot Project #100 Advisory Committee Members

FROM: Bruce Austin
Statewide Dental Director
Oregon Health Authority

RE: Synopsis of Recommendations & Feedback Received for Home Visits Modification Request

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On November 4, 2019, the Oregon Health Authority's (OHA) Dental Pilot Project Program received a modification request from the Northwest Portland Area Indian Health Board (NPAIHB) to allow Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) dental health aide therapists (DHATs) to conduct home visits under general supervision as part of Dental Pilot Project (DPP) #100.

From November 27 - December 4, 2019, OHA sought feedback and recommendations from Advisory Committee members. Members were given three options:

1. Recommend Approval of Modification Request
2. Recommend Denial of Modification Request
3. Need More Information

Below is a summary of responses received.

Advisory Committee

OHA received recommendations and feedback from 10 members of the Advisory Committee for dental pilot project #100.

- Eight members recommended approval of the modification request.
- Zero members recommended denial of the modification request.
- Two members need more information before making a recommendation.

Themes:

- It is not clear when the dentist would actually see the patient and what kind of services would be performed away from the clinic. If it is prevention services, such as screening and education, then it is great. If they are automatically a patient of record without the dentist seeing them, then more specifications need to be written in for the project.
- It is great reaching more patients in need, but the process for home visits must be thorough.

- Adding navigation and outreach is a sound idea that has been well established in medicine and through the community dental health coordinator (CDHC) auxiliary in dentistry.
- By modifying the project now, it will require a delay in accumulating the necessary data needed to assess the outcomes and merits of the pilot project.
- What are the specific services under the “preventive care needed in the home”?
- What are the metrics that will be used to assess the effectiveness of the short-term objectives stated as “efficiency...meet unmet need...provider job satisfaction...patient satisfaction”?
- What are the metrics that will be used for assessing the increase of patient education at the community level; increased treatment of decay; decreased rates of decay in pilot populations; improving overall understanding of oral health in relation to overall health; and improving oral care behaviors in pilot communities? How will the baseline in all these areas be determined so that change can be quantified?
- Other than the number of AI/AN providers, how will expanded access to care, effect of culturally competent care on overall health outcomes, efficiency of the dental team, cost effectiveness of care, and oral health outcomes be measured?

OHA Clinical Chart Review Form & Guidelines : DPP #100

Sources: IHS Oral Health Program Guide, OHA DPP#100 Advisory Committee input, Western Regional Examining Board, Kalenderian E. Classifying Adverse Events in the Dental Office. Journal of Patient Safety. 2017

Chart Number:

Tooth Number:

Reminders:

- N/A (Not Applicable) and Unable to Determine are always additional answer options
- Please provide additional comments whenever possible. Comments are required when rating below the minimum standard of care.
- Please note in comment sections whenever images are not sufficient for dependable evaluation.

CRITERIA	Description			Assessment	Comments
Diagnosis					
1. Diagnosis Description Appropriate	**Yes:** Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
2. Treatment appropriate	**Yes**: Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
Images					
1. Radiographs available and sufficient for diagnosis	**1:** Radiographs are present and adequate for evaluation	**2:** Radiographs are present, but not adequate for evaluation. Please describe why.	**3:** Radiographs are not present for this procedure		
2. Intra-Oral Images are sufficient for evaluation.	**1:** Intra-oral images are present and adequate for evaluation	**2:** Intra-oral images are present, but not adequate for evaluation. Please describe why.	**3:** Intra-oral images are not present for this procedure		
Administration of Drugs					
1. Anesthetic used appropriate for procedure	**Yes:** Appropriate anesthetic, location, and dosage	**No:** Grossly inappropriate anesthetic, location, or dosage			
2. Within recommended Limits	**Yes**: Drug dosages are within limits recommended by the Physician's Desk Reference or American Hospital Formulary Service. Dosage notation includes quantity, type, concentration and strength	**No**: Drug dosages are outside recommended limits.	**Unable to Determine**		

