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

Oregon Health Authority

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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
September 25, 2017, 10:00am – 12:00pm

Location: Portland State Office Building, 800 NE Oregon Street, Room 1E, Portland Conference Line: Dial-In Number: 1-888-636-3807 Participant Code: 793800		
10:00-10:10	Official Introductions, Agenda Review	Bruce Austin, DMD Sarah Kowalski, MS, RDH
10:10-10:20	Approve Minutes from June 14, 2017 Annual Meeting	Sarah Kowalski, MS, RDH
10:20-11:00	Review Response from NPAIHB, Discussion	Sarah Kowalski, MS, RDH
11:00-11:20	Review Informed Consent Documents, Discussion	Sarah Kowalski, MS, RDH
11:20-11:45	Overview of Recent Site Visit; Discussion	Bruce Austin, DMD Sarah Kowalski, MS, RDH
11:45-11:50	Follow Up Items, Future Meeting Dates: Doodle Survey, Next Site Visit, Closing	Sarah Kowalski, MS, RDH
11:50-12:00	Public Comment Period	

Next Meeting: Monday, November 6, 2017, Portland State Office Building 800 NE Oregon Street Portland, Oregon, Room 1D, 10:00am – 12:00pm

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Dental Pilot Project Application #100
Oregon Tribes Dental Health Aide Therapist Pilot Project
Quarterly Dental Pilot Project Advisory Committee Meeting Notes
September 25, 2017

The DPP #100 Advisory Committee meeting was held on September 25, 2017 from 10:00 am - 12:00 pm at the offices of the Oregon Health Authority, 800 NE Oregon Street, Portland, Oregon 97232.

The Oregon Health Authority (OHA) is tasked with implementing legislation as enacted by Senate Bill 738 in 2011 for the Dental Pilot Projects Program. OHA takes a neutral position on the concepts presented in the approved dental pilot projects. OHA is responsible for processing initial pilot project applications, approving projects, and monitoring approved pilot projects. The monitoring process shall include, but is not limited to, reviewing progress reports and conducting site visits. Each dental pilot project is responsible for meeting its stated objectives in the approved or amended application and in complying with statutes, regulations and OHA procedures.

DPP #100 Advisory Committee Members Present:

Leon Asseal, DMD*	Oral and Maxillofacial Surgeon; Chairman of the Board, American Dental Education Association,
Len Barozzini, DDS	General Dentist; Director of Dental Services, Multnomah County Health Department
Jennifer Clemens, DMD, MPH	General Dentist, Smilekeepers Dental Clinic
Steven Duffin, DDS	General Dentist, Shoreview Dental Clinic
Shannon English, DDS	Managing Dentist, Willamette Dental
Tony Finch, MA, MPH	Executive Director, Oregon Oral Health Coalition
Karen Hall, RDH, EPDH*	Oral Health Educator, Oregon Oral Health Coalition
Kyle Johnstone, MHA, RDH, EPP	Clinic Operations Manager, Virginia Garcia Memorial Health Center
Jill Jones, MS, RDH, EPP*	Dental Hygiene Program Faculty, Lane Community College
Richie Kohli, MS, BDS	General Dentist; Assistant Professor OHSU – School of Dentistry, OHSU Representative
Conor McNulty, CAE	Executive Director, Oregon Dental Association
Linda Mann, RDH, EPDH	Dental Hygienist; Director of Community Outreach, Capitol Dental Care
Carolyn Muckerheide, DDS	Pediatric Dentist, Behind the Smile Pediatric Dentistry
Brandon Schwindt, DMD	Pediatric Dentist, Oregon Board of Dentistry Representative, Kona Kids Pediatric Dentistry
Gita Yitta, DMD	General Dentist; AllCare Health, Associate

	Dental Director; Klamath Community College, Dental Program Coordinator

DPP #100 Advisory Committee Members Not Present:

Teri Barichello, DMD	Vice-President, Chief Dental Officer at The ODS Companies, Oregon Dental Association Representative
Paula Hendrix, M.Ed, RDH, EPDH	Dental Hygiene Program Director, Oregon Institute of Technology
Kelli Swanson Jaecks, MA, RDH	Past President ADHA & ODHA, Oregon Dental Hygiene Association Representative
Kenneth R Wright DDS, MPH	Vice-President, Dental Services Kaiser Foundation Health Plan of the Northwest

Oregon Health Authority Program Staff:

