Dental Workforce Pilot Project

Dental Hygiene Restorative Function Endorsement Model

August 22, 2019

Willamette Dental Group

Table of Contents

Section I: Dental Pilot Project Fact Sheet

1. Title of Project: Dental Workforce Pilot Project

2. Sponsoring Agency, Name, Address, City, County, Zip: Willamette Dental 6950 NE Campus Wy, Hillsboro, OR 9

3. Sponsoring Agency Contact Name, Phone, Email: Toby Absher, 503-858-7646, tabsher@willamettedental.com

4. Sponsoring Agency Type: Check All that Apply
   - ☐ Non-Profit Education Institution
   - ☐ Community Hospital or Clinic
   - ☑ Coordinated Care Organization (CCO) or Dental Care Organization (DCO)
   - ☐ Professional Dental Organization

5. Name of Administrator Signing for Application, Title Toby Absher, Director of Operations

6. Purpose of Project Goal/Purpose of Project: (Select One)
   - ○ Teaches new skills to existing categories of dental health care personnel.
   - ◉ Develops new categories of dental health care personnel.
   - ○ Accelerates the training of existing categories of dental health care personnel.
   - ○ Teaches new health care roles to previously untrained persons.

7. Project Director, Name, Address, Phone, Email Toby Absher, 6950 NE Campus Way, Hillsboro, OR 97124, 503

8. Training Supervisor, Name, Degree, Address, Phone, Email
   Shannon English, DDS, 6950 NE Campus Way, Hillsboro, 1-855-433-6825 ext. 821320, senglish@willamettedental.com
   Gail Aamodt, RDH, MS 222 SE 8th Ave, Suite 271, Hillsboro, 503-352-7242, gail.aamodt@pacificu.edu

9. Estimated Date of Project Period:
   Start Date: 6/1/19 End Date: 6/1/24

10. A Project Timeline will visualize the timeliness of project activities and accomplishments. The Project Timeline will identify for the entire project period: (1) the activities proposed, (2) the time it will take to accomplish these tasks and (3) the responsible staff.

11. Submit a Detailed Timeline as an Attachment. ***Attachment:*** Label Attachments, FS2.

12. Training and Utilization Project Sites: List where education and training will be conducted during didactic phase.

13. List where graduates of training program will be employed during utilization phase.

14. Submit a detailed narrative of the Training & Utilization Project Sites.
    Attachment: Label Attachments, FS3

15. Funding Source(s) for the Project
    Provide source(s) of funding (if known). Include attachments such as Letters of Support, commitment, memorandums of agreement, etc. if available. If Funding sources depend upon approval of the Dental Pilot Project, please provide information identifying the potential source(s) of funding if possible. (The Oregon Health Authority does not fund projects.)
    Attachment: Label Attachments FS4

16. Provide the proposed total budget for project implementation.
    The Total Project or Program Costs are the total allowable costs (inclusive of direct and indirect costs) incurred by the recipient to carry out the pilot project.
    Proposed Total Budget (Numerical amount only allowed): $ 516,782.00

MINIMUM STANDARDS: 333-010-0410

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;
   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;
   c. Provide or arrange for emergency treatment for a patient currently receiving treatment;
   d. Comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines;
   e. Not attempt to perform procedures which the trainee is not capable of performing due to physical or mental disability; and
   f. Comply with the infection control procedures in OAR 818-012-0040.
7. Provide appropriately qualified instructors to prepare trainees.
8. Assure that trainees have achieved a minimal level of competence before they enter the employment/utilization phase.
9. Inform trainees in writing that there is no assurance of a future change in law or regulations to legalize their role.
10. Demonstrate that the project has sufficient staff to monitor trainee performance and to monitor trainee supervision during the employment/utilization phase.
11. Demonstrate the feasibility of achieving the project objectives.
12. Comply with the requirements of the Dental Pilot Projects statute, Oregon Laws 2011, Chapter 716 and rules adopted thereunder.
13. Evaluate quality of care, access, cost, workforce, and efficacy;
14. Achieve at least one of the following:
   a. Teach new skills to existing categories of dental personnel.
   b. Accelerate the training of existing categories of dental personnel.
   c. Teach new oral health care roles to previously untrained personnel.
   d. Develop new categories of dental personnel.

Stat. Auth.: 2011 OL Ch. 716
Stats. Implemented: 2011 OL Ch. 716
Hist.: PH 5-2013, f. & cert. ef. 2-4-13

☑ I have read the Minimum Standards as outlined under the Oregon Administrative Rules, 333-010-0410.

Section II: Project Overview: Abstract

An abstract shall be submitted with each application. This provides a brief description of the information included in the proposal's narrative. The abstract should include the name of the sponsor, the specific purpose of the project, brief summary of student/trainee selection criteria and the proposed project activities, overall long term and short term objectives, the primary factors to be considered on the evaluation process, and the expected outcome of the project. It would also be appropriate to cite the current statutory/regulatory barriers which prohibit the proposal.

Submission Instructions

- ☐ Abstract is not to exceed two (2) pages.
- ☐ Submit Attachment (if needed). Label Attachment AB1.

The purpose of this project is to investigate the feasibility of adopting a dental therapist model as a new category of dental care provider for Oregon. There are multiple dental therapy models currently in use in the United States. This is proposing to evaluate the appropriateness of one such model in Oregon. This dental workforce pilot project is designed to determine if adding a dental therapist to the existing dental team is an efficient and cost-effective way to increase access to dental care, especially for patients who experience higher disease rates and barriers to care (i.e. the target population), while maintaining the quality of dental care and safety that all patients deserve. This dental workforce pilot project will also evaluate the efficacy of educating licensed dental hygienists to become dental therapists through a unique one-year dental therapy education program that will allow the dental hygienists to complete dental therapy education while they maintain their current employment as a dental hygienist.

This dental workforce pilot project will be sponsored by Willamette Dental Group. Pacific University will oversee the development and implementation of the dental therapy education program. In the first and second years of the dental workforce pilot project, dental hygienists from Willamette Dental Group and/or from other partner organizations will be educated as dental therapists. Following the education phase, the dental therapist participants will be added as a provider to their assigned clinical practice site working under indirect and/or general supervision of their supervising dentist. Data will be collected to evaluate how the dental therapists affect efficiency, cost, quality, patient satisfaction and patient safety.

The participants in this dental workforce pilot project will be dental hygienists who hold a current Oregon dental hygiene license in good standing with endorsements in local anesthesia and restorative functions. Participants are not required to hold an expanded practice permit or a nitrous oxide permit; however, those who hold these permits may use these skills as part of the pilot project. These dental hygienists must work in a dental practice setting that focuses on improving access to care for patients, especially those in the target population. The dental practice setting must also agree to add these educated dental therapists to their clinical practice sites and collect the data required for the evaluation plan.

(See Attachment AB1 - Continuation of Section II.)

Section III: Dental Pilot Project Narrative

1. Summary of Dental Pilot Project

Attachment PN1 – Summary of Dental Workforce Pilot Project

2. Background

Attachment PN2 – Background

3. Sponsor Information

Attachment PN3 – Sponsor Information

4. Instructors and Supervision

Number of Instructors – The dental workforce pilot project will use 2-3 instructor dentists for each on-campus session to provide instruction in dental therapy clinical skills to the participants. These lab sessions will include both typodont and patient care clinics. In addition, 8-10 faculty dentists will supervise and evaluate dental therapy clinical skills performed by the 8 participants on patients at their off-campus dental practice locations.

Instructor Qualifications – The instructor dentists will be licensed dentists with clinical experience in general dentistry. Preferred qualifications will include current knowledge of clinical teaching and evaluation methods, clinical teaching experience with dental or dental hygiene participants, and clinical experience working with patients. The Oregon Board of Dentistry licensee look-up site will be used to confirm that each instructor dentist is an Oregon licensed dentist in good standing with the Oregon Board of Dentistry.

Orientation – All instructor dentists and supervising dentists will complete an orientation program that includes an overview of the dental therapy education program, current teaching methods, and evaluation of clinical skills.

Project Director – The project director will oversee implementation and evaluation of the dental workforce pilot project. The project director will manage the evaluation plan, data collection, and budget management. The project director will provide reports to the Oregon Health Authority throughout the duration of the dental workforce pilot project. The project director will secure an outside evaluator to provide an objective evaluation of the dental workforce pilot project data and results. The project director will work with the dental director to advocate for dental therapy with dentists, policy makers, and the public.

Dental Director – The dental director will oversee the dental therapy education program and the utilization phase of the dental workforce pilot project. The dental director will work with the instructor dentists and supervising dentists to ensure that the dental therapy education program includes the didactic content, clinical skills and evaluation methods to effectively train the dental therapists. The dental director will continue to work with the faculty dentists during the utilization phase when the dental therapists are providing patient care under their indirect and/or general supervision. The Oregon Board of Dentistry licensee look-up site will be used to confirm that the dental director is an Oregon licensed dentist in good standing with the Oregon Board of Dentistry.

Instructor Dentists – The instructor dentists will work with the dental director to develop the dental therapy education program. The instructor dentists will teach the dental therapy didactic content through online modules and the dental therapy clinical skills with education manikins through weekend on-campus sessions. The instructor dentists will also evaluate participant competence in both the didactic content and clinical skills. The instructor dentists will notify the supervising dentists

when each participant has demonstrated competence with education manikins in a clinical skill so that the participant may begin providing that clinical skill for patients under the direct supervision of the supervising dentists. The Oregon Board of Dentistry licensee look-up site will be used to confirm that each instructor dentist is an Oregon licensed dentist in good standing with the Oregon Board of Dentistry.

Supervising Dentists – The supervising dentists will provide direct supervision and evaluation of dental therapy treatment provided by the participants to patients during the dental therapy education program. The supervising dentists will also provide indirect and/or general supervision and evaluation of dental therapy treatment provided by the participants to patients during the utilization phase of the dental workforce pilot project. During the utilization phase, the supervising dentists will also collect data required for the evaluation plan. The Oregon Board of Dentistry licensee look-up site will be used to confirm that each supervising dentist is an Oregon licensed dentist in good standing with the Oregon Board of Dentistry.

Selection of Instructors and Supervisors – The project director and dental director will work together to select the instructor dentists and supervising dentists.

Instructor to Trainee Ratio – The instructor dentist to trainee ratio will be 1:10 for the online didactic component of the dental therapy education program. The instructor dentist to trainee ratio will be 1:5 for on-campus clinical component with education manikins and as low as 1:3 for clinical patient sessions during Dental Therapy I and Dental Therapy II of the dental therapy education program. The supervising dentist to trainee ratio will be 1:1 for the clinical component with patients of the dental therapy education program.

Number of Supervisors – There will be 10 supervising dentists, one for each participant in the clinical component with patients of the dental therapy education program and during the utilization phase. There will only be one supervising dentist and one dental therapist per participating dental team.

Criteria for Practice Sites – The practice locations will be sites where the participants are currently employed, and the employers have agreed to participate in the dental workforce pilot project.

Attachment PN4 – Orientation for Instructor Dentists and Supervising Dentists
Attachment PN4A – Supervision Table for Dental Therapy
Attachment PN8 – Employment/Utilization Site Criteria

5. Curriculum Vitae

Attachment PN5 – Curriculum Vitae for Dental Workforce Pilot Project Staff

The following were secured as instructor dentists: Dr. Molly Saunders, Dr. Shoneen Sendelback and Dr. Shannon English. Required qualifications for instructor dentists include Oregon dental license in good standing, clinical experience in general dentistry, and excellent communication skills. Preferred qualifications for instructor dentists will include current knowledge of clinical teaching methods, clinical teaching experience with dental or dental hygiene participants, and clinical experience working with patients.

6. Participants (Trainees)

Criteria for Participants – The participants will be selected through an admissions process. Criteria for admissions will include a current Oregon dental hygiene license in good standing with local anesthesia endorsement and restorative functions endorsement (i.e. Western Regional Examining Board). In addition, the participants must be able to provide documentation of clinical competency administering local anesthesia and placing restorations. The successful candidate must be employed in a practice location with a dentist who will serve as a supervising dentist for the dental workforce pilot project.

Dental Workforce Pilot Project Participant Agreement – Participants will be informed about their responsibilities, benefits, and limitations of the dental workforce pilot program through a written Dental Workforce Pilot Project Participant Agreement that will be reviewed with the participant and then signed by the participant.

Number of Participants – The dental workforce pilot project will train 8 participants each year for 2-3 years to prepare a total of 16-24 dental therapists who will practice in their current employment settings under the guidelines of the dental workforce pilot project. In addition, 2 dental hygiene faculty members will be trained each year for 2-3 years to prepare 4-6 dental therapy educators who will be able to train future dental therapists.

Notice of Participant Entering the Utilization Phase – The project director will provide written notification to the Oregon Health Authority within 14 days of the participants entering the utilization phase of the dental workforce pilot project.

Attachment PN6 – Participant Selection Criteria
Attachment PN7 – Dental Workforce Pilot Project Participant Agreement

7. Employment/Utilization Sites

Attachment PN8 – Employment/Utilization Site Criteria

8. Curriculum

The existing dental therapy education programs in Minnesota that prepare dental hygienists to become dental therapists require one to two years of full-time education. In most cases this education model requires a dental hygienist to leave their current employment setting and not work for one to two years. The dental hygienist loses their income for one to two years and the employer dentist loses a valuable employee. The employer dentist will likely fill this vacancy with another dental hygienist and the dental hygienist who pursues dental therapy education is unlikely to be able to return to their previous employment setting. The dental therapy education program that is proposed in this dental workforce pilot project would take less time for the participant to complete, would allow the dental hygienist to continue working full-time during the education program, and would allow the employer dentist to maintain a valuable employee who could then provide patient treatment as a dental therapist.

The one-year dental therapy education program that will be used in this dental workforce pilot project will be offered for 2-3 consecutive years as a continuing education certificate program at Pacific University. Participants who complete this dental therapy education program will be awarded a certificate of completion by Pacific University. If dental therapy is approved in Oregon as it has been in other states, Pacific University plans to transition this dental therapy education program into a CODA-accredited dental therapy education program that would award a graduate certificate in dental therapy (18 graduate semester credits). Students who complete the graduate certificate program in dental therapy would have the option to continue their education toward a master's degree (approximately 15 additional graduate credits) in a program at Pacific University on a part-time basis while they continue to work as a dental therapist.

Attachment PN9 – Curriculum Plan for Dental Therapy Education Program
Attachment PN10 – Job Description for Participants
Attachment PN11 – Patient Consent Form

9. Measurable Objectives, Evaluation Plan, Data Evaluation and Monitoring Plan

Attachment PN12 – Dental Workforce Pilot Project Objectives
Attachment PN13 – Dental Workforce Pilot Project Evaluation Plan

10. Costs

Attachment PN14 – Budget Narrative
Attachment PN15 – Budget

11. Miscellaneous

Attachment PN16 – Letter of Endorsement

Section IV: Informed Consent, Modifications, Adverse Events, Project Completion

INFORMED CONSENT:

The plan used to obtain prior informed consent from patients to be treated by trainees or those legally able to give informed consent for the patients shall be described. It shall include but not be limited to the following:

a. 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.
b. A sponsor must submit an informed consent form and any accompanying information to program staff for review.

Informed consent must include but is not limited to the following:

a. An explanation of the role and status of the trainee, including the ready availability of the trainee's supervisor for consultation.
b. Assurance that the patient can refuse care from a trainee without penalty for such a request.
c. Identification that consenting to treatment by a trainee does not constitute assumption of risk by the patient.
d. Informed consent shall be provided in a language in which the patient is fluent.
e. Dental pilot project staff or trainees must document informed consent in the patient record prior to providing care to the patient.
f. Informed consent needs to be obtained specifically for those tasks, services, or functions to be provided by a pilot project trainee.

Provide a Copy of the Informed Consent Form.
Attachment: Label Attachment IC1.

MODIFICATIONS:

1. Any modifications or additions to an approved project shall be submitted in writing to program staff. Modifications include, but are not limited to the following:
   a. Changes in the scope or nature of the project. **Changes in the scope or nature of the project require program staff approval.**
   b. Changes in selection criteria for trainees, supervisors, or employment/utilization sites.
   c. Changes in project staff or instructors.
2. Changes in project staff or instructors **do not** require prior approval by program staff, but shall be reported to the program staff within two (2) weeks after the change occurs along with the curriculum vitae for the new project staff and instructors.
3. All other modifications require program staff approval prior to implementation.

☑ I have read the Modifications as outlined under the Oregon Administrative Rules, 333-010-0460.

ADVERSE EVENT REPORTING:

A sponsor must report adverse events to the Oregon Health Authority program staff the day they occur as outlined in OAR 333-010-0460. An **Adverse Event Form** must be completed and submitted as outlined in OAR 325-035-0001.

Adverse Event reports are prepared by project sponsor personnel with the intent that such reports will not contain information regarding the patient's identity. The information will be prepared as a brief anecdotal account to be submitted to the Oregon Health Authority on a prescribed form in addition to contacting program staff on the day of the adverse event.

Section IV: Informed Consent, Modifications, Adverse Events, Project Completion

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

EXAMPLES

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

☑ I have read the adverse reporting requirements as outlined under the Oregon Administrative Rules, 333-010-0435.

COMPLETION OF PROJECT:

All dental pilot projects must inform the Program in writing at least **60 days** prior to completion or discontinuation of the pilot project.

1. An approved project must notify the Authority in writing if it intends to discontinue its status as a Dental Pilot Project, at least 60 calendar days prior to discontinuation. Notification must include a closing report that includes but is not limited to:
   a. The reasons for discontinuation as a pilot project.
   b. A summary of pilot project activities including the number of persons who entered the employment/utilization phase.
   c. A description of the plan to inform trainees of the project's discontinuation, and that they are precluded from performing the skills authorized under the pilot project after discontinuation unless the role has been legalized.
2. The project must obtain written acknowledgement from trainees regarding notification of the project's discontinuation and preclusion from performing skills authorized under the pilot project after discontinuation unless the role has been legalized and the trainee has met necessary licensure requirements.
3. The project must inform the Oregon Board of Dentistry that the project is completed and provide a list of trainee names associated with the project at least 14 calendar days prior to discontinuation.

☑ I have read the Completion of Project reporting requirements as outlined under the Oregon Administrative Rules, 333-010-0465.

Section V: Suspension or Termination of a Project

SUSPENSION OR TERMINATION OF PROJECT

1. A pilot project may be suspended or terminated during the term of approval for violation of 2011 Oregon Laws, chapter 716 or any of these rules.
2. If the Authority determines that a dental pilot project is in violation of 2011 Oregon Laws, chapter 716 or these rules, the Authority may issue a Notice of Proposed Suspension or Notice of Proposed Termination in accordance with ORS 183.411 through 183.470. A sponsor who receives a Notice may request an informal meeting with the director and program staff. A request for an informal meeting does not toll the time period for requesting a hearing as described in section (3) of this rule.
3. If the Authority issues a Notice of Proposed Suspension or Notice of Proposed Termination the sponsor is entitled to a contested case hearing as provided under ORS chapter 183. The sponsor has 30 days to request a hearing.
4. If the Authority terminates a dental pilot project the order shall specify when, if ever, the sponsor may reapply for approval of a dental pilot project.

☑ I have read the Suspension or Termination of Project requirements as outlined under the Oregon Administrative Rules, 333-010-0470.

Certification and Acceptance

We, the undersigned certify that the statements herein are true and complete to the best of our knowledge and we accept the obligations to comply with the terms and conditions set forth in the Oregon Safe Employment Act and Oregon Administrative Rules

We hereby certify that we will not discriminate on the basis of age, sex, creed, disability, race or ethnic origin, in the selection of participants for Dental Pilot Projects.

We agree to submit monthly progress reports during the first six month period of the utilization/employment phase and quarterly thereafter for the duration of the pilot project. Final progress reports are due within 60 days of the termination or completion of the pilot project. A progress report on the pilot project shall be provided to The Oregon Health Authority no later than 15 days prior to a site visit. At any time, a sponsor must provide a report of information requested by The Oregon Health Authority in a format and timeframe requested.

Progress reports must include, but are not limited to, information on the following:

1. **Dental Pilot Project name, Project Identification Number, Reporting Period (e.g., 1/1/2015-4/1/2015), Primary Contact Name and Role, Telephone and Email Address**
2. **Trainee competency**
3. **Supervisor's fulfillment of roles and responsibilities**
4. **Employment/utilization site compliance with selection criteria.**
5. **Progress to achieving each of the stated objectives**

We agree to allow project staff or their designees to visit each employment/utilization site at least monthly during the first six month period and at least quarterly thereafter for the duration of the project. Site visits may occur during the didactic phase of the pilot project and are required during the utilization phase of the project. An unannounced site visit may be conducted by program staff if program staff have concerns about patient or trainee safety
We agree to promptly inform The Oregon Health Authority and Program Manager as to the:

1. **Starting and completion dates of training cycles**
2. **Starting and completion dates of preceptorship or employment/utilization (E/U) periods**
3. **Proposed changes or modifications in the project or project personnel**
4. **Changes in the names of participating trainees.**

We agree to promptly notify The Oregon Health Authority and Program Manager in the event of an adverse event. We will contact The Oregon Health Authority and Program Manager on the day of the event and complete an adverse event on a prescribed form.

Project Sponsor Signature _____ Date: 2/12/18

Project Director Signature _____ Date: 2/12/18

Legal Liability:
Sponsors and other participants are advised to ascertain the legal liability they assume when participating in a pilot project.

Continuation of Section II: Project Overview: Abstract

This dental workforce pilot project will be successful if the results indicate that the addition of a dental therapist to the dental team is a cost-effective way to increase access to dental care, especially for patients with high disease risk and least access to care, while still maintaining the quality of dental care that all patients deserve. This pilot project will also assess if the work life of health care providers including clinicians and staff are improved through the addition of a dental therapist to the dental team. This dental workforce pilot project will also be successful if dental hygienists can successfully complete the one-year dental therapy education program while they continue to work in their current employment setting.

Summary of Proposed Dental Workforce Pilot Project

Purpose – The purpose of this dental workforce pilot project is to investigate the feasibility of adopting the dental therapist model as a new category of dental care provider for Oregon. This dental workforce pilot project is designed to assess if adding a dental therapist to the existing dental team is an efficient and cost-effective way to increase access to dental care, especially for patients with high disease risk and least access to care, while still maintaining the quality of dental care and safety that all patients deserve. This pilot project will also assess if the work life of health care providers including clinicians and staff are improved through the addition of a dental therapist to the dental team. This dental workforce pilot project will also evaluate the efficacy of educating licensed dental hygienists to become dental therapists through a unique one-year dental therapy education program that will allow the dental hygienists to complete dental therapist education while they maintain their current employment as a dental hygienist.

Sponsors – This dental workforce pilot project will be sponsored by Willamette Dental Group. Pacific University will develop and implement the dental therapy education program. In the first and second years of the dental workforce pilot project, dental hygienists from Willamette Dental Group and/or other partner organizations will be educated as dental therapists. Then Willamette Dental Group and/or other partner organizations will add these educated dental therapists to their clinical practice sites and collect data to evaluate how the dental therapists affect efficiency, cost, quality, patient satisfaction and patient safety. A third education year of the dental workforce pilot project will be reserved as optional, pending funding.

Participants (Trainees) – The participants in this dental workforce pilot project will be dental hygienists who hold a current Oregon dental hygiene license in good standing with endorsements in local anesthesia and restorative functions. These dental hygienists must also work in a dental practice setting that focuses on improving access to care, especially for patients with high disease risk and least access to care (i.e. the target population). The dental practice setting must also agree to add these trained dental therapists to their clinical practice sites and collect the data required for the evaluation plan.

Dental hygienists are ideal candidates to train to become dental therapists because they already have extensive background knowledge and skills in dentistry. This background allows dental hygienists to be trained as dental therapists in the least amount of time allowing them to increase access to restorative dental services as soon as possible.

Dental hygienists who are licensed in Oregon can currently provide 13 of the 22 (see page 89 for Attachment PN9B) dental therapy procedures that the Commission on Dental Accreditation (CODA) requires for dental therapy education programs. The dental treatment most often provided by a dental therapist is restoration of teeth. This procedure includes anesthetizing the tooth, preparation and removal of decay and placing the restoration. According to the Oregon Practice Act, dental hygienists in Oregon can already anesthetize teeth, place restorations, and use high-speed handpieces, but currently they cannot prepare and remove decay. The pilot project will assess whether having existing clinical skills will expedite the education process and allow restorative dental hygienists to perform dental therapy clinical procedures sooner, as compared to a traditional dental therapy program.

Program Activities – Dental hygienists will be trained to become dental therapists through a unique one-year education program that will allow the dental hygienists to complete the dental therapy education program while they maintain their current employment as a dental hygienist. When the education phase is complete, the participants will enter the utilization phase and practice as dental therapists in their current employment setting with their supervising dentist. Patient care provided by the dental therapists will be closely monitored by the supervising dentist and data will be collected to evaluate how the dental therapists affect efficiency, cost, quality, patient satisfaction and patient safety.

Length of Project/Project Timeline – The length of this pilot project is five years. Project timeline has a different focus depending on the year. An advisory board will meet quarterly to discuss data collection and preliminary quarterly reports (see page 40).

1. Year one or as soon as the curriculum is complete: planning, curriculum development, preparation of supervising dentists, and selection of participants.

2. Year one-two: first cohort begins the program.
3. Year two-three: first cohort is providing patient care, second cohort enters the program. Data collection and evaluation of patient care begins.
4. Year three-four: first cohort continues to provide patient care, second cohort is providing patient care. Data collection and evaluation of patient care continues. Optional third cohort may begin.
5. Year four-five: all cohorts providing patient care. Data collection and evaluation of patient care continues. Final reports are published.

Evaluation Format

Important Working Definitions:

Instructor Dentist: dentists who teach in the didactic portion of the pilot.

Supervising Dentist: dentists who supervise during the preceptorship and the utilization phase of the project

The evaluation format for this pilot will be divided into the concept of the Quadruple Aim (i.e. patient experience, cost of care, population health and clinician experience).[1]

Within each portion of the Quadruple Aim, the evaluation will be divided into short- and long-term objectives with an evaluation method for each objective.

Pilot Objectives

Improved Patient Experience

Goal: To expand access to consistent, safe, and high-quality oral health care.

Objective:

1. To provide a high patient perception of customer service, safety and quality of care provided by a dental therapist.
2. To collect objective data to ensure safety and quality of treatment provided by a dental therapist.

[1] *Sikka, R. Morath, J.M. Leape, L. (2015) The Quadruple Aim: care, health, cost in meaning at work; BMJ Quality and Safety, 24(10) 608-610*

Short-term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point (with 5 being the highest) Likert scale at the point of service.
2. Less than 10% of adverse events related to irreversible procedures provided by dental therapist.[2]
3. Student Assessments will average at least 4/5 on a 5-point Likert scale.

Intermediate/Long Term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
2. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
3. Less than 10% of adverse events related to irreversible procedures provided by dental therapist through the end of the pilot.
4. Student Assessments will average at least 4/5 on a 5-point Likert scale through the end of the pilot.

Evaluation Method: Patient Survey (time of service). See page 181.

- Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale We will also compare the satisfactions surveys collected from the supervising dentists and the dental therapists.

Evaluation Method: Procedural reports in axiUm.

- Safety and quality of care provided:
    - Instructor Dentists will review each restoration from the Dental Therapist performed on a live patient prior to preceptorship.
    - Patient intraoral photographs, and direct supervision will take place through all the education phases.
    - Once we begin the utilization phase, each supervising dentist will review 10 charts from their dental therapist per month.
    - Every quarter, all charts from irreversible procedures will be sent to the external evaluator.
    - DTs will continue to take photographs of every procedure and will continue patient surveys.
    - Quality measure
        - Each Supervising Dentist will submit 1 of their own patient cases for each of the 12 dental therapy procedures for comparison to the DTs work.
            - Each of the cases submitted by the Supervising Dentist will be randomized prior to sending dental therapy cases to the Outside Reviewer. This will allow comparison of a dentist's work to a dental therapist's work to ensure quality is similar.
        - Each Supervising Dentist will review a minimum of 10 random cases from their Dental Therapist per month. These random cases may or may not be the same as the chart audits.
        - The Dental Director will perform randomly selected chart audits from the Supervising Dentists per quarter to ensure calibration of the Supervising Dentists.

[2] *E N. Rafter, A. Hickey, S. Condell, R. Conroy, P. O'Connor, D. Vaughan, D. Williams, Adverse events in healthcare: learning from mistakes, QJM: An International Journal of Medicine, Volume 108, Issue 4, April 2015, Pages 273–277, https://doi.org/10.1093/qjmed/hcu145*

- Safety
  - Volume of adverse events will assess the safety measure for this pilot project.
  - The 13-point weekly assessment completed by preceptor and supervising dentists during preceptorship and utilization phases.
    - This assessment will also help to monitor the safety of the pilot project by continually monitoring the quality and accuracy of the patient treatment.

- Dentist assessment of the quality of the Dental Therapist's work: All treatment rendered by the Dental Therapist will be reviewed and approved by the dentist **prior** to patient dismissal during the educational phases. The dentist will review the chart note for all patients **and sign off on all chart notes** for patient care by the Dental Therapist during the educational phases of the pilot.
- Student log: all Dental Therapists will keep a daily log of patient care provided on days they are performing Dental Therapy procedures.
- Each instructor/preceptor/supervising dentist will complete the "Dentist 13-point Assessment of overall competency" for each Dental Therapist at the end of each training semester and weekly during the preceptorship and monthly during the utilization phase.

Lower Cost of Care

Goal: To decrease the overall cost of providing dental care by adding a dental therapist to the dental team.

Objective: Reduce the number of procedures that the dentist would have had to complete by adding a dental therapist to the dental team (thereby freeing the dentist to target more complex treatments).

Short term Outcomes:

1. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team.

Long Term Outcomes:

1. Reduce the total cost of patient care by 20% by adding a dental therapist to the dental team through the end of the pilot. This is because a Dental Therapist's annual wage is about half of the annual wage of dentist.[3]
2. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team through the end of the pilot.

Evaluation Method: Procedural reports in axiUm.[4]

- Sample of quarterly procedural reports on pages 171, 172.
- Compare quarterly procedural reports of the cost of patient care delivered by a Dental Therapist compared to the cost of patient care delivered by a dentist for the same procedures.

Better Outcomes

Goal: To establish an efficient and effective healthcare team member that meets the needs of community members with the highest disease rates and least access to care.

Objectives

1. Increase access to dental care by adding a Dental Therapist to the dental team.
   Note: Dental therapy procedures will be provided on >50% of individuals who experience limited access to care such as: individuals with OHP coverage, adults with diabetes, older adults (65+), children with moderate to high caries risk and pregnant women with moderate to high caries risk.

[3] *Economic Research Institute (ERI), Milliman and Warren. 2018*

[4] *Definitions for all security formats are listed in the Definitions of Electronic Risk Management Formats (pg. 194)*

Short-Term Outcomes:
Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations.

Long-term Outcomes:

1. Increase the total number of procedures or number of patients treated by 20% by adding a dental therapist to the dental team by the end of the utilization phase.
2. Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations through the end of the pilot.

Evaluation Method: Quarterly procedural reports in axiUm.

- Each participating employer group is unique.
    - A list of the following will be submitted per site and individual Dental Therapist on a quarterly basis:
        - All procedures completed by the Dental Therapist.
        - Number of hours spent practicing as a Dental Therapist.
        - The baseline for all dental therapy and for all dental therapy procedures is zero because these procedures have not been implemented.
        - Information regarding patient waiting times for appointments for each participating organization.

Improved Clinician Experience

Goal: To successfully train restorative dental hygienists as competent dental therapists.

Objective: To prepare dental hygienists to become Dental Therapists through a unique education program that allows them to continue working as a dental hygienist while they are completing the dental therapy education program.

Short-term Outcomes:

1. Student course evaluations will average at least 4/5 on a 5-point Likert scale.
2. At least 8 out of 10 (80%) participants will complete the educational program on time.
3. Instructor feedback evaluations will average at least 4/5 on a 5-point Likert scale
4. Supervising Dentist Evaluations will average at least 4/5 on a 5-point Likert scale following the preceptorship phase.

Intermediate/Long-term Outcomes:

1. All Dental Therapy students who completed the training program will still be practicing the dental therapy scope through the end of the pilot.
2. Surveys will average at least 4/5 on a 5-point Likert scale rating their job satisfaction at post utilization phase for the supervising dentist and Dental Therapist.
3. Evaluations will average at least 4/5 on a 5-point Likert scale following the utilization phase.

Evaluation Method**:**

- Course evaluations for instructor Dentists and Dental Therapist trainees
- Preceptorship and utilization phase surveys for dental therapist and supervising dentist.
- A pre/post job satisfaction survey for supervising dentists and dental therapists

Program Improvement / Decision-Making – Upon implementation, data will be collected to determine in real time the impact on the clinical schedule, the patient's satisfaction, and quality of care. As these data reveal areas for improvement, the project sponsor will bring those process improvements to OHA for review.

Criteria for Success – This dental workforce pilot project will be successful if the results indicate that the addition of a dental therapist to the dental team is a cost-effective way to increase access to dental care for patients while maintaining the quality of dental care that all patients deserve. This pilot project will also assess if the work life of health care providers including clinicians and staff are improved through the addition of a dental therapist to the dental team. In addition, this pilot will be successful if dental hygienists

can successfully complete the one-year dental therapy education program while they continue to work in their current employment setting.

Process Improvement Strategy – At the end of each semester for all educational courses, the pilot team will assess the overall pilot program and make suggestions/improvements based off feedback from the following: dental director, instructor dentists, supervising dentists, project director, dental therapists, and dental team. The project team will meet quarterly to discuss this feedback in order to create and implement process improvement.

Potential to Expand Dental Workforce Pilot Project Statewide – If successful, this unique education program for dental therapists could be replicated throughout the state. The online component could be taught from any location. The clinical portion with education manikins could be taught at any facility that has education manikins and other instructional materials. The clinical portion with patients could be taught in the dental practice where the dental hygienist is employed.

See Attachment PN13 on page 154 for Evaluation Plan.

Background

State of the National Dental Union

Oral health is essential to the general health and well-being of individuals and the population. Dental disease is one of the great preventable public health challenges of the 21st century. Labeled a “silent epidemic” by the U.S. Surgeon General, dental disease ranks high in prevalence among chronic health conditions (HHS 2000). Yet significant oral health disparities persist in the U.S. population because of a web of influences that include complex cultural and social processes that affect both oral health and access to effective dental health care. In other words, it is universally prevalent, but a number of subpopulations are particularly vulnerable, including older adults, children and adolescents, low-income people, minority groups, and people with special health care needs (IOM 2011).

According to the Children’s Dental Health Project, the following examples demonstrate the societal impact of tooth decay**:**

- A national survey found that roughly 1 in 7 children ages 6-12 had suffered a toothache in the previous six months (Toothache in US Children. Arch Pediatric Adolescent Med. 2010).
- Children with poor oral health were nearly 3 times more likely to miss school due to dental pain, according to a North Carolina study.
- In a Los Angeles study, dental problems were responsible for about 1/3 of elementary school absences, among children from economically vulnerable families.
- California teens reporting recent dental pain were almost 4 times more likely to have a lower grade-point average than their healthier peers.
- Infections in the mouth can become life threatening. A 2013 study examined nine years of data and found that 66 Americans had died from dental abscesses and more than 61,000 hospitalizations were primarily caused by these abscesses.
- Prevention pays off. The average cost of applying a dental sealant to a child’s permanent teeth—a practice that reduces the risk of decay—is roughly one-third the cost of filling a cavity.
- Health equity is an issue for adults too. The CDC found that "over 40% of poor adults (20 years and older) have at least one untreated decayed tooth compared to 16% of non-poor adults."
- It even affects national security. Defense department officials have called oral health "essential to readiness" of our military forces. The Army reports that more than 1 in 5 National Guard and Reserve soldiers required dental treatments before they could be deployed overseas for Operation Desert Storm. A 2008 report revealed that 52% of new military recruits had dental problems that delayed their deployment overseas.
- Poor oral health can affect adults' job prospects and social lives. CNBC reported that most employers "make instant judgments based on appearance, including someone’s smile and teeth.” A 2008 study found that people with missing front teeth were viewed as less intelligent, less desirable and less trustworthy than people with a healthy smile.
- Dental disease is linked to broader health problems, including cardiovascular disease and strokes. Research has even linked poor oral health with Alzheimer's Disease.
- A 2013 survey of Los Angeles residents with dental insurance found that 51% delayed dental care because of concerns about the cost.
- Out-of-pocket spending for dental services—costs not paid by insurance—accounts for about 40% of all dental expenditures.
- The lifetime cost of treating one decayed molar ranges from $2,187 to $6,105.
- Americans made an estimated 830,590 visits to hospital emergency rooms in 2009 for dental conditions that were preventable.

- **Prevention pays off.** In most cities, every $1 spent on water fluoridation saves $38 in dental costs. Researchers estimate that in 2003 Colorado saved nearly $149 million in dental treatment costs because of fluoride in the public water supplies and a Texas study revealed that fluoridation saved taxpayers $24 per child, per year in state Medicaid costs.

Oral and Overall Health

While dental disease is itself a discrete health concern, like many other chronic diseases it has broader health impacts. Tooth decay causes pain, an inability to eat solid foods, and even more serious problems if left untreated. Poor oral health has been linked to increased risk for cardiovascular disease, diabetes, and other chronic conditions. For example, diabetic patients with periodontitis are six times more at risk for worsening glycemic control and are at increased risk for other diabetic health complications (Mealey and Rose 2008). Dental decay in childhood has been linked to increased risk for future decay, and chronic oral infections are associated with an array of other health problems such as heart disease, diabetes and unfavorable pregnancy outcomes. Among pregnant women, oral infections can increase the risks for premature delivery and low birth weight babies.

Dental disease has a number of broader implications. Poor oral health in children has been shown to result in decreased academic performance and can adversely affect behavioral and social development. Over 51 million school hours are lost each year due to dental problems (Pew Center on the States 2011a). Poor oral health is even a national security concern. According to a study conducted by the U.S. Department of Defense, 52 percent of new recruits were in need of urgent dental treatment that would delay their deployment (Leiendecker et al. 2008). Among adults who have lost their natural teeth, studies have shown that there is a significant impact on nutritional intake, resulting in the consumption of little or no fresh fruit and vegetables.

As evidenced, oral health affects people of all ages, in every state, in remote areas and in cities. Everyone wants and should have access to good oral health care where and when they need it: in their own communities, but across the U.S., that is not the case.

Disparities and Social Determinants of Oral Health

Oral health disparities are profound in the United States. Despite major improvements in oral health for the population as a whole, oral health disparities exist for many racial and ethnic groups, by socioeconomic status, gender, age and geographic location. Some social factors that can contribute to these differences are lifestyle behaviors such as tobacco use, frequency of alcohol use, and poor dietary choices. Just like they affect general health, these behaviors can affect oral health. The economic factors that often relate to poor oral health include access to health services and an individual's ability to get and keep dental insurance. Reducing health disparities is a major goal for public and private health agencies in the United States [1] for health professionals and for the public at large. In 2000, the Surgeon General highlighted oral health as a major component of general health and well-being [2]. Oral health implies much more than healthy teeth. The mouth is both a cause and a reflection of individual and population health and well-being.

Having a healthy mouth is an important part of overall health, and is especially important to child development. The burden of tooth decay or early childhood caries (cavities) in young children is a significant public health concern and causes needless pain and suffering for many children. Dental decay is the most common chronic disease of children aged 6 to 11 years and adolescents aged 12 to 19 years. Tooth decay is four times more common than asthma among adolescents aged 14 to 17 years. Poor oral health among children affects speech, nutrition, growth, social development and the ability to learn. For example, children with poor oral health have worse academic performance and are nearly three times more likely to miss school as a result of dental pain. More than 51 million school hours are lost each year to dental-related illness.

Some people think of dental care as a luxury — separate from health care and not as important. They view a toothache as something minor, something that children and/or adults lose sleep over until they see the dentist the next day. For those who can't get dental care when they need it, the reality is far different. They can't make the pain stop. They can't eat easily or sleep through the night. The pain forces them to miss school or work. It can go on for months — not hours or days, but months. Left untreated, tooth decay can affect overall health and lead to a lifetime of chronic illness. It can cause life-threatening infections or lead to complications that require major surgery. It is linked to increased risk of stroke, heart disease and diabetes.

Workforce and Access

In the U.S., many people have access to the best oral health care in the world, yet millions are unable to get even the basic dental care they need. Individuals who are low-income, racial or ethnic minorities, pregnant women, older adults, those with special needs, and those who live in rural communities often have a much harder time accessing a dental provider than other groups of Americans. The current dental delivery system fails one-third of the U.S. population:

- Nearly 47 million people live in federally designated dental shortage areas where there are not enough dentists to provide needed care. Millions more can't afford dental care.
- Across the U.S., an additional 6,600 dentists are needed TODAY to provide necessary services.
- Yet dentists are retiring at a rapid rate.
- Approximately 80 percent of dentists do not accept Medicaid insurance, making it difficult for millions of low-income families to get dental care.
- Many people who can't get dental care in their communities turn to local hospital emergency room departments when their problems become severe. In 2009, more than 830,000 people visited ERs for preventable dental problems, even though ER care is much more costly and less effective than regular dental care.

There are about 190,000 dentists currently practicing in the United States. Not only is this number too low to meet the current need, but an uneven distribution of dentists across the country makes the problem even worse. Dentists have a disproportionate presence in suburbs whereas those who are most in need of care are concentrated in inner cities and rural communities. In fact, more than 47 million people live in over 4,400 "dental health shortage areas" around the U.S. The Health Resources and Services Administration (HRSA) estimates it would take a net increase of nearly 9,500 providers to address the unmet need today. Although we know that additional dental providers are necessary to meet the current and growing need, dental schools are graduating fewer dentists than the number required to replace those who retire each year.

While these aggregated numbers indicate the scale of the problem, the real crisis is that too few dentists are willing to provide care to low-income populations, older adults, and people with disabilities. Only about 20 percent of the nation's practicing dentists provide care to people with Medicaid, and, of those who do, only a small percentage devote a substantial part of their practice to serving those who are poor, chronically ill, or living in rural communities. The Government Accountability Office (GAO) found that less than half of dentists in 25 states treat any people with Medicaid at all. (Oral Health Workforce, HRSA, February 8, 2012; Efforts Under Way to Improve Children's Access to Dental Services, But Sustained Attention Needed to Address Ongoing Concerns, U.S. GAO November 2010; The Cost of Delay: State Dental Policies Fail One in Five Children, Pew Center on the States February 2010; Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers, CDC 2011; Access to Affordable Dental Care: Gaps for Low-Income Adults, Kaiser Low Income Coverage and Access Survey July 2008; Toothache in U.S. Children, Archives of Pediatric Adolescent Medicine, Vol. 161, No. 11, 1059-1063; 2010; Vermont Oral Health Care for All Project, 2000; CDC. Disparities in Oral Health, CDC February 8, 2012; Professionally Active Dentists, Kaiser Family Foundation State Health Facts February 2012; Adding Dental Therapists to the Health Care Team to Improve Access to Oral Health Care for Children,

Academic Pediatrics, Vol. 9, No. 6, 446-4512009; Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations, HRSA)

National Policy Perspectives

As discussed above, persistent and consequential oral health disparities exist within the U.S. population and reducing these oral health disparities are central to the overall goal of improving population health. What these disparities are, what causes them, and how to ameliorate and prevent them requires awareness, research, knowledge accumulation, and translation of this knowledge into action. Finally, reducing oral health disparities requires the will to act. Changes are needed in resource allocation, in social and public health policy, in community organization, in the provision of effective dental health care, and in professional and individual behavior.

Since 2000, when the U.S. Surgeon General called dental disease a "silent epidemic," there has been increasing attention paid to oral health issues. For example, *Healthy People 2020*, a report issued every decade by the Department of Health and Human Services released in December 2010, includes oral health as a leading health indicator for the first time, and the Institute of Medicine published two reports in 2011 which illustrated that the lack of access to needed care and oral health disparities continue to be huge problems for millions of people.

Healthy People 2020 serves as a national framework to improve the health of all Americans by focusing on four overarching goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages

Seventeen of the *Healthy People 2020* objectives relate directly to oral health and a number of others reflect the connection between oral disease and other chronic illnesses such as diabetes and cancer. The overall goal of the *Healthy People 2020* oral health objectives is to prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services. Like general health, oral health status in the United States tends to vary based on social and economic conditions. Specifically, the objective monitored is: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year.

Dental Crisis in America: The Need to Expand Access

Unfortunately, even the landmark policy passed in 2010, the ACA, missed opportunities to address these issues. Recognizing this void, on February 29, 2012, Senator Bernie Sanders released a report titled, "*Dental Crisis in America: The Need to Expand Access*". In presenting the case for expanded access, in part by expanding the dental workforce with dental therapists, the report highlighted key findings:

- More than 47 million people live in places where it is difficult to access dental care;
- About 17 million low-income children received no dental care in 2009;
- One fourth of adults in the U.S. ages 65 and older have lost all of their teeth;
- Low-income adults are almost twice as likely as higher-income adults to have gone without a dental check up in the previous year;
- There were over 830,000 visits to emergency rooms across the country for preventable dental conditions in 2009 - a 16% increase since 2006;
- Almost 60% of kids ages 5 to 17 have cavities - making tooth decay five times more common than asthma among children of this age;
- Nearly 9,500 new dental providers are needed to meet the country's current oral health needs; however, there are more dentists retiring each year than there are dental school graduates to

replace them. (Dental Crisis in America: The Need to Expand Access, Report from Chairman Bernard Sanders, Subcommittee on Primary Health and Aging, U.S. Senate Committee on Health, Education, Labor & Pensions February 29, 2012)

The report goes on to present its case for expanded workforce as means to create access opportunities by diving deeper into the disparities and inequities and demonstrating that oral health problems affect people of all ages and backgrounds.