CRITERIA	Description					Assessment	Comments
3. Entered in Progress Notes (including anesthetic)	**Yes:** All drugs and dosages are entered in the medical and/or dental progress notes (including local anesthetic).			**No:** Must indicate deficiency in comments.			
4. Antibiotic Prophylaxis Given When Needed	**1:** Prophylaxis is called for and appropriately administered.	**2:** Prophylaxis is called for but is **not** appropriately administered. I.e. not given at all or an inappropriate amount or drug is given. Please comment.	**3:** Prophylaxis is not needed in this case and is not administered.				
5. Any previous history of anesthetic/drug/allergy/ reactions noted	**Yes:** Reactions and allergies to drugs are documented in dental record. "NKDA" is considered acceptable			**No:** Must indicate deficiency in comments.			
6. Requisite vital stats considered	**Yes:** Pre and post op vitals (including but not limited to) blood pressure for oral surgery procedures. Weight noted for all anesthetics and analgesics administered to minors age 10 and under.			**No:** Must indicate deficiency in comments.			
Evaluation of Procedure – Reviewer must use appropriate chart rubric to answer corresponding questions. Posterior Restorations (page 5), Anterior Restorations (page 7), SSC (page 9)							
1. Overall impression of procedure quality – used for all procedures	**1:** Significant deficiencies exist. Procedure can be considered a failure	**2:** Significant deficiencies exist, procedure falls under absolute minimum standard of care	**3: Minimum standard of care. Only minor deficiencies present.**	**4:** Procedure quality is adequate to good. Only minor deficiencies present.	**5:** Procedure is highly successful, no deficiencies present.		
2. Extractions – Treatment is appropriate for diagnosis	**Yes:** Minimum standard of care, tooth removed successfully with no complications			**No:** Extraction does not follow stipulated guidelines.			
Miscellaneous Documentation							
1. Rubber Dam or Isolation Documentation	**Yes:** Isolation is noted			**No:** Isolation is not noted			
2. Complications Noted	**1:** Any complications are sufficiently noted	**2:** No complications evident and none noted	**3:** No: Any complications that are present are not noted				

CRITERIA	Description		Assessment	Comments
Adverse Events				
1. Adverse Events	**Yes:** There were any Adverse Events noted during the review associated with this procedure. Please comment	**No:** There were no adverse events.		
2. AE Category	Select Dental AE Type Classification Category, if applicable. See Table 1. **Must be completed if response to Adverse Events #1 is "Yes"**			
3. AE Severity	Review Dental Adverse Severity Tree and assign an appropriate category. See Table 2. **Must be completed if response to Adverse Events #1 is "Yes"**			
4. Errors	**Yes:** There were any Errors noted during the review associated with this procedure. Please comment	**No:** There were no Errors.		
5. Error Category	Select Dental AE Type Classification Category, if applicable. See Table 1. **Must be completed if response to Errors #4 is "Yes"**			
6. Error Severity	Review Dental Adverse Severity Tree and assign an appropriate category. See Table 2. **Must be completed if response to Errors #4 is "Yes"**			

Adverse Events are categorized according to the following Dental AE Type Classification:

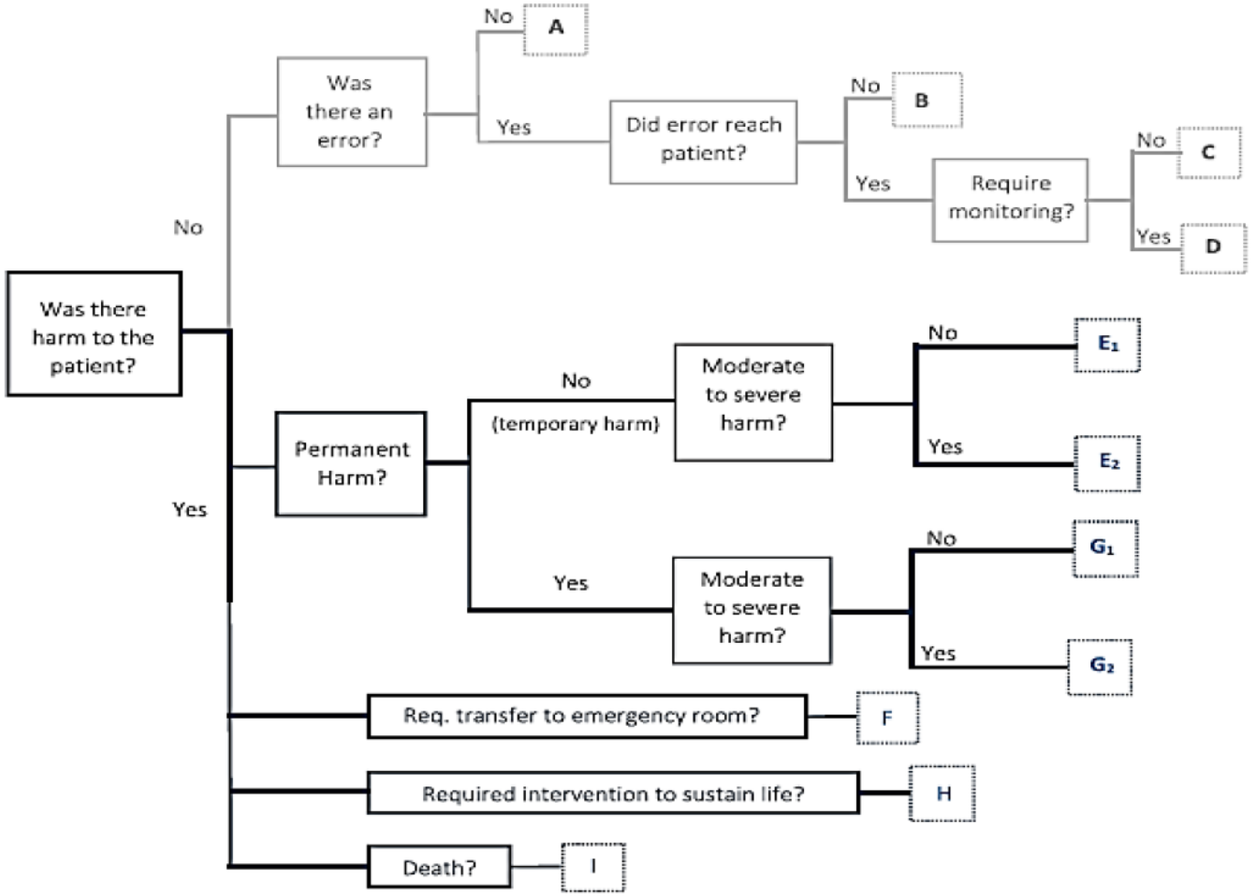
Table 1. Dental AE Type Classification[1]