Bruce Austin, DMD	Statewide Dental Director, OHA
Kelly Hansen	Research Analyst, Oral Health Program
Sarah Kowalski, MS, RDH	Dental Pilot Project Program Coordinator, Oral Health Program
Karen Phillips, MPH, RDH, EPDH	Oral Health Program Analyst
Rhiannon Simon, MPH	Public Health Educator

Members of the Public:
Pam Johnson*, Project Manager, Northwest Portland Area Indian Health Board
Jennifer Lewis-Goff, Oregon Dental Association, Director of Government Affairs to the Board
Heather Simmons*, Dental Manager, Pacific Source

*Individuals called in on the conference line

Welcome and Introductions
Sarah Kowalski, OHA Dental Pilot Project Coordinator, welcomed the meeting attendees. Ms. Kowalski provided background information on the Dental Pilot Project Program and its origins in Senate Bill 738 enacted in 2011. The goal of the Dental Pilot Projects is to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care. Ms. Kowalski asked all attendees to introduce themselves. All individuals present completed a sign-in sheet. Individuals on the phone introduced themselves. The meeting was open to the public.

The agenda for the day was reviewed.

Meeting Highlights

Review of NPAIHB Project Response to Request for Clarifications:
OHA sent NPAIHB a copy of the meeting minutes from the annual meeting in June followed by requests for clarification on several points made by the Advisory Committee. Advisory Committee members were provided a copy of the original request for clarification and the NPAIHB response. Excerpts from the request for clarification and project response have been included in the meeting minutes to provide context to the Advisory Committee discussion and the committee and OHA program requests for further clarification.

Excerpt

OHA and the Advisory Committee requesting information on the Preceptorship Process.
"Preceptorship Process The committee requests further clarification on the preceptorship process. There remains confusion regarding the process and the subjective nature as to when or why a dental therapist would be required to complete addition hours beyond the 400 clinical hour preceptorship.

A. Who determines the additional number of hours required? Is it by procedure type? B. Is the DHAT model the only education model that requires a preceptorship? Compared to the hygiene based models? C. Are there remedial steps for an individual who does not pass a preceptorship? D. What is the process for an experienced DHAT and the preceptorship period in Oregon? How is the word "experienced" defined? Number of hours practiced? E. The preceptorship requires 8 simple extractions be completed as defined by CDT code D7140. How many simple extractions are completed prior to graduation?"

NPAIHB responded*: "We disagree this is subjective. We have established criteria that specify that new DHATs must complete 400 hours, and DHATs that have been recertified in AK at least once complete 80 hours and show competency in each scope of practice. If they cannot do that, then it will require additional time. The supervising dentist determines what procedures can go in their practice plan after the preceptorship. This is all written clearly in the monitoring plan and preceptorship tracking form.*

Advisory committee members are welcome to research other program models for direct supervision and preceptorships. The model we are using has worked in Alaska for the DHAT, the supervising dentist and the patients for over 12 years.

The DHAT Education Program only graduates DHATs that prove competency for each procedure—including simple extractions--much like dental school. Each student spends a full year in a clinical setting which gives them the experience to prove those competencies. We do not ask dentists how many root canals they have done in dental school before granting a license."

Advisory Committee Discussion to NPAIHB Written Response: [Leon Asseal, Bruce Austin, Len Barozzini, Tony Finch, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

There is confusion on what constitutes a simple extraction and whether this is only defined by code or if there is an objective set of criteria such as mobility. There is a request to review what other jurisdictions require for extraction criteria. There is concern that there is tremendous latitude and discretion given by the supervising dentist and whether there should be a set of clinical protocols that are required. The committee was informed that in Minnesota, the tooth must meet a certain grade of mobility before the dental therapist is authorized to perform the extraction. Clarification is sought on this point from the project. There is confusion by members as to whether it must be an emergency for the supervising dentist to authorize the procedure. Other members explained that it was their understanding that the supervising dentist authorizes procedures as part of the standing orders however extractions always require a consultation and prior authorization from the supervising dentist. The committee requests further information on the relationship between the supervising dentist and the dental therapist, what happens if the supervising dentist leaves and a new individual replaces them, how does that process work with the providers?

Excerpt

OHA and the Advisory Committee requesting information on Outcomes and Complications:
The committee recommends that "patients who return to the office, following a procedure and have a complaint or complication must be identified and tracked. A tracking code in Dentrix could be created to allow for overall site monitoring of the number of patients who are returning due to any complication or complaint."