- **Age-based:** For many, oral health problems start when they are young and get worse over time. One quarter of children ages 2-5 and one-half of those 12-15 have tooth decay. In fact, dental caries are the most common chronic disease of childhood affecting almost 60% of children ages 5 to 17. As people grow older, they continue to be plagued by oral health problems. One in four adults ages 65 and older in the U.S. have lost all of their teeth.
- **Income-based:** While there are high rates of oral disease in all age groups, low-income Americans of any age are more likely than higher-income Americans to have oral health problems. Lack of access to a dental provider and the high costs of dental services are a major cause of these dental problems. About 17 million low-income children go each year without basic care that could prevent the need for higher cost treatment later on. Children living below the poverty line are twice as likely as their more affluent peers to suffer from toothaches, and the likelihood of experiencing this pain is even greater for kids with special needs.
- **Race/Ethnicity-based:** Some racial and ethnic minority groups have even higher rates of oral health conditions. American Indian and Alaska Natives have the highest rates of dental disease, and rates of untreated decay are also significantly higher among Mexican Americans and African Americans than among those who are White. People from minority groups are underrepresented in the dental profession although they are in greater need of care.

In addition to the high costs of care, low-income and minority families may experience other barriers to care including language and cultural barriers, transportation challenges, and difficulty finding work and childcare arrangements. Seeing a dentist is expensive, so many people seek care only when the disease is advanced and the pain is unbearable. It is at that point when many people go to the emergency room for relief because they have no other option. To make matters worse, often people are faced with the difficult decision to remove their teeth because extractions are considerably cheaper than the cost of treatments to save them, regardless of the negative health and social impacts of missing teeth.

Debate: Workforce as Solution to Access and Equity?

Exacerbating the efforts to move this policy recommendation from conversation to action is disagreement on the need; after all, throughout history, and across all provider types, attempts to increase scope of practice and/or create new mid-level providers have been met with strong resistance from the impacted professional trade associations. And, unfortunately, data is not without bias as sometimes even the best national data available are still insufficient to draw meaningful and unbiased policy conclusions. For example, in June 2017, the Pew Charitable Trusts released an analysis rebutting a May 31, 2017 report from the American Dental Association's Health Policy Institute. The report in question entailed a state-by-state estimation of the geographic proximity of publicly insured children to Medicaid providers. The report used sophisticated geomapping to match a national database of publicly insured children to state-based lists of dentists enrolled in Medicaid. However, as the Pew opined, the report's methodology for determining this is flawed and probably overestimates dentist participation in Medicaid in most states.

Here's why: The report relied on Insure Kids Now – a national website with state-submitted data that lists dentists who registered for Medicaid and the Children's Health Insurance Program (CHIP) – to project dentist participation in Medicaid. However, the survey informing this count asks only whether dentists are enrolled in the program, not how many children they served, or whether they served any at all. Medicaid experts acknowledge that in many states, the number of dentists serving meaningful numbers of publicly

insured patients, or taking on new Medicaid patients, is much lower than the Insure Kids Now list would suggest.

Take Iowa, for example. According to the state's Insure Kids Now list, Medicaid dentist participation was 86 percent in 2014. However, a survey conducted by the University of Iowa the previous year found that only 16 percent of private practice dentists accepted all new Medicaid patients, 42 percent placed conditions on accepting new Medicaid patients, and 42 percent would not see any new Medicaid patients. Yet using the Insure Kids Now list and geomapping, ADA's latest report states that 93 percent of publicly insured children live within 15 minutes of a Medicaid dentist in Iowa.

In Florida, the Insure Kids Now database finds that 30 percent of dentists were enrolled in Medicaid or CHIP in 2014. However, a 2013-14 survey of dentists conducted by the state Health Department found that less than 23 percent reported treating any Medicaid patients, and only 15 percent reported taking new ones. Finally, only 10 percent reported treating at least 125 Medicaid patients. Because a typical dental practice serves 1,500 patients, these numbers indicate that most dentists in Florida were seeing very few Medicaid patients. Meanwhile, in 2014, nearly 70 percent of Florida children on Medicaid went without a dental visit. Still, ADA's latest report finds that 96 percent of publicly insured children in the state live within 15 minutes of a Medicaid dentist.

Millions of Americans do not have access to oral health care. Although a dentist may have an office within 15 minutes of a patient on Medicaid or CHIP, that dentist might choose not to treat that patient. More surveys such as the one conducted by the University of Iowa—which asks dentists about volume of care provided and whether they treat adults, accept new Medicaid patients, and place any limits or conditions on them—should be conducted to determine the true level of access that Medicaid patients have to dental care. For example, if the supply-demand ratio were truly in-balance, it would stand to reason the ADA HPI's own performance and utilization data would reflect higher utilization across all ages. However, according to a 2017 study from the ADA HPI, in 2015, the percentage of population who visited a general dentist in the past 12-months was 48.5% for children, 43.7% for older adults, and 36% for adults. Furthermore, in the same data analysis, these ratios are bifurcated – more than four times the federal poverty level and below the poverty line. The disparity chasm this creates is startling: for children, 56.4% and 38.5%; for adults, 48.7% and 19.2%; and, for older adults, 60.3% and 22.3%.

Adequate oral health care coverage and access for low-income adults, including those enrolled in Medicaid, remain elusive in most states. Because the federal government classifies dental coverage for adults as an optional Medicaid benefit, it is often among the first benefits to be trimmed in tight fiscal times. As of November 2017, only 34 states covered services beyond medically necessary care in emergency circumstances, and only 17 offered an extensive benefit. This presents a significant barrier to oral health for low-income adults, who often cannot afford to pay out-of-pocket for services, and thus have no options for oral health care other than charity dental services, which are inconsistently available.

To better understand how adult Medicaid beneficiaries are using dental services, the Center for Health Care Strategies (CHCS), with support from the DentaQuest Foundation, analyzed 2011 dental service use and cost data for non-older adults Medicaid-enrolled adults by a number of individual-, community-, and state-level factors. Findings from this analysis showed that, compared to those with higher incomes, low-income adults are 40 percent less likely to have had a dental visit in the past 12 months and are two-and-a-half times as likely to have untreated tooth decay. Accordingly, they are affected disproportionately by oral health problems – elevating their risk for chronic conditions such as diabetes and heart disease; lost workdays and reduced employability; and preventable use of acute care. Hispanic beneficiaries had the lowest utilization rates of any racial/ethnic group, but that disparity declined significantly when controlling for state dental benefits category, degree of urban influence, and dental provider-to-resident ratio. Nearly 29 percent of adults with intellectual/development disabilities (I/DD) used dental services, compared to only 16 percent of the overall adult Medicaid population — a finding to be reconciled with

higher rates of dental disease observed in this sub-group. Roughly 25 percent of non-older adults Medicaid beneficiaries in nursing homes used dental services compared to only 16 percent of the general adult Medicaid population, but the mean number of services used and mean expenditures among service utilizers in those settings were lower. Older non-older adults, ages 45-64, have higher mean dental costs per user, likely driven by their use of more expensive services. Communities with more dentists per resident have higher outpatient utilization and lower ED utilization for dental services among Medicaid-enrolled adults. Dental service use in outpatient settings and EDs is the lowest in areas that are more urban than rural. (Examining Oral Health Care Utilization and Expenditures for Low-Income Adults, Center for Health Care Strategies 2017)

Dental Therapist as Workforce Solution to Disparities

Per the Health Resources and Services Administration (HRSA), as of December 2018, the problem has gotten worse; nearly 58 million people in the United States live in areas with dentist shortages, which equates to only 29.26 % of the need being met, and another 10,635 providers needed to close the gap. This growing supply/demand chasm is evidenced when considering only about a third of U.S. dentists accept public insurance, and yet 72 million children and adults rely on Medicaid and the Children's Health Insurance Program. Therefore, access to dental care disproportionately affects older adults, people of color, and those with low incomes.

The United States needs a multifaceted, comprehensive approach to address the dental care shortage and the disease that lack of treatment causes for tens of millions of people. Dental care in the U.S. generally is provided by small, independent practices of dentists and hygienists. In medical care, primary care physicians have extended their practices by bringing in mid-level providers such as nurse practitioners and physician assistants. Dental therapy is one important piece necessary for an effective change in dentistry. By adding mid-level dental providers such as dental therapists to their teams, dentists could expand access to care where people need it most: in their own communities.

Accordingly, there is growing interest in dental therapists—midlevel providers who work under the supervision of a dentist and provide preventive and routine restorative care. They have been shown to provide high-quality, cost-efficient care in the states where they practice and in more than 50 countries. Unlike hygienists, dental therapists can provide routine restorative procedures like filling cavities along with preventive care. These providers can also bring care directly to schools or nursing homes. Because of the potential to expand access to vulnerable people and reduce costs to the states and taxpayers, dental therapy has attracted bipartisan champions from Grover Norquist, president of Americans for Tax Reform, to Don Berwick, former administrator of the Centers for Medicare & Medicaid Services and current senior fellow at the Institute for Healthcare Improvement. Legislation to license dental therapists has progressed in Massachusetts and Michigan and is being explored in several other states.

In Minnesota, the first U.S. state to allow dentists to hire dental therapists, these providers are expanding care in areas by working in remote offices and keeping in contact with their supervising dentists using technology and electronic health records. They are also making it more cost-effective for private practices and public health centers to treat Medicaid patients. Finally, they are providing care to people who often have trouble getting to a dentist's office during working hours by treating them in public settings such as nursing homes and schools.

State of the Oregon Dental Union

Oregon is a national leader in the transformation of health care. The state has focused on achieving the triple aim for all Oregonians – better health, better care and lower costs. Hallmarks of Oregon's efforts have been attention to wellness, treating the whole person and coordination among providers. Oral health is critical in this equation. Historically, oral health care has been delivered separately from medical care. Oregon's coordinated care model is committed to integrating physical, oral and behavioral health care to

treat the whole person. Over the last several years, community stakeholders and the Oregon Health Authority (OHA) have paid increasing attention to ensuring oral health for all Oregonians.

Oregon has been relentlessly engaged in health system transformation and innovation activities at the local, regional and state level. In 2012, the Legislature approved the establishment of coordinated care organizations (CCOs), and established the Patient-Centered Primary Care Home (PCPCH) standards. By mid-2012, the Centers for Medicare & Medicaid Services (CMS) approved Oregon's waiver, helping to launch CCOs and health system transformation in Medicaid. In early 2013, 90 percent of Oregon's Medicaid beneficiaries were enrolled in CCOs and Oregon began implementing the three-year State Innovation Model (SIM) grant, which launched the Transformation Center, a hub for statewide innovation and quality improvement in health system transformation. As of December 2014, Oregon had established more than 500 recognized PCPCHs, representing over 50 percent of all eligible clinics in Oregon and serving approximately 2 million Oregonians. By 2015, close to 400,000 additional Oregonians had received Medicaid coverage (roughly a 65 percent increase from 2013 before the ACA), and 95 percent of Oregonians had health insurance. As of 2017, 98 percent of kids under 19 years of age in Oregon were insured, and the remaining 2 percent were afforded access to coverage beginning in 2018.

In March 2017, the Oregon Health Authority released the first in-depth report on oral health care data for Oregon's CCOs titled, "*Oral Health in CCOs: A Metrics Report*". Key findings from the report include:

- The percent of OHP members receiving any dental service varies by county. Any dental service includes preventive, diagnostic, and treatment services.
- Adult CCO members receive oral health services at lower rates than children. Only about 1 in 3 adults receive dental services in a given year, compared with a little more than half of children. Adults are also less likely to report having a regular dentist.
- Many members do not receive preventive dental services, like regular cleanings, fluoride treatments, and dental sealants. Only 1 in 5 adults and just over half of children (50.1%) had a preventive service between July 2015 and June 2016.
- When stratified by race/ethnicity, the data show variation between groups. Members who identify as Hawaiian/Pacific Islander consistently receive services at lower rates than other members. Members identifying as Asian American generally have higher rates of utilization and follow-up.

Oral and Overall Health

Changing demographics in Oregon and data about oral health over the lifespan highlight areas of success and identify opportunities for improvement. In Oregon, 58% of third graders have experienced tooth decay, and most adults suffer from some degree of oral disease. Thirty one percent of Oregonians aged 33 to 44 have lost teeth; 19.9% of older adults have lost six or more teeth.

The 2012 Oregon Smile Survey reported that more than half of children 6 to 9 years old already had a cavity, about one-fifth of these children had untreated decay, and more than 17,000 had rampant decay. This report also indicated that school-aged children in Oregon experience oral disease disparities based on geographic residence, household income, race and ethnicity. Young children in Oregon have a lower rate of tooth decay than the national average, likely due to Oregon's exceptional sealant coverage. The percent of young children with untreated dental decay is lower as well. However, older children (13 to 15 years old) have significantly higher levels of decay than the national average. 52% of 6- to 9-year-olds had a cavity, 20% had untreated decay and 14% had rampant decay at the time of their oral health screening. Children from counties in southeastern Oregon had higher cavity rates than those of the rest of the state. Children from lower-income households had substantially higher cavity rates compared to children from higher-income households (63% vs. 38%), almost twice the rate of untreated decay (25% vs. 13%), and more than twice the rate of rampant decay (19% vs. 8%). Hispanic/Latino children experienced particularly high rates of cavities, untreated decay and rampant decay compared to White children. Black/African American children had substantially higher rates of untreated decay compared to White children. (Oregon Smile Survey, 2012)

Data from 2014 indicates that approximately two-thirds of Oregon adults have visited a dentist at least once in the last year; this is comparable to the national average. Tooth loss due to decay or gum disease is a key measure of oral health in adults. Forty-one percent of Oregonians aged 20 to 64 have lost teeth, which is significantly lower than the national average (51.8%).

Oregon's older adults face challenges in oral health. As in other states, this is often attributed to the lack of a dental benefit in Medicare. Thirty-two percent of Oregonian older adults (65+) have lost six or more teeth; this is lower than the national average (37.4%). Thirteen percent of Oregonian older adults have lost all teeth - a bit lower than the national average (14.9%). While Oregon is faring slightly better on measures of adult tooth loss compared to the national average, the state is not doing as well in this measure (lost all teeth) than the neighboring states of California (8.7%) and Washington (11.5%).

Between July 2010 and July 2014, Oregon's 65-and-older population grew by 18 percent. The senior population in the U.S. grew by 14.2 percent in the same time period; so far, Oregon is aging at a faster rate than the nation. As the population ages, Oregon's policy efforts will need to address dental care access for this growing aging population.

Lifelong access to timely preventive dental care can reduce health care costs, but a high percentage of Oregonians are not currently receiving timely preventive care. Only about two-thirds (66.9%) of Oregon adults visit the dentist at least once a year. This can lead to costly hospital emergency care. The number of dental-related emergency visits by Oregon's Medicaid enrollees in 2010 was 31% higher than in 2008. Hospital care for a Medicaid enrollee costs nearly 10 times more than preventive care in a regular dental office. (2015-2019 State Health Improvement Plan (SHIP), Oregon Health Authority (OHA))

Disparities and the Social Determinants of Oral Health

Oregon places great emphasis on the social determinants of health, which encompasses oral health, given the coordinated care model inclusion of oral health. Most recently, the Oregon Health Policy Board, other state committees, and the Oregon Health Authority (OHA) have focused attention and initiatives to address the social determinants of health and equity.

As stated above, the elimination of health disparities is a foundational tenet of the CCOs, in part, through the coordination and integration of physical, behavioral and oral health care delivery. Now five years into the coordinated care model, Oregon's experience with CCOs has provided a wealth of information about what is working and what will need more work in the next contracting iteration, i.e. CCO 2.0. To inform this forward vision, the OHSU's Center for Health Systems Effectiveness published an evaluation of the first five years of the CCO model, which shows cost-savings, improvements in quality, and also makes suggestions to continue progress over the next five years.

Per the evaluation findings, prior to the CCO's, there were significant white-black and white–American Indian/Alaska Native disparities in utilization measures and white-black disparities in quality measures. The CCOs' transformation and implementation of health equity policies was associated with reductions in disparities in primary care visits and white-black differences in access to care, but no change in emergency department use, with higher visit rates persisting among black and American Indian/Alaska Native enrollees, compared to whites. Additionally, disparities in access to and quality of care are evident related to race/ethnicity, disability, and behavioral health status.

Additionally, in September 2017, Governor Brown asked the OHPB to focus on social determinants of health (SDOH) and equity when considering the future of CCOs. Both equity and prevention were considered priorities in the initial vision of health system transformation. As health system transformation has progressed, there has been growing awareness that social determinants of health, such as housing and education, have a greater impact on health than health care services. Prevention has subsequently

expanded to encompass far “upstream” actions that address SDOH – and there is potential to grow this work even further.

To address this charge, the OHA and OHPB conducted an analysis titled, “Health Equity and Social Determinants of Health Maturity Assessment of CCO 1.0”, which concluded, “Disparities in access to and quality of care are evident related to race/ethnicity, disability, and behavioral health status.” The following list underpins this overarching finding:

- Hispanic/Latina women less likely to have timely prenatal care.
- American Indian children less likely to receive developmental screening, likely to receive immunizations.
- American Indian and Hawaiian/Pacific Islander children less likely to receive dental sealants.
- Adolescents of color and from households speaking languages other than English are less likely to receive adolescent well care.
- Latinos/Hispanics are less likely to receive colorectal cancer screening.
- American Indians have the highest rates of smoking.
- Asian Americans are less likely to receive screening for alcohol and substance misuse.
- Asian American women at risk for unintended pregnancy are less likely to have effective contraception use.
- American Indians, African Americans/Blacks have higher rates of emergency department use.

To augment the aforementioned Medicaid and CCO specific content, a county-by-county report from the Robert Wood Johnson Foundation (RWJF) explores the size and nature of health differences by place and race/ethnicity in Oregon and how state and community leaders can take action to create environments where all residents have the opportunity to live their healthiest lives.

Measures of length and quality of life indicate American Indians/Alaskan Natives are less healthy than those living in the bottom ranked county. Asians/Pacific Islanders are healthier than those living in the top ranked county. Blacks are most similar in health to those living in the least healthy quartile of counties. Hispanics are most similar in health to those living in the healthiest quartile of counties. Whites are most similar in health to those living in the middle 50% of counties.

In addition, the report assesses poverty and its impact on limiting opportunities for quality housing, safe neighborhoods, healthy food, living wage jobs, and quality education. As poverty and related stress increase, health worsens. In Oregon, 17% of children are living in poverty compared to the U.S. rate of 20%. Children in poverty rates among Oregon counties range from 11% to 40%. Children in poverty rates among racial/ethnic groups in Oregon range from 13% to 33%.

Similarly, higher rates of educational achievement are linked to better jobs and higher incomes resulting in better health. Education is also connected to lifespan: on average, college graduates live nine years longer than those who didn’t complete high school. Oregon’s high school graduation rate is 75% compared to the U.S. rate of 83%. High school graduation rates among Oregon counties range from 46% to 87%. High school graduation rates among racial/ethnic groups in Oregon range from 55% to 84%.

Teenage motherhood is more likely to occur in communities with fewer opportunities for education or jobs. Teen mothers are less likely to complete high school and face challenges to upward economic mobility. In turn, their children often have fewer social and economic supports and worse health outcomes. The teen birth rate in Oregon is 22 births per 1,000 female population, ages 15-19, compared to the U.S. rate of 27 per 1,000. Teen birth rates among Oregon counties range from 7 to 51 per 1,000. Teen births for racial/ethnic groups in Oregon range from 8 to 42 per 1,000. (County Health Rankings & Roadmaps (CHR&R) – Oregon, Robert Wood Johnson Foundation 2018)

Workforce and Access

According to the ADA HPI's 2017 report titled, "Measuring What Matters Access to Dental Care in Oregon," in 2015, the percentage of Medicaid enrolled children with a dental visit in the past 12-months was 41.2% whereas the U.S. rate was 49.7%. This placed Oregon ahead of only 10 other states. And when comparing coverage – Medicaid vs. private insurance – the disparity variance was significant – private insurance on par with national average, but Medicaid substantially below national average for both. Correlating this low performance to workforce, the ADA goes on to present the Dental-to-Population ratio for Oregon and against national marks. The number of dentists per 100,000 in the U.S. population was 60.9% in 2015 and varied across all states. For context, Oregon had a ratio of 69.1%, which was lower than neighboring states Washington and California, 72.8% and 77.1% respectively, and substantially lower than highest performing states, Washington D.C. (89.9%), New Jersey (81.5%), and Alaska (80.8%). And, the ADA HPI project that, by 2035, Oregon will have a headcount ratio of 72.5%, a FTE based on hours/year ratio of 66.2%, and an FTE based on visits/week ratio of 63.3%.

In an attempt to demonstrate network adequacy of dentists participating in Medicaid, the ADA HPI goes on to comport these ratio into time and distance data points. The following data points highlight their argument that there is an adequate supply and geographic distribution of dentists. In general, the report states that, 91% of publicly insured children live within 15 minutes of a Medicaid dentist. 89% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time. And, 88% of the population lives in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

At a more detailed level, the report states that 9% of publicly insured children do not have a Medicaid or CHIP dentist within a 15-minute travel time. 74% of publicly insured children live in areas with more than one Medicaid or CHIP dentist within a 15-minute travel time for every 500 publicly insured children. 15%of publicly insured children live in areas with one Medicaid or CHIP dentist within a 15-minute travel time for every 500 to 2,000 publicly insured children. 2% of publicly insured children live in areas with less than one Medicaid or CHIP dentist within a 15-minute travel time for every 2,000 publicly insured children. 6% of the population does not have a dentist within a 15-minute travel time. 74% of the population lives in areas with more than one dentist within a 15-minute travel time for every 2,500 people. 14%of the population lives in areas with one dentist within a 15-minute travel time for every 2,500 to 5,000 people. 7%of the population lives in areas with less than one dentist within a 15-minute travel time for every 5,000 people.

A separate report from the ADA HPI titled, "Dentist Participation in Medicaid or CHIP" presents national and state-level statistics about Medicaid participation. According to the report, the national participation rate for 2016 was 39% and Oregon's rate was 38.9%. Clearly, when comparing these two Oregon data sets from the ADA HPI, the ability to draw an objective interpretation is challenging. If Oregon has a low participation rate it is hard to objectively determine the supply-demand and time/distance data justification and key takeaways expressed by the ADA HPI.

Yet, if this was absolute, one would expect the performance and patient experience data tell the same story. But, it does not, and the aforementioned policy rebuttal from Pew speaks to the underlying issue; data can tell whatever story it's intended to tell- bad data in, bad data out. Ironically, in presenting their key takeaways, the ADA HPI seemingly plays both sides of the issue. On one hand they state geographic coverage of dental care providers is quite extensive and the supply of dentists is expected to grow steadily in the coming years. On the other hand, they acknowledge that dental care use is low among publicly insured children, but argue the main barriers to dental care among adults relate to cost and fear, not lack of providers. They go on to recommend focusing policy efforts less on "supply" interventions, more on "navigation" interventions (e.g. connecting members to a dental home, nudging diabetics into routine dental care) and accelerating innovations in payment and care delivery models that focus on outcomes. In summary, while there is surely issues with reimbursement rates, when overlaying these two

ADA HPI workforce analysis' with utilization data, it's hard to justify the notion that there is no provider shortage issue, at a minimum its clear there is a provider distribution issue, which is probably more accurately described as provider type distribution and shortage issue.

Oregon Policy Perspectives

Oregon has a rich history of progressive health policymaking; spanning the continuum of health care, from public and private insurance coverage and funding to care delivery models and provider scope of practice. And, importantly, Oregon policy has prioritized decisions based on recognition that, individuals with low incomes are disproportionally likely to experience poor oral health, and people of color are also at risk. Recognizing the importance of oral health across the lifespan, Oregon is one of 13 states that offer comprehensive dental benefits to all adults with Medicaid, as well as children.

In this vein, a sentinel event occurred in 2009 when the Oregon Legislature established the Oregon Health Policy Board (OHPB) as the policy-making and oversight body for the Oregon Health Authority, with nine members appointed by the Governor and confirmed by the Senate. The OHPB worked alongside OHA to design and implement a comprehensive health reform plan for our state. This plan - The 2010 Action Plan for Health – addresses the issues of cost, quality, and access to health care through delivery system innovation. Fundamentally, the 2010 Action Plan for Health served as the first strategic plan for comprehensive health reform in Oregon.

State Action Plan for Health 2017-19 Refresh

By 2016, the state had moved beyond the early implementation of health reform. Therefore, OHPB asked OHA to "refresh" the 2010 Action Plan. The timing of the request allowed OHPB to capitalize on the work undertaken in the fall of 2016 through the CCO Listening Sessions to better understand the successes, challenges, and future opportunities for health system transformation in the state. At the same time, the OHA was in the process of renewing Oregon's 1115 demonstration waiver, effective January 2017.

The plan outlines key actions that OHA will take over the next two years in support of the vision and strategies that have been articulated by OHPB. As such, it serves as the OHA's 2017-2019 strategic operational plans for health system transformation goals. The plan sets a clear vision for Oregon. It lists a set of guiding principles to build on the progress achieved since 2010. In addition, it concentrates efforts where there is need for more work. It uses the guiding principles to target basic strategies that drive system change and policy action in 2017-2019. These strategies work in tandem with the State Health Improvement Plan (SHIP) to improve the health of all people in Oregon and align the work across OHA. Within each strategy, updated focus areas and key actions for 2017-2019 reflect Oregon's progress over the past six years and current opportunities and challenges. For example, the 2017 Action Plan includes a focus area addressing culturally and linguistically appropriate care and calls for implementation of the language access services policy.

Guiding principles

The guiding principles listed below serve as a long-term guide for OHPB, OHA, and other stakeholders and partners across the state in setting priorities, policy-making and decision-making. While the Action Plan operations are narrowly focused on a two-year time period, the Vision and Guiding Principles function across a longer time frame and will continue as a relevant guide throughout the next decade.

Incorporated throughout both the guiding principles and the foundational strategies is the goal of achieving health equity and ensuring that the health care system and its workforce reflects local community characteristics and needs.

To achieve a robust health system that serves all Oregonians, the Oregon Health Policy Board and the Oregon Health Authority believe that we must be guided by the following:

- **Access:** All Oregonians should have access to the right care at the right time in the right place.

- **Innovation with accountability:** Transparency, efficiency, innovation, accountability, and financial sustainability are key indicators for improved health outcomes and reduced costs.
- **Patient-centered:** Oregon health policies and practices must place the needs, interests and engagement of patients and their families at the heart of reform efforts, using a patient-centered, integrated, and coordinated care approach that optimizes the use of technology.
- **Health equity:** Achieving health equity and ensuring that the health care system and its workforce reflect local community characteristics and needs is foundational and must be embedded in all we do.
- **Collaborative partnerships:** Engaging providers, purchasers, consumers, and other stakeholders in aligning around a common framework is necessary for achieving a shared vision.
- **Social determinants of health:** We must shift the focus upstream, emphasizing prevention and promoting healthy development and healthy behaviors where people live, work, learn and play.

Foundational strategies

The guiding principles are put into operation through the foundational strategies. These seven overarching strategies serve to establish a clear, concrete, high-level description of how the guiding principles will drive system change and policy action in 2017-2019. Each guiding principle is reflected across the strategies, which encompass the work across all OHA divisions:

- Pay for outcomes and value
- Shift focus upstream
- Improve health equity
- Increase access to health care
- Enhance care coordination
- Engage stakeholders and community partners
- Measure progress

Focus areas and key actions

Underpinned by and accountable to the guiding principles established, the Plan lays out focus areas categorized to and aligned with the seven foundational strategies. Each focus area represents ongoing actions undertaken by OHA and OHPB, as well as opportunities for additional policy development and new action. As evidenced by the following, dental therapists have a role given oral health is impacted at every level of the Plan, from guiding principles to foundational strategies and focus areas:

- Strategy Area #2: Shift focus upstream
    - 2.1 Modernized public health system for the entire state
    - 2.2 State Health Improvement Plan (SHIP) goals
    - 2.3 Evidence-based prevention
    - 2.4 Social determinants of health (SDOH)
- Strategy Area #3: Improve health equity
    - 3.1 Health equity policy development
    - 3.2 Health disparities analysis and monitoring
    - 3.3 Culturally and linguistically appropriate care
    - 3.4 Funding mechanisms to support health equity
- Strategy Area #4: Increase access to care
    - 4.1 Health care workforce
    - 4.3 Oral health care access and outcomes
- Strategy 5: Enhance care coordination
    - 5.1 Integrated oral, behavioral and physical health care
    - 5.2 Health information technology (HIT) and health information exchange (HIE) support
    - 5.3 Coordinated Care Model (CCM) improvements
    - 5.4 Person-centered primary care

CCO Model/Integration of Care

Acknowledging roughly one in four Oregonians are covered by Medicaid and nearly 90% receive care through CCOs, it is important to understand how policy may have impacted disparities. Since 2012, Oregon CCOs have been charged with managing physical, behavioral, and dental health benefits for Medicaid members. CCOs are geographically defined organizations governed by health care providers, Medicaid beneficiaries, and community representatives. Specifically, Oregon's effort to transform its Medicaid program through CCOs included integration of funding for dental services and financial incentives for achieving dental quality goals.

In December 2016, the OHA released a report conducted by the OHSU Center for Health Systems Effectiveness titled, "The Impact of Dental Integration in Oregon's Medicaid Program". This report provides the first in-depth look at oral health care data in the context of Oregon's health system transformation, including the launch of the coordinated care organizations (CCOs) and expansion of its Medicaid program, Oregon Health Plan (OHP), through the Affordable Care Act. Individuals with low income are disproportionally likely to experience poor oral health, and people of color can face even worse health outcomes. Recognizing the importance of oral health across the lifespan, Oregon is one of only 13 states that offers comprehensive dental benefits to all adults with Medicaid, as well as children.† The report compared dental outcomes in two time periods before and after this policy change:

Pre-integration period: January 2012 – June 2013
Post-integration period: July 2014 – December 2015

Per the report, integration of funding for dental services into CCOs' global budgets was associated with moderate reductions in all dental outcomes from the pre-integration to the post-integration period. Overall, measures of access, utilization, and spending decreased moderately from the pre-integration to the post-integration period. ***Access to dental services decreased moderately***; the percentage of members with a visit for any dental procedure in a calendar quarter decreased by 0.6 percentage points compared with a rate of 18.3 percent in the pre-integration period. ***Utilization of dental services decreased moderately***; the number of visits for any dental procedure in a calendar quarter decreased by 28.9 per 1,000 members compared to a rate of 267.8 visits per 1,000 members in the pre-integration period. ***Emergency department (ED) visits for non-traumatic dental conditions decreased moderately*;** the number of ED visits for non-traumatic dental conditions in a calendar quarter decreased by 0.2 visits per 1,000 members compared with a rate of 2.2 visits per 1,000 members in the pre-integration period.

2018 State Health Assessment (including 2018 Oregon Areas of Unmet Health Care Need Report and Examining the Health Care Workforce Needs for Communities and Patients in Oregon)

Oregon has made meaningful progress towards ensuring coverage for and access to health care services; an evolution over decades, which started with inception of Oregon Health Plan and revolved under passage of the ACA and launch of CCOs. On a statewide basis, the data and metrics demonstrate progress made, but, in doing so, mask the variability that exists geographically and demographically. Viewed through a Social Determinants of Health lens – an emphasis on equity, reducing disparities, and addressing unmet need – the progress made statewide becomes quite varied, by geography and demography. The 2018 Oregon State Health Assessment made the same connections when stating "…Oregon also faces a shortage of dentists…Nearly a quarter of Oregon's population live in a federally-designated dental health professional shortage area."

Moreover, importantly, in looking at oral/dental health, specifically, while acknowledging progress has been made, from an unmet need, disparities and equity perspective, it's clear Oregon needs to improve, and ample opportunity to do so. For example, Oregon has made great progress around children's health coverage for, access to, and utilization of oral/dental health services, but disparities exists within certain age bands, by geography, and demography. The same cannot be said for adults; as compared to

children, wide variability exist across coverage for, access to, and utilization of oral/dental health services, and variation turns to chasms when stratifying by demography.

Coverage and access to health care services notwithstanding, as evidenced in the following statewide reports, a sizable portion of Oregonians remain underserved. From a geographic perspective, the *2018 Oregon Areas of Unmet Health Care Need Report* provides a 9-point test applied against a statewide threshold to determine degree of unmet need, and type of needs. Two of these tests – dentists per 1000 and Non-traumatic dental in the E.D. per 1000 – are specific to dental, and demonstrate variability of need, by geography. From the report, Oregon has an average non-traumatic dental Emergency Department (ED) visit rate of 4.7 per 1,000 people per year. Relatedly, the 2018 report, "*Examining the Health Care Workforce Needs for Communities and Patients in Oregon*" conjoins unmet need to workforce by using a subset of these nine tests as part of a "three lens" approach to inform and prioritize, by geography, the most needed types of providers per areas with most unmet need. As stated in the report, "gaps in access to dental services were identified in each of the three lenses"; therefore, "additional dental care capacity is needed in much of the state" – 30 of 36 counties have a higher ratio of residents to dentists than the statewide ratio and 28 have a higher ratio for certified hygienists (27 of 36 counties are higher for both). Consequently, both independently and collectively, these two reports provide demonstrable evidence of underserved Oregonians. Mindful of the importance of the social determinants of health, and acknowledging these reports limited inclusion of and focus on health equity and disparities, we leveraged a third report, 2018 Oregon State Health Assessment (SHA), to augment (buttress) and evolve (bolster) our definitional consideration. For context, "health", as defined by The World Health Organization and used in the SHA, means "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Therefore, in acknowledging no one single measure describes how healthy Oregon is, but rather a constellation of factors is needed to present, let understand, the overall picture, the SHA is organized into five areas of scope: social determinants of health; environmental health; prevention and health promotion; access to clinical services; and communicable disease control. As evidenced throughout – within each of and across all of the five areas of scope – the 2018 SHA is intentional in applying health equity and disparity lens and thorough in exploring health disparities/inequities among specific groups, including: people of color; people with disabilities; people with low income; people who identify as lesbian, gay, or bisexual; and people who live in rural or frontier areas of our state For example, the environmental health area of the report states that, "despite strong evidence that water fluoridation is safe and improves oral health, Oregon ranks 48th among U.S. states by proportion of public water systems that are fluoridated."

Population Definition/Criterion

SB 738 charges that, in approving pilot projects, the Oregon Health Authority (OHA) must ensure the following related to population(s) impacted: *"…focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care*". As underscored, a major health objective of our nation is to place a greater focus on health and not just health care. Total health and wellness are inextricably linked to oral health—it is impossible to have one without the other. The effects of oral disease on overall health are alarming. Oral disease has an impact on physical, psychological, social, and economic health and well-being, often resulting in pain, diminished function, and reduced quality of life. According to 2012 report from National Center for Health Statistics, "Selected Oral Health Indicators in the United States, 2005–2008", although tooth decay is largely preventable, more than 9 in 10 adults have experienced tooth decay (dental caries). And, approximately 1 in 5 people in all age groups has untreated dental caries. In addition, consequences of poor oral health have a negative influence on children's speech, growth and function, and social development. Missing teeth, pain, and infection from oral diseases can limit food choices and worsen nutrition. Pain caused by tooth decay may result in missed days at school and work and diminished performance.

Children are just one of the many vulnerable and underserved populations that face persistent, systemic barriers to accessing oral health care. While the majority of the U.S. population routinely obtains oral health care in traditional dental practice settings, oral health care eludes many vulnerable and underserved individuals—including people with special health care needs, older adults, pregnant women, and populations of lower socioeconomic status, among others. Lack of access to oral health care contributes to profound and enduring oral health disparities in the United States. Access is hampered by a variety of social, cultural, economic, structural, and geographic factors, but fortunately, opportunities exist in both the public and private sectors to reduce barriers to care.

Poor appearance, resulting from dental problems, and lack of coverage and/or access, can contribute to social isolation, lower wages, and loss of self-esteem. Furthermore, poor oral health is associated with increased bacterial systemic exposure and increased inflammatory factors that can lead to adverse health outcomes such as uncontrolled diabetes, cardiovascular disease, and respiratory disease. Biomedical and behavioral research provides knowledge to understand the fundamental causes of diseases and to transform that knowledge into a lifetime of better health for all people. Most dental, oral, and craniofacial conditions arise from complex interactions of biological, behavioral, environmental, and higher system-level factors.

Associating national literature and data to both Oregon and dental requires a framework to calibrate and correlate. For example, the Health Resources Services Administration (HRSA) and their Health Professional Shortage Area (HPSA), whose guidelines and scoring criterion define areas of provider shortages and unmet health care needs. In this vein, for the past 15 years, the Agency for Health Research and Quality (AHRQ), as mandated by Congress, has compiled a national report on healthcare quality and disparities – The National Healthcare Quality and Disparities Report (QDR). This Report provides a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different socioeconomic groups. Using this national framework and guide, we sought to inextricable link national/state literature, standards, programs, policy, and statistical reports addressing the following: Social Determinants of Health; Equity; Disparities; and Unmet Need.

Definition/Criterion: While the goals of this pilot include an evaluation of the effectiveness of the dental therapist in various care delivery models for all patient types, this project will focus on populations that have been shown to have the least access to dental care and/or the highest disease rates. Because they

can be identified and proactively appointed, the project will focus on serving patients who meet at least one of the following populations:

- Low-income adults as determined by patient's Medicaid eligibility (Oral Health in CCOs: A Metrics Report, Dental Crisis in America: The Need to Expand Access, Access to Affordable Dental Care: Gaps for Low-Income Adults - Kaiser Low Income Coverage and Access Survey July 2008) (https://www.medicaidplanningassistance.org/medicaid-eligibility-oregon)
- Children 0-18 who are low-income [i.e. Medicaid] and/or moderate to high risk for caries (Oral Health in CCOs: A Metrics Report, 2012 Oregon Smile Survey)
- Adults 19-64 who have diabetes (Mealey and Rose, 2008)
- Older adults 65+ (Dental Crisis in America: The Need to Expand Access)
- Pregnant women who are low-income [i.e. Medicaid] and/or moderate to high risk for caries (Access to Affordable Dental Care: Gaps for Low-Income Adults, Kaiser Low Income Coverage and Access Survey July 2008)

Periodontal treatment for all patients, including pregnant women, is treatable by a current Oregon hygienist under their state license. Periodontal treatment for any patient is not a target for this pilot as any Oregon hygienist is already authorized to provide treatment to these patients. This pilot will not teach any perio related services as Oregon hygienists with their restorative credential are already licensed to provide perio treatment within the scope of the current Oregon hygienist license. It is the intent of the program participants to treat patients who may not fall into one of the above categories if and when they present to the pilot clinics. These patients will be included in the data analysis and overall project evaluation as their demographic information may further inform the outcomes of this pilot.

Note: all Medicaid patients within the state of Oregon have on-demand access to transportation and interpretation services.

Sponsor Information

Sponsor – **Willamette Dental Group, P.C.** is the largest multi-specialty group dental practice in the Northwest and operates more than 50 dental office locations throughout Oregon, Washington and Idaho, serving more than 400,000 members. Over its 45-year history, WDG has grown to become a leader in providing proactive, evidence-based dental care, which focuses on promoting a dentist-patient partnership for ultimate long-term health.

Willamette Dental Group has been active in the development of dental therapy in Oregon, including participating in the legislative mediation and subsequent rulemaking for the state dental pilot project program. This dental workforce pilot project supports Willamette Dental Group's core values of innovation, compassion, integrity and health. If this dental workforce pilot project is successful, WDG hopes to add dental therapists to their existing dental team to expand their ability to provide accessible, culturally-sensitive preventive and restorative dental care to patients in Oregon.

Sponsor Status as a Dental Care Organization – The Willamette Dental Group is a fully capitated dental care organization. See attachment PN3A.

Participating Organizations – Pacific University School of Dental Hygiene Studies (Pacific) offers a bachelor of science in dental hygiene. Graduates have flexibility and choices for work within the dental health field that are not available with an associate's degree. They also have a foundation to pursue careers in education, public health and management.

The Virginia Garcia Memorial Health Center is a Federally Qualified Health Center (FQHC) that provides high quality, comprehensive, and culturally appropriate primary health care to the communities of Washington and Yamhill Counties with a special emphasis on migrant and seasonal farmworkers and others with barriers to receiving healthcare.

SmileKeepers is committed to preventing dental disease and improving the oral and systemic health of children and low-income patients. They create access to quality care, use evidence-based methods and provide dental leadership within the communities they serve. SmileKeepers educates dental providers to "look outside the mouth." As their providers recognize the interrelation between systemic and oral health, they can improve overall health outcomes for patients. SmileKeepers is committed to the coordination of overall health with their member's medical and behavioral health providers.

AllCare Health is a physician-led organization headquartered in Grants Pass, Oregon, offering a wide range of health plans and services designed to meet the needs of Oregon's diverse communities, while controlling costs for both patients and taxpayers. AllCare was originally founded in 1994 as Mid Rogue Independent Physician Association, Inc.

Dr. Sandra Galloway, DMD has a practice in Hillsboro, Oregon, and is committed to providing personalized dentistry for families of all ages. The foundation of her practice starts with forming a strong relationship with her patients and incorporates the whole person at all times.

Dr. Lohring Miller, DMD has a family dental practice in Eugene, Oregon where he is interested in adapting the latest dental technologies and practice concepts together in a fun family dental practice. Dr. Miller holds the honor of being a Life Member of the Oregon Dental Association.

Project Director – The role of the project director will be to oversee all aspects of administering this dental workforce pilot project including the utilization phase, funding, resources, evaluation and reporting.

Dental Director – The role of the dental director will be to oversee the dental therapy education program, supervising dentists, quality of patient care, and patient safety.

FS4 – Sponsor Funding Sources for Dental Workforce Pilot Project – The sponsor funding sources include, but are not limited to: in-kind support from Willamette Dental Group, Pacific University, PEW Charitable Trusts, and The Ford Family Foundation. Potential funders also include: Cambia Foundation, The Oregon Community Foundation, Kaiser Foundation, Providence, and others.

Advisory Group – An advisory board will be formed to provide an active liaison mechanism between the dental workforce pilot project and the community. This board will meet quarterly (two per year via phone and two in person) in order to review all aspects of this project. The composition of the advisory board will include equitable representation from several stakeholder groups, which could include, but are not limited to: the Oregon Dental Association, Oregon Dental Hygienists' Association, Oregon Board of Dentistry, Oregon Health & Science University, FQHC organizations, private practice dentists, Oregon Health Plan and funders. The function of the advisory board will be to identify community resources, provide employment information, make curriculum recommendations, and help evaluate the dental workforce pilot project. The advisory board will be used at the discretion of the sponsor to seek counsel and advice as needed. Final authority for this dental workforce pilot project will remain with the sponsor.

Collaborative Agreements – Willamette Dental Group has signed a Memorandum of Understanding with Pacific University, Virginia Garcia Memorial Health Center, SmileKeepers, AllCare Health, Dr. Sandra Galloway, & Dr. Lohring Miller in Hillsboro, OR. Pacific University will develop and implement the dental therapy education program. See attachment PN3B.

Facilities – The didactic portion of the dental therapy education program will be delivered by Pacific University through online instruction. The clinical portion of the education will be held in the facilities of Pacific University's School of Dental Hygiene Studies on their Hillsboro Campus. Initial instructor dentist supervised patient care will occur during organized clinics in Pacific University's dental hygiene clinic or a Willamette Dental Group clinic on a Saturday. Both clinics will be utilized to reduce the burden of travel for the patients. The School of Dental Hygiene Studies has a 16-unit dental hygiene clinic with restorative capabilities.

After completing a clinical competency exam for a specified skill, the participants are eligible to provide that treatment to patients under the direct supervision of their supervising dentist in their employment setting. Participants in the dental therapy education program will have access to the library and other instructional resources on the Hillsboro Campus.

The preceptorship phase of the dental workforce pilot project will be held at the employment settings for the participants under the direct and indirect supervision of their supervising dentists.

Once the program has been completed, the dental therapist may work under direct, indirect, and general supervision of their supervising dentist.

Liability Insurance – All employment settings that participate in this dental workforce pilot project will provide documentation of their liability insurance that will cover dental services provided by the dental workforce pilot project participants. See attachment PN3C.

Memorandum of Understanding

WHEREAS, The Oregon State Legislature, by passage of Senate Bill738 (2011), created the Dental Pilot Projects Program within the Oregon Health Authority for the purpose of evaluating the quality of care, access, cost, workforce, and efficacy of dental care by teaching new skills to existing categories of dental personnel; developing new categories of dental personnel; accelerating the training of existing categories of dental personnel; and

WHEREAS, Willamette Dental Group, P.C. (Willamette), AllCare Health, SmileKeepers, Virginia Garcia Memorial Health Center (Virginia Garcia), Dr. Sandra Galloway DMD, and Dr. Lohring Miller DMD have come together to collaborate with education partner Pacific University;

WHEREAS, the parties in this MOU desire to establish an Innovative Dental Workforce Pilot project, in accordance with Oregon Revised Statutes, Chapter 680.210 and Oregon Administrative Rules 333-010-0400 through 333-010-0470; and

WHEREAS, the parties intend to create and evaluate the feasibility of an educational pathway that will lead to a career in dental therapy; including Dental Therapists (DT) singularly trained in dental therapy under CODA accreditation standards resulting in a Registered Dental Hygienist (RDH) receiving training with additional continuing education certification as a dental therapist; and

WHEREAS, the parties herein desire to enter into a Memorandum of Understanding setting forth the services to be provided by the collaborative.