AE Categories:

1. **Pain**
2. **Infection**
3. **Hard tissue damage**
4. **Nerve injury**
5. **Soft tissue damage/inflammation**
6. **Other oro-facial harm**
7. **Allergy, toxicity, or foreign body response**
8. **Aspiration or ingestion of foreign body**
9. **Wrong site, wrong patient, or wrong procedure**
10. **Bleeding**
11. **Other systemic harm**
12. **Other harm**

[1] Adapted from: Kalenderian E, Obadan-Udoh E, Maramaldi P, et al. Classifying Adverse Events in the Dental Office [published online ahead of print, 2017 Jun 30]. J Patient Saf. 2017;10.1097/PTS.0000000000000407. doi:10.1097/PTS.0000000000000407

Table 2. Dental Adverse Event Severity Categories.



Category	Description of Dental Adverse Event Severity Categories using the Dental AE severity tree
A	No errors
B	Error with no impact on patient
C	Error with minimal/mild impact to patient; does not require monitoring
D	Error with moderate to severe impact to patient; requires monitoring
E1	Temporary (reversible or transient) minimal/mild harm to the patient
E2	Temporary (reversible or transient) moderate to severe harm to the patient
F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization.
G1	Permanent minimal/mild patient harm.
G2	Permanent moderate to severe patient harm.
H	Intervention required to sustain life
I	Patient death.

Scoring Criteria – Amalgam/Composite Restorations – Posterior[3]

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
P.1 Prep: Outline and Extension	• Outline is grossly and improper and lacks any definite form. • Caries remains in the enamel or is not completely accessed. • Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.	• Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit. • Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.	• Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.	• Outline is slightly irregular but does not weaken tooth. • Isthmus is slightly wider than required for lesion. • Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.	• Outline is generally smooth and flowing and does not weaken tooth in any manner. • Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained.	N/A: Unable to Determine
P.2 Prep: Internal Form	• Walls and/or floors are grossly deep with total lack of concern for the pulp. • Caries remains in the dentin or is not completely accessed. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in char	• Pulpal floor and/or axial wall is critically shallow or critically deep. • Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart)	• Pulpal floor and/or axial wall is moderately shallow or deep.	• Pulpal floor and/or axial wall is slightly shallow or deep.	• Pulpal floor depth as determined by the lesion or defect does not exceed 2.0 mm from the cavosurface. Enamel may remain on the pulpal floor. Axial wall depth at the gingival floor is appropriate.	N/A: Unable to Determine

[3] Adapted for review of radiograph and intraoral imagery from Western Regional Examining Board, Central Regional Testing Service, American Board of Dental Examiners, The Commission on Dental Competency Assessments

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
P.3 Prep: Operative Environment	• Damage to the adjacent tooth will definitely require restoration.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Management of any damage is appropriate • Documentation of difficult behavior if necessary to explain excessive damage	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	• No damage to the adjacent tooth.	N/A: Unable to Determine:
P.4 Finish: Anatomical Form	• There is gross lack of anatomical form • Grossly improper proximal contour or shape.	• Anatomical form is improper. Marginal ridge is poorly shaped. • Anatomy is too deep or too flat. • Proximal contour is poor. Embrasures are severely over or under contoured.	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.	• Slight variation in normal anatomical form is present. • There is slight variation of proximal contour and shape.	• Anatomical form is consistent and harmonious with contiguous tooth structure. • Proper proximal contour and shape are restored.	N/A: Unable to Determine:
P.5 Finish: Margins	• Multiple open margins, or gross excesses or deficiencies, are present.	• A deep open margin is present, or critical excesses or deficiencies are present.	• Moderate marginal excesses and/or deficiencies are present.	• Slight marginal excesses and/or deficiencies are present.	• There are no excesses or deficiencies anywhere along margins.	N/A: Unable to Determine:
P.6 Finish: Damage	• Gross mutilation of hard or soft tissue is evident.	• Severe damage to hard or soft tissue is evident	• Moderate damage to hard or soft tissue is evident.	• Minor damage to hard or soft tissue is evident.	• There is no damage to hard or soft tissue.	N/A: Unable to Determine