NPAIHB responded*: "We do not agree that this recommendation will result in better care for the patient, or meaningful data for OHA. Adverse outcomes are not synonymous with complication or complaint. A patient returning to the clinic with a complaint will be seen by a provider that can assess the nature and cause of complaint, and proceed with their best professional judgment. The complaint may be due to the original procedure, or due to circumstances beyond the providers' control, a new diagnosis, or may be anticipated by the provider if they were attempting to resolve an issue, with no guaranteed outcome. I.e.—trying to save a tooth with a pulpotomy instead of pulling it. A dentist and patient could agree on that treatment knowing that there was a chance of it not working, but in hopes that it could save the tooth. We will await OHA's definitions of adverse outcomes in order to better use the adverse events form already required, and we will implement a new protocol for the supervising dentist weekly review. The supervising dentist will review charts of any patient who has been seen previously by the DHAT for an irreversible procedure in the past year. This case management approach will allow the dentist to assess any complications or complaints and determine any association with the DHAT's work. Notes in the chart will then be available for the external dentist and OHA review"*

Advisory Committee Discussion to NPAIHB Written Response: [Leon Asseal, Bruce Austin, Len Barozzini, Tony Finch, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

The Advisory Committee discussed the issues in the NPAIHB response. The consensus was that this is a pilot project and projects need a process to track quality and complications should they arise in order to assess trends in patient care and patient safety. A discussion ensued stressing that the pilot project is required to demonstrate patient safety as well as efficacy and competency of the dental therapist. A list of complications and tracking should be part of the evaluation and the monitoring of the pilot project.

Excerpt:

OHA and the Advisory Committee requesting information on **complications**: "Each irreversible procedure should have a list of associated complications that must also be recorded which are procedure specific. Please define under each irreversible procedure evidence based complications and/or adverse outcomes and how they will be reported in Dentrix and ultimately the patient's chart. The advisory committee reported a concern that there will be an intrinsic bias to underreport adverse outcomes without a set of objective guidelines."

NPAIHB responded*: "This is not the standard of care. There is a standard of care that requires patients to be informed of treatment options, possible complications and alternative. DHAT are educated to understand what informed consent is and are required to document that they have received informed consent from the patient or guardian prior to treatment. The example given on pulp therapy is a research paper, not a list to advise clinical protocol.*

The redundancy of review and scrutiny of this provider delivering safe and quality care is 6-fold: Direct

supervision of all procedures during 400 hour preceptorship; Ongoing consultation between DHAT and dentist any time there is a question about best course of action and required before every extraction. Weekly chart review of every single irreversible procedure by the supervising dentist; quarterly chart review of a random sample of irreversible procedures by an external dentist; quarterly reports turned into OHA tracking every procedure performed by the DHAT; and yearly site visit and chart review by the OHA Advisory Committee. We have now agreed to add one more layer of review to address the issue of patient complications and are certain that this goes above and beyond the need for assessing the work of the DHAT."

Advisory Committee Discussion: [Leon Asseal, Bruce Austin, Len Barozzini, Shannon English, Kelly Hansen, Kyle Johnstone, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

The Advisory Committee discussed the issues in the NPAIHB response. Members suggested that tracking complications is becoming the standard of care and one way to assess quality in dental offices. OHA discussed concerns related to the project regarding informed consent. The approved project application outlined the process for informed consent as it relates to the trainee however it did not contain the actual informed consent that the provider reviews as it relates to each procedure. The administrative rules state the word form which OHA interpreted as a written document however a consensus between NPAIHB and OHA was not reached which was why the DOJ was consulted. OHA consulted with the Department of Justice to obtain their interpretation of the OAR as it relates to this issue. DOJ will require the project to submit a copy of the informed consent that is then delivered verbally to the patient and ultimately this is documented in the chart. Several members asked about the Oregon Board of Dentistry and Oregon Dental Practice Act rules around informed consent. OHA is reviewing the process required and working with the project to determine what information can be delivered verbally and what is required to be in written form. More information will be forthcoming on this point. Members discussed what types of restraint are allowed by the dental therapists. A request for clarification will be made to the project.

Excerpt

OHA and the Advisory Committee requesting information on Scope of Practice: "Procedure Clarification specifically to Extractions, CDT Code D7140, is defined at "includes removal of tooth structure, minor smoothing of socket bone, and closure if necessary." Please clarify if the dental therapist will be providing sutures? Will the dental therapist be completing minor smoothing of socket bone?