1) Description of Partner Agencies

Headquartered in Hillsboro, Oregon **Willamette Dental Group, P.C.** is the largest multi-specialty group dental practice in the Northwest and operates more than 50 dental office locations throughout Oregon, Washington, and Idaho serving more than 400,000 members.

The **Virginia Garcia Memorial Health Center** is a Federally Qualified Health Center (FQHC) that provides high quality, comprehensive, and culturally appropriate primary health care to the communities of Washington and Yamhill Counties with specialty emphasis on migrant and seasonal farmworkers and others with barriers to receiving healthcare.

Pacific University School of Dental Hygiene Studies (Pacific) offers a bachelor of science in dental hygiene. Graduates have flexibility choices for work within the dental health field that are not available with an associate's degree. They also have foundation to pursue careers in education, public health and management.

SmileKeepers is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. They create access to quality care, use evidence-based methods and provide dental leadership within the communities they serve. As their providers recognize the interrelation between systemic and oral health, they can improve overall health outcomes for patients.

AllCare Health is a physician-led organization headquartered in Grants Pass, Oregon, offering a wide range of health plans and services designed to meet the needs of Oregon's diverse communities, while controlling costs for both patients and taxpayers.

Dr. Sandra Galloway DMD, a private practice dentist.

Dr. Lohring Miller DMD, a private practice dentist.

Other parties may be added to the collaborative project, and will agree to the provisions herein.

2) Guiding Principles

NOW, THEREFORE, the parties in the MOU mutually agree to:

A. Establish a mutually beneficial collaborative relationship that allows a flexible and creative response to the organizational, missions, and fiscal needs of all parties.

B. Collaborate in planning, implementation, and continuous improvement of the Dental Workforce Pilot project including the provisions for staff and administration, curriculum development; training of student services; quality improvement, data collection and evaluation process.

C. Work in collaboration to obtain necessary funds from local, state, federal and private/foundation sources to operate the project successfully and sustainably.

3) Roles and Responsibilities

NOW, THEREFORE, it is hereby agreed by and between the parties as follows:

The parties listed in Section 1 have agreed to enter into a collaborative agreement to participate in the Dental Workforce Pilot project.

An application for the Dental Workforce Pilot project will be prepared and approved by the collaborative and will be submitted to the Oregon Health Authority on or about **July 1st, 2018.**

An application for funding of the Dental Workforce Pilot project will be prepared and approved by the collaborative and will be submitted to one or more of the following: The Ford Family Foundation, The Pew Charitable Trust, The Oregon Community Foundation Oral Health Collaborative, Cambia Foundation, Providence Community Benefit and other potential funding sources.

The proposal for approval by the OHA and for funding support from the above potential funders will:

- Describe the roles and responsibilities for each party of the collaborative, including the resources each party will contribute to the project through time in-kind contribution and/or financial support;
- Identify the representatives of the planning/development team responsible for creating and implementing project activities and how they will work together and with project staff; and
- Demonstrate a commitment to work together to achieve the stated project goals and to sustain the project over time.

4) Indemnification

To the extent permitted under Oregon law and without any defenses including governmental immunity, each party to the MOU agrees to be responsible for its own acts of negligence, which may arise in connection with any and all claims for damages, costs and expenses to person or persons and property that may arise out of or be occasioned by the MOU or any of its activities or from any act or omission of any employee or invitee of the parties of this MOU. The provisions in this paragraph are solely for the benefit of the parties to this MOU and are not intended to create or grant any rights, contractually or otherwise to any third party.

5) Term

Subject to prior termination or revocation of this MOU as provided in Section 6 of this MOU, the initial term of this MOU is in full force and effect for a period of five (5) years. This MOU begins on the date of the last signature of the parties and continues through the initial term of any subsequent renewal terms. It may be renewed for additional one-year terms by mutual written agreement of the parties.

6) Right of Revocation

Any party may terminate this MOU at any time, with or without cause, on 120 days' written notice to the other parties. Termination may occur immediately upon the breach of this MOU by one of the parties. A breach of this MOU includes, but is not limited to, a violation of the policies and rules of the Oregon Health Authority, the making of a misrepresentation or false statement by one of the parties, nonperformance of the party's duties, or the occurrence of a conflict of interests between the parties. Each party has 30 days to cure the breach.

7) Assignment

Neither party may assign their interests in this MOU without the written permission of the other parties.

8) Limitations of Authority

A. No party has the authority for or on behalf of another party except as provided in this MOU. No other authority, power or partnerships, use of rights are granted or implied.

B. This MOU represents the entire agreement by and between the parties and supersedes all previous letters, understanding or oral agreements between the partners. Any representations, promises, or guarantees made but not stated in the body of this MOU are null and void and of no effect.

C. Neither party may make, revise, alter or otherwise diverge from the terms, conditions or policies that are subject to this MOU without written amendment to this MOU signed by the parties.

D. Neither party may incur debt, obligation expense, or liability of any kind against the other without the other's express written approval.

9) Waiver

The failure of any party hereto to exercise the rights granted them herein upon the occurrence of any of the contingencies set forth in this MOU shall not in any event constitute a waiver of any such rights upon the occurrence of any such contingencies.

10) Applicable Law

This MOU and all materials and/or issues collateral thereto shall be governed by the laws of the State of Oregon applicable to contracts made and performed entirely therein.

11) Venue

Venue to enforce this MOU shall lie exclusively in Oregon.

12) Miscellaneous Provisions

A. No party shall have control over another party with respect to its hours, times, employment, etc.
B. The parties warrant that their mutual obligations shall be performed with due diligence in a safe

and professional manner in compliance with any and all applicable statutes, rules and regulations. Parties to this MOU shall comply with all Federal, State, and local law.

13) We, the undersigned have read and agree with this MOU.

By _____ Date: 7/5/18

By _____ Date: 1-15-18

By _____ Date: 6/27/18

By _____ Date: 7/31/18

By _____ Date: 7-10-18

By _____ (Sandra Galloway) Date: 7/1/18

By _____ Date: 7/4/2018

Lohring Miller - DMD

Qualifications for Instructor Dentists and Supervising Dentists

The instructor dentists will be secured after the dental workforce pilot project application is approved.

Required Qualifications for Instructor Dentists:

- Oregon dental license in good standing
- Clinical experience in general dentistry
- Excellent communication skills

Preferred Qualifications for Instructor Dentists:

- Current knowledge of clinical teaching methods
- Clinical teaching experience with dental or dental hygiene participants
- Clinical experience working with patients

Required Qualifications for Supervising Dentists:

- Oregon dental license in good standing
- Clinical experience in general dentistry
- Excellent communication skills

Orientation for Instructor Dentists and Supervising Dentists

Pacific University will develop and implement an orientation program for the instructor dentists and the supervising dentists.

This orientation program will be provided through an online module that can be completed at a convenient time for the instructor dentists and the supervising dentists.

The orientation program will include modules that cover:

- Overview of the dental therapy education program
- Goals of the dental therapy education program
- Scope of Practice for dental therapists
- Roles and responsibilities for instructor dentists
- Roles and responsibilities for supervising dentists
- Roles and responsibilities of participants
- Confidentiality of participant records
- Educational theory and practice
- Current teaching methods for instructor dentists and supervising dentists
- Calibration training for all supervising dentists will be provided by the Dental Director, instructor dentists and outside reviewer.

Supervision Table for Dental Therapy

Description of Terms for Supervision Based on the Oregon Board of Dentistry definitions

- **Direct:** 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.
- **Indirect:** means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
- **General:** 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.

Pilot Project Definition of Faculty

- **Instructor Dentist:** the instructor dentists will work with the dental director to develop the dental therapy education program. The instructor dentists will teach the dental therapy didactic content through online modules and the dental therapy clinical skills with education manikins through weekend on-campus sessions. The instructor dentist will also evaluate participant competence in the didactic content and clinical skills. The instructor dentist will notify the supervising dentists when each participant has demonstrated competence with education manikins in a clinical skill so that the participant may begin providing that clinical skill for patients under the direct supervision of the supervising dentist. All trainee education provided by the instructor dentists will be under direct supervision.
- **Supervising Dentist:** the definition of a supervising dentist is a skilled practitioner who supervises students in a clinical setting to allow practical experience with patients. The supervisor will provide direct supervision and evaluation of dental therapy treatment provided by the participants to patients during the dental therapy I and dental therapy II. The supervising dentist will provide indirect supervision during the dental therapy III, the preceptorship phase of the project. In most cases the supervising dentist will be the same dentist as the supervising dentist from dental therapy I and dental therapy II. NOTE: if procedure is attempted for the first time on a patient, direct supervision is required. The supervising dentists will provide indirect and general supervision during the utilization phase of the pilot project. They will also collect data required for the evaluation plan.

Phase of Pilot Project	Level of Supervision	Supervision by
Dental Therapy I course	Direct	Course Instructor Dentist Supervising Dentist
Dental Therapy II course	Direct	Course Instructor Dentist Supervising Dentist
Dental Therapy III – Preceptorship	Direct and Indirect	Supervising Dentist
Utilization	Indirect and general	Supervising Dentist

Curriculum Vitae for Project Director

J. Toby Absher

PERSONAL HISTORY

Born: [redacted]

Office Address: Willamette Dental Group
6950 NE Campus Way
Hillsboro, OR 97124
Phone: [redacted]
Cell: [redacted]
e-mail: [redacted]

EDUCATION

[redacted]

EXPERIENCE

[redacted]

COMMITTEE APPOINTMENTS

[redacted]

PRESENTATIONS

[redacted]

[redacted]

DENTAL THERAPY / HEALTHCARE ADMINISTRATION EXPERIENCE AND EDUCATION

[redacted]

PROFESSIONAL MEMBERSHIPS

[redacted]

REFERENCES

Available upon request

Curriculum Vitae for Dental Director

Shannon English, DDS

PERSONAL HISTORY

Born: [redacted]

Office Address: Willamette Dental
Eugene Location
2703 Delta Oaks Drive
Eugene, OR 97408
Phone: [redacted]
e-mail: [redacted]

EDUCATION

[redacted]

EXPERIENCE

[redacted]

COMMITTEE APPOINTMENTS

[redacted]

PRESENTATIONS

[redacted]

[redacted]

DENTAL THERAPY EXPERIENCE AND EDUCATION

[redacted]

PROFESSIONAL MEMBERSHIPS

[redacted]

CERTIFICATES AND LICENSURE

[redacted]

REFERENCES

Available upon request

Curriculum Vitae for Instructor Dentist

Molly Saunders, DMD

PERSONAL HISTORY

Born: [redacted]

Office Address: 1907 Mountain View Lane
Suite 400
Forest Grove, Oregon 97116
Office: [redacted]
Cell: [redacted]
e-mail: [redacted]

EDUCATION

[redacted]

EMPLOYMENT

[redacted]

DENTAL THERAPY EXPERIENCE AND TEACHING EDUCATION:

[redacted]

PROFESSIONAL MEMBERSHIPS:

[redacted]

CERTIFICATES AND LICENSURE:

[redacted]

Curriculum Vitae for Instructor Dentist

Shoneen S. Sendelback, DMD

PERSONAL HISTORY

Born: [redacted]

Office Address: 1907 Mountain View Lane
Suite 400
Forest Grove, Oregon 97116
Office: [redacted]
Cell: [redacted]
e-mail: [redacted]

EDUCATION

[redacted]

EMPLOYMENT

[redacted]

DENTAL THERAPY EXPERIENCE AND TEACHING EDUCATION:

[redacted]

[redacted]

PROFESSIONAL MEMBERSHIPS:

[redacted]

CERTIFICATES AND LICENSURE:

[redacted]

Curriculum Vitae for Supervising Dentists

Any of the following dentists could serve as supervising dentists for the dental workforce pilot project.

Supervising Dentists from Willamette Dental Group

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Callans	Jennifer	DMD	The Dental College of Georgia at Augusta University	Augusta	GA	6/2000
English	Shannon	DDS	Baylor College of Dentistry	Dallas	TX	6/1994
Ghorbani	Samira	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2007
Kharrazi	Sheida	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/1998
Kremer	Amanda	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2013
Nguyen	Truong	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2011
Pruett	Amy	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2013
Sahuon	Irini	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2002
van der Bunt	Joshua	DMD	Nova Southeastern University College of Dental Medicine	Fort Lauderdale	FL	5/2014

Instructor Dentists from Pacific University

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Saunders	Molly	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/1993
Sendelback	Shoneen	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/1994

Supervising Dentists from Virginia Garcia Memorial Health Center

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Bozzetti	Lisa	DDS	Loma Linda University School of Dentistry	Loma Linda	CA	2002

Supervising Dentists from SmileKeepers Dental

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Hanson	Christian	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2010
Tranby	Mark	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	6/2008
Hays	Courtney	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	2014

Supervising Dentists from Sandra Galloway, DMD

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Galloway	Sandra	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	1997

Supervising Dentists from Lohring Miller, DMD

Last Name	First Name	Degree	Dental School	City	State	Graduation Date
Miller	Lohring	DMD	Oregon Health and Science University School of Dentistry	Portland	OR	1977

Participant Selection Criteria

Admissions Criteria

4-2 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.
Intent: *Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program*.

B. Supportive Documentation:

1. Mission statement/goals/purpose of admission committee that recognizes the institutional and educational benefits of admitting a diverse student body

2. List of outreach programs/pipeline programs targeted to underserved minority high school and college students

3. Qualifications for serving on the admissions committee, including a commitment to diversity and diversity-related issues

Although CODA has an admission policy regarding the recruitment and admission of a diverse student population, we did not focus our admission for the pilot project specifically on diversity. However, the initial cohort did turn out to be a diverse group of individuals, including diversity in gender, age, language and cultural backgrounds. We appreciate the importance of a diverse student population and if the pilot project moves forward to the legislative process and we apply as a CODA accredited program, we will put forward admission protocol designed to include the recruitment and admission of a diverse student population.

An admissions committee will select the participants based on the following criteria:

- Oregon dental hygiene license in good standing
- Endorsements in local anesthesia and restorative functions
- Clinical experience in the placement of restorations
- Experience working with diverse patient populations in a variety of settings – may include (but is not limited to) children, older adults, low SES, Medicare and Medicaid, varying ethnic backgrounds, schools, institutions, residential facilities, homebound, etc.
- Excellent communication skills
- Ability to effectively work in a team environment
- Currently employed with a dental facility that agrees to participate in the dental workforce pilot project
- Optional: Nitrous oxide certification and/or Expanded Practice Dental Hygienist in Oregon

Response to Admissions Criteria
CODA Admissions criteria
Admission of students must be based on specific written criteria, procedures and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other

predictors of scholastic aptitude and ability must be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists. Intent: The dental hygiene education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Because enrollment is limited by facility capacity, special program admissions criteria and procedures are necessary to ensure that students are selected who have the potential for successfully completing the program. The program administrator and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures which are nondiscriminatory and ensure the quality and student diversity of the program.

Our Admissions Criteria for the pilot project include:

- Successful completion of a CODA accredited dental hygiene program
- Current Oregon licensed RDH with restorative and local anesthetic credentials
- Currently practicing in an office that permits restorative functions
- Currently employed in a practice location with a dentist who will serve as a supervising dentist for the dental workforce pilot project and is willing to follow the training and evaluation portions of the program
- All trainees were required to successfully complete a certified criminal background check prior to receiving their Oregon dental hygienist license (i.e. CERTIPHI, JD Palatine, and/or the equivalent)
- The Oregon Board of Dentistry licensee look-up site will be used to confirm that each trainee is an Oregon licensed hygienist is in good standing with the Oregon Board of Dentistry

Explanation of CRDTS

T**he Central Regional Dental Testing Service, Inc.** (CRDTS) was chosen as the testing agency for final evaluation of students of this program. **CRDTS** is a testing service made up of State Boards of Dentistry who have joined forces to develop and administer fair, valid and reliable examinations of competency to practice dentistry and dental hygiene. CRDTS currently has testing for dental therapy and we are utilizing their testing criteria to evaluate student performance throughout the program and upon completion of their training.

Explanation of when testing forms will be used

13 Point Assessment of Overall Competency: each dental therapist participant will receive a 13-point assessment weekly. This assessment will include the following: clinic protocols, dental/medical history, prescribing oral meds, diagnostic skills, patient management, treatment planning, communication/verbal skills, technical skill, clinical knowledge, self-evaluation, interaction with health care team, professionalism, and culture sensitivity & competence. See page 188-190 in the Evaluation Section.

- The document explanation will include “This form will be used weekly to evaluate the intern regarding patient care in the dental office during the preceptorship phase of the program and monthly during the utilization phase of the pilot program.”

Individual tooth evaluations on a typodont (based on CRDTS criteria)

These forms will be used during the lab portions of DT I and II. They will be used for self-evaluation, peer evaluation, faculty evaluation and as the evaluation for the competency exam prior to clearing the student for patient care.

Dental Workforce Pilot Project
Participant Agreement

Invitation to Participate
You are invited to participate in this dental workforce pilot project because you are a restorative dental hygienist and you have expressed an interest in working as a dental therapist. This document is intended to provide you with information about this dental workforce pilot project so that you can make an informed decision about your participation.

Purpose
The purpose of this dental workforce pilot project is to investigate the feasibility of adopting the dental therapist model as a new category of dental care provider for Oregon. This dental workforce pilot project is designed to assess if adding a dental therapist to the existing dental team is an efficient and cost-effective way to increase access to dental care, especially for patients who experience higher disease rates and barriers to care, while maintaining the quality of dental care and safety that all patients deserve. This dental workforce pilot project will also evaluate the efficacy of educating licensed dental hygienists to become dental therapists through a unique one-year dental therapy education program that will allow the dental hygienists to complete dental therapist education while they maintain their current employment as a dental hygienist.

Description
You will be trained to become dental therapist through a unique one-year education program that will allow you to complete the dental therapy education program while you maintain your current employment as a dental hygienist. When the education phase is complete, you will enter the utilization phase and practice as a dental therapist in your current employment setting under the indirect and/or general supervision of your supervising dentist. Patient care that you provide as a dental therapist will be closely monitored by the supervising dentist. Data will be collected to evaluate the patient care that you provide as a dental therapist in terms of efficiency, cost, quality, patient satisfaction and patient safety.

Benefits
You will receive education as a dental therapist at no cost to you. If the results of this study are positive, we hope that regulatory changes will be made to allow dental therapists to practice in Oregon. In that case, you may be able to practice as a dental therapist after this dental workforce pilot project ends.

Risks
You will not be able to practice as a dental therapist after this pilot project ends unless regulatory changes are made that will allow you to practice as a dental therapist. There may be other risks that we cannot predict.

Compensation
You will receive no additional compensation for your participation during the education and implementation phases of this pilot project.

Confidentiality and Privacy
All information collected during this dental workforce pilot project that identifies you as a participant will remain confidential. Any reports will be in aggregate form. Your individual performance in the dental workforce pilot project will not be disclosed.

Information collected on participants during the utilization phase is considered public information and will be included in reports provided to the Oregon Health Authority.

Voluntary Participation and Withdrawal
Your participation in this dental workforce pilot project is voluntary. You may withdraw from participation in this dental workforce pilot project at any time. Your decision to withdraw from this dental workforce pilot project will not result in any penalty, or adversely affect your future relations with anyone involved in this project.

Term
The term of this agreement will begin on the date of your signature below and end when the dental workforce pilot project terminates.

Declaration
I have carefully reviewed this agreement and have had adequate time to seek additional information. My signature below indicates that I understand the terms of this agreement and I agree to participate in this dental workforce pilot project voluntarily and without inducement.

_____
Print Name

_____
Signature

_____
Date

Employment/Utilization Site Criteria

Employment/utilization sites must meet the following criteria:

- Identify supervising dentists who meet required qualifications
- Require supervising dentists to complete orientation education program
- Ensure that supervising dentists provide appropriate level of supervision for participants
- Provides dental care for a variety of patient populations including a significant percentage of the target population
- Obtain patient consent to be treated by a dental workforce pilot project participant
- Assume responsibility for ensuring quality of patient care and patient safety
- Manage adverse effects that may be caused by participants
- Implement a mechanism for tracking patients and participants
- Collect and report required baseline and outcomes data
- Provide appropriate dental equipment and facilities
- Employ current standards of clinical dental practice including infection control procedures
- Comply with federal and state regulations that apply to dentistry

Examples include, but are not limited to:

Willamette Dental Clinics that provide services to commercially insured patients, OHP, fee for service, Medicare and Medicaid patients or fall within DHPSA (Dental Health Professional Shortage Areas)

Clinic Name	Address	Pilot Supervising Dentist(s)
Bend	62968 O.B. Riley Road, Suite 12, Bend, OR 97701	Dr. Joshua van der Bunt
Eugene	2703 Delta Oaks Drive, Suite 300, Eugene, OR 97408	Dr. Shannon English
Gresham	1107 NE Burnside, Gresham, OR 97030	Dr. Sheida Kharrazi
Hillsboro	5935 SE Alexander Street, Hillsboro, OR 97123	Dr. Samira Ghorbani
Medford	773 Golf View Drive, Medford, OR 97504	Dr. Jennifer Callans
Milwaukie	6902 SE Lake Road, Suite 200, Milwaukie, OR 97267	Dr. Irini Sahuon
Roseburg	2365 NW Stewart Parkway, Roseburg, OR 97471	Dr. Truong Nguyen
Stark 2	405 SE 133rd Street, Portland, OR 97233	Dr. Amanda Kremer
Weidler	220 NE Weidler Street, Portland, OR 97232	Dr. Amy Pruett

Pacific University Dental Hygiene Clinics

Clinic Name	Address	Pilot Supervising Dentist(s)
Pacific University Dental Hygiene Clinics	222 SE 8th Ave Hillsboro, OR 97123	Dr. Molly Saunders Dr. Shoneen Sendelback

Virginia Garcia Dental Clinic

Clinic Name	Address	Pilot Supervising Dentist(s)
Virginia Garcia	3305 NW Aloclek Drive, Hillsboro, OR 97124	Dr. Lisa Bozzetti

SmileKeepers Dental Clinics

Clinic Name	Address	Pilot Supervising Dentist(s)
SmileKeepers Dental	227 Q Street, Springfield, OR 97477	Dr. Christian Hanson Dr. Mark Tranby
SmileKeepers Dental	1180 Park Street, Lebanon, OR 97355	Dr. Courtney Hays

Sandra Galloway, DMD Clinic

Clinic Name	Address	Pilot Supervising Dentist(s)
Galloway Family Dental	324 SE 9th Avenue, Suite C, Hillsboro, OR 97123	Dr. Sandra Galloway

Lohring Miller, DMD Clinic

Clinic Name	Address	Pilot Supervising Dentist(s)
Lohring Miller, DMD	1310 Coburg Road, Suite 2, Eugene, OR 97401	Dr. Lohring Miller

Employment / Utilization Sites (with address)

Willamette Dental Group:

Bend
62968 O.B. Riley Road, Suite 12
Bend, OR 97701

Eugene
2703 Delta Oaks Drive, Suite 300
Eugene, OR 97408

Gresham
1107 NE Burnside
Gresham, OR 97030

Hillsboro
5935 SE Alexander Street
Hillsboro, OR 97123

Medford
773 Golf View Drive
Medford, OR 97504

Milwaukie
6902 SE Lake Road, Suite 200
Milwaukie, OR 97267

Roseburg
2365 NW Stewart Parkway, Roseburg, OR 97471

Stark 2
405 SE 133rd Street
Portland, OR 97233

Weidler
220 NE Weidler Street
Portland, OR 97232

Site Details

Willamette Dental Group, P.C. is the largest multi-specialty group dental practice in the Northwest and operates more than 50 dental office locations throughout Oregon, Washington and Idaho, serving more than 400,000 members. Over its 45-year history, WDG has grown to become a leader in providing proactive, evidence-based dental care, which focuses on promoting a dentist-patient partnership for ultimate long-term health.

Willamette Dental Group has been active in the development of dental therapy in Oregon, including participating in the legislative mediation and subsequent rulemaking for the state dental pilot project program. This dental workforce pilot project supports Willamette Dental Group's core values of innovation, compassion, integrity and health. If this dental workforce pilot project is successful, WDG hopes to add dental therapists to their existing dental team to expand their ability to provide accessible, culturally sensitive preventive and restorative dental care to patients in Oregon.

Bend
Designated HPSA? Yes
HPSA Score: 17
Medicaid % (July 2018): 20.6%
County Medicaid %: 24.6%

Eugene
Designated HPSA? Yes
HPSA Score: 19
Medicaid % (July 2018): 24.2%
County Medicaid %: 28.7%

Gresham
Designated HPSA? No
HPSA Score: -- (No HPSA Score)
Medicaid % (July 2018): 29.7%
County Medicaid %: 26.9%

Hillsboro
Designated HPSA? No
HPSA Score: -- (No HPSA Score)
Medicaid % (July 2018): 23.7%
County Medicaid %: 18.8%

Medford
Designated HPSA? Yes
HPSA Score: 18
Medicaid % (July 2018): 22.8%
County Medicaid %: 33.0%

Milwaukie
Designated HPSA? No
HPSA Score: -- (No HPSA Score)
Medicaid % (July 2018): 26.8%
County Medicaid %: 18.6%

Roseburg
Designated HPSA? Yes
HPSA Score: 17
Medicaid % (July 2018): 20.4%
County Medicaid %: 33.2%

Stark 2
Designated HPSA? Yes
HPSA Score: 14
Medicaid % (July 2018): 37.3%
County Medicaid %: 26.9%

Weidler
Designated HPSA? Yes
HPSA Score: 20
Medicaid % (July 2018): 27.2%
County Medicaid %: 26.9%

Galloway Family Dental
324 SE 9th Avenue, Suite C
Hillsboro, OR 97123

Dr. Sandra Galloway: General family FFS dentist. She provides general and cosmetic FFS dentistry for families of all ages.

Criteria for the pilot: She represents a “pure” FFS private practice. We want to demonstrate the potential effectiveness for dental therapists in the Medicaid, commercial and FFS aspects of dentistry; she fills the example for the FFS doc. A majority of Dr. Galloway’s patient base is elderly patients over 65 years of age and patient’s with disabilities.

HPSA Score: -- (No HPSA Score)
Medicaid %: 0%
County Medicaid %: 18.8%

Lohring Miller, DMD
1310 Coburg Road, Suite 2
Eugene, OR 97401

Dr. Lohring Miller: His practice is approximately 75% Oregon Health Plan and 25% private uninsured or preferred provider insured patients. He is an Advantage owner (1% buy in) as

well as Moda OHP. He also participates in some special Pacific Source capitated plans such as those serving the University of Oregon Graduate Teaching Assistants. He accepts about 100 new patients a month including emergency patients that he tries to convert to full service patients.

Criteria for the pilot: Dr. Lohring represents a mix of Medicaid, commercial and FFS patients (not unlike Willamette Dental Group). It is very important to WDG that we demonstrate the effectiveness of dental therapy for individual providers and companies that may be similar to WDG, but are not WDG. In other words, we want to show that dental therapy works well outside of a larger company like WDG. Dr. Lohring represents the individual provider similar, but not connected to WDG.

HPSA Score: 19
Medicaid %: 75%
County Medicaid %: 28.7%

SmileKeepers Dental Clinics:
SmileKeepers Dental
227 Q Street
Springfield, OR 97477

SmileKeepers Dental
1180 Park Street
Lebanon, OR 97355

SmileKeepers is committed to preventing dental disease and improving the oral and systematic health of children and low-income patients. They create access to quality care, use evidence-based methods and provide dental leadership within the communities they serve.

Criteria for the pilot: SmileKeepers primarily serves the Oregon Medicaid population, but can see FFS patients as well. This represents another model to serve the Medicaid population.

Springfield
HPSA Score: 19
Medicaid %: 95%
County Medicaid %: 28.7%

Lebanon
HPSA Score: 16
Medicaid %: 95%
County Medicaid %: 31.5%

Virginia Garcia Dental Clinic
3305 NW Aloclek Drive
Hillsboro, OR 97124

Virginia Garcia is an FQHC that provides high quality, comprehensive, culturally appropriate dental health care to the communities of Washington and Yamhill counties with a specialty emphasis on migrant and seasonal farmworkers and others with barriers to receiving oral health care.

Criteria for the pilot: Virginia Garcia represents an FQHC and their purpose is to improve oral healthcare and access to oral healthcare for Medicaid and uninsured individuals.

HPSA Score: -- (No HPSA Score)
Medicaid %: 100%
County Medicaid %: 18.8%

Pacific University Dental Hygiene Clinics
222 SE 8th Ave
Hillsboro, OR 97123

Pacific University offers a bachelor of science in dental hygiene. Graduates have a foundation to pursue careers in education, public health and management.

Criteria for the pilot: Pacific University is the educational institution providing the training for this dental therapy pilot. In addition, their dental hygiene clinic offers care at reduced fees for all patients. Besides dental hygiene services, restorative care is offered each spring. Clientele for the clinic are primarily uninsured or underinsured patients who do not have a dental home.

HPSA Score: -- (No HPSA Score)
Medicaid %: 10%
Uninsured %: 90%
County Medicaid %: 18.8%

Patient Outreach

In order to meet the intent of SB 738, each pilot site will ensure that a minimum of 51% of the dental therapists' schedule is dedicated to treating patients in the target population. The actual number of patients in the target population in the pilot sites exceeds 29,000 for Willamette Dental Group alone. WDG has the ability to manipulate the supervising dentist and dental therapist's schedules to focus on this population at each participating site.

Each participating partner organization will use a variety of methods to outreach to the target population who have not yet engaged in care. Outreach techniques include, but are not limited to: texting, emailing, reminder cards, phone calls.

In addition, to providing care in a traditional dental home setting (i.e. dental office or clinic) this pilot will provide mobile patient care through Pacific University's dental van. The van travels to vineyards, churches, school for the blind, nurseries, or other locations by request.

Pacific University Dental Hygiene Clinic

- Patients are predominately Hispanic.
- Most patients do not have any dental insurance and we refer most restorative care to outside clinics.
- We do not offer any restorative procedures in the fall and summer semesters; one clinic per week in the spring is open for restorative care where 4 dentists prep teeth and the dental hygiene students pack and carve the restorations.
- The clinic has reduced fees.
- We would open a clinic chair for Dental Therapy care during our existing clinics when Molly Saunders or Shoneen Sendelback are scheduled as clinic instructors.

Pacific University SmileCare Van

- Patients are predominately Hispanic.
- The van travels to vineyards, churches, school for the blind, nurseries, or other areas that request our presence.
- Most patients do not have any dental insurance and are of low SES.
- Utilized year round to provide hygiene services only. At this time, we are unable to offer restorative treatment.
- In the utilization phase, we could offer restorative care by the Dental Therapist

- The van utilizes a reduced fee schedule.
- We would be able to add 1 restorative day per week to offer restorative care for these populations.

Senior Centers

- 2 sites are visited in the fall and spring semester (a nursing home and a residential center).
- Residents live full time at each site and have limited access to transportation.
- Residents are senior citizens or have disabilities that require full time care.
- We currently offer dental hygiene care at each site.
- There is a full dental unit at each site.
- Most do not have dental insurance but some do have Medicare/Medicaid.
- A mobile dental unit comes sporadically to provide care to those that have dental insurance in one of the sites.
- We would like to offer care to those patients that do not have dental insurance.

Curriculum for Dental Therapy Education Program

Accreditation – The Commission on Dental Accreditation (CODA) has established Accreditation Standards for Dental Therapy Education Programs. These standards outline the administration, faculty, staff, curriculum, outcomes assessment, resources and financial support that are required for an accredited dental therapy education program. The educational curriculum for this dental therapy education program is based on the CODA accreditation standards. Although this pilot project is based on CODA standards, certain liberties were taken in order to organize this pilot project. After the pilot project is complete, the intention of Pacific University is to create a dental therapy program that adheres to all CODA rules and regulations.

Program Length – CODA standards require that dental therapy education programs include three academic years of full-time instruction or its equivalent. Advanced standing may be awarded for participants who have already demonstrated competency in some areas.

This dental therapy education program is designed for dental hygienists currently licensed in Oregon who already have endorsements in local anesthesia and restorative functions. In addition, these dental hygienists must have current restorative knowledge and clinical experience in a dental practice setting that focuses on improving access to care, especially for those in the target population and has agreed to add these trained dental therapists to their clinical practice sites. These dental hygienists have already demonstrated competency in many of the areas that would be included in an accredited dental therapy education program (see PN9-A) which will allow the dental hygienists to complete this program within one academic year (fall, spring, summer).

Curriculum Design – This dental therapy education program will be offered in 2 dental therapy skills courses (didactic with lab) and 1 preceptorship course over a period of one academic year. The didactic content will be taught through online modules that can be completed at a time convenient for the participant. The clinical procedures will be taught on alternate weekends by instructor dentists using education manikins. The students will also participate in providing patient care in instructor dentist supervised clinics. After students demonstrate competency on education manikins, the participants are eligible to provide clinical procedures on patients in their employment setting under the direct supervision of their supervising dentist during Dental Therapy I and II. Students must complete a minimum of 128 hours of clinical care under the direct supervision of their supervising dentist prior to beginning their preceptorship phase of the program.

Following the completion of their skills courses, participants will complete an additional 172-hour preceptorship in their employment setting where they will provide dental therapy treatment to patients under the direct and indirect supervision of their supervising dentist.

Dental Therapy Courses:

Dental Therapy I

This course will provide an introduction to dental therapy practice. Didactic content will include dental therapy scope of practice, legal & ethical aspects of dental therapy practice, collaborative assessment and treatment planning in operative dentistry. Clinical procedures will include pulp vitality testing, cavity preparation and placement of direct restorations in permanent teeth, liners and bases, atraumatic restorative treatment (ART), indirect and direct pulp capping on permanent teeth, and emergency palliative treatment for dental pain.

Participants will practice clinical procedures on education manikins and indirect patient care until they demonstrate competency. After successful completion of competency exams, participants will practice clinical procedures on patients in their employment setting under the direct supervision of their supervising dentist. Participants must successfully complete this course before moving into the next course.

The clinical portion on manikins and patient care will occur for 8 hours on every other Saturday for a total of 8 Saturdays; equivalent to 64 hours of lab time. In addition, participants will begin to provide patient care under the direct supervision of the supervising dentist.

Didactic Online	=	3 hours per week for 15 weeks	=	45 hours	(3 credits)
Clinical with Manikins	=	8 hours per week for 8 weeks	=	64 hours	(2 credits)
Clinical with Patients	=	Will vary upon clinic site	=	up to 64 hours of total 128 hours needed in DT I & II	
Total				109+ hours	

Dental Therapy II
This course will provide further development of dental therapy practice. Didactic content will include prosthodontics, oral surgery, geriatric dentistry, pediatric dentistry. Clinical procedures will include a continuation of cavity preparation for pediatric teeth, and indirect pulp capping on primary teeth, complex amalgam and composite restorations, preparation and placement of preformed crowns on primary teeth, placement and removal of space maintainers, placement of single-tooth temporary crowns, extraction of teeth with severe periodontal disease, simple extraction of erupted primary teeth, minor adjustments and repairs on removable prostheses, and emergency palliative treatment for dental pain.

Participants will practice clinical procedures on education manikins and indirect patient care until they demonstrate competency. After successful completion of competency exams, participants will practice clinical procedures on patients in their employment setting under the direct supervision of their supervising dentist. Participants must successfully complete this course before moving into the next course.

The clinical portion on manikins and patient care will occur for 8 hours on every other Saturday for a total of 8 Saturdays; equivalent to 64 hours of lab time. In addition, participants will begin to provide patient care under the direct supervision of their supervising dentist.

Didactic Online	=	3 hours per week for 15 weeks	=	45 hours	(3 credits)
Clinical with Manikins	=	8 hours per week for 8 weeks	=	64 hours	(2 credits)
Clinical with Patients	=	Will vary upon clinic site	=	balance of 128 hours needed in DT I and II	(2 credits)
Total				173+ hours	

Dental Therapy III
This course will provide the participant with additional clinical practice providing dental therapy treatment to patients in their employment setting under the indirect supervision of their supervising dentist. Focus will be placed upon preparing participants for employment as a dental therapist. Participants must successfully complete this course before moving into the utilization phase of this dental workforce pilot project.

Clinical with Patients = 21-22 hours per week for 8 weeks = 172 hours (6 credits)

Student Evaluation Methods – Participants will be evaluated on didactic content through case worksheets and quizzes that are incorporated into the online education modules. Clinical procedures on both education manikins and patients will be evaluated by the participant (self-evaluation), the instructor and/or supervising dentists (at Pacific University and at the dental therapist's employment) using standardized evaluation forms that assess both process and product. A sample evaluation form appears as attachment PN9C (see page 133).

Curriculum Review and Revision – The curriculum for this dental therapy education program will be reviewed at the end of each course, and again when participants complete the program. The curriculum review will evaluate the course content, sequence of topics, time allocated to each topic, clinical evaluation forms, and other aspects of the program. The curriculum will be revised if the review reveals any opportunities where improvements can be made. Participants will be asked to provide their feedback throughout the program so that changes can be made as needed.

Pacific University
School of Dental Hygiene Studies

Course: Dental Therapy I
Term: TBD 2019
Date prepared: December 2018
Class time: Saturdays as assigned 8:00 - 5:00
Weekly asynchronous online didactic portion
Room: HPC 252B
Instructor: Dr. Sendelback, Dr. Saunders, Dr. Shannon English, Gail Aamodt RDH, MS
Office Hours: by appointment
Contact Email: _____ (subject line must read Dental Therapy I)
Email communication with instructor only through outlook and response will take place within 2 business days.

Course Description

This course will provide an introduction to dental therapy practice. Didactic content will include dental therapy scope of practice, legal & ethical aspects of dental therapy practice, collaborative assessment and treatment planning and operative dentistry.

Clinical procedures will include pulp vitality testing, preparation and placement of direct restorations in primary and permanent teeth, atraumatic restorative treatment (ART), indirect and direct pulp capping on permanent teeth, and indirect pulp capping on primary teeth.

Participants will practice clinical procedures on training manikins and patients in the clinical setting. When students have passed a competency exam on an identified procedure, they will then proceed to provide that clinical procedure on patients in their employment setting under the direct supervision of their supervising dentist. Participants must successfully complete this course before moving into the next course.

The clinical portion on manikins and patient care will meet for 8 hours on alternating 9 Saturdays for a total of 64 clinical hours (dates to be determined based on program acceptance.

Required Textbooks

Note: all required textbooks are available on closed reserve in the library.

- Hilton T, Ferracane J & Broome J. Summitt's Fundamentals of Operative Dentistry, a Contemporary Approach, 4th Ed. 2013. Quintessence Books. ISBN 978-0-86715-528-0

References

- Available online, in Moodle or in the library as posted
- Heymann H, Swift E, Ritter A, Sturdevant's Art and Science of Operative Dentistry, 6th Ed. 2013. Elsevier Mosby. ISBN 978-0-323-08333-1
- Research articles as provided
- dentalcare.com courses: available on line
- Reserved readings as assigned in the library
- Student and Clinic Handbooks: available on Moodle

Teaching Methods

This course consists a 15 week online didactic portion and an 8-week Saturday clinical lab portion as assigned. In addition, typodont preparations, self-grading and case studies will be assigned as homework in between the clinical lab weeks. Lecture, discussion and group work will be utilized during class time. Assigned readings will be assigned and completed prior to each lecture session. Power point presentations will be posted for each topic. Participants will practice clinical procedures on training manikins and patients in the clinical setting. Upon passing a competency exam on an identified procedure in the lab, they will then proceed to provide that clinical procedure on patients in their employment setting under the direct supervision of their supervising dentist.

Learning Support Services for Students with Disabilities

Services and accommodations are available to students covered under the American with Disabilities Act. If you require accommodations in this course, you must immediately contact Edna K. Gehring, Director of Learning Support Services for Students with Disabilities at x-2107 or email her at [redacted]. She will meet with you, review the documentation of your disability and discuss the services Pacific offers and any accommodations you require for specific courses. It is extremely important that you begin this process at the beginning of the semester. Please do not wait until the first test or paper.

Course Policies

All courses will follow policies set forth in the student and clinic handbooks. Please refer to the handbook for specific guidelines.

Course Expectations and Assignments

During this course it is expected that the student be prepared for class. There are assigned readings upon which discussions and assignments will be based. This information is on the content page. In order to build upon the information presented in the text, the readings are to be completed before the scheduled assigned meeting time. Students should be prepared to participate in active learning discussion and activities in each class on the topic assigned for that day.

Assignments:

- Typodont tooth preparations as assigned
- Extracted teeth tooth preparations as assigned
- Portfolio documentation of restorative procedures
- Case studies as assigned
- **3 exams:** (25 points each) Exams may be a combination of multiple choice, short answer and case study items.
- **Comprehensive final exam:** (50 points) Exams may be a combination of multiple choice, short answer and case study items.

  NOTE: If you wish contest how an item is graded, you must find supporting evidence and contact the instructor within one week to schedule an appointment with the instructor to discuss the item in question with the realization that one of three determinations will be made: 1) the grade will not change, 2) the grade will change positively, or 3) the grade will change negatively.

Grading (250 pt total)

A ≥ 92% or 230 and above

B ≥ 82% or 205-229

C ≥ 75% or 187.5 -204

No Pass = 204 and below or academic dishonesty, unprofessional conduct, unsatisfactory clinical progress, or unsafe clinical practice.

Policy Regarding Attendance, Late Work and Electronic Devices

In order to be successful learners, students must assume an active role in the learning process. The student responsibilities listed below emphasize behaviours that contribute directly to student academic success.

Attendance

- Attendance and punctuality is the responsibility of a professional, therefore it is expected the student will be in attendance and on time for all scheduled classes/clinics/events for this course. Should a student be late to class or fail to notify the instructor of an absence prior to class, the student will forfeit points on that day.
- See current student handbook for complete policy.

Late Work

- Complete all assignments and projects by established deadlines unless **prior** arrangements have been made with the faculty. If unable to attend class it is the student's responsibility to make arrangements for submission of the assignment at the scheduled time. A grade deduction of 10% will be made for assignments turned in late.
- All assignments must be completed at a satisfactory level in order to receive credit for the course.
- Assignments can be turned in early, but may not be graded early.

Electronic Devices

- Use of laptop computers or other electronic devices for anything other than course related activities can adversely affect student learning, distract students and faculty, and is disrespectful to others. If students are using the internet or other electronic devices during class for anything other than course related work, the instructor reserves the right to ask the student to leave the room and attendance for the session will be considered as an unexcused absence.

Course Objectives & Learning Outcomes: Upon completion of this course the student will satisfactorily:

- Explore the role the process of treatment planning plays in the dental therapy scope of practice.
- Engage in formulation of treatment plans within the context of collaborative management agreements and authorization by a dentist.
- Integrate appropriate data collection and assessment of findings into problem-based care planning.
- Prioritize patient care planning into logical sequence based on health status, chief concern, and actual/potential patient problems.
- Incorporate patient education and prevention strategies to promote oral and general health.
- Recognize the value of professional consultations and referrals to manage and facilitate patient care.
- Incorporate appropriate medico-legal documentation into oral health practitioner practice.
- Demonstrate knowledge of appropriate consultations and referrals with other healthcare professionals in relationship to tooth preparation/restoration in the practice of dental therapy.
- Demonstrate knowledge and skill of appropriate permanent tooth preparation and restoration for amalgam, composite resin, and glass ionomer restorations in the simulation laboratory.
- Demonstrate knowledge and skill of appropriate selection and application of direct restorative for the permanent dentition in the dental therapy scope of practice in the simulation laboratory.
- Demonstrate multiple modes of pulp vitality testing.

- Demonstrate knowledge of biological and mechanical principles of permanent tooth preparation and techniques related to dental therapy scope of practice in the simulation laboratory.
- Demonstrate knowledge and skill of the placement of liners and bases used in the practice of permanent & primary tooth restoration in the simulation laboratory.
- Demonstrate knowledge and skill of moisture control techniques and the rationale for their application in the dental therapy scope of practice in the simulation laboratory.
- Demonstrate knowledge of the basic principles of permanent tooth preparation and restoration related to dental therapy scope of practice in the simulation laboratory.
- Demonstrate knowledge of the fundamental concepts and techniques of enamel and dentin adhesion related dental therapy scope of practice in the simulation laboratory.
- Demonstrate knowledge of the terminology and instruments used in the practice of permanent & primary tooth preparation and restoration related to dental therapy scope of practice in the simulation laboratory.
- Demonstrate knowledge of tooth preparation and restoration in the dental therapy scope of practice in the simulation laboratory.
- Explain the value of commitment to self-assessment and improvement of knowledge and skills related to permanent tooth preparation and restoration in dental therapy scope of practice.

- Demonstrate knowledge and skill of temporization techniques of the permanent and primary dentition related to dental therapy scope of practice in the simulation laboratory.

***The instructor reserves the right to adjust/change the syllabus and class schedule as necessary throughout the semester depending on the learning of the students.** Notices will be posted through email and it is recommended that students check this frequently for any changes.

Campus Safety

Campus Public Safety – 7207 (from a campus phone)
or 503-352-7207

Mission

The mission of the Pacific University Campus Public Safety Department is to provide:

- A safe, secure, and enjoyable environment for the University Community.
- Protection for the members of the Pacific University Community and the property of the University.