Scoring Criteria: Anterior Composite Restorations[4]

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
A.1 Prep: Outline and Extension	• Cavosurface has multiple gross irregularities and/or enamel weaknesses that will cause the restoration to fail. • Cavosurface angles are grossly inappropriate for the situation and will lead to fracture of the restoration. ○	• Cavosurface angles will lead to enamel fracture or fracture of the restoration. ○	• Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. ○	• Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration. ○	• Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained. • Cavosurface forms a smooth continuous curve with no sharp angles. • There are no acute cavosurface angles. ○	N/A: ○ Unable to Determine: ○
A.2 Prep: Shape and Extension	• Caries remains in the dentin or is not completely accessed. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart) • Outline is grossly improper and/or lacks any definite form. • Gingival wall is grossly overextended. ○	• Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart) • Outline is severely over or underextended. • Gingival wall is in contact or obviously overextended. • Incisal extension has broken contact. ○	• Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth. • Gingival margin is moderately overextended. • Any overextension that severely weakens tooth is properly documented ○	• Outline is slightly over or under extended. • Outline is slightly irregular but does not weaken the tooth. ○	• Outline provides optimal access for caries removal and insertion of restorative material. ○	N/A: ○ Unable to Determine: ○

[4] Adapted for review of radiograph and intraoral imagery from Western Regional Examining Board, Central Regional Testing Service, American Board of Dental Examiners, The Commission on Dental Competency Assessments

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
A.3 Operative Environment	• Damage to the adjacent tooth will definitely require restoration.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	• No damage to the adjacent tooth.	N/A: Unable to Determine:
A.4 Finish: Anatomical Form	• There is gross lack of anatomical form • Grossly improper proximal contour or shape.	• Anatomical form is improper. Marginal ridge is poorly shaped. • Anatomy is too deep or too flat. • Proximal contour is poor. Embrasures are severely over or under contoured	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.	• Slight variation in normal anatomical form is present. • There is slight variation of proximal contour and shape.	• Anatomical form is consistent and harmonious with contiguous tooth structure. • Proper proximal contour and shape are restored.	N/A: Unable to Determine:
A.5 Finish: Margins	• Multiple open margins, or gross excesses or deficiencies, are present.	• A deep open margin is present, or critical excesses or deficiencies are present.	• Moderate marginal excesses and/or deficiencies are present.	• Slight marginal excesses and/or deficiencies are present.	• There are no excesses or deficiencies anywhere along margins.	N/A: Unable to Determine:
A.6 Finish: Damage	• Gross mutilation of hard or soft tissue is evident.	• Severe damage to hard or soft tissue is evident.	• Moderate damage to hard or soft tissue is evident.	• Minor damage to hard or soft tissue is evident.	• There is no damage to hard or soft tissue.	N/A: Unable to Determine:

Scoring Criteria: Stainless Steel Crowns

	1 Unacceptable	2 Inadequate	3 Acceptable	4 Appropriate	5 Optimal	Comments
SSC.1 Prep: Occlusal Reduction/ Incisal Reduction /Proximal reduction	• Sharp angles would preclude adequate crown adaptation. • Reduction is insufficient to allow full seating of the crown and results in the SSC being in moderate-severe hyperocclusion • Reduction is excessive and results in compromise of the tooth due to insufficient tooth structure remaining or pulpal exposure	• Sharp angles will affect crown prognosis. • Reduction is insufficient to allow full seating of the crown and results in the SSC being in mild-moderate hyperocclusion	• Deviates up to 1.0 mm from optimal. • Sharp angles may affect the restoration.	• Slightly deviates from optimal. • Occlusal reduction is sufficient. • Interproximal reduction sufficient.	• Occlusal Reduction/Incisal Reduction 1-1.5 mm compared to adjacent teeth. • Sharp cusp tips removed, line angles are rounded. • Bevel occlusal 1/3 of buccal and lingual.	N/A: Unable to Determine:
SSC.2 Prep: Caries Removal	• Caries remains in the enamel or dentin or is not completely accessed. • (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol)	• Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol)			• Complete Caries Removal	N/A: Unable to Determine:
SSC.3 Prep: Operative Environment	• Damage to the adjacent tooth will definitely require restoration. • Gross mutilation of hard or soft tissue is evident.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration. • Severe damage to hard or soft tissue is evident.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Moderate damage to hard or soft tissue is evident.	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact. • Minor damage to hard or soft tissue is evident.	• No damage to the adjacent tooth. • There is no damage to hard or soft tissue.	N/A: Unable to Determine:

	1 Unacceptable	2 Inadequate	3 Acceptable	4 Appropriate	5 Optimal	Comments
SSC.4 Adaptation, Cementation, Occlusion	• Fit of crown not appropriate (too large, small, short, or long) • Crown is positioned incorrectly. • Excessive cement remains. • Crown in obvious hyperocclusion. ◯		• Fit of crown is good (good contacts, length, and occlusion) • Correct position • Slight evidence of cement remaining radiographically • Occlusion appears good ◯		• Fit and contours of crown good. • Correct position • All remaining cement removed • Occlusion appears good ◯	N/A: ◯ Unable to Determine: ◯
SSC.5 Finish: Function	• Occlusion is grossly in hyper occlusion. ◯		• Occlusion is slightly in hyper-occlusion. ◯	• Occlusion is restored to proper centric but there some lateral interferen ◯	• Occlusion is restored to proper centric with no l interferences. ◯	N/A: ◯ Unable to Determine: ◯

Final Comments:

Reviewer Name

Time Spent on Review (minutes)

Chart ID

OHA Clinical Chart Review Form & Guidelines : DPP #100

Sources: IHS Oral Health Program Guide, OHA DPP#100 Advisory Committee input, Western Regional Examining Board, Kalenderian E. Classifying Adverse Events in the Dental Office. Journal of Patient Safety. 2017

Chart Number:

Tooth Number:

Reminders:

- N/A (Not Applicable) and Unable to Determine are always additional answer options
- Please provide additional comments whenever possible. Comments are required when rating below the minimum standard of care.
- Please note in comment sections whenever images are not sufficient for dependable evaluation.

CRITERIA	Description			Assessment	Comments
Diagnosis					
1. Diagnosis Description Appropriate	**Yes:** Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
2. Treatment appropriate	**Yes**: Falls within minimum standard of care.	**No:** Must indicate deficiency in comments.			
Images					
1. Radiographs available and sufficient for diagnosis	**1:** Radiographs are present and adequate for evaluation	**2:** Radiographs are present, but not adequate for evaluation. Please describe why.	**3:** Radiographs are not present for this procedure		
2. Intra-Oral Images are sufficient for evaluation.	**1:** Intra-oral images are present and adequate for evaluation	**2:** Intra-oral images are present, but not adequate for evaluation. Please describe why.	**3:** Intra-oral images are not present for this procedure		
Administration of Drugs					
1. Anesthetic used appropriate for procedure	**Yes:** Appropriate anesthetic, location, and dosage	**No:** Grossly inappropriate anesthetic, location, or dosage			
2. Within recommended Limits	**Yes**: Drug dosages are within limits recommended by the Physician's Desk Reference or American Hospital Formulary Service. Dosage notation includes quantity, type, concentration and strength	**No**: Drug dosages are outside recommended limits.	**Unable to Determine**		

CRITERIA	Description					Assessment	Comments
3. Entered in Progress Notes (including anesthetic)	**Yes:** All drugs and dosages are entered in the medical and/or dental progress notes (including local anesthetic).			**No:** Must indicate deficiency in comments.			
4. Antibiotic Prophylaxis Given When Needed	**1:** Prophylaxis is called for and appropriately administered.	**2:** Prophylaxis is called for but is **not** appropriately administered. I.e. not given at all or an inappropriate amount or drug is given. Please comment.	**3:** Prophylaxis is not needed in this case and is not administered.				
5. Any previous history of anesthetic/drug/allergy/ reactions noted	**Yes:** Reactions and allergies to drugs are documented in dental record. "NKDA" is considered acceptable			**No:** Must indicate deficiency in comments.			
6. Requisite vital stats considered	**Yes:** Pre and post op vitals (including but not limited to) blood pressure for oral surgery procedures. Weight noted for all anesthetics and analgesics administered to minors age 10 and under.			**No:** Must indicate deficiency in comments.			
Evaluation of Procedure – Reviewer must use appropriate chart rubric to answer corresponding questions. Posterior Restorations (page 5), Anterior Restorations (page 7), SSC (page 9)							
1. Overall impression of procedure quality – used for all procedures	**1:** Significant deficiencies exist. Procedure can be considered a failure	**2:** Significant deficiencies exist, procedure falls under absolute minimum standard of care	**3: Minimum standard of care. Only minor deficiencies present.**	**4:** Procedure quality is adequate to good. Only minor deficiencies present.	**5:** Procedure is highly successful, no deficiencies present.		
2. Extractions – Treatment is appropriate for diagnosis	**Yes:** Minimum standard of care, tooth removed successfully with no complications			**No:** Extraction does not follow stipulated guidelines.			
Miscellaneous Documentation							
1. Rubber Dam or Isolation Documentation	**Yes:** Isolation is noted			**No:** Isolation is not noted			
2. Complications Noted	**1:** Any complications are sufficiently noted	**2:** No complications evident and none noted	**3:** No: Any complications that are present are not noted				