NPAIHB Response*: "Dental Therapist in our pilot will not be providing sutures, and will not be using a bone file to smooth socket bone."*

Advisory Committee Discussion: [Leon Asseal, Bruce Austin, Len Barozzini, Steven Duffin, Shannon English, Kyle Johnstone, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

The Advisory Committee discussed the issues in the NPAIHB response. Members discussed and questioned why the dental therapists are able to provide extractions but are not allowed to suture. There were several members who stated that this should be part of their scope of practice. Members questioned what clinical protocols were being used to control for hemostasis. There were also concerns about multiple teeth being extracted in an adjacent area and how dental therapists control bleeding if unable to provide sutures. Members requested more information on this point.

Excerpt

OHA and the Advisory Committee requesting information on Scope of Practice: "Who is determining the classification and distinction of the type of extraction, as defined between CDT Code D7140 and CDT Code D7210."

NPAIHB Response: *"DHATs do not perform D7210. During the preceptorship the dentist will identify the classification, and after the preceptorship it will be made in consultation with the DHAT and the dentist, as is the case in all extractions."*

Advisory Committee Discussion: [Leon Asseal, Bruce Austin, Len Barozzini, Shannon English, Kelly Hansen, Kyle Johnstone, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

The Advisory Committee discussed the issues in the NPAIHB response. OHA explained that it was their understanding that project supervising dentists determine if the extraction meets the criteria for a simple extraction. Members discussed concerns over what steps are taken if extraction appears to be simple but becomes complication during the process. A discussion ensued that many dentists do not perform any extractions at all in their offices and refer all extractions out. The committee would like more information on why nitrous oxide is also not part of their scope of practice. The dental therapists are co-located with dentists at the NARA site and the CTCLUSI site, is there nitrous oxide being used at those clinics? Do the dental therapists receive training in nitrous oxide? OHA will research whether nitrous and sutures are part of the scope of practice in the other states.

Excerpt

OHA and the Advisory Committee requesting information on Scope of Practice: **"**Is there a moratoria on third molar extractions?"

NPAIHB Response: *"No, there isn't unless it is a restriction in their practicing plan. A tooth with an emergency is an emergency, and there are third molar cases that are not complicated. This again will be something they discuss with supervising dentist during consultation."*

Advisory Committee Discussion: [Leon Asseal, Bruce Austin, Len Barozzini, Shannon English, Kelly Hansen, Kyle Johnstone, Sarah Kowalski, Carolyn Muckerheide, Brandon Schwindt]

The Advisory Committee discussed the issues in the NPAIHB response. The committee was informed that in the Minnesota dental therapy model, tooth mobility of grade three or more is required for their dental therapists to complete the extraction procedure. The committee discussed confusion on the requirement that the procedure be completed only when it is an emergency as stated in their response. More information and clarification is requested on this point and how it fits into the dental therapist scope of practice.

Site Visit Review: Bruce Austin and Sarah Kowalski, OHA program staff, conducted a site visit to Alaska in September, 2017. Highlights of the visit were discussed with the committee members. The purpose of the site visit was to attend the supervising dentist training in both Bethel, Alaska and Anchorage, Alaska. Dr. Wineland from the NARA Site in Portland was in attendance. The overall assessment was that there is a robust education program; the program is preparing to apply to CODA

and if accredited will be the first in the United States. Dr. Austin explained that the program is innovative in that they were the first. The Alaska model is different from Minnesota, Maine and Vermont is several ways. The dental therapists are certified by a federal certification board however there are no WREB type of clinical examinations or written exams conducted by a third party. The supervising dentist is integral to accessing the competency of the dental therapist operating under them. Alaska is an extremely large state with many areas inaccessible months out of the year. The dental therapists operating in remote villages consult with their supervising dentist who might be several hundred miles way. The model has brought oral healthcare to underserved areas, decay rates are dropping according to studies and oral health is improving. OHA is in the process of writing the site visit report.

Chart Review: Kelly Hansen, OHA program staff research analyst, explained the process under development to conduct chart reviews. OHA explained that only dentists are able to conduct the full chart review as only individuals who can perform the procedures should be making assessments.

Closing: Members of the Advisory Committee [Kyle Johnstone, Brandon Schwindt, Carolyn Muckerheide] eexpressed concern about the overall tone of the response received from the NPAIHB. Members stated that they do not feel that there is a collaborative approach being taking by the NPAIHB. It is the goal of the Advisory Committee to understand the concept of the pilot project, clarify when necessary and advise both OHA and the project as needed.

There was a request to review the syllabus of each of the courses that the dental therapist takes as part of their education in Alaska.