The goal is achieved in part by maintaining a highly visible department through regular patrol patterns by vehicle, bicycle, and foot. By having this high visibility, crime is deterred and responsible civil behavior is encouraged.

Student Help, Conduct and Responsibilities

For additional information and help regarding student and University policies, please see your student handbook. An e-link to this information is:

http://www.pacificu.edu/studentlife/handbook/index.cfm

Pacific University
School of Dental Health Science

Course:	Dental Therapy II
Term:	TBD 2019
Date prepared:	January 2019
Class time:	Saturdays as assigned 8:00 - 5:00 Weekly asynchronous online didactic portion
Room:	HPC 252B
Instructor:	Dr. Sendelback, Dr. Saunders, Dr. Shannon English, Gail Aamodt RDH, MS
Office Hours:	by appointment
Contact Email:	_____ (subject line must read Dental Therapy II)

Email communication with instructor only through outlook and response will take place within 2 business days.

Course Description

This course will provide further development of dental therapy practice. Didactic content will include prosthodontics, oral surgery, geriatric dentistry, pediatric dentistry, Clinical procedures will include preparation and placement of preformed crowns on primary teeth, placement and removal of space maintainers, placement of single-tooth temporary crowns, extraction of teeth with severe periodontal disease, simple extraction of erupted primary teeth, minor adjustments and repairs on removable prostheses, and emergency palliative treatment for dental pain.

Participants will practice clinical procedures on training manikins and patients in the clinical setting. When students have passed a competency exam on an identified procedure, they will then proceed to provide that clinical procedure on patients in their employment setting under the direct supervision of their supervising dentist. Participants must successfully complete this course before moving into the next course.

The clinical portion on manikins and patient care will meet for 8 hours on alternating 8 Saturdays for a total of 64 clinical hours (dates to be determined based on program acceptance.

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Course Objectives & Learning Outcomes: Upon completion of this course the student will satisfactorily:

This course will provide further development of dental therapy practice. Didactic content will include prosthodontics, oral surgery, geriatric dentistry, pediatric dentistry, Clinical procedures will include preparation and placement of restorations, including preformed crowns on primary teeth, placement and removal of space maintainers, placement of single-tooth temporary crowns, extraction of teeth with severe periodontal disease, simple extraction of erupted primary teeth, minor adjustments and repairs on removable prostheses, and emergency palliative treatment for dental pain.

- Demonstrate knowledge of biological and mechanical principles of primary tooth preparation and techniques related to dental therapy scope of practice in the simulation laboratory.
- Demonstrate critical thinking skills and fine motor skills by appropriate evidence-based selection and application of direct restorative materials used in the primary dentition by oral health practitioners while in the laboratory setting.
- Demonstrate knowledge of milestones in child behavior and development.

- Demonstrate knowledge of the principles of primary tooth preparation and restoration related to DT scope of practice.

- Demonstrate the ability to develop and manage a comprehensive treatment plan for the pediatric and adolescent patient according to their individual needs within the context of a collaborative management agreement.
- Describe and evaluate basic assessment data for the pediatric and adolescent patient within the dental therapist/advanced dental therapist (DT) scope of practice.
- Explore appropriate preventive procedures for pediatric and adolescent patients according to their individual needs.
- Integrate appropriate considerations and behavior management techniques for managing pediatric and adolescent patients within the DT scope of practice.
- Integrate the principles and techniques of space maintenance in the simulation setting in regard to arch integrity into oral health practitioner scope of practice and develop the critical thinking and judgment for appropriate referrals.
- Determine when referral to other healthcare providers is indicated and make referrals as indicated.
- Recognize the need for, develop and implement treatment modifications required for patients with special dental access needs.
- Utilize effective communication skills and demonstrate cultural competence during patient interviews.
- Discuss proper post-operative instructions with patient and/or care giver.
- Dispense and administer analgesics, anti-inflammatories and antibiotics, when indicated.
- Identify and prevent medical emergencies in the dental setting.
- Perform proper emergency medical procedures in the simulation laboratory.
- Recognize and describe proper handling of post-operative complications, where applicable.

***The instructor reserves the right to adjust/change the syllabus and class schedule as necessary throughout the semester depending on the learning of the students.** Notices will be posted through email and it is recommended that students check this frequently for any changes.

Campus Safety

Campus Public Safety – 7207 (from a campus phone)
or 503-352-7207

Mission

The mission of the Pacific University Campus Public Safety Department is to provide:

- A safe, secure, and enjoyable environment for the University Community.
- Protection for the members of the Pacific University Community and the property of the University.

The goal is achieved in part by maintaining a highly visible department through regular patrol patterns by vehicle, bicycle, and foot. By having this high visibility, crime is deterred and responsible civil behavior is encouraged.

Student Help, Conduct and Responsibilities

For additional information and help regarding student and University policies, please see your student handbook. An e-link to this information is:

http://www.pacificu.edu/studentlife/handbook/index.cfm

School of Dental Health Science

Course:	Dental Therapy III – Preceptorship
Term:	TBD 2019
Date prepared:	January 2019
Class time:	As determined between the student and the preceptorship site. A minimum of 172 hours of patient care under the direct and indirect supervision of the dentist is required.
Instructor:	Preceptorship site dentist assigned to the student
Office Hours:	by appointment

Contact Email: _____ (subject line must read Dental Therapy III)
Email communication with instructor only through outlook and response will take place within 2 business days.

Course Description

Course Description: This preceptorship offers in-depth dental therapy experiences providing primary and preventive oral health care services to a patient population of the oral health care practitioner student's choosing. Emphasis will be placed on providing primary and preventive oral health care dental services under the guidance of a dentist preceptor. Competent, professional dental treatment and comprehensive management of patient-centered dental problems within the context of dental therapy practice is the course focus.
Delivery: Direct on-site patient care under the supervision of a preceptor (dentist) with online reporting of preceptorship experience.

Required Textbooks

Note: all required textbooks are available on closed reserve in the library.

- Hilton T, Ferracane J & Broome J. Summitt's Fundamentals of Operative Dentistry, a Contemporary Approach, 4th Ed. 2013. Quintessence Books. ISBN 978-0-86715-528-0

References

- Heymann H, Swift E, Ritter A, Sturdevant's Art and Science of Operative Dentistry, 6th Ed. 2013. Elsevier Mosby. ISBN 978-0-323-08333-1

Teaching Methods

This course consists a minimum of 300 hours of direct patient care under the supervision of the assigned dentist.

Learning Support Services for Students with Disabilities

Services and accommodations are available to students covered under the American with Disabilities Act. If you require accommodations in this course, you must immediately contact Edna K. Gehring, Director of Learning Support Services for Students with Disabilities at x-2107 or email her at [redacted]. She will meet with you, review the documentation of your disability and discuss the services Pacific offers and any accommodations you require for specific courses. It is extremely important that you begin this process at the beginning of the semester. Please do not wait until the first test or paper.

Course Policies

All courses will follow policies set forth in the student and clinic handbooks. Please refer to the handbook for specific guidelines.

Course Expectations and Assignments

During this course it is expected that the student be prepared for clinical procedures and patient care in the assigned site.

Assignments:

- Self-reflections
- Evaluations of patient care: self-evaluation and evaluation by supervising dentist
- Portfolio documentation of restorative procedures

Policy Regarding Attendance, Late Work and Electronic Devices

In order to be successful learners, students must assume an active role in the learning process. The student responsibilities listed below emphasize behaviours that contribute directly to student academic success.

Attendance

- Attendance and punctuality is the responsibility of a professional, therefore it is expected the student will be in attendance and on time for clinics.

Course learning outcomes. Students will:

- Accurately evaluate and assess patient medical/dental histories/interviews and clinical status in relation to preventing, identifying, and managing medical emergencies in the dental setting.
- Appropriately consult with or refer to a collaborative management dentist or other

healthcare professionals.

- Assess and manage dental caries and caries risk factors associated with dental caries.
- Deliver properly sequenced treatment utilizing appropriate pain management techniques within the dental therapy scope of practice.
- Demonstrate accurate and effective recordkeeping for all clinical experiences.
- Demonstrate appropriate critical thinking, clinical judgment, and psychomotor motor skills while providing emergency palliative treatment of dental pain, placing temporary restorations, or while recementing permanent crowns.
- Demonstrate appropriate critical thinking, clinical judgment, and psychomotor skills while preparing and restoring faulty tooth structure to proper form and function.
- Demonstrate compassion, respect, and cultural competence in all communication with patients and colleagues.
- Demonstrate professionalism and ethical judgment and behavior while providing dental therapy patient care and associated activities.
- Provide appropriate reparative services to patients with defective oral prostheses.
- Provide, administer, and dispense medications appropriate to dental therapy scope of practice and patients' dental needs.
- Self-evaluate the dental therapy services provided to patients across the lifespan and demonstrate willingness for self-improvement.
- Utilize sound clinical judgment and decision making to determine when a patient can be treated within the dental therapy scope of practice or when patient referral to the collaborative management agreement dentist or other professionals for diagnosis and treatment is appropriate.
- Demonstrate and apply knowledge of the principles of wound healing.
- Demonstrate appropriate critical thinking, clinical judgment, and psychomotor motor skills while providing emergency palliative treatment of dental pain, placing temporary restorations, or while recementing permanent crowns.
- Demonstrate appropriate critical thinking, clinical judgment, and psychomotor skills while preparing and restoring faulty tooth structure to proper form and function.
- Demonstrate appropriate critical thinking, clinical judgment, and psychomotor skills while providing direct or indirect pulp capping on permanent or primary teeth or pulpotomies on primary teeth.
- Demonstrate appropriate critical thinking, sound judgment, and psychomotor motor skills while providing dental therapy non-surgical exodontia and tissue sample collection services.
- Demonstrate professionalism and ethical judgment and behavior while providing dental therapy patient care and associated activities.
- Apply various oral surgery procedures and their indications in the practice of general dentistry.
- Determine and manage complications associated with tooth extractions consistent with dental therapy scope of practice and collaborative management authorization.
- Gather appropriate data, evaluate and assess the data to create individualized, problem-based treatment plans within the context of collaborative management authorization while considering patient values and concerns.

- Identify and manage preventive oral health strategies and procedures for patients across the lifespan.
- Plan for safe and effective oral health care delivery as defined by dental therapy scope of practice.

Advanced Standing for Dental Hygienists

Dental hygienists who meet the admission requirements for this dental therapy education program will be awarded advanced standing because they have already demonstrated competency in many of the areas that are required in an accredited dental therapy education program.

The charts below list the didactic content and clinical procedures required in an accredited dental therapy education program. **DH** indicates knowledge and clinical procedures in which dental hygienists have already demonstrated competency. **DT** indicates knowledge and clinical procedures that will be included in this dental therapy education program.

Didactic Content
CODA Standard 2-12 – Didactic dental science content must ensure an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:

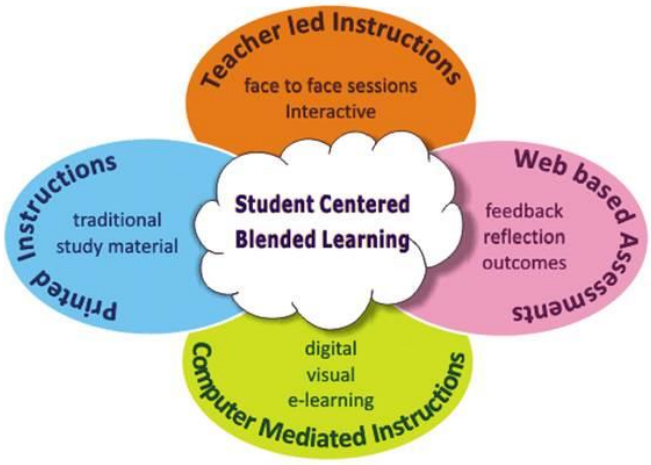
a.	Tooth Morphology	DH
b.	Oral Pathology	DH
c.	Oral Medicine	DH
d.	Radiology	DH
e.	Periodontology	DH
f.	Cariology	DH
g.	Atraumatic Restorative Treatment (ART)	DT
h.	Operative Dentistry	DT
i.	Pain Management	DH
j.	Dental Materials	DH
k.	Dental Disease Etiology and Epidemiology	DH
l.	Preventive Counseling and Health Promotion	DH
m.	Patient Management	DH
n.	Pediatric Dentistry	DT
o.	Geriatric Dentistry	DT
p.	Medical and Dental Emergencies	DH
q.	Oral Surgery	DT
r.	Prosthodontics	DT
s.	Infection and hazard control management, including provision of oral health care services to patients with blood-borne infectious diseases	DH

Clinical Procedures
CODA Standard 2-20 – At a minimum, graduates **must** be competent in providing oral health care within the scope of dental therapy practice with supervision as defined by the state practice acts, including:

a.	Identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals	DH
b.	Comprehensive charting of the oral cavity	DH
c.	Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis	DH
d.	Exposing radiographic images	DH
e.	Dental prophylaxis including sub-gingival scaling and/or polishing procedures	DH
f.	Dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider	DH
g.	Applying topical preventive or prophylactic agents (i.e. fluoride), including fluoride varnish, antimicrobial agents, and pit and fissure sealants	DH
h.	Pulp vitality testing	DH
i.	Applying desensitizing medication or resin	DH
j.	Fabricating athletic mouth guards	DH
k.	Changing periodontal dressings	DH
l.	Administering local anesthetic	DH
m.	Simple extraction of erupted primary teeth	DT
n.	Emergency palliative treatment of dental pain limited to the procedures in this section	DT
o.	Preparation and placement of direct restoration in primary and permanent teeth	Prep – DT Place – DH
p.	Fabrication and placement of single-tooth temporary crowns	DT
q.	Preparation and placement of preformed crowns on primary teeth	DT
r.	Indirect and direct pulp capping on permanent teeth	DT
s.	Indirect pulp capping on primary teeth	DT
t.	Suture removal	DH
u.	Minor adjustments and repairs on removable prostheses	DT
v.	Removal of space maintainers	DT

Dental Therapy Teaching Manual

2019



Contents

This manual is designed to help the clinical faculty identify best teaching methods when working with the dental therapy student.

IMPORTANT: All codes and protocol can be found in the DT clinic manual; all faculty are responsible for knowing the information in the DT clinic manual.

Teaching Methodology

For the Clinical Instructor
Internship Experience

Objectives

- Identify and implement effective guidelines for working with students.
- Provide effective feedback.
- Understand generation categories and how to work with students from each category.
- Identify styles of learning.
- Differentiate between types of knowledge and learning.
- Understand critical thinking and how problem based learning is used in the development of critical thinking.

Guidelines for Working with Students

Do

- Compliment success and growth
- Give feedback frequently
- Model professional behavior
- Follow all HIPAA, FERPA & OSHA guidelines

Don't

- Intentionally embarrass a student
- Discuss students outside of Pacific University
- Give out any information about a student to anyone

Feedback

Praise keeps you in the game, but real feedback helps you improve.

Informs a student what they did or did not do and enables them to self adjust.

Highly specific information about how a student did in light of what he or she attempted; intent versus effect; actual verses ideal performance.

Feedback

Effective:

- Provides confirming (or disconfirming) useful evidence of effect
- Compares current performance and trends to successful result (standard)
- Concise

Ineffective:

- Provides nonspecific advice, praise/blame, or exhortations.
- Assumes that process (instructions, hard work and advice) is sufficient to reach the goal.
- Lengthy

Examples of Feedback

Effective:

- It is important to have the x-rays up and ready before the exam so that time is not wasted during the exam.
- Last week you were running consistently 15-30 minutes behind schedule. This week you seem much more relaxed and able to stay on schedule while providing excellent patient care.
- We have received several compliments from patients about how thorough you are.

Ineffective:

- You need to speed up!
- Much better this week.
- Mrs. Jones returned for her restorative appointment and said.....
  Mike said.....
  Barbara said .....



How can we go from ↑ to ↓ ?


Understanding the Student!

- Identify what generation you come from and how this might differ from the student's generation
- Identify what type of learner you are and how this might differ from the student
- Identify what the adult learner needs

Multiple Generations of Student Learners

1. *Traditionalists*
2. *Baby Boomers*
3. *Generation X*
4. *Generation Y*
5. *NetGen*

Multiple Generations of Student Learners

1. *Traditionalists*
2. *Baby Boomers*
3. *Generation X*
4. *Generation Y*
5. *NetGen*

Teaching Isn't Easy!

Knowing a topic well and being able to teach it well are two very different things. (We have all had teachers who were topic experts but could not teach!)

The ability to adapt teaching to a wide variety of people, places, and things is a challenge.

A great learning experience involves both the educator and the participants using equal energy and being actively involved and interested.

(Instant Teaching Tools for the New Millennium, M. Deck, 2004)

Multiple Generations of Student Learners

1. *Traditionalists*
2. *Baby Boomers*
3. *Generation X*
4. *Generation Y*
5. *NetGen*

Traditionalist - born before 1946

Most typically found as:

- Faculty
- Continuing education participants

Traditionalists

- Have seen history being made every day and have their own perspective on education and on-the-job learning
- Prefer to receive their information verbally in a face-to-face format
- Like to take their time
- Singular in focus and do not like to multitask
- Learned to stop and appreciate all that life has brought to them
- Respect and follow those in authority

Baby Boomer – born 1946-1960
the "overworked" generation

Baby Boomers

- Jobs often define their identity
- First generation to think they could "have it all"
- Never hesitated to arrive early and stay late at work
- "Super" parents and community workers, working much more than 40 hours per week

Generation X

- Raised to be independent
- Reluctant to commit in both their personal and professional lives
- Talent for technology and dealing with change at a rapid pace
- Know how to relax and many see work as a means to an end
- Like to learn rapidly and conveniently in the most visual way possible

Generation X – born 1961-1980

Generation "X"

- They will work to better their skills, yet do not hesitate to look elsewhere when work conditions are bad
- Willing to follow individuals who are competent and excel at their jobs, even if those individuals do not carry a title
- Grown up with the media and expect to be entertained while learning.

Generation X

- Raised to be independent
- Reluctant to commit in both their personal and professional lives
- Talent for technology and dealing with change at a rapid pace
- Know how to relax and many see work as a means to an end
- Like to learn rapidly and conveniently in the most visual way possible

Generation Y – born 1981-2002
"the millennium generation"

Generation Y

- Technology savvy -an age of internet learners who can access any source of information in minutes and expect learning to follow the same pattern
- Love kinesthetic/active learning experiences and lose interest very quickly when bored
- A short attention span and prefer to learn in sound bites in a technological or hands-on format

Generation Y

- Technology savvy -an age of internet learners who can access any source of information in minutes and expect learning to follow the same pattern
- Love kinesthetic/active learning experiences and lose interest very quickly when bored
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Generation Y

- Seeking a more traditional life and commitment to family
- Large in numbers and the most ethnically diverse group to date
- Marrying earlier and beginning families at a younger age
- They are not listeners; but have been identified as seers and doers
- Seem to have money to spend, and are targeted by marketing and the media

Generation Y

- Technology savvy -an age of internet learners who can access any source of information in minutes and expect learning to follow the same pattern
- Love kinesthetic/active learning experiences and lose interest very quickly when bored
- A short attention span and prefer to learn in sound bites in a technological or hands-on format

Net Generation – born 2003-

Net Generation

- The Net Generation is optimistic, positive and driven to succeed.
- High achievers, they crave rewards and accolades for their hard work.
- They're aware of the many significant problems affecting the world, but they're confident that through youthful innovation and ever-improving technology, these problems will be solved.
- They are no stranger to community service. Volunteer projects have been a part of their academic and extracurricular life since kindergarten.
- They value work that has meaning and improves the lives of others.

Net Generation

- Net Generation college students are strongly motivated by academic projects that have a real-world component, particularly those that address a major issue like the environment, homelessness or poverty.
- Net Generation students work in teams to research an issue, create a plan and put that plan into action within their local community.
- Net Generation students consider themselves active "global citizens," participating in international study and service projects.
- The Net Generation is constantly connected. Not just to the Internet, but to each other. (Cell phones!)

Net Generation

- Net Generation students are infamous for their multitasking skills and short attention spans.
- Growing up online, they're trained to quickly and simultaneously consume and process information from multiple media sources -- and to ignore anything "boring" or otherwise uninspiring.
- Research shows that Net Generation college students are strong visual learners and weaker textual learners.
- Researchers have found that Net Generation students have very close, open relationships with their parents, with whom they share many of the same values.

ADULT LEARNERS

Working with the Adult Learner

Adult learners enter education with a high level of motivation to learn.

They appreciate a program that is organized and structured with requirements and objectives clearly specified.

Adult learners want to know how the course content or experience will benefit them.

They expect the material to be relevant and they quickly grasp the practical use of the content.

Working with the Adult Learner

- Adult learners respect an instructor who is fully knowledgeable about the subject and presents it effectively.
- Adult learners bring to class an extensive experience from their personal and working lives.
- Adult learners are usually self-directed and independent.
- Adult learners want to participate in decision making. They want to cooperate with the instructor in mutual assessment of needs and goals, the choice of activities, and decisions on how to evaluate learning.

Working with the Adult Learner

Adult learners may be less flexible than younger students. They do not like to be placed in embarrassing situations. Before accepting a different way of doing something, they want to understand the advantages of doing so.

Adult learners like to cooperate in groups and socialize together. Small-group activities and an atmosphere for interaction during breaks are important.

Learning Styles

WHAT'S

YOUR

LEARNING

STYLE?

Learning Styles (LS)

www.ncsu.edu/felder-public/ILSpage.html

Definition: T\traits that refer to how an individual tends to approach learning new material or tasks

Generally, we tend to teach in the manner we prefer to learn…which may not be the best way to work with an individual.

Understanding learning styles may help instructors know how to relate to the student in the clinical setting.

Sensing learning style

- Detail oriented, practical
- Likes learning facts and solving problems
- Likes connections to real world
- Dislikes complications and/or surprises

Working with this individual

- Identify specific examples of concepts and relate information to real world situations

Intuitive learning style

- Innovative, dislikes memorization and routine calculations
- Likes discovering possibilities
- Tends to work faster

Working with this individual

- Find theoretical connections and apply to facts
- Slow down to avoid mistakes due to lack of attention to detail

Visual learning style

- Tends to remember what they see
- Likes pictures, charts and diagrams
- Dislikes strictly reading text

Working with this individual

- Use charts, radiographs, and diagrams to represent visual connections
- Draw pictures and take photographs to aid memory of information

Intuitive learning style

- Innovative, dislikes memorization and routine calculations
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- Dislikes strictly reading text

Working with this individual

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- Draw pictures and take photographs to aid memory of information

Verbal learning style

- Tends to remember words (written and spoken)

Working with this individual

- Write outlines or rewrite information in your own words
- Working in groups may be helpful as the student hears others verbalize information

Sequential learning style

- Tends to understand in linear steps
- Follows a logical path in problem solving
- Dislikes skipping steps or jumping from topic to topic

Working with this individual

- Outline material in a logical order
- Study in the order of the textbook, handouts, or as the information was presented in class
- Create inventories

Global learning style

- Tends to gather information somewhat randomly, often without initially identifying the connections.
- Frequently experiences the "Ah ha" moment of suddenly understanding a concept.

Working with this individual

- Identify the "big picture" of a topic before trying to master the details
- Review the objectives and skim the entire chapter to get an overview prior to focusing on details
- Try to relate the topic to things already known
- Rather than planning to study several topics in an evening, try to set aside larger blocks of study time for individual subjects

Active learning style

- Tends to retain and understand information best by doing something active. This may include explaining or discussing material with others.

Working with this individual

- Study in a group to facilitate an active relay of information on the topic
- Create games or role plays to review information
- Brainstorm with a peer
- Participate in active discussion

Reflective learning style

- Tends to think about information
- Often prefers to work alone

Working with this individual

- Pause while studying new material to review the reading
- Pause to think of possible applications or questions about the information presented
- Write a simple summary of the information to help retain the material

Understanding, Knowledge & Critical Thinking

Understanding: they really "get it"

- Involves sophisticated insights and abilities, in varied performances and contexts.
- Gained over a continuum, developing as a result of ongoing inquiry and rethinking.

Teaching for understanding involves more than the student understanding but identifying the *destination as well!*

6 Facets of Understanding

1. **Explanation**: can explain facts and data
2. **Interpretation**: answers the questions
   What does it mean? Why does it matter? How does it relate to me? What makes sense?
3. **Application**: ability to use knowledge in new situations and diverse contexts.

6 Facets of Understanding

4. **Perspective:** The ability to see and hear points of view through critical eyes.

5. **Empathy:** To grasp the world from someone else's point of view; requires respect for people different from ourselves.

6. **Self-knowledge:** The ability to identify personal style, prejudices, projections, and habits of mind that both shape and impede our own understanding. Being aware of what we do not understand and why understanding is so difficult.

We Teach "Critical Thinking"

An awareness of a real problem or when there is uncertainty about a solution.

It is based on the evaluation and integration of existing data and theory into a solution about the problem at hand

A solution that can be defended as reasonable, taking into account the conditions under which the problem is being solved.

Critical Thinking

Critical thinking develops over time.

When students address problems that have obvious importance within their discipline, they begin to realize that merely receiving information from the instructor will NOT prepare them for life after graduation. They come to understand the importance of taking an active role in their learning.

Overall - Enjoy the Experience of Mentoring the Developing Professional

Thank you!

**All policies related to FERPA according to Pacific University, Willamette Dental Group and the participating organizations will be adhered to throughout the Dental Workforce Pilot Project.*

FERPA TRAINING
Family Educational Rights and Privacy Act

The material provided in this training is designed to prepare authorized members of the campus community to fully understand the responsibilities of handling student record information under FERPA and Pacific University's student record policy. Pacific University is legally and ethically obligated to protect the confidentiality of students' records. Everyone with access to student data is required to review this training material.

The following material will be covered in this training module:

- *What is FERPA?*
- *Why is FERPA important?*
- *What are the basics of FERPA?*
- *What is directory information?*
- *Who and what is protected under FERPA?*
- *What is considered acceptable "permission" to release records?*
- *What are the student's rights under FERPA?*
- *What are the parent's rights under FERPA?*
- *What are a spouse's rights under FERPA?*
- *Important reminders*
- *Who may I contact if I have a question about what can be released under FERPA?*
- *Where do I find Pacific University's full FERPA policy?*
- *Test*

What is FERPA?

- FERPA is an acronym for the Family Educational Rights and Privacy Act of 1974.
- FERPA is a federal law (known as the Buckley Amendment)
- FERPA protects the privacy of a student's education records

Why is FERPA important?

- If an employee of the university violates FERPA, the Department of Education could take away the university's student federal funding
- Violation of FERPA may constitute grounds for staff dismissal
- Our students depend on us to keep their academic information confidential

FERPA Basics:

- Student educational records are considered confidential and may not be released without the written consent of the student.
- As a faculty or staff member, you have a responsibility to protect education records in your possession.
- Under FERPA, some information (called "Directory Information") can be released without the student's written permission. However, the student may opt to consider this information confidential as well. Before releasing any Directory Information, the faculty or staff member should consult with the University's Registrar’s Office to determine whether the student has

chosen to not disclose and to insure any release of information is consistent with University policy.
- Faculty and staff have access to information only for legitimate use in completion of your responsibilities as a university employee. Legitimate educational need to know is the basic principle to consider before accessing student information.
- If in doubt, do NOT release any information until you talk to the office responsible for student records. Contact the University Registrar's Office at: registrar's office or refer the request to that office.

What is considered "Directory Information"?

- Directory Information is information which is not normally considered a violation of a person's privacy.
- Directory Information may be disclosed without a student's written consent unless a student has requested that this information not be released.
- Directory Information typically includes:
  Name (including both maiden name and married name, where applicable)
  Address, telephone listing and email address
  Date and place of birth
  Major field of study
  Anticipated graduation date
  Enrollment status (undergraduate or graduate, full-time or part-time)
  Dates of attendance
  Degrees and awards received
  Participation in officially recognized sports and activities
  Weight and height (members of athletic teams)

- NOTE: Pacific University has chosen not to release Directory Information, as defined in the Policy, to parties outside the University. Exceptions to this guideline include but are not limited to Deans Lists, Academic or Athletic Honors/Awards or programs, or information to hometown newspapers of students attending the university. Directory Information for use within the university is permitted in accordance with FERPA guidelines; however, disclosure within the university does not constitute institutional authorization to transmit, share, or disclose any or all information received to a third party.

Putting it into Practice

- If you do not have a way of knowing whether or not a student has requested confidentiality of directory information, do NOT release it.
- The university considers a student's right to privacy to be very important and does not share directory information with third parties.
- A student may request that directory information be made confidential. All requests for directory holds must be in writing and submitted to the Registrar's Office, which is the sole office authorized to maintain directory holds.
- If a student requests confidentiality of directory information, it is an all-or-nothing directive. In this instance, not even the student's name will appear in on-line directories.

WHO IS PROTECTED?

Eligible students are protected under FERPA. An eligible student is an individual who has reached 18 years of age, is or has ever been in attendance at Pacific University.

WHAT IS PROTECTED?

The student's education record is protected. The definition of an education record refers to any record that is directly related to a student and kept by the university or someone acting on behalf of the university from which a student, or students, can be identified. This can include: files, documents and materials in any medium (handwritten, tape, disks, film, microfilm, microfiche, etc.). When in doubt, assume that any item that relates to a student is an education record and seek further assistance from the registrar's office.

- PUBLIC POSTING OF STUDENT GRADES. FERPA regulations clearly state that the public posting of grades either by the student's name, or institutional student identification number without the student's written permission is a violation. In order to post grades an instructor must either obtain the student's uncoerced written permission to do so or by using code words or randomly assigned numbers that only the instructor and individual student know. Note: posting of grades by social security number is NOT allowed.

- LETTERS OF RECOMMENDATION. Pacific University school officials are encouraged to support students in their efforts to attend graduate school, apply for scholarship programs, or seek professional employment. In order to submit letters of recommendation in accordance with FERPA regulations, school officials must request that students submit "Consent for Release of Information" (Appendix 5) or its equivalent prior to providing student information to third parties. This consent for release shall be maintained by the appropriate school official in accordance with the maintenance guidelines.

PERMISSION

Written permission must be obtained from a student before releasing an educational record (unless the request fits a specific exception as outlined in Pacific University's FERPA policy)

All student requests for release of information must be in writing (FAX requests for release of information are allowed under FERPA regulations.), dated, and must include:

1. Purpose of the release
2. Specific information to be released
3. Specific parties to whom the information is to be released
4. The student's signature

Telephone request for information:

Pacific University does NOT release academic information via the telephone. Verification from the Registrar's Office must be secured prior to release of any information.

STUDENT'S RIGHTS UNDER FERPA

1. The right to see the information that the institution is keeping on the student
2. The right to seek amendment to those records and in certain cases append a statement to the record
3. The right to consent to disclosure of his/her records
4. The right to file a complaint with the U.S. Department of Education

Students may *not* inspect and review the following as outlined by the Act:

1. Financial information submitted by their parents
2. Confidential letters and recommendations associated with admissions
3. Employment or job placement, or honors to which they have waived their rights of inspection and review
4. Education records containing information about more than one student, in which case the institution will permit access only to that part of the record which pertains to the inquiring student.

PARENT'S RIGHTS

1. When a student reaches the age of 18, or begins attending a postsecondary institution (regardless of age), FERPA rights transfer to the student.
2. Parents may obtain non-directory information (grades, GPA, etc.) ONLY at the discretion of the institution, WITH a signed consent from students who have chosen to allow release of non-directory information to parents AND after it has been documented that their child is legally their dependent. ALL PARENTS should be referred to the Registrar's office.

SPOUSE'S RIGHTS

The spouse has NO rights under FERPA to access the student's education record. All inquiries should be referred to the Registrar's office.

IMPORTANT REMINDERS

- Do not display student scores or grades publicly in association with names, student ID numbers or other personal identifiers.
- Do not put papers or lab reports containing student names and grades in publicly accessible places. Students should not have access to scores and grades of other students.
- Do not share student record information, including grades or grade point averages, with other faculty or staff members of the University unless their official responsibilities identify their "legitimate educational interest" in the information for that student.
- Do not share by phone or correspondence information from student education records, including grades or grade point averages, with parents or others outside the institution, including letters of recommendation.
- Do not circulate a printed class list with the students' names and Social Security numbers as an attendance sheet.

WHO DO I CONTACT IF I HAVE QUESTIONS? Please contact Pacific University Registrar's Office at 503-352-2234 or by e-mail at mailto:registrar@pacificu.edu

WHERE DO I FIND PACIFIC UNIVERSITY'S FERPA POLICY?
http://www.pacificu.edu/registrar/privacy.cfm AND
www.pacificu.edu/parent/ferpa.cfm

Quiz begins on the next page

FERPA QUIZ (Questions from Case University but answers based on Pacific University FERPA Policy)

1. You get a phone call from someone identifying himself as a student, asking about his grades or evaluation. Can you give out that information?
    a. Yes
    b. No

2. You receive an e-mail message from a reputable employer asking for names and addresses for students with GPA of 3.0 or better. They have good job information to offer. Can you help students get jobs by giving out that information?
    a. Yes
    b. No

3. You receive a subpoena in the mail. It appears to be a legal, court ordered subpoena. Should you supply the information?
    a. Yes
    b. No

4. You get a frantic phone call from an individual who says he is a student's (husband/brother/father) and must get in touch with her immediately because of a family emergency. Can you tell him where and when they will be present today?
    a. Yes
    b. No

5. Is it wrong for professors to leave personally identifiable exams or papers in a box for students to pick up?
    a. Yes
    b. No

6. An unauthorized person retrieves information from a computer screen that was left unattended. Under FERPA, is the institution responsible?
    a. Yes
    b. No

7. Professor X wants to know the GPA of Student Y and says he is entitled to it because he is a school official and needs it to complete his official academic responsibilities. Do you give it to him without further question?
    a. Yes
    b. No

8. A newspaper reporter calls to ask for a student's major and dates of attendance. Is it OK to give it out as long as the student has not requested directory information confidentiality?
    a. Yes
    b. No

9. An employer asks you if you can verify that a student has received a degree. The student has no confidentiality hold, so should you do it?
    a. Yes
    b. No

10. Your daughter attends school at Pacific University. She needs her transcript sent to a company so she can get a job. There is a deadline and your daughter does not have time to take care of it herself. Can you make the request on her behalf?
    a. Yes
    b. No

FERPA QUIZ answers (Questions from Case University but answers based on Pacific University FERPA Policy)

1. You get a phone call from someone identifying himself as a student, asking about his grades. Can you give out that information?
    - **a.** Yes
    - **b.** No

Answer: No, Pacific University does not release academic information over the phone.

2. You receive an e-mail message from a reputable employer asking for names and addresses for students with GPA of 3.0 or better. They have good job information to offer. Can you help students get jobs by giving out that information?
    - **a.** Yes
    - **b.** No

Answer: No, without a written request for the release of this information from the student to the employer we are not allowed to supply this information (regardless of the good intention of the employer)

3. You receive a subpoena in the mail. It appears to be a legal, court ordered subpoena. Should you supply the information?
    - **a.** Yes
    - **b.** No

Answer: No, it is appropriate to refer this request to the registrar's office for evaluation.

4. You get a frantic phone call from an individual who says he is a student's (husband/brother/father) and must get in touch with her immediately because of a family emergency. Can you tell him where and when the student will be present today?
    a. **Yes**
    b. **No**

Answer: No; under Pacific University's policy the appropriate response would be to reply: "If the person is in coming, a message will be given to the student to phone them as soon as possible".

5. Is it wrong for professors to leave personally identifiable exams or papers in a box for students to pick up?
    - **a.** Yes
    - **b.** No

Answer: Yes, any academic record with identification cannot be placed in an area where others could access it.

6. An unauthorized person retrieves information from a computer screen that was left unattended. Under FERPA, is the institution responsible?
    - **a.** Yes
    - **b.** No

Answer: Yes. FERPA requires that any computer screen with student information be closed, when left unattended, in order to protect student privacy.

7. Professor X wants to know the GPA of Student Y and says he is entitled to it because he is a school official and needs it to complete his official academic responsibilities. Do you give it to him without further question?
    a. Yes
    b. No

Answer: No. It would be more appropriate to refer Professor X to the Registrar's office to explain why or how this information is needed to complete his official academic responsibilities. Prior GPA information could potentially bias the Professor's assessment of the student.

8. A newspaper reporter calls to ask for a student's major and dates of attendance. Is it OK to give it out as long as the student has not requested directory information confidentiality?
    a. Yes
    b. No

Answer: No, even though this information is considered "directory information" and is typically approved for release by FERPA, Pacific University's FERPA Policy will supersede the release of this information without student approval. It would be appropriate to ask the Registrar's office for guidance in this situation.

9. An employer asks you if you can verify that a student has received a degree. The student has no confidentiality hold, so should you do it?
    a. Yes
    b. No

Answer: No, it would be appropriate to refer the employer to the registrar's office.

10. Your daughter attends school at Pacific University. She needs her transcript sent to a company so she can get a job. There is a deadline and your daughter does not have time to take care of it herself. Can you make the request on her behalf?
    a. Yes
    b. No

Answer: No, your daughter must provide a written request to the registrar's office (as outlined in the FERPA policy).

Please forward a copy of your quiz to [redacted]
Thank you

Questioning for Critical Thinking in Clinical Teaching
---The Before During After (BDA) model

Brief

Who is your patient?

What procedure are you doing today?

What stage are you at?

Before treatment

What is unique about this patient? (e.g., high caries risk or dry mouth)

How do you know this? (e.g., CAMBRA, med hx)

What is your differential diagnose?

What is your ideal treatment plan?

What are other alternative treatment plans?

How does the patient's specific needs or condition influence your treatment planning?

What is the short, medium, long term RBA for this patient with or without your treatment plan?

During treatment

What are the steps for today's procedure? (e.g., show me appropriate models of x-rays).

How long do you plan to spend on each step of the procedure?

What if…?

Why isn't the patient responding to the treatment?

Do you have any questions? (check-in with students during treatment)

After treatment

What have you done well?

What could we do differently next time?

What did you learn from this case?

How has this case changed your thinking about…?

Why wasn't this an ideal treatment?

CLINICAL TEACHING TIPS

1. What Clinical Teachers Should Do For Every Student

Before Patient Treatment:

- Clarify expectations; how the student will interact with you and patient
- Ask the student to explain assessment of patient & the treatment plan
- Praise the student for responses & insight
- Give anticipatory guidance and encourage questions

During Patient Treatment:

- Be available as soon as feasible and check in several times
- Remember the 4P's: praise in public; perfect (improve) in private
- Make notes to remind yourself about needed follow-up
- Try to give everyone one on one guidance as time allows. Be aware to spread your time equally between students

After Patient Treatment:

- Have a "close-out" debriefing
- Ask questions to stimulate student's self-assessment & reflection
- Provide overall feedback to the group, both suggestive & praise

2. 7 Traits of Effective Feedback

- Descriptive & non-judgmental ("just the facts")
- Specific & focuses on immediate issues
- Behaviorally anchored:
    - Focus on behavior student can change
    - Include a recommendation
- Well-timed & expected
- Regulated in quantity (less is more)
- Balanced: positive as well as corrective
- Anticipatory guidance (priming): suggestions, reminders
- Prompts & "just in time" coaching
- **Research:** Schonwetter. Students' perceptions of effective classroom & clinical teaching in dental and dental hygiene education. *J Dent Educ*. 2006; 70: 624-635.
  Irby. Teaching and learning in ambulatory Settings: Thematic review of the literature. *Acad Med*. 1995; 70; (10):898-931.

3. What Are Dental Students' Opinions About Effective Clinical Teaching?

Valued Instructor Characteristics:

- Respectful communication
- Collegial manner ("we're in this together")
- Available and approachable
- Positive & encouraging
- Eager to help
- Involved in patient care; not by-stander
- Proactive: models, explains & demonstrates
- Suggested feedback

Research: Ende. Preceptors' strategies for correcting in an ambulatory care medicine setting: Qualitative analysis. *Acad Med*. 1995; 70: 224-229

4. Five Specific Times When Feedback Should Be Given to Dental Students

- During pre-treatment planning: student's assessment of the patient and treatment plan
- During patient care: specific, tangible guidance to resolve difficulties
- End of patient encounter: correct actions & alternatives to correct deficiencies
- Monthly formative (progress) feedback:
    - How is student progressing, overall, toward entry-level professional competency?
    - What areas does student need to focus on during the coming month?

5. Feedback Tips

- Ask students to **self-assess**; opens the door for coaching.
- Raise issues with **questions** (avoid labeling) "What is your assessment of why Mrs. _____ discontinued treatment?"
- Use **"talk about"** instead of questions if student is anxious: "Talk about the difficulties with #12."
- Use collective **"we" instead of "you":** "When did we start to run into problems with Mr. _____?"
- Start with questions students can answer
    - **Reporting facts** (students report patient data)
    - **Comprehension questions** (student explains a concept)
    - **Avoid "WDY"** (Why didn't you) questions that are negative
    - Stay balanced: provide **positive and corrective** feedback
    - Remember both parts of corrective feedback:
        - Identify problems student encountered and causes
- Provide a specific "Here's how to do it better next time…"

Research: Victoroff & Hogan. Students' perceptions of effective learning experiences in dental school: A qualitative study using critical incident technique. *J Dent Educ*. 70 (2006); 124-132.

6. The 5 C's of Clinical Teaching

Fundamental: If you criticize, you have an obligation to coach the student.

- **Correct (offer specific recommendation)**
- **Coach actively, especially during patient care**
    - Show & explain how
    - Provide suggestions for alternative methods
    - Ask questions encouraging students to solve problems
- **Concise Feedback**
    - One-minute prescription – one point at a time
    - 4 Ps – Praise in Public, Perfect (improve) in Private
- **Confirmation by Student**
    - Have students explain their understanding of feedback message ("no confirmation, no comprehension")
- **Congratulate students for actions/decisions well done**

Research: Branch, Paranjape. Feedback & reflection: Teaching methods for clinical settings. *Acad Med*. 2002; 77: 1185-88.

Research*:* Neher. Microskills model of clinical teaching. *J Am Baord Fam Pract.* 1993; 6: 86-87.

7. Four Step Process for Teaching Psychomotor Skills

It's more than "see one, do one, teach one"

1. Orientation & explanation (but not "too much") • **Explain reasons for learning skill** • **Show or describe the desired outcome** • **Describe alerts: complications, risks, "time", likely problems**
2. Instructor talk-through (narrated demonstration) • **Make sure learners can see (over your shoulder view is best)** • **Describe each step before you perform** • **Provide "learning time" demonstration; pause for time-outs**
3. Learner talk-through with couching & time-outs • **Ask participant to describe each step, then do it** • **Give prompts and praise – "take this slow" "looks good"** • **Ask: "What can I explain better?"**
4. Learner talk-through without coaching (return demonstration) • **Observe learner's actions** • **Provide praise for correct actions** • **Provide prescriptive feedback (reminders, anticipatory guidance)**

Research: Feil et al. Designing preclinical instruction for psychomotor skills. *J Dent Educ*. 1994; 58: 806-812.

8. Four Levels of "Teaching" Questions in the Clinic

Intellectual of Question — **Student's Job:**

Level 1: Request facts about case

- Any evidence of trauma?
- Length of time on medication?
- How was pain described?

Reports Facts

Level 2: Check student's knowledge

- Symptoms we could likely see?
- Is pain radiating to the jaw a common finding in…?
- How could a drug interaction cause this?

Demonstrate Comprehension

Level 3: Assess ability to analyze and make decisions

- What should we do for Mrs. Jones?
- What's your assessment of this radiograph?
- What if the patient showed no signs of trauma?

Explain/justify an assessment

Level 4: Help clarify student's thinking

- What concerns do you have about this procedure?
- What parts of this case don't make sense to you?
- How has this case changed your thinking about…?

Debrief: explore uncertainties; reflect on actions

Research: Feil et al. Designing preclinical instruction for psychomotor skills. *J Dent Educ*. 1994; 58: 806-812.

9. Bookends Strategy for Clinical Teaching

Orient students before patient encounter

- Ask level 3 questions "assessment & planning" questions
  - What do you plan to do & how do did you develop this plan?
  - How and why did you rule – out alternatives?
  - What are the advantages of this approach over others?
- Ask Priming & anticipatory guidance questions
  - Ask "what if" questions – encourage student to think ahead and anticipate potential problems and solutions

Debrief students after patient encounter

- Ask Level 4 reflection & self-assessment questions
  - What is the most important thing you learned today?
  - What could we do differently next time?
  - Review specific trouble spots

Research: Chambers. Association amongst factors thought important by instructors in dental education & perceived effectiveness of these instructors by students. *Eur J Dent Educ*. 2004; 8:147-51.

Sample Evaluation Form

This form will be used for self-reflection by the participant as well as feedback by the supervising dentist during the first 2 education phases of the program; it will be used in labs and during patient care.