CRITERIA	Description		Assessment	Comments
Adverse Events				
1. Adverse Events	**Yes:** There were any Adverse Events noted during the review associated with this procedure. Please comment	**No:** There were no adverse events.		
2. AE Category	Select Dental AE Type Classification Category, if applicable. See Table 1. **Must be completed if response to Adverse Events #1 is "Yes"**			
3. AE Severity	Review Dental Adverse Severity Tree and assign an appropriate category. See Table 2. **Must be completed if response to Adverse Events #1 is "Yes"**			
4. Errors	**Yes:** There were any Errors noted during the review associated with this procedure. Please comment	**No:** There were no Errors.		
5. Error Category	Select Dental AE Type Classification Category, if applicable. See Table 1. **Must be completed if response to Errors #4 is "Yes"**			
6. Error Severity	Review Dental Adverse Severity Tree and assign an appropriate category. See Table 2. **Must be completed if response to Errors #4 is "Yes"**			

Adverse Events are categorized according to the following Dental AE Type Classification:

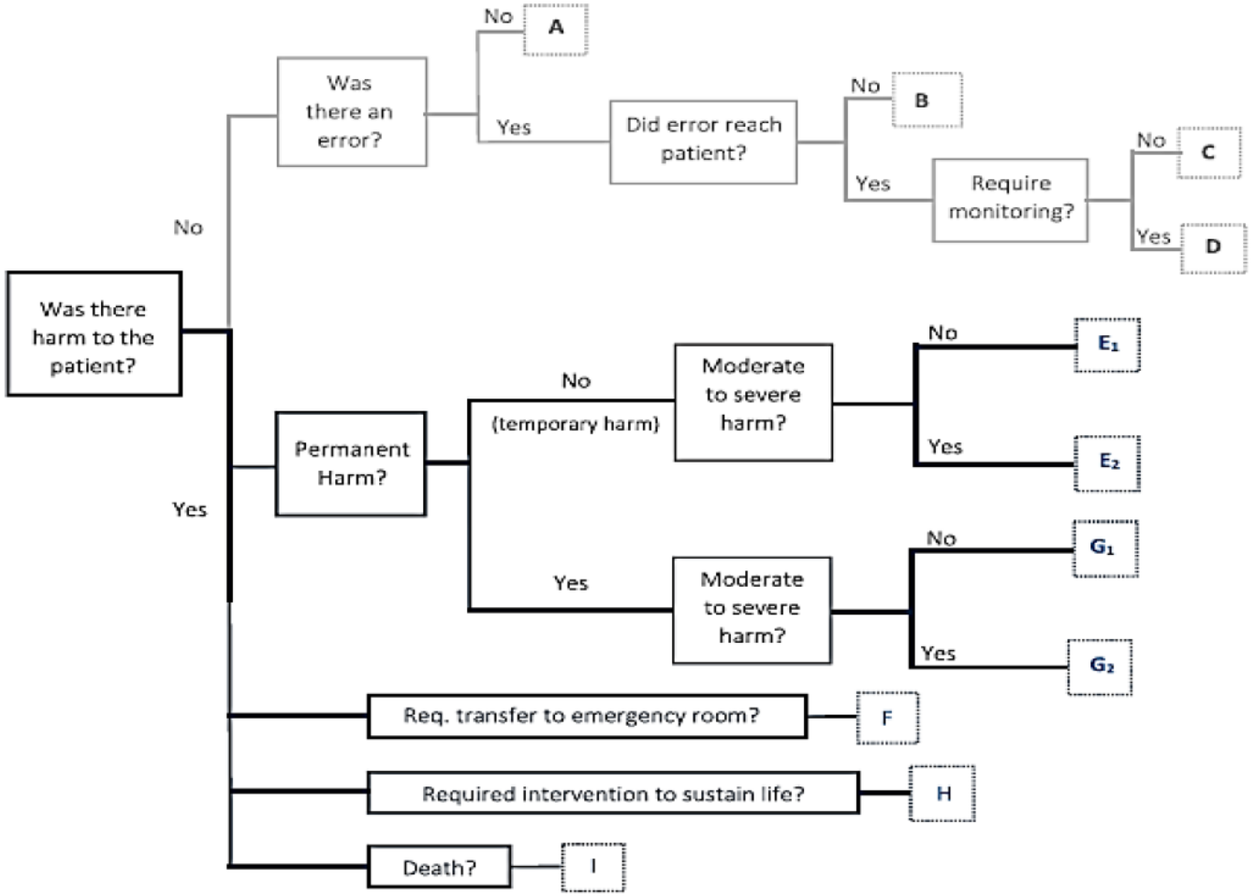
Table 1. Dental AE Type Classification[1]

AE Categories:

1. **Pain**
2. **Infection**
3. **Hard tissue damage**
4. **Nerve injury**
5. **Soft tissue damage/inflammation**
6. **Other oro-facial harm**
7. **Allergy, toxicity, or foreign body response**
8. **Aspiration or ingestion of foreign body**
9. **Wrong site, wrong patient, or wrong procedure**
10. **Bleeding**
11. **Other systemic harm**
12. **Other harm**

[1] Adapted from: Kalenderian E, Obadan-Udoh E, Maramaldi P, et al. Classifying Adverse Events in the Dental Office [published online ahead of print, 2017 Jun 30]. J Patient Saf. 2017;10.1097/PTS.0000000000000407. doi:10.1097/PTS.0000000000000407

Table 2. Dental Adverse Event Severity Categories.