There was a request as to when data will be available as part of the quarterly progress reports. OHA explained that projects own their data; projects understand that they are required to submit raw data to OHA. OHA will provide summarized data to the committee.

Public Comments: NPAIHB [Pam Johnson] responded to the concerns of the committee related to the perceived tone of their project stating that “If you have questions about the tone of the response or what we are doing, remember there has been a lot of money spent to oppose the DHAT model, much of it coming from the dental establishment.”

Follow-Up with the NPAIHB: OHA to send summary of meeting with request for information to the project.

Next Meeting: November 6, 2017, PSOB 800 NE Oregon, Street, 10am-12pm

Meeting adjourned at 12pm

Attached Summary Document outlining action items, items for clarification and deliverables

Action Items, Items for Clarification, Deliverables*

Site Visit Completed a. Site visit completed September 11-12th to Alaska i. OHA developing site visit report ii. Follow-Up questions submitted to project for clarification iii. Site Visit Report due back to NPAIHB on November 12th or sooner	
OHA Action Items:**	• Submitted follow-up questions to NPAIHB on September 18, 2017 • Complete site visit report by November 12th
NPAIHB* Action Items:**	• Submit Completed Follow-Up Questions for Clarification to OHA by October 2, 2017
NARA Site Visit a. Dates i. Due to feedback from Advisory Committee members regarding the chart review process and the need to develop calibration among reviewers, site dates for November have been cancelled ii. Currently proposed sites dates are either January 29th or February 26th pending confirmation b. Site Visit Process i. Site visit process documents under development for DPP #100 ii. Examples of site visit process (utilized for DPP #200) previously sent to NPAIHB iii. Site visit process documents will be sent to NPAIHB once chart review process documents are complete, estimated end of November/early December c. Chart Review Process i. Process in development with consultation from Subject Matter Experts on Advisory Committee ii. See "Chart Review Process" (next box) for details	
OHA Action Items:**	• Send Site Visit Process Documents to NPAIHB – estimated deliverable end of November/beginning of December • Develop Chart Review Process (see below) • Doodle Poll Advisory Committee for site visit participation once confirmation of dates received
NPAIHB* Action Items:**	• Confirm proposed site visit dates by October 31, 2017
Chart Review Process a. Comprehensive Chart Review Process in Development with Advisory Committee Subject Matter Experts b. A sufficient number of randomized de-identified patient charts will be requested to provide a satisfactory number of charts for each procedure under review. In addition, charts will be reviewed for basic charting protocol, infection control protocol, informed consent, diagnosis and treatment planning and unanticipated adverse events. c. Chart Review processes will include reviewer standardization guidelines to ensure interrater reliability which are currently under development using the following sources. i. WREB documents/process	

ii. Indian Health Services Chart Review Document
iii. DHAT Training Curriculum materials
iv. Literature Review

c. Review process with input from Advisory Committee at next Quarterly meeting in November
i. Chart Review clinical parameters
ii. Review NPAIHB Chart Review Document

OHA Action Items:**	• Develop chart review process for use during site visits
NPAIHB* Action Items:**	• Provide list of anticipated complications, by procedure, for chart review process by October 31, 2017

Informed Consent

a. Process of Informed Consent (IC) in Pilot Projects
i. The form provided in the application complies with the OARS for item 2 a, b, c of the OARS but does not comply with item 5. 333-010-0440 "(5) Informed consent needs to be obtained specifically for those tasks, services, or functions to be provided by a pilot project trainee."
ii. Members of the Advisory Committee have expressed concern that the Informed Consent document in the application contains inflammatory language that is not pertinent to the Informed Consent process in education patients about the trainee role
iii. OHA consulted Department of Justice for administrative rule interpretation after consensus between OHA and NPAIHB could not be obtained.
iv. DOJ interpretation of OARs
a. The project must submit a form to OHA that provides the Informed Consent by procedure.
b. Examples are not sufficient.
c. OHA is required to review the form and approve the document.
v. DHAT/Clinic is not required to give an IC document by procedure to the patient. IC can be obtained verbally and documented "PARQ" in the chart.
vi. Suggestion to group the procedures together into groupings that have identical Informed Consent, i.e Class I, Class II, Class III Composites have the same Informed Consent, Stainless Steel Crowns require a different Informed Consent, etc.
vii. OHA received draft of Informed Consent document on September 23, 2017. This Informed Consent document is currently under review
i. Initial assessment by OHA is that the Informed Consent document submitted by NPAIHB is incomplete. OHA understands that this is a draft document pending further review by NPAIHB supervising dentists.