Student Clinician: _____Date: _____Chart #_____

Point Key (√ appropriate box): S (satisfactory) = 3 I (improvable) = 1.5 or incomplete U (unsatisfactory) = 0 or omitted N/A (not applicable)

Student check list	S	I	U	N A	Criteria
Assessment and Treatment Planning					
Problem list					
Dental Hx & risk assessment					
Assessment of Radiographs					Assessment of Radiographs with Approval by Dentist
Clinical Assessment					Approval by Dentist needed
Recommendation of Treatment					Approval by Dentist needed
Tx sequencing					Approval by Dentist needed
Patient Preparation					
Instrument & material set-up					Organized tray set-up and needed supplies
Infection control					Appropriate infection control used at all times
Anesthesia/pain management					Correct selection, administration and supervision
Rubber dam and/or isolation					Proper isolation for restorative procedure
Tooth Preparation					
Outline form					Margins placed on sound tooth structure. As much sound tooth structure preserved as possible.
Resistance & Retention form					Amalgam: opposing walls // to each other or converges slightly occlusally. Enamel margins prepared at a right or slightly obtuse angle. Occlusogingival thickness of at least 1.5 mm Undercuts utilized if there is no extension into the Occl. Depth cuts created for complex preparations
Carious tooth structure eliminated					
Packing and Carving of the Restoration					
Bases, liners & adhesives					Follows recommendations and correct placement
Overall form, margins, & interprox					
Occlusion					
Record Keeping/chart note					
Consent form					Completed with signatures and approval
Anesthesia					Correct documentation
Materials					Correct documentation
Intraoral photos					All pre, prep and post op photos completed
PARQ & post op instructions					Appropriate post-op instructions & PARQ documented

Tooth #, surface & material				**Tooth #, surface & material**				**Tooth #, surface & material**			
	S	I	Redo (No pass)		S	I	Redo (No pass)		S	I	Redo (No pass)
Preparation				Preparation				Preparation			
Restoration				Restoration				Restoration			
Occlusion				Occlusion				Occlusion			

Credit (circle)	Yes	No	Yes	No	Yes	No

Preceptorship Dentist Evaluation	**Chart #**

Assessment & Treatment Planning

Grading Item	**S**	**I**	**U**	**NA**	**Criteria**
Assessment & Tx Plan					

Tooth #, surface & material	S	I	Redo (No pass)
Preparation			
Restoration			
Occlusion			

Tooth #, surface & material	S	I	Redo (No pass)
Preparation			
Restoration			
Occlusion			

Tooth #, surface & material	S	I	Redo (No pass)
Preparation			
Restoration			
Occlusion			

Credit (check)	□ Yes	□ No	□ Yes	□ No	□ Yes	□ No

Dentist Comments:

Overall PROFESSIONALISM Evaluation

Grading Item	**S**	**I**	**U**	**NA**	**Criteria**
Professional & Ethical behavior					Judgment based on RDH & Dental code of ethics. Works within the DT scope of practice.
Willingness to accept instruction					Openness to suggestion and feedback of staff & faculty
Time management & punctuality					Prompt, ready and effective use of time
Infection control					Follows all OSHA, CDC and infection control protocols
Communication					Professional communication with pt and dental team
Follows clinic protocol					Follows all clinic protocol as outlined by the site
Follows HIPAA regulations					Follows all HIPAA regulations

Dentist/Faculty _____

Additional review: during the preceptorship portion of the program, there will be random chart audits on 10% of the patients that have received treatment of all dental therapists in the program

CDT Code List of Procedures (additional codes to be added for the dental therapist)

Code	Procedure
D0140	Limited oral evaluation – problem focused
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver
D0181	Re-evaluation – post operative office visit
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewings – 7-8 radiographic images
D0330	Panoramic radiographic image
D0460	Pulp vitality tests
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1550	Re-cement or rebond a space maintainer
D1555	Removal of fixed space maintainer
D2140	Amalgam – one surface, primary or permanent
D2150	Amalgam – two surfaces, primary or permanent
D2160	Amalgam – three surfaces, primary or permanent
D2161	Amalgam – four or more surfaces, primary or permanent
D2330	Resin – based composite – one surface, anterior
D2331	Resin – based composite – two surfaces, anterior
D2332	Resin – based composite – three surfaces, anterior
D2335	Resin – based composite – four or more surfaces, or involving incisal angle, anterior
D2391	Resin – based composite – one surface, posterior
D2392	Resin – based composite – two surfaces, posterior
D2393	Resin – based composite – three surfaces, posterior
D2394	Resin – based composite – four or more surfaces, posterior
D2799	Fabrication and placement of single tooth temporary crowns
D2920	Re-cement or re-bond crown
D2930	Prefabricated stainless steel crown – primary tooth
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration
D2951	Pin retention per tooth
D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3221	Pulpal debridement, primary and permanent teeth
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D5410 D5411 D5421 D5422	Denture adjustments or partial denture adjustments
D7111	Extraction, coronal remnants – primary tooth
D7140	Extraction of tooth (NOTE: periodontally involved Class III mobility only)
D9110	Palliative (emergency treatment of dental pain – minor procedure

D9311	Consultation with a medical health care professional
D9995 D9996	Teledentistry – synchronous Teledentistry – asynchronous

	CODA Standards under 2-12 & 2-20 that are not covered in a DH program and will be taught in the pilot program.
1.	**Understanding scope of practice of a dental therapist:** Identify oral and systemic conditions requiring evaluation and/or tx by dentists, physicians or other healthcare providers, and manage referrals.
2.	**Pharmacology:** Dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider
3.	**Extractions:** Simple extraction of erupted primary teeth and teeth with severe periodontal disease (class III mobility)
4.	**Emergency Care:** Emergency palliative treatment of dental pain limited to the procedures within the scope of practice of a dental therapist
5.	**Restorative:** Preparation and direct restorations in primary and permanent teeth. (Placement of direct restorations in primary & permanent teeth is already covered in dental hygiene programs with restorative functions)
6.	**Temporary Crowns:** Fabrication and placement of single tooth temporary crowns
7.	**Stainless steel crowns:** Fabrication and placement of preformed crowns on primary teeth
8.	**Pulp capping – permanent teeth:** Indirect and direct pulp capping on permanent teeth
9.	**Pulp capping – primary teeth:** Indirect pulp capping on primary teeth
10.	**Prosthetics:** Minor adjustments and repairs on removable prostheses
11.	**Space maintainer removal:** Removal of space maintainers
12.	**Diagnosis of decay including pulp vitality testing**
13.	**Placement of sutures.** (Removal of sutures is already a covered procedure in dental hygiene programs)

List of CDT codes that correspond to the procedures allowed by a dental therapist

I. Codes currently allowed for the registered dental hygienist in Oregon

Code	Procedure
D0190	Screening of a patient (pre-diagnostic service) A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist.
D0191	Assessment of a patient (pre-diagnostic service) A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.
D1110	Prophylaxis – adult Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors
D1120	Prophylaxis – child Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors

Topical Fluoride Treatment (Office Procedure). Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride – excluding varnish
D1310	Nutritional counseling for control of dental disease Counseling on food selection and dietary habits as a part of treatment and control of periodontal disease and caries.
D1320	Tobacco counseling for the control and prevention of oral disease
D1330	Oral hygiene instructions
D1351	Sealant – per tooth
D1353	Sealant repair – per tooth
D1354	Interim caries arresting medicament application – per tooth Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.
D0412	Blood glucose level test – in –office using a glucose meter. This procedure provides an immediate finding of a patient's blood glucose level at the time of sample collection for the point-of-service analysis
D4341	Periodontal scaling and root planing – four or more teeth per quadrant This procedure involves instrumentation of the crown and soot surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.
D4342	Periodontal scaling and root planing – one-three teeth per quadrant Same as above.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.
D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit Full mouth debridement involves the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. Not to be completed on the same day as D0150, D0160, or D0180
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth FDA approved subgingival delivery devices containing antimicrobial medication(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These

	devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.
D4910	Periodontal maintenance This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.
D4921	Gingival irrigation – per quadrant Irrigation of gingival pockets with medicinal agent. Not to be used to report use of mouth rinses or non-invasive chemical debridement.
D5730-31	Denture reline (chairside)
D5986	Fluoride gel carrier
D9210	Local anesthesia – not in conjunction with operative or surgical procedures
D9215	Local anesthesia – in conjunction with operative or surgical procedures
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis *(NOTE: if the Dental Therapist has a current nitrous oxide permit)*
D9410	House/extended care facility call Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed
D9420	Hospital or ambulatory surgical center call Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.
D9910	Application of desensitizing medicament Include in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners, or adhesives used under restorations.
D9911	Application of desensitizing resin for cervical or root surface, per tooth Typically reported on a "per visit" basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.
D9932-35	Cleaning and inspection of removable complete or partial denture (no adjustments)
D9941	Fabrication of athletic mouth-guard
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays
D9993	Dental case management – motivational interviewing
D9994	Dental case management – patient education to improve oral health literacy

DH with a Restorative Functions Endorsement

Pack and carve amalgam and composite restorations on teeth that have been prepared by a dentist. Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc., acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration.

II. Codes to be added for the dental therapist corresponding to the 13 additional procedures taught in the pilot program.

Code	Procedure
D0140	Limited oral evaluation – problem focused An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.
D0120	Periodic oral evaluation – established patient. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver Diagnostic services performed for a child under the age of 3, preferably within the first 6 months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.
D0171	Re-evaluation – post operative office visit
D1999	Unspecified preventive procedure, by report Used for a procedure that is not adequately described by a code. Describe the procedure
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewings – 7-8 radiographic images
D0330	Panoramic radiographic image
D0460	Pulp vitality tests Includes multiple teeth and contra lateral comparison(s), as indicated.
D0601	Caries risk assessment and documentation, with a finding of low risk Using recognized assessment tools.
D0602	Caries risk assessment and documentation, with a finding of moderate risk Using recognized assessment tools
D0603	Caries risk assessment and documentation, with a finding of high risk Using recognized assessment tools
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth Conservative restoration of an active cavitated lesion in a pit or fissure that does not

extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.

D1555 Removal of fixed space maintainer
Procedure performed by dentist or practice that did not originally place the appliance.

Amalgam Restorations (Including Polishing). Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951)

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent

Resin-Based Composite Restorations – Direct. Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330 Resin – based composite – one surface, anterior
D2331 Resin – based composite – two surfaces, anterior
D2332 Resin – based composite – three surfaces, anterior
D2335 Resin – based composite – four or more surfaces, or involving incisal angle, anterior
D2391 Resin – based composite – one surface, posterior
D2392 Resin – based composite – two surfaces, posterior
D2393 Resin – based composite – three surfaces, posterior
D2394 Resin – based composite – four or more surfaces, posterior
D2930 Prefabricated stainless steel crown – primary tooth
D2934 Prefabricated esthetic coated stainless steel crown – primary tooth
D2940 Protective restoration
Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under restoration.
D2941 Interim therapeutic restoration – primary dentition
D2951 Pin retention – per tooth, in addition to restoration
D2999 Unspecified restorative procedure, by report
Use for a procedure that is not adequately described by a code. Describe the procedure.
D2990 Resin infiltration of incipient smooth surface lesions
Placement of an infiltrating resin restoration for strengthening, stabilizing and/or limiting the progression of the lesion
D3110 Pulp cap – direct (excluding final restoration)
Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.
D3120 Pulp cap – indirect (excluding final restoration)
Procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin. This code is not to be used for bases and liners when all caries

has been removed.

D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of a medicament

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintain the vitality of the remaining portion by means of an adequate dressing.

- To be performed on primary or permanent teeth.
- This is not to be construed as the first stage of root canal therapy
- Not to be used for apexogenesis

D5410-11 Denture adjustments or partial denture adjustments

D5421-22

D7111 Extraction, coronal remnants – primary tooth

Removal of soft tissue-retained coronal remnants.

D7140 Extraction, erupted tooth or exposed root

NOTE: DT will be limited to the removal of a class III mobility periodontally involved tooth

D9110 Palliative (emergency) treatment of dental pain – minor procedure

This is typically reported on a “per visit” basis for emergency treatment of dental pain

D9311 Consultation with a medical health care professional

Treating dentist consults with a medical health care professional concerning medical issues that may affect patient’s planned dental treatment.

D9995 Teledentistry – synchronous. Real time encounter. Reported in addition to other procedures

(e.g., diagnostic) delivered to the patient on the date of service.

D9996 Teledentistry – asynchronous. Information stored and forwarded to dentist for subsequent review. Reported in addition to other procedures. (e.g., diagnostic) delivered to the patient on the date of service.

D2931 Prefabricated stainless steel crown – permanent tooth

D2932 Prefabricated resin crown

Job Description for Participants

Position Title: Dental Therapist

Position Description
The dental therapist provides preventive and restorative dental care to patients under the indirect and/or general supervision of a licensed dentist.

Duties & Responsibilities
Provide the following preventive and restorative dental care to patients under the indirect and/or general supervision of a dentist:

- Identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals
- Comprehensive charting of the oral cavity
- Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis
- Expose radiographic images
- Dental prophylaxis including sub-gingival scaling and/or polishing procedures
- Dispense and administer via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider
- Apply topical preventive or prophylactic agents (i.e. fluoride), including fluoride varnish, antimicrobial agents, and pit and fissure sealants
- Pulp vitality testing
- Apply desensitizing medication or resin
- Fabricate athletic mouth guards
- Change periodontal dressings
- Administer local anesthetic
- Simple extraction of erupted primary teeth
- Emergency palliative treatment of dental pain limited to dental therapy procedures
- Preparation and placement of direct restoration in primary and permanent teeth
- Preparation and placement of preformed crowns on primary teeth
- Indirect and direct pulp capping on permanent teeth
- Indirect pulp capping on primary teeth
- Suture removal
- Minor adjustments and repairs on removable prostheses
- removal of space maintainers
- Extraction of erupted primary teeth
- Extraction of periodontally involved teeth with class III mobility
- Pulpotomy on primary teeth
- Recement a crown
- Dental sealants
- Scaling and root planing
- Fabrication and delivery of bleach trays
- Note: nitrous oxide may be utilized ONLY if the participant has current state certification in Inhalation of nitrous oxide/analgesia, anxiolysis
- Soft tissue reline/tissue conditioning
- Denture adjustment
- Prophylaxis
- Nutritional counseling
- Tobacco intervention
- Nitrous Oxide (with permit only)

Qualifications & Requirements

- Completion of a dental therapy education program
- Current knowledge of dental infection control procedures, radiation safety, emergency management, HIPAA and FERPA
- Current certification in Basic Life Support for Healthcare Providers
- Works effectively as a member of the dental team
- Experience working with patients who have limited access to dental care
- Experience using computer-based dental practice management systems
- Establishes professional relationships and maintains appropriate boundaries
- Responds appropriately to stressful situations, accidents and emergencies
- Presents a professional appearance and attitude

PN11

Patient Consent Form: Education Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have direct supervision from an adjunct instructor dentist with Pacific University and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Date

From The Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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

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

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 of this 2011 Act. [2011 c.716 §1]

Sec. 17. The Dental Pilot Projects Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Dental Pilot Projects Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of carrying out the provisions of section 1, chapter 716, Oregon Laws 2011. [2011 c.716 §17; 2013 c.113 §2] Note: Section 2, chapter 842, Oregon Laws 2015, provides:

Sec. 2. A provider of dental services in a dental pilot project approved by the Oregon Health Authority pursuant to section 1, chapter 716, Oregon Laws 2011, is eligible to be reimbursed for covered services provided to a recipient of medical assistance. [2015 c.842 §2]

Note: Section 2, chapter 716, Oregon Laws 2011, provides:

Sec. 2. (1) Section 1, chapter 716, Oregon Laws 2011, is repealed on January 2, 2025.

2) Section 17, chapter 716, Oregon Laws 2011, as amended by section 2, chapter 113, Oregon Laws 2013, is repealed January 2, 2025.

(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Patient Consent Form: Preceptorship Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have direct supervision from an adjunct instructor dentist with Pacific University and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Date

From The Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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

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

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 of this 2011 Act. [2011 c.716 §1]

Sec. 17. The Dental Pilot Projects Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Dental Pilot Projects Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of carrying out the provisions of section 1, chapter 716, Oregon Laws 2011. [2011 c.716 §17; 2013 c.113 §2] Note: Section 2, chapter 842, Oregon Laws 2015, provides:

Sec. 2. A provider of dental services in a dental pilot project approved by the Oregon Health Authority pursuant to section 1, chapter 716, Oregon Laws 2011, is eligible to be reimbursed for covered services provided to a recipient of medical assistance. [2015 c.842 §2]

Note: Section 2, chapter 716, Oregon Laws 2011, provides:

Sec. 2. (1) Section 1, chapter 716, Oregon Laws 2011, is repealed on January 2, 2025.

2) Section 17, chapter 716, Oregon Laws 2011, as amended by section 2, chapter 113, Oregon Laws 2013, is repealed January 2, 2025.

(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Patient Consent Form: Full Utilization Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have indirect and/or general supervision from a supervising dentist and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Printed Name

From The Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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

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

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 of this 2011 Act. [2011 c.716 §1]

Sec. 17. The Dental Pilot Projects Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Dental Pilot Projects Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of carrying out the provisions of section 1, chapter 716, Oregon Laws 2011. [2011 c.716 §17; 2013 c.113 §2] Note: Section 2, chapter 842, Oregon Laws 2015, provides:

Sec. 2. A provider of dental services in a dental pilot project approved by the Oregon Health Authority pursuant to section 1, chapter 716, Oregon Laws 2011, is eligible to be reimbursed for covered services provided to a recipient of medical assistance. [2015 c.842 §2]

Note: Section 2, chapter 716, Oregon Laws 2011, provides:

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2) Section 17, chapter 716, Oregon Laws 2011, as amended by section 2, chapter 113, Oregon Laws 2013, is repealed January 2, 2025.

(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Dental Workforce Pilot Project Objectives

Purpose

The purpose of this dental workforce pilot project is to investigate the feasibility of adopting the dental therapist model as a new category of dental care provider for Oregon. This dental workforce pilot project is designed to assess if adding a dental therapist to the existing dental team is an efficient and cost-effective way to increase access to dental care, especially for patients who experience higher disease rates and barriers to care, while maintaining the quality of dental care and safety that all patients deserve. This dental workforce pilot project will also evaluate the efficacy of educating licensed dental hygienists to become dental therapists through a unique one-year dental therapy education program that will allow the dental hygienists to complete dental therapy education while they maintain their current employment as a dental hygienist.

Evaluation Format

Important Working Definitions:

Instructor Dentist: dentists who teach in the didactic portion of the pilot.

Supervising Dentist: dentists who supervise during the preceptorship and the utilization phase of the project

The evaluation format for this pilot will be divided into the concept of the Quadruple Aim (i.e. patient experience, cost of care, population health and clinician experience).[5]

Within each portion of the Quadruple Aim, the evaluation will be divided into short- and long-term objectives with an evaluation method for each objective.

[5] *Sikka, R. Morath, J.M. Leape, L. (2015) The Quadruple Aim: care, health, cost in meaning at work; BMJ Quality and Safety, 24(10) 608-610*

Pilot Objectives

Improved Patient Experience

Goal: To expand access to consistent, safe, and high-quality oral health care.

Objective:

1. To provide a high patient perception of customer service, safety and quality of care provided by a dental therapist.
2. To collect objective data to ensure safety and quality of treatment provided by a dental therapist.

Short-term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point (with 5 being the highest) Likert scale at the point of service.
2. Less than 10% of adverse events related to irreversible procedures provided by dental therapist.[6]
3. Student Assessments will average at least 4/5 on a 5-point Likert scale.

Intermediate/Long Term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
2. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
3. Less than 10% of adverse events related to irreversible procedures provided by dental therapist through the end of the pilot.
4. Student Assessments will average at least 4/5 on a 5-point Likert scale through the end of the pilot.

Evaluation Method: Patient Survey (time of service). See page 181.

- Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale We will also compare the satisfactions surveys collected from the supervising dentists and the dental therapists.

Evaluation Method: Procedural reports in axiUm.

- Safety and quality of care provided:
    - Instructor Dentists will review each restoration from the Dental Therapist performed on a live patient prior to preceptorship.
    - Patient intraoral photographs, and direct supervision will take place through all the education phases.
    - Once we begin the utilization phase, each supervising dentist will review 10 charts from their dental therapist per month.
    - Every quarter, all charts from irreversible procedures will be sent to the external evaluator.
    - DTs will continue to take photographs of every procedure and will continue patient surveys.

[6] *E N. Rafter, A. Hickey, S. Condell, R. Conroy, P. O'Connor, D. Vaughan, D. Williams, Adverse events in healthcare: learning from mistakes, QJM: An International Journal of Medicine, Volume 108, Issue 4, April 2015, Pages 273–277, https://doi.org/10.1093/qjmed/hcu145*

- Quality measure
  - Each Supervising Dentist will submit 1 of their own patient cases for each of the 12 dental therapy procedures for comparison to the DTs work.
    - Each of the cases submitted by the Supervising Dentist will be randomized prior to sending dental therapy cases to the Outside Reviewer. This will allow comparison of a dentist's work to a dental therapist's work to ensure quality is similar.
  - Each Supervising Dentist will review a minimum of 10 random cases from their Dental Therapist per month. These random cases may or may not be the same as the chart audits.
  - The Dental Director will perform randomly selected chart audits from the Supervising Dentists per quarter to ensure calibration of the Supervising Dentists.
- Safety
  - Volume of adverse events will assess the safety measure for this pilot project.
  - The 13-point weekly assessment completed by preceptor and supervising dentists during preceptorship and utilization phases.
    - This assessment will also help to monitor the safety of the pilot project by continually monitoring the quality and accuracy of the patient treatment.

- Dentist assessment of the quality of the Dental Therapist's work: All treatment rendered by the Dental Therapist will be reviewed and approved by the dentist **prior** to patient dismissal during the educational phases. The dentist will review the chart note for all patients **and sign off on all chart notes** for patient care by the Dental Therapist during the educational phases of the pilot.
- Student log: all Dental Therapists will keep a daily log of patient care provided on days they are performing Dental Therapy procedures.
- Each instructor/preceptor/supervising dentist will complete the "Dentist 13-point Assessment of overall competency" for each Dental Therapist at the end of each training semester and weekly during the preceptorship and monthly during the utilization phase.

Lower Cost of Care

Goal: To decrease the overall cost of providing dental care by adding a dental therapist to the dental team.

Objective: Reduce the number of procedures that the dentist would have had to complete by adding a dental therapist to the dental team (thereby freeing the dentist to target more complex treatments).

Short term Outcomes:

1. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team.

Long Term Outcomes:

1. Reduce the total cost of patient care by 20% by adding a dental therapist to the dental team through the end of the pilot. This is because a Dental Therapist's annual wage is about half of the annual wage of dentist.[7]
2. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team through the end of the pilot.

Evaluation Method: Procedural reports in axiUm.[8]

- Sample of quarterly procedural reports on pages 171, 172.
- Compare quarterly procedural reports of the cost of patient care delivered by a Dental Therapist compared to the cost of patient care delivered by a dentist for the same procedures.

[7] *Economic Research Institute (ERI), Milliman and Warren. 2018*

[8] *Definitions for all security formats are listed in the Definitions of Electronic Risk Management Formats (pg. 194)*

Better Outcomes

Goal: To establish an efficient and effective healthcare team member that meets the needs of community members with the highest disease rates and least access to care.

Objectives

1. Increase access to dental care by adding a Dental Therapist to the dental team.

   Note: Dental therapy procedures will be provided on >50% of individuals who experience limited access to care such as: individuals with OHP coverage, adults with diabetes, older adults (65+), children with moderate to high caries risk and pregnant women with moderate to high caries risk.

Short-Term Outcomes:
Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations.

Long-term Outcomes:
1. Increase the total number of procedures or number of patients treated by 20% by adding a dental therapist to the dental team by the end of the utilization phase.
2. Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations through the end of the pilot.

Evaluation Method: Quarterly procedural reports in axiUm.

- Each participating employer group is unique.
  - A list of the following will be submitted per site and individual Dental Therapist on a quarterly basis:
    - All procedures completed by the Dental Therapist.
    - Number of hours spent practicing as a Dental Therapist.
    - The baseline for all dental therapy and for all dental therapy procedures is zero because these procedures have not been implemented.
    - Information regarding patient waiting times for appointments for each participating organization.

Improved Clinician Experience

Goal: To successfully train restorative dental hygienists as competent dental therapists.

Objective: To prepare dental hygienists to become Dental Therapists through a unique education program that allows them to continue working as a dental hygienist while they are completing the dental therapy education program.

Short-term Outcomes:
1. Student course evaluations will average at least 4/5 on a 5-point Likert scale.
2. At least 8 out of 10 (80%) participants will complete the educational program on time.
3. Instructor feedback evaluations will average at least 4/5 on a 5-point Likert scale
4. Supervising Dentist Evaluations will average at least 4/5 on a 5-point Likert scale following the preceptorship phase.

Intermediate/Long-term Outcomes:
1. All Dental Therapy students who completed the training program will still be practicing the dental therapy scope through the end of the pilot.
2. Surveys will average at least 4/5 on a 5-point Likert scale rating their job satisfaction at post utilization phase for the supervising dentist and Dental Therapist.
3. Evaluations will average at least 4/5 on a 5-point Likert scale following the utilization phase.

Evaluation Method**:**

- Course evaluations for instructor Dentists and Dental Therapist trainees
- Preceptorship and utilization phase surveys for dental therapist and supervising dentist.
- A pre/post job satisfaction survey for supervising dentists and dental therapists

Program Improvement / Decision-Making

Upon implementation, data will be collected to determine in real time the impact on the clinical schedule, the patient's satisfaction, and quality of care. As these data reveal areas for improvement, the project sponsor will bring those process improvements to OHA for review.

Timeline for Achieving Objectives

	June 2019-June 2020	June 2020-June 2021	June 2021-June 2022	June 2022-June 2023	June 2023-June 2024	June 2024-December 2024
Cohort 1 = 8-10	Education	Utilization	Utilization	Utilization	Utilization	Utilization
Cohort 2 = 6-10		Education	Utilization	Utilization	Utilization	Utilization
Cohort 3 = 0-8 (Optional)			Education	Utilization	Utilization	Utilization
Totals		**8**	**16**	**16-24**	**16-24**	**16-24**

Note: A more detailed pilot project timeline is available in the evaluation.

Note: All timeline dates are subject to change based on the length of the OHA pilot approval process.

Dental Workforce Pilot Project Evaluation Plan

Table of Contents

Dental Workforce Pilot Project Evaluation

Introduction

This evaluation plan will assess the goals of the dental workforce pilot project.

During the pilot project period, up to ten Dental Therapists will be trained at Pacific University each year for two years (maximum of 20 Dental Therapists). Following the training and preceptorship periods, each Dental Therapist will work in their current place of employment performing both dental therapy and dental hygiene procedures as is warranted by their respective clinic.

This pilot project expects the Dental Therapists trained in it to complete safe, efficient and effective patient treatment within a dental team setting across a variety of oral health treatment models (i.e. large group practices, FQHCs, private practice, etc.). In addition, we believe that the number of procedures completed by a Dental Therapist working within a dental team will have a positive impact to the dental team's efficiency and overall patient access in all employers/offices involved in the pilot. The data collection formats involved include: baseline data, surveys completed by patients, surveys taken via phone, emailed surveys, assessments completed by supervising dentists, Dental Therapists, auxiliary staff, as well as collected data and reports from an electronic dental health system and evaluations by supervising dentists.

It is the intention of this program to use the Quadruple Aim to guide our evaluations with the patients, clinicians and dentists (See 'Evaluation Format', below).

At the point of service, all patients who have received care by a Dental Therapist will receive a satisfaction survey. This survey will be anonymous and voluntary. At 6 months after the point of service each patient will be emailed the same survey. For non-respondents at 6 months, a follow up email will be sent in attempt to get survey responses. All responses will be kept confidential and not connected to the patient's chart in any way.

All data collected from this pilot will be protected using the axiUm electronic health record. Confidentiality of the sites and persons will be maintained. Sites will be numbered and staff will be identified by their title only, such as dental assistant, hygienist, dentist, etc. All providers and auxiliary staff participating in this pilot project were required to confirm that they have read and understand the expectations involved in HIPAA at their respective sites. In compliance with HIPAA and other relative federal, state, and local security laws, Willamette Dental and the participating organizations in this pilot have implemented a security plan that includes technical, physical, and administrative security controls to mitigate risks that could potentially compromise the integrity, confidentiality, or availability of Protected Health Information. All patient information gathered during this pilot project will be housed with Willamette Dental Group. Examples of areas covered in Willamette Dental's security plan are as follows: risk management, access control, change management, password control, patch management, media disposal, monitoring, incident management, network security, security awareness training and business continuity.[9]

[9] *Definitions for all security formats are listed in the Definitions of Electronic Risk Management Formats (pg. 194)*

Evaluation Format

Important Working Definitions:

Instructor Dentist: dentists who teach in the didactic portion of the pilot.

Supervising Dentist: dentists who supervise during the preceptorship and the utilization phase of the project

The evaluation format for this pilot will be divided into the concept of the Quadruple Aim (i.e. patient experience, cost of care, population health and clinician experience).[10]

Within each portion of the Quadruple Aim, the evaluation will be divided into short- and long-term objectives with an evaluation method for each objective.

Pilot Objectives

Improved Patient Experience

Goal: To expand access to consistent, safe, and high-quality oral health care.

Objective:

1. To provide a high patient perception of customer service, safety and quality of care provided by a dental therapist.
2. To collect objective data to ensure safety and quality of treatment provided by a dental therapist.

Short-term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point (with 5 being the highest) Likert scale at the point of service.
2. Less than 10% of adverse events related to irreversible procedures provided by dental therapist.[11]
3. Student Assessments will average at least 4/5 on a 5-point Likert scale.

[10] *Sikka, R. Morath, J.M. Leape, L. (2015) The Quadruple Aim: care, health, cost in meaning at work; BMJ Quality and Safety, 24(10) 608-610*

[11] *E N. Rafter, A. Hickey, S. Condell, R. Conroy, P. O'Connor, D. Vaughan, D. Williams, Adverse events in healthcare: learning from mistakes, QJM: An International Journal of Medicine, Volume 108, Issue 4, April 2015, Pages 273–277, https://doi.org/10.1093/qjmed/hcu145*

Intermediate/Long Term Outcomes:

1. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
2. Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale at the point of service through the end of the pilot.
3. Less than 10% of adverse events related to irreversible procedures provided by dental therapist through the end of the pilot.
4. Student Assessments will average at least 4/5 on a 5-point Likert scale through the end of the pilot.

Evaluation Method: Patient Survey (time of service). See page 181.

- Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale We will also compare the satisfactions surveys collected from the supervising dentists and the dental therapists.

Evaluation Method: Procedural reports in axiUm.

- Safety and quality of care provided:
    - Instructor Dentists will review each restoration from the Dental Therapist performed on a live patient prior to preceptorship.
    - Patient intraoral photographs, and direct supervision will take place through all the education phases.
    - Once we begin the utilization phase, each supervising dentist will review 10 charts from their dental therapist per month.
    - Every quarter, all charts from irreversible procedures will be sent to the external evaluator.
    - DTs will continue to take photographs of every procedure and will continue patient surveys.
    - Quality measure
        - Each Supervising Dentist will submit 1 of their own patient cases for each of the 12 dental therapy procedures for comparison to the DTs work.
            - Each of the cases submitted by the Supervising Dentist will be randomized prior to sending dental therapy cases to the Outside Reviewer. This will allow comparison of a dentist's work to a dental therapist's work to ensure quality is similar.
        - Each Supervising Dentist will review a minimum of 10 random cases from their Dental Therapist per month. These random cases may or may not be the same as the chart audits.
        - The Dental Director will perform randomly selected chart audits from the Supervising Dentists per quarter to ensure calibration of the Supervising Dentists.
    - Safety
        - Volume of adverse events will assess the safety measure for this pilot project.
        - The 13-point weekly assessment completed by preceptor and supervising dentists during preceptorship and utilization phases.
            - This assessment will also help to monitor the safety of the pilot project by continually monitoring the quality and accuracy of the patient treatment.

- Dentist assessment of the quality of the Dental Therapist's work: All treatment rendered by the Dental Therapist will be reviewed and approved by the dentist **prior** to patient dismissal during the educational phases. The dentist will review the chart note for all patients **and sign off on all chart notes** for patient care by the Dental Therapist during the educational phases of the pilot.
- Student log: all Dental Therapists will keep a daily log of patient care provided on days they are performing Dental Therapy procedures.

- Each instructor/preceptor/supervising dentist will complete the "Dentist 13-point Assessment of overall competency" for each Dental Therapist at the end of each training semester and weekly during the preceptorship and monthly during the utilization phase.

Lower Cost of Care

Goal: To decrease the overall cost of providing dental care by adding a dental therapist to the dental team.

Objective: Reduce the number of procedures that the dentist would have had to complete by adding a dental therapist to the dental team (thereby freeing the dentist to target more complex treatments).

Short term Outcomes:

1. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team.

Long Term Outcomes:

1. Reduce the total cost of patient care by 20% by adding a dental therapist to the dental team through the end of the pilot. This is because a Dental Therapist's annual wage is about half of the annual wage of dentist.[12]
2. Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team through the end of the pilot.

Evaluation Method: Procedural reports in axiUm.[13]

- Sample of quarterly procedural reports on pages 171, 172.
- Compare quarterly procedural reports of the cost of patient care delivered by a Dental Therapist compared to the cost of patient care delivered by a dentist for the same procedures.

Better Outcomes

Goal: To establish an efficient and effective healthcare team member that meets the needs of community members with the highest disease rates and least access to care.

Objectives

1. Increase access to dental care by adding a Dental Therapist to the dental team.

   Note: Dental therapy procedures will be provided on >50% of individuals who experience limited access to care such as: individuals with OHP coverage, adults with diabetes, older adults (65+), children with moderate to high caries risk and pregnant women with moderate to high caries risk.

Short-Term Outcomes:
Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations.

Long-term Outcomes:

1. Increase the total number of procedures or number of patients treated by 20% by adding a dental therapist to the dental team by the end of the utilization phase.
2. Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations through the end of the pilot.

[12] *Economic Research Institute (ERI), Milliman and Warren. 2018*

[13] *Definitions for all security formats are listed in the Definitions of Electronic Risk Management Formats (pg. 194)*

Evaluation Method: Quarterly procedural reports in axiUm.

- Each participating employer group is unique.
    - A list of the following will be submitted per site and individual Dental Therapist on a quarterly basis:
        - All procedures completed by the Dental Therapist.
        - Number of hours spent practicing as a Dental Therapist.
        - The baseline for all dental therapy and for all dental therapy procedures is zero because these procedures have not been implemented.
        - Information regarding patient waiting times for appointments for each participating organization.

Improved Clinician Experience

Goal: To successfully train restorative dental hygienists as competent dental therapists.

Objective: To prepare dental hygienists to become Dental Therapists through a unique education program that allows them to continue working as a dental hygienist while they are completing the dental therapy education program.

Short-term Outcomes:

1. Student course evaluations will average at least 4/5 on a 5-point Likert scale.
2. At least 8 out of 10 (80%) participants will complete the educational program on time.
3. Instructor feedback evaluations will average at least 4/5 on a 5-point Likert scale
4. Supervising Dentist Evaluations will average at least 4/5 on a 5-point Likert scale following the preceptorship phase.

Intermediate/Long-term Outcomes:

1. All Dental Therapy students who completed the training program will still be practicing the dental therapy scope through the end of the pilot.
2. Surveys will average at least 4/5 on a 5-point Likert scale rating their job satisfaction at post utilization phase for the supervising dentist and Dental Therapist.
3. Evaluations will average at least 4/5 on a 5-point Likert scale following the utilization phase.

Evaluation Method**:**

- Course evaluations for instructor Dentists and Dental Therapist trainees
- Preceptorship and utilization phase surveys for dental therapist and supervising dentist.
- A pre/post job satisfaction survey for supervising dentists and dental therapists

Program Improvement / Decision-Making

Upon implementation, data will be collected to determine in real time the impact on the clinical schedule, the patient's satisfaction, and quality of care. As these data reveal areas for improvement, the project sponsor will bring those process improvements to OHA for review.

Logic Model
Dental Workforce Pilot Project
Dental Hygiene Restorative Function Endorsement Model

Improved Patient Experience **Overall Goal: To expand access to consistent, safe, high-quality oral health care**					
Objectives	Resources	Activities	Outputs	Short-term Outcomes	Mid- to Long-term Outcomes
To provide a high patient perception of customer service, safety and quality of care provided by a dental therapist.	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific University and preceptorship/utilization sites		• Patient Satisfaction survey at the time of service • Patient satisfaction survey given after 6 months	• Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale through the end of the pilot. • Patient satisfaction surveys will average at least 4/5 on a 5-point Likert scale through the end of the pilot.	
To collect objective data on to ensure safety and quality of treatment provided by a dental therapist.	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific University and preceptorship/utilization sites	• Competency skills tests on manikins • Competency skills tests on patients • 13-point assessment completed by instructor and supervising dentists • Direct and indirect supervision of dental therapy student during preceptorship • Chart and intraoral photo reviews by supervising dentists	• Number and types of procedures performed by dental therapists • Volume of adverse events	• Less than 10% of adverse events related to irreversible procedures provided by dental therapist[14] • Student Assessments will average at least 4/5 on a 5-point Likert scale.	• Student Assessments will average at least 4/5 on a 5-point Likert scale through the end of the pilot.

		for all irreversible procedures during preceptorship • 10 chart reviews per month by supervising dentist during utilization phase • 1:1 ratio for supervising dentist to dental therapist in preceptorship and utilization phase	• 13-point assessment completed by supervising dentists		
<u>Lower Cost</u> **Overall Goal: Decrease the overall cost of providing dental care by adding a dental therapist to the dental team.**					
Objectives	Resources	Activities	Outputs	Short-term Outcomes	Mid- to Long-term Outcomes
Reduce the number of procedures that the dentist would have had to complete (thereby freeing the dentist to target more complex treatments).	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific University and preceptorship/utilization sites	• Dental therapist treats patients doing dental hygiene and/or dental therapy scope of practice based on the patient needs	• Number and types of procedures performed by a dental therapist • Number and types of procedures performed by the dentist	• Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team	• Reduce the total cost of patient care by 20% by adding a dental therapist to the dental team by the end of the pilot. • Increase the amount of complex procedures (procedures a dental therapist can't perform) performed by the dentists by adding a dental therapist to the dental team through the end of the pilot.

Better Outcomes **Overall Goal: To establish an efficient and effective healthcare team member that meets the needs of community members with the highest disease rates and least access to care.**					
Objectives	Resources	Activities	Outputs	Short-term Outcomes	Mid- to Long-term Outcomes
Increase access to dental care by adding a Dental Therapist to the dental team.	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific University and preceptorship/utilization sites	• Schedule Dental Therapist to perform both dental hygiene and dental therapy procedures based on patient need. • Schedule of dental therapy procedures on >50% of patients who have highest disease rates and least access to care (population differs based on site) • 1:1 ratio for supervising dentist to dental therapist in preceptorship and utilization phase	• Patient waiting times for appointments for each participating location	• Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations.	• Increase the total number of procedures or number of patients treated by 20% by adding a dental therapist to the dental team by the end of the utilization phase. • Focus at least 51% of dental therapy procedures performed by the dental therapy Trainee on target populations through the end of utilization phase.
Improved Clinician Experience **Goal: To successfully train restorative dental hygienists to be competent Dental Therapists.**					
Objectives	Resources	Activities	Outputs	Short-term Outcomes	Mid- to Long-term Outcomes
To Prepare dental hygienists to become Dental Therapists through a unique 1-year education program that allows them to continue working as a dental hygienist while they are completing the dental	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific	• Online curriculum delivery and didactic assessments • Clinical lab sessions held every other week. • Competency skills tests on manikins • Competency skills tests on patients	• Course evaluations at the end of each phase of the program by students. • Number of participants who successfully complete the educational program on time. • Supervising dentists	• Evaluations will average at least 4/5 on a 5-point Likert scale • At least 8 out of 10 (80%) participants will complete the educational program on time. • Instructor feedback evaluations will	• All Dental Therapy students who completed the training program will still be providing practicing the dental therapy scope through the end of the pilot. • surveys will average at least 4/5 on a 5-point

therapy education program.	University and preceptorship/utilization sites	• 13-point assessment completed by instructor and supervising dentists • Instructor and supervising dentist feedback	and dental therapist Job satisfaction surveys at the pre and post beginning the utilization phase. • Feedback Survey at the end of each phase of the program by instructor dentists. • Preceptorship evaluations at the end of this phase of the program by supervising dentists. • Utilization phase evaluations at the 6-month intervals during the pilot by supervising dentist.	average at least 4/5 on a 5-point Likert scale • Supervising Dentist Evaluations will average at least 4/5 on a 5-point Likert scale following the preceptorship phase.	Likert scale rating their job satisfaction at post utilization phase for the supervising dentist and Dental Therapist. • Evaluations will average at least 4/5 on a 5-point Likert scale following the utilization phase.
Improve the work life of oral health care providers through the addition of a dental therapist to the dental team	• External funding PEW, Ford Foundation, and Willamette Dental • In kind staff support Willamette dental and Pacific University • Instructor and supervising dentists • Facility use at Pacific University and preceptorship/utilization sites	• Schedule Dental Therapist to perform both dental hygiene and dental therapy procedures based on patient need. • Dental Therapy students continue to work while in the training portion. • Online curriculum delivery and didactic assessments. • Clinical lab sessions held every other week.	• Pre/Post utilization phase job satisfaction surveys for dental therapists • Pre/Post utilization phase job surveys for supervising dentists	• Job satisfaction will increase after beginning to provide treatment as a dental therapist. • Overall satisfaction of supervising dentists will increase after incorporating the dental therapist into the dental team.	• Job satisfaction will increase by beginning to provide treatment as a dental therapist through the end of the pilot. • Overall satisfaction of supervising dentists will increase by incorporating the dental therapist into the dental team through the end of the pilot.

[14] *E N. Rafter, A. Hickey, S. Condell, R. Conroy, P. O'Connor, D. Vaughan, D. Williams, Adverse events in healthcare: learning from mistakes, QJM: An International Journal of Medicine, Volume 108, Issue 4, April 2015, Pages 273–277, https://doi.org/10.1093/qjmed/hcu145*

Evaluation Questions and Designs

As the project sponsor, Willamette Dental Group will assume responsibility for the collection and storage of any information collected from this pilot project.

Evaluation Design

Baseline data for all dental therapy procedures performed by a Dental Therapist in this pilot will be collected monthly, quarterly and yearly. The Dental Therapists will continue to provide dental hygiene procedures based on their schedule and the dental hygiene procedures will not be assessed as part of this pilot project. Patient surveys will be collected at time of service and 6 months post treatment by a Dental Therapist. Surveys for Dental Therapists, Supervising Dentists, auxiliary staff and instructors will be collected prior to training and after each 15-week semester.

We will begin the 6-month baseline collection on the first day of the utilization phase of the dental therapy pilot.

The Supervising Dentist will be required to read each chart note during the preceptorship. This will allow the Supervising Dentist to become familiar with how the Dental Therapist is documenting patient care. When the dental therapy student completes the preceptorship phase and moves to the utilization phase, each Preceptor Dentist becomes the Supervising Dentist and will perform a minimum of 5 random chart audits per quarter for each Dental Therapist that they supervise.

Evaluation Implementation Plan

All patient data will be collected and housed at Willamette Dental Group (WDG) in the axiUm electronic health system. All data collected from participating organizations that do not utilize axiUm will be collected and entered into the axiUm system by Willamette Dental Group. All patient information will be kept confidential and will be protected by the Information Technology Security Department at WDG.

The following baseline data will be collected prior to the utilization phase. This data will include:

- Number of patients currently receiving dental care
- Current costs of providing dental care to patients
- Number and type of procedures performed by dentists
- Current expense and revenue for providing dental care

The following data will be collected and analyzed at quarterly intervals throughout the utilization phase to assess if adding a Dental Therapist to the dental team is an efficient and cost-effective way to increase access to dental care while maintaining high quality of dental care for patients with the highest disease rates and the least access to care.

This data will include:

- Number of patients who are receiving dental care
- Cost of providing dental care to patients
- Expense and revenue for providing dental care
- Average number of hours that Dental Therapists work
- Number and type of patients treated by Dental Therapists
- Number and type of procedures performed by Dental Therapists
- Number and type of procedures performed by supervising dentists
- Information regarding patient waiting times for appointments for each participating organization
- Patient acceptance and satisfaction with Dental Therapists
- Patient complaints and reason for complaints
- Adverse events and how they were handled

The data will be collected through:

- Direct observation of Dental Therapist practice by their Supervising Dentist
- Review of patient records (i.e. chart audits)
    - Random chart audits to assess accurate reporting of assessments, radiographs, examination, consent, chart notes and care provided.
- Review of adverse events
- Review of clinic management reports
- Cost analysis
- Surveys with Dental Therapists and supervising dentists.
- Patient surveys

The following data will be collected and analyzed to assess if the dental therapy education program effectively prepares dental hygienists to become Dental Therapists while they continue to work as dental hygienists. The information will include, but is not limited to:

- Number of participants who successfully complete the education program on schedule
- Competency in clinical skills performed on education manikins
- Competency in clinic skills performed on patients
- Participant feedback on education program
- Faculty dentists and supervising dentists' feedback on education program
- Cost of education program per participant

Reporting Intervals

The Project Director will provide Quarterly reports which will be generated to monitor the progress of the utilization phase. Annual reports will be generated for comparison with prior year reports.

Adverse Events

The Project Director and Dental Director will provide the Oregon Health Authority with all applicable information pertaining to adverse events. The Project Director will be responsible for reporting the adverse event to the OHA within the required timeframe.[15] All participating pilot providers and staff will adhere to their academic and/or employers' expectations and documentation regarding body fluid exposures.

Review and Revision

The Project Director and Dental Director will review and revise the evaluation plan at least once a year. The curriculum will be revised annually as we review the quarterly data. Any future curriculum adjustment will focus on comfort level and competency of the Dental Therapists as well as the confidence level of the instructor dentists and supervising dentists regarding the project objectives.