Category	Description of Dental Adverse Event Severity Categories using the Dental AE severity tree
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C	Error with minimal/mild impact to patient; does not require monitoring
D	Error with moderate to severe impact to patient; requires monitoring
E1	Temporary (reversible or transient) minimal/mild harm to the patient
E2	Temporary (reversible or transient) moderate to severe harm to the patient
F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization.
G1	Permanent minimal/mild patient harm.
G2	Permanent moderate to severe patient harm.
H	Intervention required to sustain life
I	Patient death.

Scoring Criteria – Amalgam/Composite Restorations – Posterior[3]

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
P.1 Prep: Outline and Extension	• Outline is grossly and improper and lacks any definite form. • Caries remains in the enamel or is not completely accessed. • Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.	• Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit. • Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.	• Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.	• Outline is slightly irregular but does not weaken tooth. • Isthmus is slightly wider than required for lesion. • Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.	• Outline is generally smooth and flowing and does not weaken tooth in any manner. • Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained.	N/A: Unable to Determine
P.2 Prep: Internal Form	• Walls and/or floors are grossly deep with total lack of concern for the pulp. • Caries remains in the dentin or is not completely accessed. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in char	• Pulpal floor and/or axial wall is critically shallow or critically deep. • Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart)	• Pulpal floor and/or axial wall is moderately shallow or deep.	• Pulpal floor and/or axial wall is slightly shallow or deep.	• Pulpal floor depth as determined by the lesion or defect does not exceed 2.0 mm from the cavosurface. Enamel may remain on the pulpal floor. Axial wall depth at the gingival floor is appropriate.	N/A: Unable to Determine

[3] Adapted for review of radiograph and intraoral imagery from Western Regional Examining Board, Central Regional Testing Service, American Board of Dental Examiners, The Commission on Dental Competency Assessments

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
P.3 Prep: Operative Environment	• Damage to the adjacent tooth will definitely require restoration.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Management of any damage is appropriate • Documentation of difficult behavior if necessary to explain excessive damage	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	• No damage to the adjacent tooth.	N/A: Unable to Determine:
P.4 Finish: Anatomical Form	• There is gross lack of anatomical form • Grossly improper proximal contour or shape.	• Anatomical form is improper. Marginal ridge is poorly shaped. • Anatomy is too deep or too flat. • Proximal contour is poor. Embrasures are severely over or under contoured.	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.	• Slight variation in normal anatomical form is present. • There is slight variation of proximal contour and shape.	• Anatomical form is consistent and harmonious with contiguous tooth structure. • Proper proximal contour and shape are restored.	N/A: Unable to Determine:
P.5 Finish: Margins	• Multiple open margins, or gross excesses or deficiencies, are present.	• A deep open margin is present, or critical excesses or deficiencies are present.	• Moderate marginal excesses and/or deficiencies are present.	• Slight marginal excesses and/or deficiencies are present.	• There are no excesses or deficiencies anywhere along margins.	N/A: Unable to Determine:
P.6 Finish: Damage	• Gross mutilation of hard or soft tissue is evident.	• Severe damage to hard or soft tissue is evident	• Moderate damage to hard or soft tissue is evident.	• Minor damage to hard or soft tissue is evident.	• There is no damage to hard or soft tissue.	N/A: Unable to Determine

Scoring Criteria: Anterior Composite Restorations[4]

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
A.1 Prep: Outline and Extension	• Cavosurface has multiple gross irregularities and/or enamel weaknesses that will cause the restoration to fail. • Cavosurface angles are grossly inappropriate for the situation and will lead to fracture of the restoration. ○	• Cavosurface angles will lead to enamel fracture or fracture of the restoration. ○	• Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. ○	• Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration. ○	• Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained. • Cavosurface forms a smooth continuous curve with no sharp angles. • There are no acute cavosurface angles. ○	N/A: ○ Unable to Determine: ○
A.2 Prep: Shape and Extension	• Caries remains in the dentin or is not completely accessed. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart) • Outline is grossly improper and/or lacks any definite form. • Gingival wall is grossly overextended. ○	• Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol, and must be noted in chart) • Outline is severely over or underextended. • Gingival wall is in contact or obviously overextended. • Incisal extension has broken contact. ○	• Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth. • Gingival margin is moderately overextended. • Any overextension that severely weakens tooth is properly documented ○	• Outline is slightly over or under extended. • Outline is slightly irregular but does not weaken the tooth. ○	• Outline provides optimal access for caries removal and insertion of restorative material. ○	N/A: ○ Unable to Determine: ○