OHA Action Items:**	• Review draft Informed Consent document submitted by NPAIHB • Return document to NPAIHB for further editing October 6th, 2017 • Review re-submitted Informed Consent document after October 31, 2017 • Submit to Advisory Committee for comment and review
NPAIHB* Action Items:**	• Deliver Informed Consent documents that are provided by each clinic for specific procedures, i.e. any documents signed by the patient • Submit Informed Consent document provided to patients about the DHAT as a trainee

	• Resubmit Informed Consent form to OHA for approval, by procedure, due back to OHA by October 31, 2017

Adverse Events

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

OHA Action Items:**	• Define Adverse Events v Adverse Outcomes v Complications and Complications – (Anticipated/Excepted/Common vs Rare/Unusual/Unexpected) • Literature Review and reporting guidelines • Define OHA Adverse Event reporting procedure
NPAIHB* Action Items:**	• Clarify Adverse Event tracking procedure within each site v Complications – Timeline TBD

Advisory Committee: Quarterly Meeting on September 25, 2017

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

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

c. **Committee requests clarification on clinical parameters as to when extractions are authorized for DHATs to complete on patients**
   i. OHA to review other states legislation: Minnesota, Maine, Vermont that have specific clinical protocols outlined in their legislation
   ii. Request clarification on clinical protocols that are utilized when the supervising dentist authorizes a DHAT to complete an extraction

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

d. **Clarification on Sutures**

i. NPAIHB response states that DHATs are not authorized to perform sutures.
ii. Advisory Committee requests clarification and justification as to why a simple extraction procedure would be part of the DHAT scope of practice but suturing is not.
iii. Concerns that it is inappropriate to not allow the DHAT a full access to a full armamentarium in the event of bleeding etc. that may necessitate the use of sutures or other hemostasis instruments/medicaments/etc.
    i. Clarification needed on suturing as part of the scope of practice in Minnesota/Maine/Vermont.

e. **Committee requests clarification on data reporting**

i. Project submitting data as part of their quarterly reports
ii. Pilot projects own their data; projects plan to publish data in the future
ii. OHA will submit summary of data to Advisory Committee

f. **Clarify patient restraint policies**

i. Addendum to application states that DHATs are not using papoose boards in the pilot projects in Oregon
ii. Active restraint: clarification on whether this is being used in the clinics by the DHATs
iii. Definitions of restraint used in dentistry
    a. Papoose Board
    b. Active restraint

g. **Nitrous Oxide**

i. Advisory Committee requests clarification and justification as to why nitrous oxide would is not part of the DHAT scope of practice.
ii. Clarification is needed about whether Nitrous Oxide is utilized in the clinics.
iii. Clarification is needed about whether DHAT trainees working on patients that are placed under Nitrous Oxide or other analgesics
iv. OHA to review other states legislation: Minnesota, Maine, Vermont that have specific clinical protocols outlined in their legislation with regard to the use of Nitrous Oxide

h. **Advisory Committee has requested copies of the syllabus for the entire training program**

i. Examples are not sufficient for thorough review by the committee

I**. Supervising Dentist**

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

iii. Clarification requested regarding process of new supervising dentist and preceptorship process; is a new preceptorship required?	
OHA Action Items:**	• Define restraint used in dentistry: Papoose Board and Active restraint • Review other states legislation: Minnesota, Maine, Vermont that have specific clinical protocols outlined in their legislation on suturing • Review other states legislation: Minnesota, Maine, Vermont that have specific clinical protocols outlined in their legislation on Nitrous Oxide • OHA to provide NPAIHB with project data summary recording template
NPAIHB* Action Items:**	• Submit anticipated complications, by procedure, to OHA. • Provide clarification on tracking of complications at each site, case management process • Submit copies of each of the syllabus, by course, to OHA • Clarify use of all types of restraint utilized in the clinics, if any, by the DHATs • Clarify justification regarding limiting scope of practice on suturing and nitrous oxide for DHATs • Clarify supervising dentist management relationship and process for new supervising dentist • Submit requests for clarification for Advisory Committee and OHA by October 31, 2017

Next Meeting: Quarterly Meeting: Dental Pilot Project Program: DPP #100

November 6th, 2017 10am-12pm, Room 1D, Portland State Office Building, 800 NE Oregon Street Portland, Oregon

*These are action items, not minutes
**Oregon Health Authority (OHA)
***Northwest Portland Area Indian Health Board (NPAIHB)