[15] OARs 333-010-0700 through 333-010-002

External Evaluator

The outside evaluator that has been identified with this project will not be affiliated with the Dental Therapist pilot project or have financial or commercial interest in the outcome of the dental therapy pilot project. The results of this outside evaluation and any Dental Therapist pilot project modification will be submitted by the outside evaluator in writing to the Oregon Health Authority.

The External Evaluator and the Oregon Health Authority will receive all quarterly reports produced in the pilot as they are collected. All surveys will be entered into a spreadsheet and given to the Outside Evaluator for analysis.

The contracted outside evaluator for this pilot is:

- Bill Piskorowski, DDS
    - UCLA School of Dentistry
        - UCLA Community Based Health Program Department
            - Dr. Lisa Nguyen, DDS (Pediatric Dentist)
            - Dr. Steve Lee, DDS (IT Specialist)

BILL PISKOROWSKI, D.D.S.

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Biography

Dr. Bill Piskorowski holds a DDS from Loyola University, Chicago, IL and practiced dentistry from 1979 to 2006, which he left to take a full-time position at the University of Michigan School of Dentistry as Director of Outreach and Community Affairs. As Asst. Dean for Community-Based Dental Education, he grew the program from a 3-week experience for dental students at 4 external sites with 8 preceptors in 2006 to a maximum of 12 weeks of experience with over 30 sites and 117 credentialed preceptors. Connected to this growth was also the creation of a one-of-a-kind nationally recognized program that was financially self-sustaining. In 2013 he received the prestigious William J. Gies Award for Outstanding Innovation by a Dental Educator as recognition of his achievements in this area and in 2014 the recipient of the Emmett C. Bolden Dentist Citizen of the Year Award from the Michigan Dental Association and just recently recognized for Innovation in HealthCare Award, presented by the Hamilton Community Health Network at their 35th Anniversary Celebration Banquet, Bringing Oral Health Care Services to underserved populations of Flint, Michigan.

Dr. Piskorowski is passionate about access to care issues for those less fortunate and has delivered numerous presentations to state legislators and component dental societies regarding the school's community involvement. Recently retiring from U of M and saluted by the regents with the honor of Clinical Associate Professor Emeritus of Dentistry. Leaving a program that is on solid ground, in order to further enhance student's education and access to care for vulnerable populations in California he recently accepted the position of Associate Dean for Community-Based Clinical Education, Health Science Clinical Professor at UCLA.

Educational & Professional Background

- DDS, Dentistry, Loyola University, Chicago, IL, 1979
- BS, Biology, University of Detroit, Detroit, MI, 1975
- Pre-Dent, Oakland University, Rochester, MI, 1971

Research & Interests

Enhancing student's education while increasing access to care for vulnerable populations.

Professional Memberships

- 1973-1975: Alpha Epsilon Delta – Honor Society (Member)
- 1975-present: Delta Sigma Delta – Dental Fraternity (Member)
- 2002-2010: Francis B. Vedder Society of Crown and Bridge Prosthodontics (Member)
- 2006-2014: Michigan Oral Health Care Coalition – (Member, Board of Directors) (Chair – elect)
- 2006-present: American Dental Education Association (Member)
- 2007-2015: Vice – Chair Board, Michigan Community Dental Clinics (MCDC)
- 2008-2017: Michigan access to oral health care work group (Member)
- 1979-present: American Dental Association (Member)
- 1979-present: Macomb Dental Association (Member)
- 1979-present: Michigan Dental Association (Member)
- 2016-present: ADEA Leadership Institute Class of 2016

Awards

- 2001-2002: Clinical Instructor of the Year, University of Michigan (2nd floor blue clinic)
- 2002-2003: Commendation for Teacher Performance, University of Michigan
- 2002-2006: Clinical Instructor of the Year, University of Michigan (2nd floor blue clinic)
- 2005: Outstanding Leadership Award, Honorable Mention, University of Michigan's Workplace Selection Committee
- 2011.10.04: Inducted into the Pierre Fauchard Academy
- 2012.02.17: ADA Golden Apple Award, Michigan Dental Association, Member of care work group
- 2012.11: ADEA Gies Foundation "Gies Award for Outstanding Innovation - by a Dental Educator" Dr. Wilhelm A. Piskorowski, University of Michigan School of Dentistry
- 2013.10: Inducted into The International College of Dentists at the American Dental Association Annual session in New Orleans, Louisiana
- 2014.05.01: Recipient of the "Emmett C. Bolden Dentist Citizen of the Year Award" from the Michigan Dental Association Board of Trustees
- 2016.07: Notification to be inducted to the American College of Dentists, 2018 Annual Session in Honolulu, Hawaii, Deferred Induction per my request in 2018 because of previous conflict.
- 2017.07.17: Regents of the University of Michigan salute "Wilhelm A. Piskorowski, Clinical Associate Professor Emeritus of Dentistry"
- 2017.08.03: Innovation in HealthCare Award, presented by the Hamilton Community Health Network at their 35th Anniversary Celebration Banquet, Bringing Oral Health Care Services to underserved populations of Flint, Michigan

Representative Publications

- **Piskorowski WA**, Fitzgerald M, Mastey J, Krell R. Development of a sustainable community-based dental education program. *J Dent Educ* 2011; 75:1038-1043.
- **Piskorowski WA**, Bailit HL, McGowan T, Krell RE. Dental school and community clinic financial arrangements. *J Dent Educ* 2011 75:S42-S47.
- **Piskorowski WA**, Stefanac S, Fitzgerald M, Green TG, Krell R. Influence of community-based dental education on dental students' preparation and intent to treat underserved populations. *J Dent Educ* 2012; 76:534-539.
- Nebeker CD, Briskie DM, Maturo RA, **Piskorowski WA**, Sohn W, Boynton JR. Michigan dentists' attitudes toward Medicaid and an alternative public dental insurance system for children" *Pediatric Dent* 2014; 36:34-38.
- Rohra AK, **Piskorowski WA**, Inglehart MR. Community-based education and dentists attitudes and behavior concerning patients from underserved populations. *J Dent Educ* 2014; 78:119-130.
- Vidya Ramaswamy, **Wilhelm Piskorowski**, Mark Fitzgerald, Howard A. Hamerink, Stephen Stefanac, Rachel Greene, and Marilyn S. Lantz. Psychometric Evaluation of a 13-Point Measure of Students' Overall Competence in Community-Based Dental Education Program J Dent Educ. 2016; 80:1237-1244 http://www.jdentaled.org/content/80/10/1237.abstract

Additional Information

Dr. Piskorowski taught in Comprehensive Care Clinic, Principles of Operative Dentistry and Lecture/ Lab to dental hygienists. Also, he was the director or co-course director for Community Based Clinical Education, Societal and Regulatory Issues Affecting Dentistry, Practice Management, Introduction to the Profession and Oral Health Promotion, and Health Care Systems and Policy.

Data Retention

All raw data about participants and the implementation of the Dental Therapist pilot project will be retained in a secure and confidential manner in an electronic health record system for at least two years after the Dental Therapist pilot project ends.

Data Collection and Monitoring Plan

The following data will be collected, monitored and evaluated. All patient identifiers will be removed from this data. This data will include:

- Number of procedures performed by the Dental Therapist
- Number of patients treated by each Dental Therapist
- Patient Care – appropriate, quality, complete, effective, safety, adverse events
- Level of satisfaction – patient, Dental Therapist and supervising dentist
- Cost of procedure performed by the Dental Therapist compared to cost of procedures performed by the dentist

The project director and dental director will oversee data collection and monitor for completeness. All protected patient information will be retained in a secure and confidential manner through the electronic health record system (axiUm).

The following information will be tracked via the axiUm electronic health record software. This information will include, but is not limited to:

- Treatment Date – Date of Service
- ADA Code – Procedure code (ADA CDT codeset)
- Procedure Description – Description of procedure code
- Treatment Site/Surface – Tooth # (or site) and Surfaces
- Diagnostic Code – Diagnosis code (DDS codeset) assigned to the procedure
- Diagnostic Term – Diagnosis code description
- Hygienist Code – Code identifying the Hygienist
- Clinic Id – Clinic code identifying the location of services
- Clinic Zip – Zip code of location of services
- Pt Age – Age of patient at time of service
- Gender – Gender of patient
- Pt Zip – Zip code of patient (based on home address)
- Smoker – Risk factor: User/non-user based on tobacco use
- Heavy Plaque – Risk factor: Did the patient have heavy plaque? Yes/No
- Diabetic – Risk factor: Was the patient Diabetic?
- Caries Risk – Caries Risk assessed as Low, Moderate or High
- Perio Diagnosis – Perio Diagnosis assessed as Healthy, Gingivitis, Slight, Moderate or Severe Periodontitis
- Teeth with Decay – # of teeth that had decay at time of visit

A sample of all listed bullet points is provided on Attachment PN13A. This is real (and accurate) data for the January 2018 period but, it does not include patient identifiers other than the Pt Zip.

Monitoring Plan

A monitoring plan will be used during the utilization phase to ensure that patients are receiving safe and high-quality care, Dental Therapists are working within their scope of practice, supervising dentists are fulfilling their responsibilities, and all required data is being collected. The Project Director and Dental

Director will meet on a monthly basis to review these aspects of the utilization phase. The Project Director and Dental Director will conduct regular bi-annual visits to each utilization site.

Online meetings with all Dental Therapists and supervising dentists will be held at regular intervals (quarterly). A password protected virtual space will be created to provide a venue for ongoing communication between all Dental Therapists and supervising dentists (i.e. blog).

An Advisory Committee will be selected and meet quarterly to review all data and provide critical feedback. The Advisory Committee will consist of: FFS Dentists, representatives from CCOs, ODA, OHSU and will be held in-person at Willamette Dental Group. Notes will include best practices, pitfalls, accuracy of documentation, data into axiUm, and questions from Dental Therapists and supervising dentists. Detailed notes of the quarterly Advisory Committee discussion will be sent to all participants in the project (i.e. supervising clinicians, Dental Therapists), the outside evaluator and the OHA.

Supervising dentists will provide quarterly chart audits. Each supervising dentist will provide a minimum quarterly chart audits per dental therapy participant.

All data will be collected utilizing the axiUm software. Since Willamette Dental Group and Pacific University both use axiUm, all participating organizations that are not using axiUm will provide their data to the Project Director. Where possible, all patient data will be electronically transferred from an electronic health record into the axiUm health record system. Where it is not possible, (i.e. participating dentist does not have an electronic health record system) the Project Director will oversee the data management to manually enter their patient data into our axiUm database.

The axiUm electronic health record is a robust system for data collection. It has the capacity to collect more data than we have listed in this pilot application. During the pilot, we may find additional information that we wish to share with the Oregon Health Authority (OHA). If this occurs, we will inform the OHA of our intention and seek their approval.

Appendices

- Sample of Quarterly Procedural Reports
- Patient Consent Forms
    - Education Phase
    - Preceptorship Phase
    - Full Utilization Phase
- Interview Questions
    - Supervising Dentist
    - Hygienists with Restorative Credential
- Surveys
    - Patient Experience/Satisfaction
    - Supervising Dentists (Utilization Phase)
    - Dental Therapists
    - Participant Feedback Survey
    - Dental Team
    - Dental Therapist Participant
    - Evaluation by the Supervising Dentist (13-Point Assessment of Overall Competency)
    - Chart Review
- Information Regarding the Advisory Committee

Willamette Dental Group

Generic Hygiene Production Information Sample

PN13A

Treatment Date	ADA Code	Procedure Description	Treatment Site/Surf.	Diagnosis Code	Diagnosis Term	Hygienist Code	Clinic Id	Clinic Zip	Pt Age	Gender	Pt Zip	Smoker	Heavy Plaque	Diabetic	Caries Risk	Perio Diagnosis	Teeth with Decay	Appt Book Date	Access Days
02-JAN-18	D2332	Resin-based comp - 3 surf, ant	22 DFL	759185	D3+ - Primary active exten dentin caries inner p	HRWHG	245	97305	21	F	97305	Non-user	No	No	Low	Healthy Periodontium	5	19-DEC-17	14
02-JAN-18	D2393	Resin-based comp- 3 surf, post	3 MOL	583730	Defective restoration: fracture	HSCWH	567	98406	45	F	98444	Non-user	No	No	Low	Healthy Periodontium	0	13-DEC-17	20
02-JAN-18	D2392	Resin-based comp- 2 surf, post	5 DO	941503	D3 - Primary active moderate dentin caries mid	HJMHG	202	97233	21	M	97230	Non-user	No	No	High	Gingivitis	1	02-JAN-18	0
02-JAN-18	D2392	Resin-based comp- 2 surf, post	5 DO	976062	D3* - Recurrent active moderate dentin caries	HRWHG	245	97305	40	F	97360	Non-user	No	No	Low	Gingivitis	0	07-DEC-17	26
02-JAN-18	D0170	Re-evaluation Limited		579834	Localized Moderate Chronic Periodontitis	HKCAA	575	98133	56	F	98125	Non-user	No	No	Low	Moderate Chronic Periodontitis	0	12-DEC-17	21
02-JAN-18	D2392	Resin-based comp- 2 surf, post	30 OB	941503	D3 - Primary active moderate dentin caries mid	HSNAH	203	97005	14	F	97003	Non-user	No	No	Low	Healthy Periodontium	0	02-JAN-18	0
02-JAN-18	D2391	Resin-based comp- 1 surf, post	29 O	941503	D3 - Primary active moderate dentin caries mid	HSNAH	203	97005	14	F	97003	Non-user	No	No	Low	Healthy Periodontium	0	02-JAN-18	0
02-JAN-18	D2391	Resin-based comp- 1 surf, post	28 O	941503	D3 - Primary active moderate dentin caries mid	HSNAH	203	97005	14	F	97003	Non-user	No	No	Low	Healthy Periodontium	0	02-JAN-18	0
02-JAN-18	D2393	Resin-based comp- 3 surf, post	15 DOB	759185	D3+ - Primary active exten dentin caries inner p	HAYHH	202	97233	21	M	97233	User	Yes	No	High	Healthy Periodontium	10	12-DEC-17	21
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	LR	501493	Generalized Severe Chronic Periodontitis	HDAD	240	97321	48	M	97321	Non-user	No	No	High	Severe Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D4921	Gingival irrigation per quadrant	LR	501493	Generalized Severe Chronic Periodontitis	HDAD	240	97321	48	M	97321	Non-user	No	No	High	Severe Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D2940	Protective Restoration	19 D	941503	D3 - Primary active moderate dentin caries mid	HSCWH	567	98406	53	F	98499	Non-user	No	No	High	Moderate Chronic Periodontitis	0	22-DEC-17	11
02-JAN-18	D2392	Resin-based comp- 2 surf, post	20 DO	976062	D3* - Recurrent active moderate dentin caries	HAYHH	202	97233	55	M	97216	Non-user	No	No	Moderate	Healthy Periodontium	0	13-DEC-17	20
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	UL	579834	Localized Moderate Chronic Periodontitis	HMWHG	213	97408	32	M	97402	Non-user	No	No	Low	Moderate Chronic Periodontitis	0	28-DEC-17	5
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	LL	579834	Localized Moderate Chronic Periodontitis	HMWHG	213	97408	32	M	97402	Non-user	No	No	Low	Moderate Chronic Periodontitis	0	28-DEC-17	5
02-JAN-18	D4921	Gingival irrigation per quadrant	UL	579834	Localized Moderate Chronic Periodontitis	HMWHG	213	97408	32	M	97402	Non-user	No	No	Low	Moderate Chronic Periodontitis	0	28-DEC-17	5
02-JAN-18	D4921	Gingival irrigation per quadrant	LL	579834	Localized Moderate Chronic Periodontitis	HMWHG	213	97408	32	M	97402	Non-user	No	No	Low	Moderate Chronic Periodontitis	0	28-DEC-17	5
02-JAN-18	D2140	Amalgam-1 surface	2 O	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	19	M	97338	Non-user	No	No	Moderate	Healthy Periodontium	0	07-DEC-17	26
02-JAN-18	D2150	Amalgam-2 surfaces	20 DO	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	19	M	97338	Non-user	No	No	Moderate	Healthy Periodontium	0	07-DEC-17	26
02-JAN-18	D2392	Resin-based comp- 2 surf, post	5 MO	941503	D3 - Primary active moderate dentin caries mid	HSLH	240	97321	33	F	97301	Non-user	No	No	High	Gingivitis	3	18-NOV-17	45
02-JAN-18	D2331	Resin-based comp - 2 surf, ant	6 DL	941503	D3 - Primary active moderate dentin caries mid	HSLH	240	97321	33	F	97301	Non-user	No	No	High	Gingivitis	3	18-NOV-17	45
02-JAN-18	D2331	Resin-based comp - 2 surf, ant	7 DL	941503	D3 - Primary active moderate dentin caries mid	HSLH	240	97321	33	F	97301	Non-user	No	No	High	Gingivitis	3	18-NOV-17	45
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	UR	785649	Generalized Moderate Chronic Periodontitis	HDAD	240	97321	41	M	97301	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	LR	785649	Generalized Moderate Chronic Periodontitis	HDAD	240	97321	41	M	97301	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D4921	Gingival irrigation per quadrant	UR	785649	Generalized Moderate Chronic Periodontitis	HDAD	240	97321	41	M	97301	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D4921	Gingival irrigation per quadrant	LR	785649	Generalized Moderate Chronic Periodontitis	HDAD	240	97321	41	M	97301	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	18-NOV-17	45
02-JAN-18	D2391	Resin-based comp- 1 surf, post	18 B	976062	D3* - Recurrent active moderate dentin caries	HYBZH	244	97266	58	F	97266	User	No	No	Moderate	Healthy Periodontium	0	02-JAN-18	0
02-JAN-18	D2330	Resin-based comp - 1 surf, ant	22 F	941503	D3 - Primary active moderate dentin caries mid	HYBZH	244	97266	58	F	97266	User	No	No	Moderate	Healthy Periodontium	0	02-JAN-18	0
02-JAN-18	D2140	Amalgam-1 surface	4 D	976406	D3+* - Recurrent active exten dentin caries inn	HBGHH	206	97030	33	F	97080	Non-user	No	No	High	Slight Chronic Periodontitis	0	18-DEC-17	15
02-JAN-18	D2330	Resin-based comp - 1 surf, ant	11 L	976062	D3* - Recurrent active moderate dentin caries	HBGHH	206	97030	33	F	97080	Non-user	No	No	High	Slight Chronic Periodontitis	0	18-DEC-17	15
02-JAN-18	D2391	Resin-based comp- 1 surf, post	15 O	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	18	M	97301	Non-user	No	No	Moderate	Healthy Periodontium	0	07-DEC-17	26
02-JAN-18	D2391	Resin-based comp- 1 surf, post	31 B	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	18	M	97301	Non-user	No	No	Moderate	Healthy Periodontium	0	07-DEC-17	26
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	LR	375160	Generalized Slight Chronic Periodontitis	HCHVH	242	97330	45	M	97330	Non-user	No	No	Low	Slight Chronic Periodontitis	0	22-NOV-17	41
02-JAN-18	D4342	Scaling root planing 1-3 teeth per quad	UR	375160	Generalized Slight Chronic Periodontitis	HCHVH	242	97330	45	M	97330	Non-user	No	No	Low	Slight Chronic Periodontitis	0	22-NOV-17	41
02-JAN-18	D4921	Gingival irrigation per quadrant	UR	375160	Generalized Slight Chronic Periodontitis	HCHVH	242	97330	45	M	97330	Non-user	No	No	Low	Slight Chronic Periodontitis	0	22-NOV-17	41
02-JAN-18	D4921	Gingival irrigation per quadrant	LR	375160	Generalized Slight Chronic Periodontitis	HCHVH	242	97330	45	M	97330	Non-user	No	No	Low	Slight Chronic Periodontitis	0	22-NOV-17	41
02-JAN-18	D2150	Amalgam-2 surfaces	19 MO	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	25	F	97477	User	No	Diabetic	High	Healthy Periodontium	6	28-NOV-17	35
02-JAN-18	D2140	Amalgam-1 surface	18 O	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	25	F	97477	User	No	Diabetic	High	Healthy Periodontium	6	28-NOV-17	35
02-JAN-18	D2940	Protective Restoration	22 F	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	25	F	97477	User	No	Diabetic	High	Healthy Periodontium	6	28-NOV-17	35
02-JAN-18	D2940	Protective Restoration	21 B	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	25	F	97477	User	No	Diabetic	High	Healthy Periodontium	6	28-NOV-17	35
02-JAN-18	D2160	Amalgam-3 surfaces	4 MOD	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	60	F	97477	Non-user	No	No	High	Healthy Periodontium	0	22-NOV-17	41
02-JAN-18	D2161	Amalgam-4+ surfaces	18 MOBL	941503	D3 - Primary active moderate dentin caries mid	HCEY	216	97477-3413	60	F	97477	Non-user	No	No	High	Healthy Periodontium	0	22-NOV-17	41
02-JAN-18	D2331	Resin-based comp - 2 surf, ant	6 DL	976062	D3* - Recurrent active moderate dentin caries	HCEY	216	97477-3413	60	F	97477	Non-user	No	No	High	Healthy Periodontium	0	22-NOV-17	41
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	UL	785649	Generalized Moderate Chronic Periodontitis	HATSH	245	97305	61	M	97305	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	16-DEC-17	17
02-JAN-18	D4921	Gingival irrigation per quadrant	UL	785649	Generalized Moderate Chronic Periodontitis	HATSH	245	97305	61	M	97305	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	16-DEC-17	17
02-JAN-18	D4342	Scaling root planing 1-3 teeth per quad	LL	579834	Localized Moderate Chronic Periodontitis	HATSH	245	97305	61	M	97305	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	16-DEC-17	17
02-JAN-18	D4921	Gingival irrigation per quadrant	LL	579834	Localized Moderate Chronic Periodontitis	HATSH	245	97305	61	M	97305	Non-user	No	No	Moderate	Moderate Chronic Periodontitis	0	16-DEC-17	17
02-JAN-18	D1206	Topical application of fluoride varnish		612006	Caries risk moderate	HAAHH	241	97232	18	M	97211	Non-user	Yes	No	Moderate	Slight Chronic Periodontitis	0	21-DEC-17	12
02-JAN-18	D2330	Resin-based comp - 1 surf, ant	11 D	941503	D3 - Primary active moderate dentin caries mid	HAYHH	202	97233	37	F	97233	Non-user	No	No	High	Gingivitis	0	13-DEC-17	20
02-JAN-18	D2391	Resin-based comp- 1 surf, post	18 D	941503	D3 - Primary active moderate dentin caries mid	HAYHH	202	97233	37	F	97233	Non-user	No	No	High	Gingivitis	0	13-DEC-17	20
02-JAN-18	D1110	Prophylaxis - adult		976378	Healthy Periodontium	HKQH	219	97526	35	F	97415	Non-user	No	No	High	Healthy Periodontium	3	05-DEC-17	28
02-JAN-18	D4342	Scaling root planing 1-3 teeth per quad	UR	579834	Localized Moderate Chronic Periodontitis	HIGH	564	98506	55	F	98503	Non-user	No	No	Moderate	Slight Chronic Periodontitis	0	06-DEC-17	27
02-JAN-18	D4342	Scaling root planing 1-3 teeth per quad	UL	579834	Localized Moderate Chronic Periodontitis	HIGH	564	98506	55	F	98503	Non-user	No	No	Moderate	Slight Chronic Periodontitis	0	06-DEC-17	27
02-JAN-18	D4921	Gingival irrigation per quadrant	UR	579834	Localized Moderate Chronic Periodontitis	HIGH	564	98506	55	F	98503	Non-user	No	No	Moderate	Slight Chronic Periodontitis	0	06-DEC-17	27
02-JAN-18	D4921	Gingival irrigation per quadrant	UL	579834	Localized Moderate Chronic Periodontitis	HIGH	564	98506	55	F	98503	Non-user	No	No	Moderate	Slight Chronic Periodontitis	0	06-DEC-17	27
02-JAN-18	D2150	Amalgam-2 surfaces	3 MO	583730	Defective restoration: fracture	HSLH	240	97321	47	F	97355	Non-user	No	No	Low	Healthy Periodontium	0	20-NOV-17	43
02-JAN-18	D2980	Crown repair due to restorative material failure	9	583730	Defective restoration: fracture	HSLH	240	97321	47	F	97355	Non-user	No	No	Low	Healthy Periodontium	0	20-NOV-17	43
02-JAN-18	D2392	Resin-based comp- 2 surf, post	29 DO	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	25	F	97303	Non-user	No	No	Moderate	Healthy Periodontium	0	12-DEC-17	21
02-JAN-18	D2392	Resin-based comp- 2 surf, post	30 OB	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	11	M	97375	Non-user	No	No	Moderate	Healthy Periodontium	2	01-DEC-17	32
02-JAN-18	D2391	Resin-based comp- 1 surf, post	14 O	941503	D3 - Primary active moderate dentin caries mid	HRWHG	245	97305	15	M	97375	Non-user	No	No	Moderate	Healthy Periodontium	0	12-DEC-17	21
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	UL	674943	Localized Severe Chronic Periodontitis	HNTHH	202	97233	55	M	97220	User	No	No	High	Severe Chronic Periodontitis	0	05-DEC-17	28
02-JAN-18	D4341	Scaling root planing 4 or more teeth per quad	LL	674943	Localized Severe Chronic Periodontitis	HNTHH	202	97233	55	M	97220	User	No	No	High	Severe Chronic Periodontitis	0	05-DEC-17	28
02-JAN-18	D4921	Gingival irrigation per quadrant	UL	674943	Localized Severe Chronic Periodontitis	HNTHH	202	97233	55	M	97220	User	No	No	High	Severe Chronic Periodontitis	0	05-DEC-17	28
02-JAN-18	D4921	Gingival irrigation per quadrant	LL	674943	Localized Severe Chronic Periodontitis	HNTHH	202	97233	55	M	97220	User	No	No	High	Severe Chronic Periodontitis	0	05-DEC-17	28

Willamette Dental Group

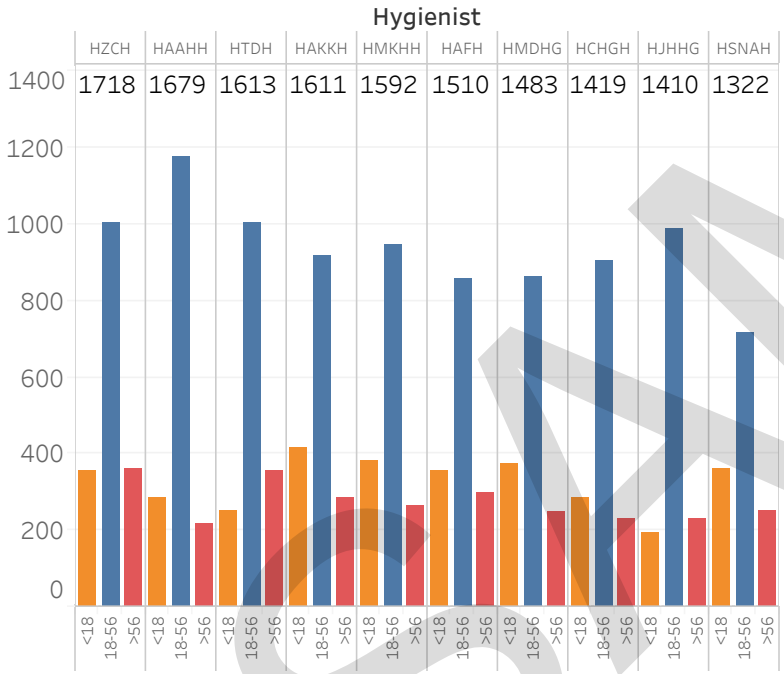
PN13B

Hygienist	Patients Seen	Services Delivered	% of Children	% with Decay	% of Preventive Services	Average Access (Days)
HAAHH	1,679	3,809	17.0%	22.3%	43.1%	14.4
HAFH	1,510	4,823	23.4%	36.2%	40.3%	11.7
HAKKH	1,611	2,591	25.6%	23.3%	68.4%	18.4
HCHGH	1,419	2,643	20.0%	26.1%	66.1%	10.8
HJHHG	1,410	1,990	13.7%	14.4%	69.5%	25.1
HMDHG	1,483	2,968	25.2%	30.0%	39.6%	26.6
HMKHH	1,592	2,771	24.0%	22.2%	62.3%	14.3
HSNAH	1,322	2,584	27.1%	18.8%	58.0%	11.1
HTDH	1,613	2,391	15.6%	24.7%	75.9%	12.5
HZCH	1,718	2,755	20.6%	22.1%	63.1%	15.8
Average	**1,536**	**2,933**	**21.2%**	**24.0%**	**58.6%**	**16.1**

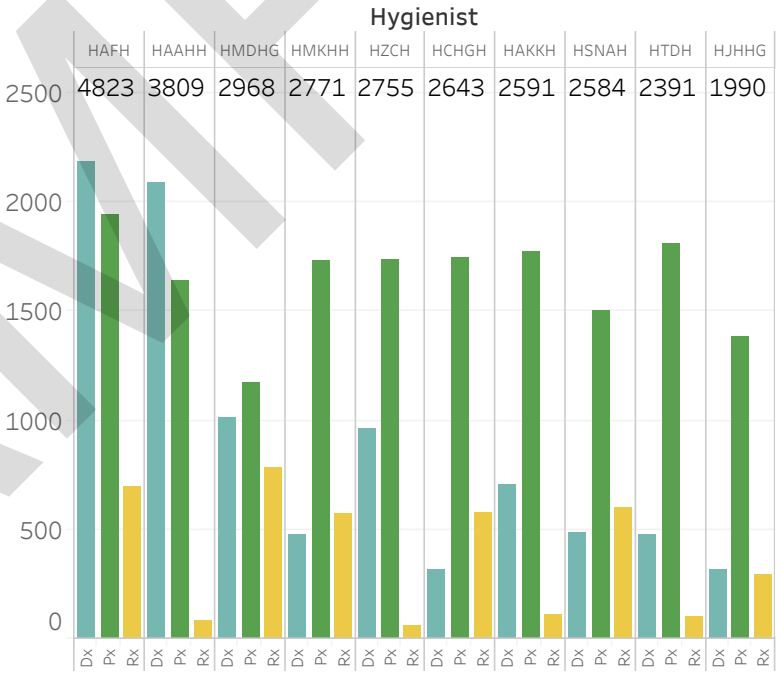
Age Groups
- <18
- 18-56
- >56

Service Types
- Dx
- Px
- Rx

Patients Seen by Age Group



Procedures Delivered by Service Type



PN11

Patient Consent Form: Education Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have direct supervision from an adjunct instructor dentist with Pacific University and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Date

From the Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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

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

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 of this 2011 Act. [2011 c.716 §1]

Sec. 17. The Dental Pilot Projects Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Dental Pilot Projects Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of carrying out the provisions of section 1, chapter 716, Oregon Laws 2011. [2011 c.716 §17; 2013 c.113 §2] Note: Section 2, chapter 842, Oregon Laws 2015, provides:

Sec. 2. A provider of dental services in a dental pilot project approved by the Oregon Health Authority pursuant to section 1, chapter 716, Oregon Laws 2011, is eligible to be reimbursed for covered services provided to a recipient of medical assistance. [2015 c.842 §2]

Note: Section 2, chapter 716, Oregon Laws 2011, provides:

Sec. 2. (1) Section 1, chapter 716, Oregon Laws 2011, is repealed on January 2, 2025.

2) Section 17, chapter 716, Oregon Laws 2011, as amended by section 2, chapter 113, Oregon Laws 2013, is repealed January 2, 2025.

(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Patient Consent Form: Preceptorship Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have direct supervision from an adjunct instructor dentist with Pacific University and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Date

From the Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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

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

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 of this 2011 Act. [2011 c.716 §1]

Sec. 17. The Dental Pilot Projects Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Dental Pilot Projects Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of carrying out the provisions of section 1, chapter 716, Oregon Laws 2011. [2011 c.716 §17; 2013 c.113 §2] Note: Section 2, chapter 842, Oregon Laws 2015, provides:

Sec. 2. A provider of dental services in a dental pilot project approved by the Oregon Health Authority pursuant to section 1, chapter 716, Oregon Laws 2011, is eligible to be reimbursed for covered services provided to a recipient of medical assistance. [2015 c.842 §2]

Note: Section 2, chapter 716, Oregon Laws 2011, provides:

Sec. 2. (1) Section 1, chapter 716, Oregon Laws 2011, is repealed on January 2, 2025.

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(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Patient Consent Form: Full Utilization Phase

Treatment to be Administered by Registered Restorative Dental Hygienist

Willamette Dental Group and other participating organizations are excited to partner with Pacific University in a pilot project to educate Restorative Dental Hygienists to become Dental Therapists. A Dental Therapist is to dentistry as a Nurse Practitioner is to medicine – a 'mid-level' provider option that will increase the population's access to dental care.

During the later stages of education, the dental therapy participant provides care for select patients. The dental therapy participant will have indirect and/or general supervision from a supervising dentist and will be evaluated at specific points during your (or your child's) treatment. Many aspects of your (or your child's) treatment will be procedures that a Restorative Hygienist is already allowed to do. Procedures that are part of the Dental Therapy education include, but are not limited to: preparing the tooth for restorations, stainless steel crown preparation and placement, pulpotomies, extractions of primary teeth and extractions of permanent teeth with restrictions regarding degree of mobility.

_____ is a Registered Restorative Dental Hygienist, licensed as such in the state of Oregon, and a participant of Dental Therapy with Pacific University. He/she will be providing the allowable clinical treatment today under the direct supervision of Dr. _____.

Should you wish to ask any questions about your care or the Dental Workforce Pilot Program, please feel free to do so at any time.

It is your right to stop a procedure at any time if you do not feel comfortable, and you may ask for a second opinion from the supervising licensed dentist.
You have the right to be treated by a licensed dentist for any procedures that are part of the Dental Therapist education program. You may revoke or withdraw your consent to treatment by this dental therapy participant at any time.

I _____ (name of patient or person acting on patient's behalf) have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment.

_____

Signature (or legal guardian signature)

_____

Printed Name

From the Oregon board of Dentistry in regards to Dental Pilot Projects:

DENTAL PILOT PROJECTS

Note: Sections 1 and 17, chapter 716, Oregon Laws 2011, provide:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects 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. The authority may approve a pilot project that is designed to:

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(A) The process used to evaluate the progress and outcomes of the pilot project;

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(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

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(3) Section 2 of this 2015 Act [section 2, chapter 842, Oregon Laws 2015] is repealed on January 2, 2025. [2011 c.716 §2; 2015 c.842 §3]

Interview Questions

Supervising Dentist:

DDS/DMD: _____

Date: _____

- What do you know about dental therapy?
- Describe your practice experience (i.e. years practicing, offices, etc.)
- How often do you utilize a restorative hygienist?
- Tell us about a time when you questioned someone's clinical work. What was the situation, the feedback and the outcome?
- Tell us about your apprehensions for being responsible for the continual supervision of a DT in your office for the next 5 years.
- Describe how you feel about speaking to your patients about DT in an attempt to allow the DT to provide the treatment? (Note: there will be training on presenting to pts).
- Describe your strengths and then where you need to make improvements in regard to supervision and teaching a DT.
- What experience have you had in teaching? Note, this does not have to be in a formal setting.
- How would you handle a situation when you need to step in to make a correction on a patient that the DT is treating?
- What will you do if you are not chosen for this program?
- Describe any other apprehensions that you have for participating in this pilot.
- What questions do you have for us?

Dental Hygienist: Restorative Credential

Interview Questions

RDH: _____

Date: _____

- Who is your current Supervising Dentist?
- What do you know about dental therapy?
- Why do you want to participate in this pilot?
- Describe your experience as hygienists: (i.e. years practicing, offices, etc.).
- Describe your restorative experience:
- Tell us about a time when your clinical work was questioned? What was the situation, the feedback and the outcome?
- Describe your strengths and then where you need to make improvements.
- Describe the apprehensions that you have for participating in this pilot.
- Why are you the best person to represent WDG, PU, Oregon and DT?
- What will you do if you are not chosen for this program?
- What questions do you have for us?

Surveys

Patient Satisfaction Point of Service Survey: Dental Workforce Pilot

	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5	Not Applicable 9
During this visit, please rate the quality of the dental staff in doing the following:	1	2	3	4	5	9
How would you rate the overall skills and expertise of your Dental Therapist?	1	2	3	4	5	9
How well the Dental Therapist listened to your health concerns?	1	2	3	4	5	9
How thorough do you feel his/her explanations and instructions for care are?	1	2	3	4	5	9
How well do you feel about the time that the Dental Therapist takes time to answer your questions?	1	2	3	4	5	9
How attentive, caring and understanding do you feel your Dental Therapist is?	1	2	3	4	5	9
Overall, how would you rate your most recent experience with your Dental Therapist?	1	2	3	4	5	9

Please provide us a narrative of any question that was answered fair, poor or very poor?

_____

_____

_____

Additional Feedback:

_____

_____

Dental Therapist/Hygienist: _____ **Office:** _____

Date: _____ **Practicing Under Doctor:** _____

Circle: Point of Svs/ 6 Mos

Supervising Dentist Survey (Preceptorship & Utilization Phase)

	Very Low	Low	Neutral	High	Very High
1. Rate your expectations regarding of the success of this dental therapy project pilot?	1	2	3	4	5
3. Rate your willingness about being responsible for the continual supervision of a DT in your office for the next 5 years.	1	2	3	4	5
4. Rate your perception of the acceptance of patients when asking them to allow the DT to provide the treatment.	1	2	3	4	5
5. Rate your satisfaction level of the experience teaching, mentoring and supervising a Dental Therapist?	1	2	3	4	5
6. Rate your confidence level in the Dental Therapist's ability to complete the necessary patient treatment without your intervention?	1	2	3	4	5

7. Describe your perception of how adding a Dental Therapist to your dental team will impact your practice experience.

_____
_____
_____

8. Please provide us a narrative of any question that was answered fair, poor or very poor?

_____
_____
_____

9. Additional Feedback:

_____
_____

Job Satisfaction Survey

Explanation: this survey is to be completed prior to beginning the preceptorship phase of the dental therapy pilot project. It is completed by both dental therapy trainees and supervising dentists. Your feedback is important to us. Please fill out the form completely.

Course (circle): Pre-Survey Post-Survey

Role (circle):

Supervising Dentist

Dental Therapy Trainee

Rate your agreement with the following statements about your overall job satisfaction.	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
1. I find my work meaningful.					
2. I feel valued for my contributions.					
3. I have the tools and support to do my job well.					
4. Each team member contributes effectively toward the overall goal of the patient's treatment.					
5. My job responsibilities are clearly defined.					
6. My current job makes good use of my skills and abilities.					
7. My supervisor value my feedback.					
8. My job makes a difference in the lives of others.					
9. My supervisor seems invested in the success of our team.					
10. Overall, I am satisfied with my work.					

Dental Therapist Education Program Evaluation Survey

Explanation: this survey is to be completed at the end of each course (DT I, DT II, DT III (Preceptorship) by the course instructors to evaluate the effectiveness of the course and the dental therapy student. Your feedback is important to us. Please fill out the form completely.

Course (circle): DT I DT II DT III

Dental Therapy Trainee:

Rate your agreement with the following statements about the course and student identified.	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5	Not Applicable 9
1. The course/program information was clear and easy to follow.						
2. The number of typodont experiences was adequate to prepare me for patient care.						
3. I felt adequately prepared in my clinical skills prior to providing patient care in the dental office.						
4. The supervision I received was adequate.						
5. I clearly understood my role, expectations and limitations as a Dental Therapist.						
6. I felt adequately supported by the dental team in the dental office.						
7. Please use the space below to provide any additional feedback on the program that you would like to share.						

Instructor Dentist Program Feedback Survey

Explanation: this survey is to be completed at the end of each course (DT I, DT II, DT III (Preceptorship) by the course instructors to evaluate the effectiveness of the course and the dental therapy student. Your feedback is important to us. Please fill out the form completely.

Course (circle): DT I DT II DT III

Instructor name:

Rate your agreement with the following statements about the course and student identified.	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
8. The students came prepared for all labs and clinic sessions					
9. The didactic portion of the course provided adequate knowledge preparation prior to all lab sessions					
10. The number of typodont experiences were adequate for skill development					
11. The evaluation forms provided valuable feedback in the learning process					
12. The students are adequately prepared in the procedures permitted at this time.					
13. There was adequate time during the semester to practice each skill and reach lab competency					
14. Identify any problems that you noticed during the semester that will need adjustment					
15. Please use the space below to provide any feedback on the program that you would like to share.					

Supervising Dentist Survey (Preceptorship & Utilization Phase)

Explanation: this survey is to be completed at the end of each course (DT I, DT II, DT III, and utilization phase) by the course instructors to evaluate the effectiveness of the courses, the dental therapy student and their preparation to work with the student. Your feedback is important to us. Please fill out the form completely.

Phase (circle): DT I DT II DT III Utilization phase
Student:

Rate your agreement with the following statements about the course and student identified.	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
1. The student was adequately prepared didactically to implement the procedures permitted at this time.					
2. The student was adequately prepared clinically to implement the procedures permitted at this time.					
3. I clearly understand my role of supervision during this phase of the program.					
4. The evaluation forms and chart audits needed at this phase of the program were easy to follow.					
5. I was adequately prepared to supervise the dental therapy student.					
6. Overall, patients were agreeable to having the Dental Therapist provide their dental care.					
7. I am willing to continue to be responsible for the supervision of a DT in my office for the next 5 years.					
8. I am satisfied with the experience teaching, mentoring and supervising a Dental Therapist.					
9. I am confident in the Dental Therapist's ability to complete the necessary patient treatment without my intervention.					
10. Please provide us a narrative of any question that was answered neutral, disagree or strongly disagree.					
11. Describe your perception of how adding a Dental Therapist to your dental team will impact your practice experience.					
12. Additional Feedback:					

CRDTS Competency Examination

RESTORATIVE EXAMINATION - 100 POINTS

CONTENT	FORMAT
Class II Amalgam – Preparation Class II Amalgam – Restoration OR Class II Composite – Preparation Class II Composite – Restoration OR Class II Composite Slot – Preparation Class II Composite Slot – Restoration AND Class III Composite – Preparation Class III Composite – Restoration	Performed on a Patient

Scoring System

The examination scoring system was developed in consultation with three different measurement specialists; the scoring system is criterion-based and was developed on an analytical model. The examination is conjunctive in that its content is divided into separate Parts containing related skill sets and competence must be demonstrated in each one of the Parts. A compensatory scoring system is used within each Part to compute the final score for each Part, as explained below.

Only State Boards of Dentistry are legally authorized to determine standards of competence for licensure in their respective jurisdictions. However, in developing the examination, CRDTS has recommended a score of 75 to be a demonstration of sufficient competence; and participating State Boards of Dentistry have agreed to accept that standard. In order to achieve "CRDTS status" and be eligible for licensure in a participating state, candidates must achieve a score of 75 or more in each Part of the examination. It is 75/100 points or 75%.

WREB's testing criteria:

The Operative Section is a WREB required section that is performed on a live patient. The Candidate may complete up to two procedures to demonstrate competence on the Operative Section. A Class II must be completed to pass the WREB exam:

- Direct Posterior Class II Composite Restoration (MO, DO or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO or MOD)

A second procedure, if required, may be any of the following:

- Direct Posterior Class II Composite Restoration (MO, DO or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO or MOD)
- A Direct Anterior Class III Composite Restoration (ML, DL, MF, DF)

If the Candidate is successful, (3.00 or higher), on the first procedure, the section is passed, with no need to complete another procedure. If the first procedure scores below a 3.00, the Candidate may proceed with a second procedure, which will be averaged with the first procedure. For states requiring two Operative procedures, Candidates will have the option to complete a second procedure, even if the first procedure scored above a 3.00. The average of the two procedures must be 3.00 or higher to pass the section. If a second procedure is completed and the average scores below 3.00, the attempt is completed and reported as failing. In this instance, the Candidate must pay to retake the full Operative Exam at a different site. No onsite retakes are available for Operative.

Competency Assessment

Pilot 300 Evaluation by the Preceptor and Supervising Dentist
13 Point Assessment of Overall Competency
Criteria Explanation for Evaluators

(Vidya Ramaswamy, **Wilhelm Piskorowski**, Mark Fitzgerald, Howard A. Hamerink, Stephen Stefanac, Rachel Greene, and Marilyn S. Lantz. Psychometric Evaluation of a 13-Point Measure of Students' Overall Competence in Community-Based Dental Education Program J Dent Educ. 2016; 80:1237-1244 http://www.jdentaled.org/content/80/10/1237.abstract)

Student Intern _____ Supervising Dentist _____ Date _____

Notes regarding evaluating interns for overall competency:

- This form will be used to evaluate the intern regarding patient care in the dental office
- These criteria are designed to describe behaviors of competent clinical Dental Therapists/dentists
- Dental Therapist interns follow a course of development toward competency and this form is used to track their progress. Interns (students) on their last rotation can be expected to perform at a higher level than during their first rotation.
- This evaluation is a summative evaluation based on the preceptor's experience with the intern over time. You should have worked with the intern more than once to complete the evaluation.
- Students nearing the end of their preceptorship are expected to perform these behaviors at least "often". If a student demonstrates any of these behaviors "occasionally or rarely, please contact the course director before the end of the day.
- Overall assessment should be consistent with category assessments.
- You may enter "N/A" if the criterion is not applicable during your week of observation.
- **Complete this evaluation form weekly during the Preceptorship phase (DT III).**
- **Return the form to:**

You may add comments in this box to provide further details on your intern's performance

The evaluation is on the back of this page. Thank you for working with the Dental Therapists.