[4] Adapted for review of radiograph and intraoral imagery from Western Regional Examining Board, Central Regional Testing Service, American Board of Dental Examiners, The Commission on Dental Competency Assessments

	1 Unacceptable	2 Inadequate	3 Acceptable – Minimum Standard of Care	4 Appropriate	5 Optimal	Comments
A.3 Operative Environment	• Damage to the adjacent tooth will definitely require restoration.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	• No damage to the adjacent tooth.	N/A: Unable to Determine:
A.4 Finish: Anatomical Form	• There is gross lack of anatomical form • Grossly improper proximal contour or shape.	• Anatomical form is improper. Marginal ridge is poorly shaped. • Anatomy is too deep or too flat. • Proximal contour is poor. Embrasures are severely over or under contoured	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.	• Slight variation in normal anatomical form is present. • There is slight variation of proximal contour and shape.	• Anatomical form is consistent and harmonious with contiguous tooth structure. • Proper proximal contour and shape are restored.	N/A: Unable to Determine:
A.5 Finish: Margins	• Multiple open margins, or gross excesses or deficiencies, are present.	• A deep open margin is present, or critical excesses or deficiencies are present.	• Moderate marginal excesses and/or deficiencies are present.	• Slight marginal excesses and/or deficiencies are present.	• There are no excesses or deficiencies anywhere along margins.	N/A: Unable to Determine:
A.6 Finish: Damage	• Gross mutilation of hard or soft tissue is evident.	• Severe damage to hard or soft tissue is evident.	• Moderate damage to hard or soft tissue is evident.	• Minor damage to hard or soft tissue is evident.	• There is no damage to hard or soft tissue.	N/A: Unable to Determine:

Scoring Criteria: Stainless Steel Crowns

	1 Unacceptable	2 Inadequate	3 Acceptable	4 Appropriate	5 Optimal	Comments
SSC.1 Prep: Occlusal Reduction/ Incisal Reduction /Proximal reduction	• Sharp angles would preclude adequate crown adaptation. • Reduction is insufficient to allow full seating of the crown and results in the SSC being in moderate-severe hyperocclusion • Reduction is excessive and results in compromise of the tooth due to insufficient tooth structure remaining or pulpal exposure	• Sharp angles will affect crown prognosis. • Reduction is insufficient to allow full seating of the crown and results in the SSC being in mild-moderate hyperocclusion	• Deviates up to 1.0 mm from optimal. • Sharp angles may affect the restoration.	• Slightly deviates from optimal. • Occlusal reduction is sufficient. • Interproximal reduction sufficient.	• Occlusal Reduction/Incisal Reduction 1-1.5 mm compared to adjacent teeth. • Sharp cusp tips removed, line angles are rounded. • Bevel occlusal 1/3 of buccal and lingual.	N/A: Unable to Determine:
SSC.2 Prep: Caries Removal	• Caries remains in the enamel or dentin or is not completely accessed. • (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol)	• Affected dentin remains. (All caries must be removed except in the area of imminent pulp exposure, evidence based partial caries removal protocol)			• Complete Caries Removal	N/A: Unable to Determine:
SSC.3 Prep: Operative Environment	• Damage to the adjacent tooth will definitely require restoration. • Gross mutilation of hard or soft tissue is evident.	• Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration. • Severe damage to hard or soft tissue is evident.	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Moderate damage to hard or soft tissue is evident.	• Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact. • Minor damage to hard or soft tissue is evident.	• No damage to the adjacent tooth. • There is no damage to hard or soft tissue.	N/A: Unable to Determine:

	1 Unacceptable	2 Inadequate	3 Acceptable	4 Appropriate	5 Optimal	Comments
SSC.4 Adaptation, Cementation, Occlusion	• Fit of crown not appropriate (too large, small, short, or long) • Crown is positioned incorrectly. • Excessive cement remains. • Crown in obvious hyperocclusion. ◯		• Fit of crown is good (good contacts, length, and occlusion) • Correct position • Slight evidence of cement remaining radiographically • Occlusion appears good ◯		• Fit and contours of crown good. • Correct position • All remaining cement removed • Occlusion appears good ◯	N/A: ◯ Unable to Determine: ◯
SSC.5 Finish: Function	• Occlusion is grossly in hyper occlusion. ◯		• Occlusion is slightly in hyper-occlusion. ◯	• Occlusion is restored to proper centric but there some lateral interferen ◯	• Occlusion is restored to proper centric with no l interferences. ◯	N/A: ◯ Unable to Determine: ◯

Final Comments:

Reviewer Name

Time Spent on Review (minutes)

Chart ID