Frequency Rating

1 – Rarely	Doesn't occur at all or very inconsistently
2 – Occasionally	Doesn't occur more often than it does
3 – Often	Occurs more often than not
4 – Frequently	Occurs with rare exception
5 – Consistently	Occurs in every instance

Criterion	Target Behaviors of the Intern	Rating
1. **Clinic Protocols:** adheres to protocols established by the clinic & profession	• Demonstrates awareness of and follows protocols and standards of care • Follows clinic policies	
2. **Dental/Medical Hx:** gathers & interprets required information for recognition of important conditions	• Gathers a thorough dental and medical history • Asks appropriate follow up questions and seeks to clarify patient responses • Discriminates between significant and non-significant findings	
3. Prescribing Oral Meds: selects appropriate medications and dosages	• Selects appropriate medications and dosages • Completes and documents prescriptions accurately	
4. **Diagnostic Skills:** makes appropriate Dx, including caries	• Makes diagnoses, including differential diagnoses • Identifies caries, including extent and activity level • Classifies caries risk status	
5. **Patient Management:** demonstrates effective time management, communication & attention to patient concerns & comfort	• Makes efficient use of time • Communicates clearly with patients using terms they can understand • Demonstrates empathy of patient concerns and comfort	
6. **Treatment Planning:** appropriately gathers and records information and selects & sequences tx	• Gathers and accurately records patient data • Identifies and selects treatment options • Sequences treatment • Records treatment plan • Obtains informed consent	
7. **Communication/Verbal Skills:** communicates effectively in written & verbal formats	• Accurately and succinctly records treatment notes • Proactively communicates regarding patient issues • Accepts and responds appropriately to feedback	
8. **Technical Skill:** safely & effectively performs appropriate clinical procedures	• Demonstrates technical ability to perform procedures • Adapts technique as needed to address patient circumstances • Refers or seeks assistance when necessary	

9. **Clinical Knowledge:** demonstrates understanding of steps of procedures, potential risks & means to overcome them.	• Completes procedures in a logical sequence and can articulate steps when asked • Applies clinical judgment to adapt to patient circumstances • Identifies potential problems & plans to overcome them	
10. **Self-Evaluation:** accurately assesses strengths & weaknesses	• Accurately assesses own performance • Articulates strengths and weaknesses • Recognizes personal limitations & areas for growth	
11. **Interaction with Health Care Team:** demonstrates professional & effective communication and interaction with the health care team	• Demonstrates respect for all team members • Supports the team with words and actions • Speaks and behaves in a professional manner	
12. **Professionalism:** behaves in a conscientious, dependable & truthful manner	• Follows ADA & ADHA Code of Ethics • Is aware of patient needs and seeks to meet them • Is punctual and meets commitments • Tells the truth	
13. **Cultural Sensitivity & Competence:** demonstrates effective, sensitive & respectful communication (verbal & nonverbal) and interactions	• Interacts effectively and respectfully with people of different cultures. Seeks to understand how a person's culture may impact patient care • Demonstrates sensitivity to cultural differences	

Chart Review

Dental Workforce Pilot Project Chart Review

Dental Therapist: _____ Office: _____

Supervising Dentist: _____ Date: _____

	Yes	No	N/A	Comments
Medical/Dental History, Vitals				
Complete				
Reviewed				
Proper precautions/consultation				
Medications/Allergies				
Medications reviewed/updated				
Allergies reviewed and updated				
Chart notes				
Complete				
PARQ				
Consents signed and attached				
Oral Surgery Consent				
Nitrous Consent				
SDF Consent				
Coding				
Proper diagnostic code				
Proper Treatment code				
Proper provider code				
Dental Emergency Treatment				
SOAP used				
Diagnosis consistent with findings				
Treatment Consistent with diagnosis				
ART/Amalgam/Composite				
Sufficient pre-op radiograph				
Sufficient pre-op photograph				
Partial/Complete decay removal noted				
Appropriate treatment				
Preparation photograph				
Post-op photograph				
Complications noted				
Restoration adequate				
Follow up noted if indicated				
Stainless Steel Crowns				
Sufficient radiographs/photos				
Appropriate treatment				
Preparation photograph (if appropriate)				N/A if hall crown is used.
SSC adequate				
Cementation documented				
Post-op photograph				
Complications noted				

Pulpal Therapy				
Sufficient pre-op radiograph				
Appropriate treatment				
Medicament documented				
Complications noted				
If permanent- Medical ER documented				
Extractions				
Sufficient pre-op radiograph				
Appropriate treatment				
Appropriate approval				
Sutures documented				
Photograph of extracted tooth				
Hemostasis noted				
Complications noted				
Post-op instructions written/verbal				
Pain management discussed				
Space Maintainer/Partial Adjustments				
Pre-op photograph				
Appropriate treatment				
Description of treatment				
Cementation documented				
Complications noted				
Post-op photograph				

Advisory Committee Information

An advisory committee will provide critical feedback concerning all aspects of this pilot project.

The members of this committee will not be directly involved of this pilot in any way, other than to serve in an advisory capacity.

The advisory committee will potentially include, but is not limited to representatives from the following:[16]

- Willamette Dental Group
- Pacific University
- SmileKeepers
- Virginia Garcia
- AllCare
- Board of Dentistry
- Director from another hygiene school
- Medical Doctor
- RN/PA
- ODA (Oregon Dental Association)
- Providence Health System
- OHSU (Oregon Health and Science University)
- Oregon State Government
- Community
- NHC (Neighbor Health Center)

[16] Participation from these organizations is dependent on their availability and not guaranteed.

Definitions of Electronic Risk Management Formats

Risk Management: identifying things that can go wrong in our computer system and finding ways to prevent/detect them.

Access Control: limiting employee permissions on the computers to the least amount necessary to do their work.

Change Management: documenting, testing, and receiving management approval to make changes to the computer system to minimize unexpected/undesirable outcomes.

Password Control: placing restrictions on what is required when employees create passwords (i.e., password length of 8 characters, mixed numbers and letters, uppercase/lowercase).

Patch Management: planning for what software needs to be upgraded to fix new weaknesses in the software that allows hackers to take unexpected control of your computers.

Media Disposal: approved methods for securely discarding devices that store sensitive data (i.e., shredding hard drives).

Monitoring: watching for abnormal activity in a computer system that could indicate it has been breached by hackers.

Incident Management: procedures to contain and recover from an incident where sensitive data was not protected.

Network Security: devices and software built into networking hardware that looks for abnormal/malicious activity and blocks it.

Security Awareness Training: teaching employees how to detect/prevent incidents where they are tricked into divulging sensitive data to someone who is not authorized to receive it (i.e., identifying phishing emails).

Business Continuity: procedures the business follows to continue business operations in the event of an unexpected disaster (i.e., earthquake, flood, fire).

Clinical Assessments

Explanation of CRDTS/WREB

A recognized testing agency such as The Central Regional Dental Testing Service, Inc. (CRDTS) or Western Regional Exam Board (WREB) will be selected as the testing agency for the final evaluation of students of the program.

CRDTS is a testing service made up of State Boards of Dentistry who have joined forces to develop and administer fair, valid and reliable examinations of competency to practice dentistry and dental hygiene. CRDTS currently has testing for dental therapy and we are utilizing their testing criteria to evaluate student performance throughout the program and upon completion of their training.

The mission of the Western Regional Examining Board is to develop and administer competency assessments for State agencies that license dental professionals. This pilot will utilize the same WREB examinations for any applicable dental therapy procedure involved in this pilot that WREB uses for dental students.

Explanation of When Testing Forms Will Be Used

13-Point Assessment of Overall Competency

This form will be used weekly to evaluate the intern regarding patient care in the dental office during the preceptor phase of the program and monthly during the utilization phase of the pilot program.

Individual Tooth Evaluations on a Typodont (based on CRDTS criteria)

These forms will be used during the lab portions of DT I and II. They will be used for self-evaluation, peer evaluation, faculty evaluation and as the evaluation for the competency exam prior to clearing the student for patient care.

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION (on a typodont)
Tooth #L – Cervical Margin and Draw

Name/Candidate _____

Date _____

Margin/ Extension

SAT	The margins should be at the crest of the simulated free gingival margin
ACC	The cervical margins is not more than 0.5mm apical or coronal to the crest of the simulated free gingival margin
SUB	The cervical margin is overextended more than 0.5 mm but more than 1.0 mm apical to the crest of the simulated free gingival margin. The cervical margin is under-extended, more than 0.5 mm but no more than 1.0 mm coronal to the crest of the simulated free gingival margin
DEF	The cervical margin is over-extended more than 1.0 mm apical to the crest of the simulated free gingival margin. The ervial margin is under-extended more than 1.0 mm coronal to the crest of the simulated free gingival margin

Margin/Definition

SAT	The cervical margin is smooth, continuous, well defined
ACC	The cervical margin is continuous but slightly rough and lacks some definition
SUB	The cervical margin has some continuity, is significantly rough and is poorly defined
DEF	The cervical margin has no continuity and/or definition

Line of Draw

SAT	The appropriate path of insertion varies less than 10° from parallel to the long axis of the tooth on all axial surfaces and a line of draw is established
ACC	The path of insertion/line of draw deviates 10° to less than 20° from the long axis of the tooth
SUB	The path of insertion/line of draw deviates 20° to less than 30° from the long axis of the tooth
DEF	The path of insertion/line of draw is grossly unacceptable, deviating 30° or more from the long axis of the tooth

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION (on a typodont)
Tooth #L – Walls, Taper and Finish Line

Axial Tissue Removal

SAT	Axial tissue removal is optimally 1.0 mm to be sufficient for convenience, retention and resistance form
ACC	The axial tissue removal deviates no more than ± 0.5 mm from optimal
SUB	The axial tissue removal is over-reduced no more than + 1.0 mm from optimal
DEF	The axial tissue removal is grossly over-reduced more than 2 mm or under-reduced less than 0.5 mm

Axial Wall-Smoothness

SAT	Walls are smooth and well-defined
SUB	The walls are slightly rough and lack some definition
DEF	The axial walls are rough

Taper

SAT	There is full visual taper (6° – 16°)
ACC	Taper is present, but nearly parallel (>16°, but <24°)
SUB	There is no taper or excessive taper (>24°)
DEF	The taper is grossly over-reduced (30°)

Cervical Finish line

SAT	The margin is knife-edge or feather-edge with no ledges present
ACC	The margin, although predominantly knife-edge or feather-edge, has some areas of ledging that do not exceed 0.5 mm in width
SUB	The margin varies significantly from the knife-edge or feather-edge design exhibiting ledges and/or width no more than 1.0 mm
DEF	The margin exhibits excessive shoulders, chamfers, or ledges and/or width more than 1.0 mm

Occlusal Reduction

SAT	Reduction of the occlusal wall is optimally 1.0 mm
SUB	Occlusal reduction deviates no more than ± 0.5 mm from optimal

DEF	The occlusal wall is grossly over-reduced, greater than 1.5 mm; or grossly under-reduced, less than 0.5 mm, resulting in insufficient occlusal clearance for adequate restorative material

Internal Line Angles

SAT	Internal line angles and cusp tips are rounded
ACC	Internal line angles and cusp tip areas are not completely rounded and show a slight tendency of being sharp
SUB	The internal line angles and cusp tip areas show only minimal evidence of rounding or are excessively sharp

Occlusal Anatomy

SAT	The general occlusal anatomy is maintained
SUB	The occlusal anatomy is flat

MANIKIN PROCEDURES
Treatment Management
PENALTY POINTS ONLY

Adjacent Tooth Damage

SAT	The adjacent and/or opposing teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact. Opposing hard tissue shows evidence of damage and/or alteration inconsistent with the procedure
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration. There is evidence of gross damage and/or alteration to opposing hard tissue inconsistent with the procedure

Soft Tissue Damage

SAT	The simulated gingiva and/or typodonts is/are free from damage
ACC	There is slight damage to simulated gingival and/or typodonts consistent with the procedure
SUB	There is iatrogenic damage to the simulated gingival and/or typodonts inconsistent with the procedure
DEF	There is gross iatrogenic damage to the simulated gingiva and/or typodonts inconsistent with the procedure

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION (on a typodont)
Tooth #J – Cervical Margin and Draw

Name/Candidate _____

Date _____

Margin/Extension

SAT	The extension of the crown into the simulated gingival sulcus is optimally 1 mm
ACC	The extension of the crown into the stimulated gingival sulcus is over-extended greater than 1.0 mm but less than 1.5 mm. The extension of the crown into the simulated gingival sulcus is under-extended less than 1.0 mm but does not extend occlusally above the free gingival margin
SUB	The extension of the crown into the stimulated gingival sulcus is over-extended greater than 1.5 mm but less than 2.0 mm. The extension of the crown into the simulated gingival sulcus is under-extended occlusally above the free gingival margin but not more than 0.5
DEF	The extension of the crown into the simulated gingival sulcus is over-extended greater than 2.0 mm. The extension of the crown into the simulated gingival sulcus is under-extended occlusally above the free gingival margin more than 0.5 mm

Margin/Definition

SAT	The crown margins have been properly crimped to exhibit adaptation to the tooth surface with isolated discrepancies less than 0.5 mm
ACC	The crown margins have been crimped to exhibit adaptation to the tooth surface with isolated discrepancies greater than 0.5 mm but less than 1.0 mm
SUB	The crown martins exhibit adaptation to the tooth surface with generalized prevalent discrepancies greater than 0.5 mm but less than 1.0 mm
DEF	The crown margins exhibit minimal adaptation to the tooth surface with discrepancies greater than 1.0 mm

Surface Finish

SAT	The crown surfaces, including margins, are well polished with no scratches or plier marks
ACC	The crown surfaces, including margins, are polished but show slight evidence of scratches or pliers marks
SUB	The crown surfaces, including margins, are rough and/or show significant evidence of scratches or plier marks

Cement Removal

SAT	There is no evidence of cement visible on the crown surface, on the marginal areas, in the gingival sulcus, in the interproximal area of the adjacent tooth, on the gingival tissues or other adjacent teeth surfaces
ACC	There is no evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is minimal evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces.
SUB	There is no evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is moderate evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces
DEF	There is evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is significant evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION (on a typodont)
Tooth #J – Contour, Contact and Occlusion

Interproximal Contact

SAT	Interproximal contact is present, the contact is visually closed and properly contoured; and there is definite, but not excessive, resistance to waxed dental floss when passed through the interproximal area
ACC	Interproximal contact is present, the contact is visually closed and properly contoured; but demonstrates little resistance to waxed dental floss when passed through the interproximal area
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to waxed dental floss or shreds or breaks the floss
DEF	The interproximal contact is visually open or will not allow waxed dental floss to pass through the contact area

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment
DEF	There is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

Occlusal Anatomy

SAT	The crown is positioned properly on the tooth to replicate the normal physiological contours, marginal ridge height and alignment, not rotated or axially inclined
ACC	The crown does not replicate the normal physiological contours, marginal ridge height and alignment, but would not be expected to adversely affect the tissue health
DEF	Thee is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATIONS EXAM
Critical Errors

	Fractured Restoration
	The restoration is debonded and/or movable in the preparation

MANIKIN PROCEDURES
Treatment Management
PENALTY POINTS ONLY

Adjacent Tooth Damage

SAT	The adjacent and/or opposing teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact. Opposing hard tissue shows evidence of damage and/or alteration inconsistent with the procedure
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration. There is evidence of gross damage and/or alteration to opposing hard tissue inconsistent with the procedure

Soft Tissue Damage

SAT	The simulated gingiva and/or typodonts is/are free from damage
ACC	There is slight damage to simulated gingival and/or typodonts consistent with the procedure
SUB	There is iatrogenic damage to the simulated gingival and/or typodonts inconsistent with the procedure
DEF	There is gross iatrogenic damage to the simulated gingiva and/or typodonts inconsistent with the procedure

#A PRIMARY MOLAR PULPOTOMY PROCEDURE (on a typodont)
Access Opening

Name/Candidate _____

Date _____

Placement

SAT	The placement of the access opening is the mesial triangular pit and central fossa of the tooth and would allow for straight-line access to the root canal system
ACC	The placement of the access opening is not directly over the pulp chamber but would allow for the straight-line access to the root canal system
SUB	The placement of the access opening is not over the pulp chamber and would not allow straight-line access to the root canal system
DEF	The placement of the access opening is not over the pulp chamber and would not allow access to the root canal system

Size

SAT	The access opening is of optimal size and allows for complete debridement of the pulp chamber
SUB	The access opening is under-extended allowing for partial debridement of the pulp chamber
DEF	The access opening is under-extended so that debridement of the pulp chamber or access to one or more canal orifices is impossible

Integrity of Occlusal Anatomy

SAT	The access opening preserves 1.0 mm or more of the mesial marginal ridge, oblique ridge, and all cusp tips
SUB	The access opening is over-extended but preserves at least 0.5 mm but less than 1.0 mm of the mesial marginal ridge, oblique ridge, and/or any cusp tip
DEF	The access opening is under-extended but preserves less than 0.5 mm of the mesial marginal ridge, oblique ridge, and/or any cusp tip or extends over the occlusal table

Internal Form

SAT	The internal form tapers to the canal opening with no ledges
SUB	The internal form lacks taper to the canal orifice(s), gouges are present that do not affect access to the canal orifice
DEF	The internal form exhibits excessive ledging or gouges that do not allow access to the canal orifices and/or the pulp chamber is not entered and/or there is incomplete removal of the pulp chamber roof and/or there is a perforation of the crown or the floor of the pulp chamber

Pulp Horn Removal

SAT	All pulp horns are removed through the access opening
ACC	Pulp horns are not fully removed through the access opening
SUB	Pulp horns are not entered

MANIKIN PROCEDURES
Treatment Management
PENALTY POINTS ONLY

Adjacent Tooth Damage

SAT	The adjacent and/or opposing teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact. Opposing hard tissue shows evidence of damage and/or alteration inconsistent with the procedure
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration. There is evidence of gross damage and/or alteration to opposing hard tissue inconsistent with the procedure

Soft Tissue Damage

SAT	The simulated gingiva and/or typodonts is/are free from damage
ACC	There is slight damage to simulated gingival and/or typodonts consistent with the procedure
SUB	There is iatrogenic damage to the simulated gingival and/or typodonts inconsistent with the procedure
DEF	There is gross iatrogenic damage to the simulated gingiva and/or typodonts inconsistent with the procedure

#T PRIMARY MOLAR AMALGAM RESTORATION (on a typodont)
Margin Integrity and Surface Finish

Name/Candidate _____

Date _____

Margin Deficiency

SAT	There is no marginal deficiency. There is no evidence of voids or open margins
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than 0.5 mm
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin

Margin Excess

SAT	There is no detectable excess at the cavosurface margin either visually or with the tine of an explorer
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2.0 mm
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2.0 mm

Gingival Overhang

SAT	The restoration exhibits no gingival overhang
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health

Surface Finish

SAT	The surface of the restoration is uniformly smooth and free of pits and voids
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

Contiguous Tooth Structure

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure, contiguous to the restoration (enameloplasty)
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (enameloplasty)
DEF	There is gross enameloplasty resulting in the exposure of dentin

#T PRIMARY MOLAR AMALGAM RESTORATION (on a typodont)
Contact, Contour, and Occlusion

Interproximal Contact

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal area
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact areas

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment
DEF	There is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

Anatomy/Contour

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health

#T PRIMARY MOLAR AMALGAM RESTORATION (on a typodont)
Critical Errors

Margin Deficiency

	Fractured Restoration

MANIKIN PROCEDURES
Treatment Management
PENALTY POINTS ONLY

Adjacent Tooth Damage

SAT	The adjacent and/or opposing teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact. Opposing hard tissue shows evidence of damage and/or alteration inconsistent with the procedure
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration. There is evidence of gross damage and/or alteration to opposing hard tissue inconsistent with the procedure

Soft Tissue Damage

SAT	The simulated gingiva and/or typodonts is/are free from damage
ACC	There is slight damage to simulated gingival and/or typodonts consistent with the procedure
SUB	There is iatrogenic damage to the simulated gingival and/or typodonts inconsistent with the procedure
DEF	There is gross iatrogenic damage to the simulated gingiva and/or typodonts inconsistent with the procedure

POSTERIOR COMPOSITIE PREPARATION GRADING (CRDTS)
PE & Mock Board - External Outline Form

Name/Candidate _____

Date _____

Proximal Clearance

SAT	Contact is visibly open proximally up to 0.5 mm
ACC	Proximal contact is visibly open, & proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls
SUB	Proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls

Gingival Clearance

SAT	Contact is open gingivally of to 0.5 mm
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open
DEF	The gingival clearance is greater than 3.0 mm

Outline Shape/Continuity/Extension

SAT	The outline form included all carious and non-coalesced fissures, and is smooth, rounded and flowing with no sharp curves or angles
SUB	The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s). the outline form is under-extended and non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form
DEF	The outline form is overextended so that is compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the marginal ridge is 1 mm or less

Isthmus

SAT	The isthmus may be up to 2 mm wide, but not more than ¼ the intercuspal width of the tooth.
ACC	The isthmus is more than ¼ and not more than 1/3 the intercuspal width
SUB	The isthmus is more than 1/3 and not more than ½ the intercuspal width
DEF	The isthmus is greater than ½ the intercuspal width

Cavosurface Margin

SAT	The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The proximal gingival point angles may be rounded or sharp
ACC	The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel
SUB	The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s)

Sound Marginal Tooth Structure

SAT	The external cavosurface margin meets the enamel at 90°
SUB	The proximal cavosurface margin deviates from 90° & is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s)

Sound Marginal Tooth Structure

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material, including sealants, at the cavosurface margin. There is no decalcification on the gingival margin
SUB	The cavosurface margin does not terminate in sound natural tooth structure; or there is explorer penetrable decalcification remaining on any cavosurface margin, or the cavosurface margin terminates in a previously placed pit & fissure sealant

POSTERIOR COMPOSITE PREPARATION GRADING (CRDTS)
PE & Mock Board - Internal Form

Axial Walls

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, 0.5 mm from the DEJ
ACC	The depth of the axial wall is 0.5 to 1.5 mm beyond the DEJ
SUB	The axial wall is more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ
DEF	The axial wall is more than 2.5 mm beyond the DEJ or there is no gingival floor

Pulpal Floor

SAT	The pulpal floor must be at 1.5 to 2.0 mm in all areas; there may be remaining enamel
SUB	The pulpal floor is greater than 0.5 mm but less than 1.5 mm or up to 3.0 mm
DEF	The pulpal floor is less than 0.5 mm or is more than 3.0 mm from the cavosurface margin

Caries/Remaining Material

SAT	All caries and/or previous restorative material are removed
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries

Proximal Box Walls

SAT	The wall so the proximal box should be parallel or converge occlusally
ACC	The walls of the proximal box are divergent
DEF	The walls of the proximal box are grossly convergent so that the buccal-lingual gingival floor width is > than 2 times the buccal-lingual width of the occlusal access or divergent so that the occlusal access is > 2 times the width of the buccal-lingual gingival floor

Prepared Surfaces

SAT	Prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined

POSTERIOR COMPOSITE PREPARATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Wrong tooth/surface treated
	Unrecognized exposure
	Critical lack of clinical judgment/diagnostic skills

POSTERIOR COMPOSTIE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - MARGIN INTEGRITY & SURFACE FINISH

Margin Deficiency

SAT	There is no marginal deficiency. There is no evidence of voids or open margins
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than 0.5 mm
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm but up to 1 mm, which can include pits & voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin

Margin Excess

SAT	There is no detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2 mm
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2 mm

Gingival Overhang

SAT	The restoration exhibits no gingival overhang
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health

Surface Finish

SAT	The surface of the restoration is uniformly smooth and free of pits
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

Contiguous Tooth Structure

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration no greater than 0.5 mm
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration no greater than 0.5 mm
DEF	There is gross enameloplasty resulting in the exposure of dentin

POSTERIOR COMPOSTIE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board – CONTOUR, CONTACT & OCCLUSION

Margin Deficiency

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact areas
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment
DEF	There is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

Anatomy/Contour

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect he tissue health

POSTERIOR COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Fractured restoration
	The restoration is debonded and/or movable in the preparation

RESTORATIVE PROCEDURES
Treatment Management
Penalty Points ONLY

Condition of Adjacent Teeth

SAT	The adjacent teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration

Condition of Soft Tissue

SAT	The soft tissue is free from damage or there is tissue damage that is consistent with the procedure
SUB	There is iatrogenic soft tissue damage that is inconsistent with the procedure
DEF	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and pre-existing condition of the soft tissue

POSTERIOR COMPOSITE SLOT PREPARATION GRADING (CRDTS)
PE & Mock Board - External Outline Form

Name/Candidate _____

Date _____

Proximal Clearance

SAT	Contact is visibly open proximally up to 0.5 mm
ACC	Proximal contact is visibly open, & proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls
SUB	Proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls

Gingival Clearance

SAT	Contact is open gingivally of to 0.5 mm
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open
DEF	The gingival clearance is greater than 3.0 mm

Outline Shape/Continuity/Extension

SAT	The outline form is smooth, rounded and flowing with no sharp curves or angles
DEF	The outline form is overextended so that is compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the marginal ridge is 1 mm or less

Cavosurface Margin

SAT	The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The proximal gingival point angles may be rounded or sharp
ACC	The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel
SUB	The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s)

Sound Marginal Tooth Structure

SAT	The external cavosurface margin meets the enamel at 90°
SUB	The proximal cavosurface margin deviates from 90° & is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s)

Sound Marginal Tooth Structure

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no decalcification on the gingival margin
SUB	The cavosurface margin does not terminate in sound natural tooth structure; or there is explorer penetrable decalcification remaining on any cavosurface margin

POSTERIOR COMPOSITE SLOT PREPARATION GRADING (CRDTS)
PE & Mock Board - Internal Form

Axial Walls

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, 0.5 mm from the DEJ
ACC	The depth of the axial wall is 0.5 to 1.5 mm beyond the DEJ
SUB	The axial wall is more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ
DEF	The axial wall is more than 2.5 mm beyond the DEJ or there is no gingival floor

Caries/Remaining Material

SAT	All caries and/or previous restorative material are removed
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries

Proximal Box Walls

SAT	The wall so the proximal box should be parallel or converge occlusally
ACC	The walls of the proximal box are divergent
DEF	The walls of the proximal box are grossly convergent so that the buccal-lingual gingival floor width is > than 2 times the buccal-lingual width of the occlusal access or divergent so that the occlusal access is > 2 times the width of the buccal-lingual gingival floor

Prepared Surfaces

SAT	Prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined

POSTERIOR COMPOSITE PREPARATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Wrong tooth/surface treated
	Unrecognized exposure
	Critical lack of clinical judgment/diagnostic skills

POSTERIOR COMPOSITE SLOT RESTORATION GRADING (CRDTS)
PE & Mock Board - MARGIN INTEGRITY & SURFACE FINISH

Margin Deficiency

SAT	There is no marginal deficiency. There is no evidence of voids or open margins
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than 0.5 mm
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm but up to 1 mm, which can include pits & voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin

Margin Excess

SAT	There is no detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2 mm
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2 mm

Gingival Overhang

SAT	The restoration exhibits no gingival overhang
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health

Surface Finish

SAT	The surface of the restoration is uniformly smooth and free of pits
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

Contiguous Tooth Structure

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration no greater than 0.5 mm
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration no greater than 0.5 mm
DEF	There is gross enameloplasty resulting in the exposure of dentin

POSTERIOR COMPOSITE SLOT FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board – CONTOUR, CONTACT & OCCLUSION

Margin Deficiency

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact areas
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment
DEF	There is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

Anatomy/Contour

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect he tissue health

POSTERIOR COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Fractured restoration
	The restoration is debonded and/or movable in the preparation

RESTORATIVE PROCEDURES
Treatment Management
Penalty Points ONLY

Condition of Adjacent Teeth

SAT	The adjacent teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration

Condition of Soft Tissue

SAT	The soft tissue is free from damage or there is tissue damage that is consistent with the procedure
SUB	There is iatrogenic soft tissue damage that is inconsistent with the procedure
DEF	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and pre-existing condition of the soft tissue

ANTERIOR COMPOSITE CLASS III PREPARATION GRADING (CRDTS)
PE & Mock Board - External Outline Form

Name/Candidate _____

Date _____

Outline Extension

SAT	Outline form provides adequate access for complete removal of caries and/or previous restorative material and insertion of composite resin. Access entry is appropriate to the location of caries and tooth position. If a lingual approach is initiated, facial contact may or may not be broken as long as the margin terminates in sound tooth structure.
ACC	The wall opposite the access, if broken, may extend no more than 1.0 mm beyond the contact area. The outline form is overextended mesiodistally 0.5-1 mm beyond what is necessary for complete removal of caries and/or previous restorative material.
SUB	The outline form is underextended making caries removal or insertion of restorative material questionable. The outline form is overextended mesiodistally more than 1 mm, but no more than 2 mm beyond what is necessary for complete removal of caries and/or previous restorative material. The incisal cavosurface margin is overextended so that the integrity of the incisal angle is removed or fractured. A Class Iv restoration is now necessary without justification. The wall opposite the access opening extends more than 1 mm beyond the contact area.
DEF	The outline form is underextended making it impossible to manipulate and finish the restorative material. The outline form is overextended mesiodistally more than 2 mm, but no more than 2 mm beyond what is necessary for complete removal of caries and/or previous restorative material. The incisal cavosurface margin is overextended so that the integrity of the incisal angle is compromised. The wall opposite the access opening extends more than 2.5 mm beyond the contact area.

Gingival Contact Broken

SAT	The gingival contact must be broken. The incisal contact need not be broken, unless indicated by the location of the caries
ACC	The gingival clearance does not exceed 1.5mm
SUB	The gingival clearance is greater than 1.5 mm the gingival contact is not visibly broken
DEF	The gingival clearance is greater than 2 mm

Margin Smoothness/Continuity/Bevels

SAT	Cavosurface margins form a smooth continuous curve with no sharp angles. Enamel cavosurface margins may be beveled
ACC	The cavosurface margins are slightly irregular. Enamel cavosurface margin bevels, if present, do not exceed 1 mm in width

SUB	The cavosurface margin is rough and severely irregular. Enamel cavosurface margin bevels, if present, exceed 1 mm in width, are not uniform or are inappropriate for the size of the restoration

Sound Marginal Tooth Structure

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material, including sealants, at the cavosurface margin. All unsupported enamel is removed unless it compromises facial esthetics
ACC	There is a small area of unsupported enamel which is not necessary to preserve facial esthetics
SUB	There are large or multiple areas of unsupported enamel which are not necessary to preserve facial esthetics. The cavosurface margin does not terminate in sound natural tooth structure; or, the cavosurface margin terminates in previous restorative material

ANTERIOR CLASS III COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - Internal Form

Axial Walls

SAT	The axial wall follows the external contours of the tooth and the depth does not exceed 0.5 mm beyond the DEJ
ACC	The depth of the axial wall is no more than 1.5 mm beyond the DEJ
SUB	The axial wall is more than 1.5 mm beyond the DEJ
DEF	The axial wall is more than 2.5 mm beyond the DEJ

Internal Retention

SAT	If used, rounded internal retention is placed in the dentin of the gingival and incisal walls just axial to the DEJ as dictated by cavity form. Retention is tactilely and visually present
SUB	When used, retention is excessive and undermines enamel or jeopardizes the incisal angle or encroaches on the pulp
DEF	

Caries/Remaining Material

SAT	All caries and/or previous restorative material are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries

ANTERIOR CLASS III COMPOSITE PREPARATION GRADING (CRDTS)
PE & Mock Board – Critical Errors

	Wrong tooth/surface treated
	Unrecognized exposure
	Critical lack of clinical judgment/diagnostic skills

ANTERIOR CLASS III COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board – Margin Integrity and Surface Finish

Margin Deficiency

SAT	There is no marginal deficiency. No marginal deficiency is detectable at the restoration-tooth interface either visually or with the tine of an explorer. There is no evidence of voids or open margins
ACC	There is a detectable marginal deficiency at the facial or lingual restoration-tooth interface either visually or with the tine of an explorer, but it is less than 0.5 mm
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin. And/or there is an open margin

Margin Excess

SAT	No marginal excess is detectable at the cavosurface margin either visually or with the tine of an explorer
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1 mm
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of lingual marginal excess, more than 1 mm and up to 2 mm. there is facial and or lingual flash with contamination underneath, but it is not internal to the cavosurface margin, and could be removed by polishing or finishing
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2 mm, and/or there is internal contamination at the facial and/or lingual interface between the restoration and the tooth

Gingival Overhang

SAT	The restoration exhibits no gingival overhang
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health

Surface Finish

SAT	The surface of the restoration is uniformly smooth and free of pits and voids
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

Contiguous Tooth Structure

SAT	There is no evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration is no greater than 0.5 mm
SUB	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty). Excess present that is not contiguous with the restoration is greater than 0.5 mm
DEF	There is gross enameloplasty resulting in the exposure of dentin

Shade Selection

SAT	The shade of the restoration blends with the surrounding tooth structure
SUB	The shade of the restoration contrasts markedly with the surrounding tooth structure.

Shade Selection

SAT	The shade of the restoration blends with the surrounding tooth structure
SUB	The shade of the restoration contrasts markedly with the surrounding tooth structure

ANTERIOR CLASS III COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board – Contour, Contact and Occlusion

Interproximal Contact

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact areas
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss, shreds the floss or is visually open but deflects floss
DEF	The interproximal contact allows standardized dental floss to pass without deflection or resistance or will not allow dental floss to pass through the contact area

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment
DEF	There is gross hyper-occlusion so that the restoration is the only point of occlusion in that quadrant

Anatomy/Contour

SAT	The restoration reproduces the normal anatomical contours of the tooth, including facial, lingual, proximal and marginal ridge anatomy when compared to contiguous tooth structure
ACC	The restoration deviates slightly from the normal anatomical contours of the tooth, when compared to contiguous tooth structure but would not be expected to adversely affect the tissue health
DEF	The restoration deviates significantly from the normal anatomical contours of the tooth, including facial, lingual, proximal or marginal ridge anatomy, and/or would be expected to adversely affect the tissue health

ANTERIOR COMPOSITE FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	The restoration is debonded

RESTORATIVE PROCEDURES
Treatment Management
Penalty Points ONLY

Condition of Adjacent Teeth

SAT	The adjacent teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration

Condition of Soft Tissue

SAT	The soft tissue is free from damage or there is tissue damage that is consistent with the procedure
SUB	There is iatrogenic soft tissue damage that is inconsistent with the procedure
DEF	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and pre-existing condition of the soft tissue

AMALGAM PREPARATION GRADING (CRDTS)
PE & Mock Board - External Outline Form

Name/Candidate _____

Date _____

Proximal Clearance

SAT	Contact is visibly open proximally
ACC	Proximal contact is visibly open, & proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls
SUB	Proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls

Gingival Clearance

SAT	Contact is open gingivally of to 0.5 mm
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open
DEF	The gingival clearance is greater than 3.0 mm

Outline Shape/Continuity/Extension

SAT	The outline form included all carious and non-coalesced fissures
SUB	The outline form is inappropriately overextended and non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form
DEF	The outline form is overextended so that is compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less

Isthmus

SAT	The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
ACC	The isthmus is more than ¼ and not more than 1/3 the intercuspal width
SUB	The isthmus is more than 1/3 and not more than ½ the intercuspal width
DEF	The isthmus is greater than ½ the intercuspal width or less than 1 mm

Cavosurface Margin

SAT	The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The proximal gingival point angles may be rounded or sharp
ACC	The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel
SUB	The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s)

Sound Marginal Tooth Structure

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material, including sealants, at the cavosurface margin. There is no decalcification on the gingival margin
SUB	The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on any cavosurface margin, or the cavosurface margin terminates in a previously placed pit and fissure sealant

AMALGAM PREPARATION GRADING (CRDTS)
PE & Mock Board - Internal Form

Axial Walls

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, 0.5 mm from the DEK
ACC	The depth of the axial wall is 0.5 to 1.5 mm beyond the DEJ
SUB	The axial wall is more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ
DEF	The axial wall is more than 2.5 mm beyond the DEJ or there is no gingival floor

Pulpal Floor

SAT	The pulpal floor is optimally 1.5 to 2.0 mm from the cavosurface margin at its shallowest point
SUB	The pulpal floor is less than 1.5 mm at its shallowest point or greater than 2.0 mm but not greater than 3.0 from the cavosurface margin
DEF	The pulpal floor is more than 3.0 mm from the cavosurface margin or is 0.5 mm or less at its shallowest point

Pulpal-Axial Line Angle

SAT	The pulpal-axial line angle is rounded
SUB	The pulpal-axial line angle is sharp

Caries/Remaining Material

SAT	All caries and/or previous restorative material are removed
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries

Proximal Box Walls

SAT	The wall so the proximal box should be convergent occlusally & meet the external surface at a 90° angle
ACC	The walls of the proximal box are parallel, but appropriate internal retention is present
DEF	The walls of the proximal box diverge occlusally which offers no retention and will jeopardize the longevity of the tooth or restoration

Prepared Surfaces

SAT	Prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined

AMALGAM PREPARATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Wrong tooth/surface treated
	Retention, when used, grossly compromises the tooth or restoration
	Unrecognized exposure
	Critical lack of clinical judgment/diagnostic skills

AMALGAM FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - Critical Errors

	Fracture Restoration

AMALGAM FINISHED RESTORATION GRADING (CRDTS)
PE & Mock Board - MARGIN INTEGRITY & SURFACE FINISH

Margin Deficiency

SAT	There is no marginal deficiency. There is no evidence of voids or open margins
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than 0.5 mm
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm but up to 1 mm, which can include pits & voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin

Margin Excess

SAT	There is no detectable excess at the cavosurface margin either visually or with the tine of an explorer
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2 mm
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2 mm

Gingival Overhang

SAT	The restoration exhibits no gingival overhang
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health

Surface Finish

SAT	The surface of the restoration is uniformly smooth and free of pits
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

Contiguous Tooth Structure

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty)
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration (Enameloplasty)
DEF	There is gross enameloplasty resulting in the exposure of dentin

RESTORATIVE PROCEDURES
Treatment Management
Penalty Points ONLY

Condition of Adjacent Teeth

SAT	The adjacent teeth and/or restorations are free from damage
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration

Condition of Soft Tissue

SAT	The soft tissue is free from damage or there is tissue damage that is consistent with the procedure
SUB	There is iatrogenic soft tissue damage that is inconsistent with the procedure
DEF	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and pre-existing condition of the soft tissue

Dental Workforce Pilot Project Timeline

Year	Date(s)	Event	Owner
2018-2019	Nov-Jan	Develop Curriculum	Gail Aamodt, Dental Director, Instructor Dentists
2019	Jan-May	Collect Baseline Data	Project Director
2019	Feb	Resubmit Application to the OHA	Project Director
2019	Feb-May	Technical Review Process	OHA
2019	May	Train First Cohort's Supervising Dentists	Gail Aamodt, Dental Director, Instructor Dentists
2019	June	Submit Baseline Data	Project Director
2019	June	Start First Cohort at Pacific University, First 15 Month Semester (8-10 RDHs)	Gail Aamodt, Dental Director, Instructor Dentists
2019	Sept	Submit Quarterly Report to OHA and Outside Evaluator	Project Director
2019	Sept	Quarterly Technical Advisory Committee Meeting	Project Director
2019	Sept	Start First Cohort, Second 15 Month Semester	Gail Aamodt, Dental Director, Instructor Dentists
2019	Oct	First Bi-Annual Site Visit	Dental Director, Project Director
2020	Jan	Start First Cohort, Preceptorship at RDH Employment Sites	Dental Director, Instructor Dentists, Supervising Dentists
2020	Jan	Quarterly Technical Advisory Committee Meeting	Project Director
2020	Jan	Submit Quarterly Report to OHA and Outside Evaluator	Project Director
2020	April	Quarterly Technical Advisory Committee Meeting	Project Director
2020	April	Bi-Annual Site Visit	Dental Director, Project Director
2020	April	Quarterly Report Submitted to OHA and Outside Evaluator	Project Director

2020	May	Train Second Cohort's Supervising Dentists	
2020	June	Start Second Cohort at Pacific University, First 15 Month Semester (6-10 RDHs)	Gail Aamodt, Dental Director, Instructor Dentists
2020	June	Quarterly Technical Advisory Committee Meeting	Project Director
2020	July	Submit Quarterly Report to OHA and Outside Evaluator	Project Director
2020	Sept	Quarterly Technical Advisory Committee Meeting	Project Director
2020	Sept	Start Second Cohort at Pacific University Second 15 Month Semester (6-10 RDHs)	Gail Aamodt, Dental Director, Instructor Dentists
2020	Oct	Quarterly Report Submitted to OHA and Outside Evaluator	Project Director
2021	Jan	Start Second Cohort, Preceptorship at RDH Employment Sites	Gail Aamodt, Dental Director, Instructor Dentist
2021	Jan	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2021	Jan	Quarterly Technical Advisory Committee Meeting	Project Director
2021	April	Quarterly Technical Advisory Committee Meeting	Project Director
2021	April	Bi-Annual Site Visit	Dental Director, Project Director
2021	April	Bi-Annual Site Visit	Dental Director, Project Director
2021	May	Train Optional 3rd Cohort's Supervising Dentists	Gail Aamodt, Dental Director, Instructor Dentists
2021	June	Optional 3rd Cohort at Pacific University, First 15 Month Semester (0-10 RDHs)	Gail Aamodt, Dental Director, Instructor Dentists
2021	June	Quarterly Technical Advisory Committee Meeting	Project Director
2021	July	Submit Quarterly Report to OHA and Outside Evaluator	Project Director
2021	Sept	Quarterly Technical Advisory Committee Meeting	Project Director
2021	Sept	Optional 3rd Cohort, Second 15 Month Semester	Gail Aamodt, Dental Director, Instructor Dentists

2021	Oct	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2022	Jan	Optional 3rd Cohort, Preceptorship at RDH Employment Sites	Dental Director, Instructor Dentists, Supervising Dentists
2022	Jan	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2022	Jan	Quarterly Technical Advisory Committee Meeting	Project Director
2022	April	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2022	April	Quarterly Technical Advisory Committee Meeting	Project Director
2022	June	Submit Quarterly Report to OHA and Outside Evaluator	Project Director
2022	July	Quarterly Technical Advisory Committee Meeting	Project Director
2022	Sept	Quarterly Technical Advisory Committee Meeting	Project Director
2022	Oct	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2022	Oct	Bi-Annual Site Visit	Dental Director, Project Director
2023	Jan	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2023	Jan	Quarterly Technical Advisory Committee Meeting	Project Director
2023	April	Bi-Annual Site Visit	Dental Director, Project Director
2023	April	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2023	April	Quarterly Technical Advisory Committee Meeting	Project Director
2023	June	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2023	July	Quarterly Technical Advisory Committee Meeting	Project Director
2023	Sept	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2023	Oct	Quarterly Technical Advisory Committee Meeting	Project Director
2024	Jan	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director

2024	Jan	Quarterly Technical Advisory Committee Meeting	Project Director
2024	April	Bi-Annual Site Visit	Dental Director, Project Director
2024	April	Submit Quarterly Report to the OHA and Outside Evaluator	Project Director
2024	June	Submit Final Quarterly Report to the OHA and Outside Evaluator	Project Director
2024	July	Final Quarterly Technical Advisory Committee Meeting	Project Director
2024	Sept	Outside Reviewer: Findings Submitted to the OHA and Pilot Project Team	Dr. Bill Piskorowski, DDS & Team

Note: All timeline dates are subject to change based on the length of the OHA pilot approval process.

Patient Risk Assessment Guideline

Pilot Treatment Philosophy

There will be 3 patient risk categories in the Dental Workforce Pilot Project:

Low Moderate High

Workflow for risk category decision making:

Question 1: Are there any active D3/D3+/D4 lesions since the last Caries Risk Assessment/Recall or in the last 3 years if they are a new patient. If yes, they are a high-risk patient (subject to change if additional factors are present).

Question 2: Are incipient lesions (D1/D2/D2+) present. If yes and there are no active lesions making them high risk, then they are moderate risk.

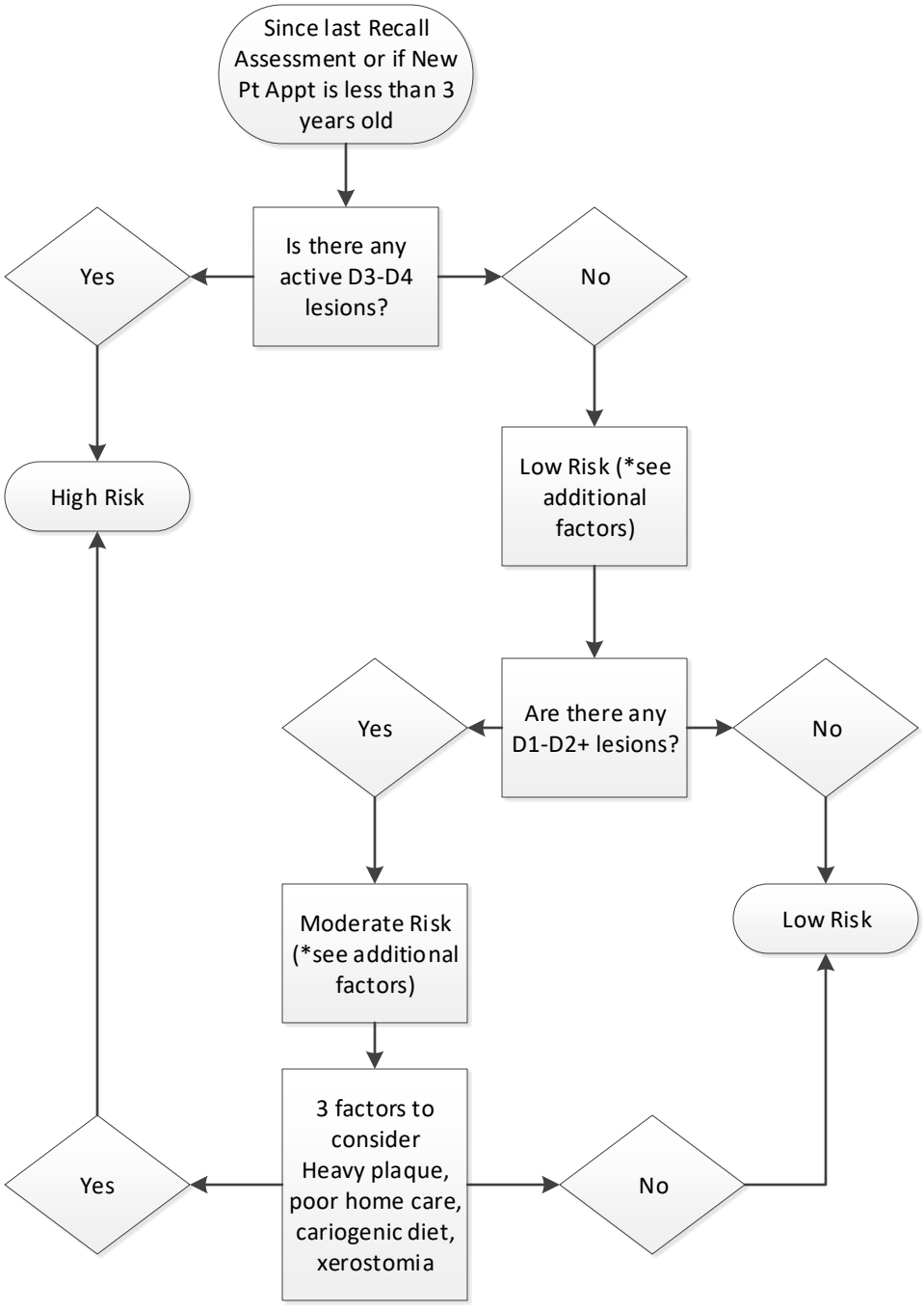
If both answers are ‘no’, then they are low risk, but then we look at the next 3 factors and if any are ‘yes’ then their risk bumps into the next highest category.

Question 3: Does the patient have any of these factors: heavy plaque/poor home care, cariogenic diet and xerostomia.

Note: There is also examiner discretion (a solitary active occlusal lesion on #16 may be moderate risk vs a preteen with poor home care and cariogenic diet but no active decay or incipiencies might be a high risk).

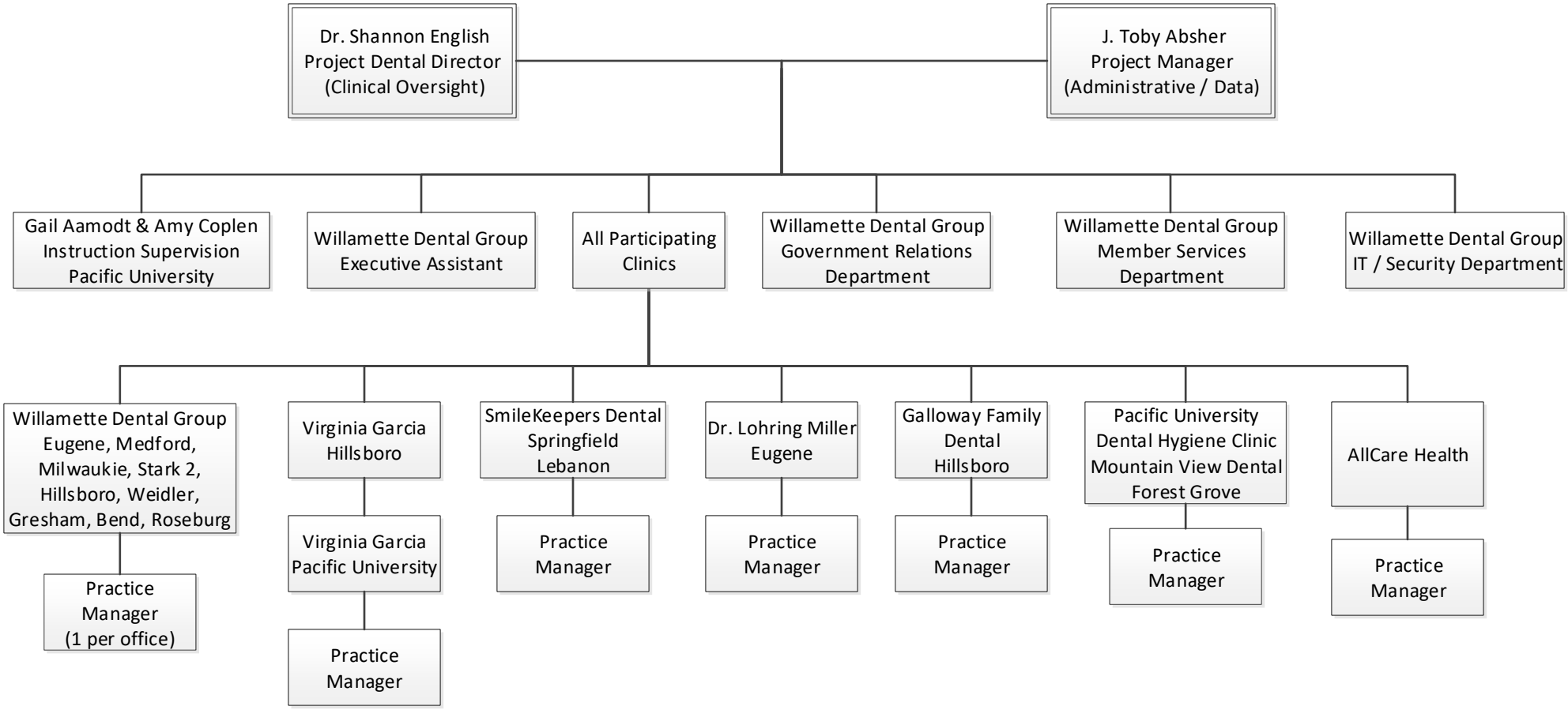
An example of an extreme risk patient that is very common is active decay and xerostomia, another being rampant decay and poor home care.

Patient Risk Factor Decision Tree



Note: Although the intent of this decision tree is adherence, it does not remove examiner discretion.

Oregon Dental Workforce Pilot
Organizational Chart



Budget Narrative

Personnel

Project Director

The Project Director position will be filled by Toby Absher, Director of Operations at Willamette Dental. The Project Director position will oversee all aspects of the project. He will manage, lead, inspire, and track progress on all aspects of the initiative. He will ensure operational processes and procedures are compliant and will work to help lead the public policy aspect during the final phase of the project. We have projected an annual increase of 2% per year in salary and fringe. All work from the project director has been donated as in-kind support from Willamette Dental Group.

Dental Director

The Dental Director role will be filled by Dr. Shannon English from Willamette Dental. She will provide oversight in the development and implementation of the work with clinical and education partners to develop evaluation criteria; work with dental directors at practice settings to determine preceptorship requirements and required experiences for participants; provide oversight for clinical monitoring for the Oregon Health Authority; act as an advocate for dental therapy with dentists, policy makers, and the public; and work with the Oregon Dental Board to work ultimately towards acceptance and licensure of dental therapists. We have projected an annual increase of 2% per year in salary and fringe. All work from the dental director has been donated as in-kind support from Willamette Dental Group.

Project Evaluator

The project evaluator position will be filled by contracting with a dentist from outside both organizations. The project evaluator has been identified as Bill Piskorowski from UCLA School of Dentistry. Bill's team will be responsible for review clinical practices to ensure compliance as well as serve as the evaluator of our data and processes and procedures. This person will compile all data relative to the project to help inform the public policy initiative in the final phase of the project. The Project evaluation team will be compensated $90,000 for analyzing the project data to be supported through grant funding and student tuition.

Fund Development

The fund development role will be shared with Amy Callahan Tracewell, Corporate and Foundation Relations Specialist, and Amy Coplen, Director of the Dental Hygiene Studies at Pacific. These two will be responsible for identifying funding agencies, preparing budgets, and developing new partnerships to support the project. Amy will coordinate reporting requirements for all funding agencies. In addition, Amy will be supported by the university's development budget and office of sponsored. We have been front loading a lot of the identification work and the application preparation. In the later stages of the project, the majority of their time will be spent on grant administration and marketing. Current sponsored funding includes $125,000 from the PEW Charitable Trusts and $114,000 from Ford Family Foundations. In addition, Willamette dental has agreed to sponsor 6 students per year at a rate of $15,000 a student. We have projected an annual increase of 2% per year in salary and fringe. All work from the fund developer has been donated as in-kind support from Pacific University.

Curriculum Development
Gail Aamodt, Professor and Clinic Education Coordinator at Pacific's Dental Hygiene Studies School, will be overseeing the development of the curriculum with support from Dr. Shannon English at Willamette Dental Group. Additionally, we are looking for independent evaluators to help us hone our curriculum. We anticipate having this work completed in the first phase of the project with small revisions throughout. Gail will continue to spend 20% of her time on the development and monitoring of curriculum deliver throughout the program. The total cost for Gail's effort supported through grant funding and student tuition is estimated to be $81,205 over the course of 4 years. We have projected an annual increase of 2% per year in salary and fringe.

Administrative Assistant Willamette
Toby Absher will require administrative support in his role as Project Lead and Director of Operations at Willamette. This captures .25 FTE of his administrative support person. We have projected an annual increase of 2% per year in salary and fringe. All work from the administrative assistant has been donated as in-kind support from Willamette Dental Group.

Administrative Assistant Pacific University
Pacific University will require administrative support for scheduling patients and any clinics that take place on Pacific University's campus. Ongoing administrative support is necessary during the didactic and clinical teaching to handle all management of ordering and grant money allocation. It has been determined to require approximately 20% time throughout the pilot project for a total of $26,321 supported through grant funding and student tuition. We have projected an annual increase of 2% per year in salary and fringe.

Didactic and Clinical Instructor Dentists
Clinical instructors for classroom academic instruction will be provided by hygiene instructional staff at Pacific University. $9,450 for each dentist to develop the curriculum and $23,355 for delivery of didactic and clinical education per year. Since they will be teaching two cohorts of students the total cost for the effort of the instructor dentists will be $56,160 per dentist over the course of 3 years. The grand total cost for curriculum development and curriculum delivery of two dentists is $112,320 over the course of 3 years supported by grant funding and student tuition.

Supervising Dentists
Supervising dentists will be provided by Willamette Dental Group. Each supervisor will have the title of Managing Dentist or Associate Dentist if a proxy is necessary. Since the 14-26 restorative hygienists will be performing their preceptor education in the office where they are employed. We are projecting .25 FTE per dental therapy participant for in-kind support. The dental therapy participant FTE was determined from an annual FTE amount and deducting the total preceptor hours required (e.g. 500 hours). Operations Enrollment for 10 participants. This figure accounts for the cost of the education program per participant. Willamette Dental is providing funding in this category for the first two years.

Dental Therapists
The expense to train each dental therapist through all three courses is estimated at $26,000 per student.

Travel
We are anticipating travel costs and reimbursements for some participants coming from out of the area, as well as the cost of Preceptor Dentists travelling to provide oversight. This will also cover some costs for instructor travel. $4,000 has been budgeted through grant funding for travel costs.

Convening Support
These funds will cover all the meetings necessary for the development phase of the project including food, venue, and travel stipends for participants. In-kind support will be provided when possible by both Pacific University and Willamette. $7,000 has been budgeted through grant funding for convening support costs.

Supplies, Education and Equipment
This will cover additional supplies needed to run the program. The total cost of equipment and student instrument supply kits which include all materials as well as student laptop computers to complete instruction all instructor supplies are estimated at $77,941 for course of the program to each two cohorts. This cost will be covered through grant funding and student tuition.

Overhead and Indirect Costs
This will cover personnel and overhead costs incurred by both Willamette and Pacific throughout the course of the project. Total indirect cost of the project has been determined through federal regulations at $40,860 for the length of the project. This cost will be covered through grant funding, student tuition and in-kind support by Willamette Dental group and Pacific University.

Total Costs
Total cost of the pilot project has been estimated to be $516,782.

PACIFIC UNIVERSITY

PN15

PROJECT TITLE:	Dental Therapist Spreadsheet Cost Calculation
PI:	
START:	
END:	

Be sure to select the appropriate F&A rate on line 131.

ACCT						Development Phase Year 1		Cohort 1 Implementation Year 2		Cohort 2 Implementation Year 3		Evaluation & Dissemination Year 4		Total Project
	SALARIES AND WAGES					% effort		% effort		% effort		% effort		
7001	Pacific University Personnel				Annual Salary									
	Total Number of Hours	Employee Name												
	0.80	Gail Aamodt	Faculty		$97,051.00	20.00%	$19,410	20.00%	$19,993	20.00%	$20,592	20.00%	$21,210	**$81,205**
	0.00		Faculty		$0.00	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	**$0**
	0.60	Alma Heredia/Brenda Marraquin	Staff		$41,000.00	0.00%	$0	20.00%	$8,446	0.2	$8,784	0.2	$9,091	**$26,321**
	0.00		Faculty		$0.00	0.00%	$0	0.00%	$0	0.0	$0	0.0	$0	**$0**
	0.00		Select E-Class		$0.00	0.00%	$0	0.00%	$0	0.0	$0	0.0	$0	**$0**
	0.00		Adjunct Faculty		$0.00	0.00%	$0	0.00%	$0	0.0	$0	0.0	$0	**$0**
					Total Pacific University Salaries & Wages	$19,410		$28,439		$29,376		$30,301		$107,526
					TOTAL SALARIES AND WAGES	**$19,410**		**$28,439**		**$29,376**		**$30,301**		**$107,526**
7090	FRINGE BENEFITS													
	Pacific University Personnel	Gail Aamodt	Faculty		35.0%	$6,794		$6,998		$7,207		$7,424		**$28,423**
			0 Faculty		35.0%	$0		$0		$0		$0		**$0**
		Alma Heredia/Brenda Marraquin	Staff		35.0%	$0		$2,956		$3,074		$3,182		**$9,212**
			0 Faculty		35.0%	$0		$0		$0		$0		**$0**
			0 Select E-Class		0.0%	$0		$0		$0		$0		**$0**
			0 Adjunct Faculty		0.0%	$0		$0		$0		$0		**$0**
					Total Pacific University Fringe Benefits	$6,794		$9,954		$10,281		$10,606		$37,635
					TOTAL FRINGE BENEFITS	**$6,794**		**$9,954**		**$10,281**		**$10,606**		**$37,635**
					TOTAL SALARIES AND BENEFITS	**$26,204**		**$38,393**		**$39,657**		**$40,907**		**$145,161**
73xx	TRAVEL			Number Yr 1 Yr 2 Yr 3 Yr 4 Yr 5										
	1. Domestic Travel	Description			Item Cost									
	Airfare	RELATED TO PROJECT EVAL				$0		$0		$0		$3,000		**$3,000**
	Lodging					$0		$0		$0		$0		**$0**
	Meals					$0		$0		$0		$0		**$0**
	Taxi/Ground Transport					$0		$0		$0		$0		**$0**
	Airfare					$0		$0		$0		$0		**$0**
	Lodging					$0		$0		$0		$0		**$0**
	Meals					$0		$0		$0		$0		**$0**
	Select Travel Cost from List					$0		$0		$0		$0		**$0**
	Select Travel Cost from List					$0		$0		$0		$0		**$0**
					Total Domestic Travel	$0		$0		$0		$3,000		$3,000
					TOTAL TRAVEL	**$0**		**$0**		**$0**		**$3,000**		**$3,000**
74xx	CONTRACTUAL SERVICES		Description											
	7448 - Contractual Services		Molly Saunders			$9,450		$23,355		$23,355		$0		**$56,160**
	7448 - Contractual Services		Shoneen Sendleback			$9,450		$23,355		$23,355		$0		**$56,160**
	7448 - Contractual Services		Bill Piskerowski			$0		$30,000		$30,000		$30,000		**$90,000**
	7448 - Contractual Services		Toby Absher - in Kind (0.25 FTE)			$0		$0		$0		$0		**$0**
	7449 - Contractual Services		Shannon English - In Kind (0.25 FTE)			$0		$0		$0		$0		**$0**
	Select Contractual Cost from List					$0		$0		$0		$0		**$0**
	Select Contractual Cost from List					$0		$0		$0		$0		**$0**
					Total Other Contractual Srvs	$18,900		$76,710		$76,710		$30,000		**$202,320**
					TOTAL CONTRACTUAL SERVICES	**$18,900**		**$76,710**		**$76,710**		**$30,000**		**$202,320**
7xxx	COMMODITIES		Description											
	7230 - Supplies-Lab		Student Kits $1500 x 10 of students			$0		$15,000		$15,000		$0		**$30,000**
	7230 - Supplies-Lab		Student laptops $1500 x 8 of students (Pacific Faculty don't need a laptop)			$0		$12,000		$0		$0		**$12,000**
	7230 - Supplies-Lab		Advisory committee meeting supplies			$3,500		$3,500		$0		$0		**$7,000**
	7230 - Supplies-Lab		Typodonts, rods, handpieces, pedo DXTTR, Instructor supplies			$0		$32,241		$0		$0		**$32,241**
	7230 - Supplies-Lab		Office supplies			$0		$100		$100		$0		**$200**
	7230 - Supplies-Lab					$0		$0		$0		$0		**$0**
	7230 - Supplies-Lab					$0		$0		$0		$0		**$0**
					TOTAL COMMODITIES	**$3,500**		**$62,841**		**$15,100**		**$0**		**$81,441**
	PARTICIPANT SUPPORT COSTS													
	Stipends					$0		$0		$0		$0		**$0**
	Travel					$0		$2,000		$2,000		$0		**$4,000**
	Subsistence					$0		$0		$0		$0		**$0**
	Other	Enrollment for 2 students				$0		$15,000		$15,000		$0		**$30,000**
	Training Stipends	[PEW STUDENT TUITION STIPENDS FOR 8 STUDENTS @$1250 PER STUDENT]				$0		$5,000		$5,000		$0		**$10,000**
					TOTAL PARTICIPANT SUPPORT COSTS	**$0**		**$22,000**		**$22,000**		**$0**		**$44,000**
	A. Total Direct Costs					**$48,604**		**$199,944**		**$153,467**		**$73,907**		**$475,922**
	B.1. Total costs subject to Federally negotiated F&A/overhead rate: Pacific University salary and wages only					**$19,410**		**$28,439**		**$29,376**		**$30,301**		**$107,526**
	B.2. Pacific University F&A/Overhead Rate			Organized Research	38.0%	**$7,376**		**$10,807**		**$11,163**		**$11,514**		**$40,860**
	c. Total Sponsor Request (A + B.2)					**$55,980**		**$210,751**		**$164,630**		**$85,421**		**$516,782**

Expense Object Codes

10/20/10 updated

OBJ	Description	Group	Comments
7001	FT Faculty sal	Payroll	
7002	FT Admin sal	Payroll	
7003	FT Staff wages	Payroll	
7004	PT Faculty sal	Payroll	
7005	PT Admin sal	Payroll	
7006	PT Staff wages	Payroll	
7007	Staff O/T	Payroll	
7008	Bonuses	Payroll	
7009	Add'l Payment	Payroll	
7010	Resident Assts	Payroll	
7011	Interns	Payroll	
7014	Music Lesson	Payroll	
7015	Coach Salary	Payroll	
7020	Student Wage FWS	Payroll	
7021	Student Wage PWS	Payroll	
7022	Student Wages Dept	Payroll	
7023	Student stipends Dept	Payroll	
7030	Housing Allow	Payroll	
7031	Car Allow	Payroll	
7032	Moving/Reloc Compe	Payroll	
7033	Deferred Comp	Payroll	
7034	Sabbaticals	Payroll	
7035	Uniform Allowance	Payroll	
7036	Temp Employ Agency	Payroll	
7037	Indep Contractors	Payroll	
7055	Tuition Grant	Payroll	
7081	Meal Plan remission	Payroll	
7090	Alloc'd Fringe/PR tax	Payroll	
7093	Admin/staff salary pool	Payroll	
7095	Sal/Frg allc'd to grant	Payroll	
7201	Supp- Office	7601 BP	
7202	Supp-instruct'l	7601 BP	
7203	Supp-maint	7601 BP	
7204	Supp-custodial	7601 BP	
7205	Supp-electrical	7601 BP	
7206	Supp-athletic	7601 BP	
7207	Supp-medical	7601 BP	
7208	Supp-food/concessions	7601 BP	
7209	Minor equip-under $5K	7601 BP	
7210	Supp-Camp Bkstore	7601 BP	
7211	Supp-Central Stores	7601 BP	
7212	Supp-grounds	7601 BP	
7213	Supp-uniforms/costumes	7601 BP	
7214	Supp-construction	7601 BP	
7215	Supp-empl training	7601 BP	
7216	Supp-gasoline	7601 BP	
7217	Supp-HVAC	7601 BP	
7218	Supp-plumbing	7601 BP	
7219	Supp-painting	7601 BP	
7221	Supp-ID cards	7601 BP	
7222	Supp-performance	7601 BP	
7223	Supp-photographic	7601 BP	
7224	Supp-research	7601 BP	
7226	Supp-exhibit	7601 BP	
7227	Supp-music ensemble	7601 BP	
7229	Supp-parking	7601 BP	
7230	Supp-lab	7601 BP	
7231	Supp-photocopying	7601 BP	
7232	Supp-lighting	7601 BP	
7234	Supp-diplomas	7601 BP	

OBJ	Description	Group	Comments
7235	Supp-chem equip	7601 BP	
7236	Supp-fac evaluations	7601 BP	
7240	Supp-resource ctr	7601 BP	
7242	Supp-locks/security	7601 BP	
7255	Supp-motor pool maint	7601 BP	
7256	Supp-facil vehicle maint	7601 BP	
7257	Supp-facil cart maint	7601 BP	
7259	Minor bldg fixtures	7601 BP	
7260	Supplies-Bldg upgrades	7601 BP	
7301	Travel-conference	7601 BP	
7302	Travel-professional	7601 BP	
7303	Travel-donor/alum relations	7601 BP	
7304	Admin recruitment	7601 BP	
7305	Faculty recruitment	7601 BP	
7306	Travel-student recruitment	7601 BP	
7307	Tavel-student groups	7601 BP	
7308	Travel-local mileage/meals	7601 BP	
7309	Travel-post season	7601 BP	
7310	Travel-motor pool charges	7601 BP	
7311	Travel-workshops	7601 BP	
7320	Employee relations	7601 BP	
7321	Public relations	7601 BP	
7322	Student relations	7601 BP	
7323	Student activities	7601 BP	
7324	Event tickets	7601 BP	
7325	McCormick Hall activities	7601 BP	
7326	Clarke Hall activities	7601 BP	
7327	Walter Hall activities	7601 BP	
7328	Conference activities	7601 BP	
7329	Prof'l/business meetings	7601 BP	
7330	Faculty events/ceremonies	7601 BP	
7331	Receptions/exhibits	7601 BP	
7332	Graduation events	7601 BP	
7333	Vandervelden Hall Activities	7601 BP	
7339	Manager Development	7601 BP	
7340	Faculty Development	7601 BP	
7341	Staff Development	7601 BP	
7342	Program Development	7601 BP	
7343	House Tutors	7601 BP	
7347	Account Transfer	7601 BP	**same as 7555 not in BP**
7372	Travel class-London	7601 BP	
7373	Travel class-D	7601 BP	
7381	Travel class-Arizona	7601 BP	
7401	Postage	7601 BP	
7402	Postage-Campus Mail	7601 BP	
7403	Freight/expr delivery	7601 BP	
7404	Telephone/fax	7601 BP	
7405	Telephone install/maint	7601 BP	
7406	Telecommunication services	7601 BP	
7407	Subsrciptions/periodicals	7601 BP	
7410	Computer Software	7601 BP	
7411	Photocpy-outside	7601 BP	
7412	Photocopy-Serv Ctr	7601 BP	
7413	Printing/publication	7601 BP	
7414	Memberships/assoc dues	7601 BP	
7415	Advertising-classified	7601 BP	**same as 7580 not in BP**
7416	Advertising-publicity	7601 BP	**same as 7580 not in BP**
7417	Telephone carrier-admin	7601 BP	
7418	Telephone carrier-student	7601 BP	
7419	Long dist resale	7601 BP	
7420	Educ'l serv/training	7601 BP	
7422	Database/research serv	7601 BP	
7421	Res Life Cable Bills	7601 BP	
7423	Environmental Site Assess	7601 BP	

OBJ	Description	Group	Comments
7424	Computer hardware	7601 BP	
7429	Independent Contract	7601 BP	
7430	Contractual exp reimb	Other	
7431	Consulting services	Other	
7432	Legal services	Other	
7433	Acctg/auditing services	Other	
7434	Invest mgmt/trustee fees	Other	
7435	Collect/billing services	Other	
7436	Technical services	Other	
7437	Artistic/design services	Other	
7438	Photography/video services	Other	
7439	Honorariums	Other	
7440	Outside catering services	Other	
7441	Campus food service	Other	
7442	Templ emply agencies	Other	
7443	Student supervision services	Other	
7444	Speaking/performance serv	Other	
7445	Security/alarm systems	Other	
7446	Bldg repair/remodel serv	Other	
7447	Facilities Dept services	Other	
7448	Contractual services	Other	
7449	Equip repair/service contracts	Other	
7450	Exterminating services	Other	
7451	Outside custodial services	Other	
7453	Outside maintenance services	Other	
7454	Outside grounds services	Other	
7455	Motor pool maint serv	Other	
7456	Facility vehicle maint serv	Other	
7457	Facility cart maint serv	Other	
7459	Laundry/cleaning services	Other	
7460	Ins-property	Other	
7461	Ins-liability	Other	
7462	Ins-workers comp	Other	
7463	Ins-athletic	Other	
7464	Ins-life (univ benef)	Other	
7469	Alloc'd insur	Other	
7470	Util-electricity	Other	
7471	Util-fuel oil	Other	
7472	Util-nat gas	Other	
7473	Util-water	Other	
7474	Util-waste disposal	Other	
7475	Util-hazard waste disp'l	Other	
7476	Util-sewer	Other	
7480	Rent-bldg/room	Other	
7482	Rent-equip	Other	
7484	Rent-interlibrary loans	Other	
7490	LT lease-bldg	Other	
7491	LT lease-equip	Other	
7492	Membership/Assoc dues	Other	**Gen'l Admin only**
7493	Library-Periodicals	Other	
7494	Library- Electronic Resources	Other	
7495	Printing	Other	**Admissions only**
7496	Bulk-supplies	Other	
7497	Dept Chargeback (1)	Other	
7498	Dept Chargeback (2)	Other	
7501	Interest expense	Other	
7503	Bank chgs/bank card cngs	Other	
7504	Depreciation exp	Other	
7505	Bad debt expense	Other	
7506	Cost of Goods Sold	Other	
7507	Cash over/short	Other	
7508	Permits/licenses	Other	
7509	Loss-sale of securities	Other	
7511	Uninsured loss/theft	Other	

OBJ	Description	Group	Comments
7512	Sellings Exp for donations	Other	
7517	Cost of Goods/Consignment	Other	
7518	Expense Reimbursement clearing account	Other	
7519	Fee/Revenue transfers	Other	
7521	Acct reconciliation	Other	
7523	Copyright royalties	Other	
7524	Fines/penalties/service chgs	Other	
7525	Indirect Cost recovery	Other	
7526	Room/board payments	Other	
7527	Accreditation exp	Other	
7528	Property Taxes	Other	
7529	Legal settlements	Other	
7530	State CT-12 fee	Other	
7531	Advances-o/s	Other	
7537	Bond issuance costs	Other	
7538	Misc plant fund exp	Other	
7540	Write-off uncoll pledges	Other	
7543	Research incentives	Other	
7544	Amort leasehold improve	Other	
7546	990-T Tax/fee	Other	
7547	Adv o/s credit card	Other	
7550	Misc distributions	Other	
7554	Amort leasehold improve	Other	
7555	Account transfers	Other	**same as 7457 in BP**
7557	Travel Class - Kenya	Other	
7558	Travel Class - London	Other	
7559	Travel Class -Chimpanzee	Other	
7560	Travel Class-Arizona	Other	
7561	Travel Class - Costa Rica	Other	
7562	Travel Class - Mexico/Cabello	Other	
7563	Travel Class-Hawaii/Gallahan	Other	
7564	Travel Class- Belize	Other	
7565	Travel Class - Hawaii/Jordan	Other	
7566	Travel Class - Hawaii/Culture	Other	
7567	Travel Class - Africa	Other	
7568	Travel Class - Wallowas	Other	
7569	Travel Class - Ghana	Other	
7571	Travel Class - Hawaii	Other	
7573	Travel Class - Hawaii/Art	Other	
7574	Travel Class -reserved	Other	
7575	Travel Class - Barcelona	Other	
7578	Travel Class - Austria	Other	
7579	Travel Class - Italian culture	Other	
7580	Advertising	Other	**same as 7415/7416 in BP**
7581	Test Materials	Other	
7582	EM Certifications	Other	
7601	Bdgt pool - operating/FOR **BUDGET ONLY**	BP Umb	**DO NOT USE FOR ACTUAL EXPENSES**
7704	Cap exp-bldgs/improvements	Cap/Trans	
7707	Cap equip-$5000 & over item	Cap/Trans	
7708	Cap exp-network	Cap/Trans	
7709	Cap exp-library books	Cap/Trans	
7711	Cap exp-artifacts/collections	Cap/Trans	
7745	Tfr-oper to plant	Cap/Trans	
7746	Trf-debt serv	Cap/Trans	
7747	Trf-cap expenditures	Cap/Trans	
7748	Trf-cap libr bks	Cap/Trans	
7749	Tfr-oper to plant/Cap. Leases	Cap/Trans	
7761	Tfr-endw to oper TR	Cap/Trans	
7767	Tfr-quasi to oper TR	Cap/Trans	
7771	Tfr-ann/life inc to oper	Cap/Trans	
7781	Tfr-plant to oper	Cap/Trans	
7786	Tfr-intraplant	Cap/Trans	

Drop-down list directions:
Type your list selections on this page, as the other examples
Highlight the list (you only need to highlight the first column) and select "Insert" from the menu
Select "Name" and then "Define"
Give the selections a descriptive name
Put the cursor in the cell you want a drop-down list
Select "Data" from the menu
Then select "Validation"
Select the "Settings" tab
Allow "List"
Find the name of your data

Name: 'SeniorPersonnel' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Faculty
Adjunct Faculty
Staff

Name: 'OtherPersonnel' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Faculty
Staff
Adjunct Faculty

Name: 'Student' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Undergrad, summer
Undergrad, academic
Graduate, summer
Graduate, academic

Name: 'Fabrication' - Note: List selections must match same names on "Benefits and F&A" worksheet
Select E-Class
NR - Classified Staff
NT - Temp Staff
NX - Extended Temp

Name: 'Travel'
Select Travel Cost from List
Airfare
Meals
Lodging
Taxi/Ground Transport
Car Rental
Mileage

Name: 'Commodity'
Select Commodity from List
7201 - Supplies- Office
7202 - Supplies-Instructional
7207- Supplies-Medical
7208 - Supplies-Food/Concessions
7209 - Minor Equipment-under $5K
7216 - Supplies-Gasoline
7223 - Supplies-Photographic
7224 - Supplies-Research
7226 - Supplies-Exhibit
7229 - Supplies-Parking
7230 - Supplies-Lab
7231 - Supplies-Photocopying
7410 - Computer Software
7412 - Photocopy-Service Ctr
7581 - Test Materials
Commodity (include description)

Name: 'Contractual'
Select Contractual Cost from List
7403 - Freight/expr delivery
7404 - Telephone/fax
7407 - Subsrciptions/periodicals
7413 - Printing/publication
7414 - Memberships/assoc dues
7406 - Telecommunication services
7431 - Consulting services
7432 - Legal services
7435 - Collect/billing services
7436 - Technical services
7437 - Artistic/design services
7438 - Photography/video services
7440 - Outside catering services
7441 - Campus food service
7444 - Speaking/performance serv
7448 - Contractual Services
7449 - Equip repair/service contracts
7480 - Rent-bldg/room
7482 - Rent-equip
Contractual Service (include description)

Drop-down list directions:
Type your list selections on this page, as the other examples
Highlight the list (you only need to highlight the first column) and select "Insert" from the menu
Select "Name" and then "Define"
Give the selections a descriptive name
Put the cursor in the cell you want a drop-down list
Select "Data" from the menu
Then select "Validation"
Select the "Settings" tab
Allow "List"
Find the name of your data

Name: 'SeniorPersonnel' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Faculty
Adjunct Faculty
Staff

Name: 'OtherPersonnel' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Faculty
Staff
Adjunct Faculty

Name: 'Student' - Note: List selections must match same names on "Benefits and F&A" spreadsheet
Select E-Class
Undergrad, summer
Undergrad, academic
Graduate, summer
Graduate, academic

Name: 'Fabrication' - Note: List selections must match same names on "Benefits and F&A" worksheet
Select E-Class
NR - Classified Staff
NT - Temp Staff
NX - Extended Temp

Name: 'Travel'
Select Travel Cost from List
Airfare
Meals
Lodging
Taxi/Ground Transport
Car Rental
Mileage

Name: 'Commodity'
Select Commodity from List
7201 - Supplies- Office
7202 - Supplies-Instructional
7207- Supplies-Medical
7208 - Supplies-Food/Concessions
7209 - Minor Equipment-under $5K
7216 - Supplies-Gasoline
7223 - Supplies-Photographic
7224 - Supplies-Research
7226 - Supplies-Exhibit
7229 - Supplies-Parking
7230 - Supplies-Lab
7231 - Supplies-Photocopying
7410 - Computer Software
7412 - Photocopy-Service Ctr
7581 - Test Materials
Commodity (include description)

Name: 'Contractual'
Select Contractual Cost from List
7403 - Freight/expr delivery
7404 - Telephone/fax
7407 - Subsrciptions/periodicals
7413 - Printing/publication
7414 - Memberships/assoc dues
7406 - Telecommunication services
7431 - Consulting services
7432 - Legal services
7435 - Collect/billing services
7436 - Technical services
7437 - Artistic/design services
7438 - Photography/video services
7440 - Outside catering services
7441 - Campus food service
7444 - Speaking/performance serv
7448 - Contractual Services
7449 - Equip repair/service contracts
7480 - Rent-bldg/room
7482 - Rent-equip
Contractual Service (include description)

Acknowledgements

The dental work force pilot project application was made possible with the support, courage, and vision of the following individuals:

Eugene Skourtes, DMD, President & Chief Executive Officer, Willamette Dental Group
Kristen Simmons, BSDH, MHA, Chief Operating Officer, Willamette Dental Group
Russ House, Vice President & General Counsel, Willamette Dental Group
Shannon English, DDS, Managing Dentist – Eugene Office, Willamette Dental Group
J. Toby Absher, Director of Operations, Willamette Dental Group
Lisa Rowley, Professor & former Director, Pacific University
Gail Aamodt, Professor & Clinic Education Coordinator, Pacific University
Amy Coplen, Director of Dental Hygiene Studies, Pacific University
Amy Tracewell, Corporate & Foundation Relations, Pacific University
Matthew Sinnott, Sr. Director of Government Affairs & Contract Management, Willamette Dental Group
Dayna Steringer, Contract Compliance & Government Affairs Coordinators, Willamette Dental Group
Yuberca Pena, Contracts Administrator & Compliance Specialist, Willamette Dental Group
Chanel Wick, Quality Improvement Specialist, Willamette Dental Group
Elisa Turpen, Executive Assistant, Willamette Dental Group

Willamette Dental Group

First In Proactive Dental Care

6950 NE Campus Way, Hillsboro, OR 97124
Tel 503.952.2000 Fax 503.952.2200
www.willamettedental.com

January 2, 2018

To Whom It May Concern,

The purpose of the Dental Workforce Pilot Project is to reduce oral health disparities for vulnerable communities in Oregon. Forming an academic and community based partnership with Pacific University will educate and train Dental Hygienists to become Dental Therapists that can be incorporated into the dental professional team. Willamette Dental Group, P.C. continues to be a champion of the concept of team dentistry. Under this model, we expect each member of the team to utilize the full scope of their practice in a lawful, appropriate and efficient manner that ultimately leads to the best possible outcome of health for the patients that we serve. By utilizing our existing restorative hygiene employees in Oregon, we support the continued evolution of mid-level oral health providers in a dental team setting in both urban and rural areas.

The Dental Workforce Pilot Project supports our core values of innovation, compassion, integrity and health. We strive to embrace change, encourage invention and continually remain at the forefront of advances in oral health for the good of our patients, colleagues and company. Willamette Dental Group demonstrates caring and sensitivity for the diverse backgrounds of our patients and colleagues and generosity in our communities. We seek to exemplify and promote whole-person wellness through education and support of programs that keep our patients and employees healthy. Our company works to adhere to high ethical and professional standards, demonstrating commitment to our responsibilities with trust, honesty and respect for all.

Willamette Dental Group is proud to sponsor this project while collaborating with Virginia Garcia Memorial Health Center and the educational institution of Pacific University to establish the Dental Workforce Pilot Project to create and utilize dental therapists to address the ongoing need in Oregon for accessible, culturally-sensitive dental care and preventive services.

Sincerely,

Dr. Eugene Skourtes, DMD
President and CEO of Willamette Dental Group, Chairman of the Board of the Skourtes Institute

Dr. Nick Skourtes, DMD
Managing Doctor of Willamette Dental Group, Board Member of the Skourtes Institute

Additional Supplemental Document A – Employment/Utilization Sites

Willamette Dental Group Clinics

Each Willamette Dental Group office in Oregon has a diverse patient population that includes Medicaid, commercial capitation and fee for service patients. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Bend
62968 O.B. Riley Road, Suite 12
Bend, Oregon 97703

Eugene
2703 Delta Oaks Drive, Suite 300
Eugene, Oregon 97408

Gresham
1107 NE Burnside Road
Gresham, Oregon 97030

Hillsboro
5935 SE Alexander Street
Hillsboro, Oregon 97123

Medford
773 Golf View Drive
Medford, Oregon 97504

Milwaukie
6902 SE Lake Road, Suite 200
Milwaukie, Oregon 97267

Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97471

Portland - Stark 2
405 SE 133rd Street
Portland, Oregon 97233

Portland - Weidler
220 NE Weidler Street
Portland, Oregon 97232

Pacific University Clinics

The School of Dental Hygiene Studies at Pacific University treats a mixture of patients including low socioeconomic, Hispanic, uninsured and at risk patients. Mountain View Dental provides care to a diverse patient base that includes children and commercial insurances. Drs. Saunders and Sendelback also provide instruction and treatment at the School of Dental Hygiene Studies at Pacific University. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Pacific University Dental Hygiene Clinics
222 SE 8th Ave
Hillsboro, OR 97123

SmileCare Everywhere Van

Virginia Garcia Clinics

Virginia Garcia Health System provides dental care to a diverse patient population that includes migrant workers, Hispanic and pregnant women. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Beaverton Wellness Center
2725 SW Cedar Hills Blvd, Suite 200
Beaverton, Oregon 97005

Cornelius Wellness Center
1151 N. Adair St.
Cornelius, Oregon 97113

Hillsboro Clinics
226 SE 8th Ave.
Hillsboro, Oregon 97123

McMinnville Clinics
115 NE May Lane
McMinnville, Oregon 97128

Newberg Clinics
2251 E Hancock St, Suite 103
Newberg, Oregon 97132

Women's Clinic
333 SE 7th Ave, Suite 5500
Hillsboro, Oregon 97123

Beaverton School District
13000 SW 2nd St
Beaverton, Oregon 97005

Forest Grove School District
1715 Nichols Lane
Forest Grove, Oregon 97116

Hillsboro School District
1998 SE Century Blvd.
Hillsboro, Oregon 97124

Tigard High School
9000 SW Durham Road, Building 7110
Tigard, Oregon 97224

Tualatin High School
22300 SW Boones Ferry Road
Tualatin, Oregon 97062

Willamina School District
1100 NE Oaken Hills Drive
Willamina, Oregon 97396

SmileKeepers Clinics

Each Capitol Dental/SmileKeepers office in Oregon sees a variety of patients that include Medicaid, commercial capitation and fee for service patients. These populations include patients that have been identified as having higher disease rates and lower access to care.[1] Note: Capitol Dental and SmileKeepers are owned by the same corporation.

Gentle Dental Albany
2708 Santiam Hwy, SE
Albany, Oregon 97322

Gentle Dental Albany Childrens
2815 Willetta SW Ste.#A1
Albany, Oregon 97321

Gentle Dental Albany Pacific
717 SE Geary Street, Ste. # 102
Albany, Oregon 97321

Gentle Dental Bend
20516 Robal Road, Ste. 100
Bend, Oregon 97701

Gentle Dental Coburg Station
440 Coburg Rd. Ste. #104
Eugene, Oregon 97401

Gentle Dental Corvallis
1830 NW 9th Street, Ste. 106
Corvallis, Oregon 97330

Gentle Dental Dallas
244 E. Ellendale, Ste. #4
Dallas, Oregon 97338

Gentle Dental Keizer
6395 Keizer Station Blvd., Ste. 101
Keizer, Oregon 97303

Gentle Dental North Eugene
2401 River Rd. Ste. 120
Eugene, Oregon 97404

Gentle Dental Northgate
11 Rossanley Drive
Medford, Oregon 97501

Gentle Dental Skyline
4755 Liberty Rd. South
Salem, Oregon 97302

Gentle Dental Valley River
1800 Valley River Drive, Ste. 200
Eugene, Oregon 97401

SmileKeepers Corvallis
1769 NW Kings Blvd. #8
Corvallis, Oregon 97330

SmileKeepers DUC
1880 Lancaster Dr. NE , Ste. 104
Salem, Oregon 97305

SmileKeepers Eugene
1680 Chambers Rd. Suite 204
Eugene, Oregon 97402

SmileKeepers Gateway
948 NE 102nd Ave, Ste. 105
Portland, Oregon 97220

SmileKeepers Grants Pass
1201 NE 7th St., Ste. A
Grants Pass, Oregon 97526

SmileKeepers Lebanon Main
165 Main St.
Lebanon, Oregon 97355

SmileKeepers Lincoln City
2825 W. Devils Lake Rd.
Lincoln City, Oregon 97367

SmileKeepers McMinnville
510 E 8th St.
McMinnville, Oregon 97128

SmileKeepers Medford Children
925 Town Centre Drive, Ste. B
Medford, Oregon 97504

SmileKeepers Medford Main
826 E. Main St.
Medford, Oregon 97504

SmileKeepers Milwaukie
15121 SE McLoughlin Blvd.
Milwaukie, Oregon 97267

SmileKeepers Newberg
710 E. Foothills Dr., Ste. 710A
Newberg, Oregon 97132

SmileKeepers Salem Capitol
408 Lancaster Dr. NE
Salem, Oregon 97301

SmileKeepers Salem Childrens
1880 Lancaster Dr. NE Ste. 109
Salem, Oregon 97305

SmileKeepers Salem Lancaster
1251 Lancaster Dr. NE, Ste. A
Salem, Oregon 97301

SmileKeepers Sheridan
411 W. Main Street
Sheridan, Oregon 97378

SmileKeepers Springfield
227 Q. St.
Springfield, Oregon 97477

SmileKeepers Stark
13908 SE Stark Street, Ste. E
Portland, Oregon 97233

SmileKeepers Stayton
151 W. Washington Street
Stayton, Oregon 97383

Sandra Galloway, DMD Clinic
Dr. Galloway treats a variety of patients that include fee for service with a high ratio of older adult patients. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Galloway Family Dental
324 SE 9th Avenue
Suite C
Hillsboro, Oregon 97123

Lohring Miller, DMD Clinic
Dr. Lohring Miller treats a patient population that includes a variety of insurances such as Pacific Source, Advantage and all Delta dental insurances. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Lohring Miller, DMD
1310 Coburg Road, Suite 2
Eugene, Oregon 97401

AllCare Clinics
AllCare Health is a Coordinated Care Organization that treats Medicaid, Medicare and Medicare Advantage patients. These populations include patients that have been identified as having higher disease rates and lower access to care.[1]

Coast Community Health Center
1010 1st St SE #110
Bandon, Oregon 97411

Curry Community Health - 5th Street Clinic
615 5th Street
Brookings, Oregon 97415

Curry Community Health - School Based Health Center
629 Easy Street
Brookings, Oregon 97415

Curry Community Health - Gold Rush Center / Spicer Health Clinic
29692 Ellensburg Ave
Gold Beach, Oregon 97444

Curry Community Health - Clubhouse
29845 Airport Way
Gold Beach, Oregon 97444

Curry Community Health - Mental Health / Public Health
1403 Oregon Street
Port Orford, Oregon 97465

Curry Health Network
500 5th St
Brookings, Oregon 97415

Rogue Community Health - Medford Health Center
19 Myrtle Street
Medford, Oregon 97504

Rogue Community Health - Butte Falls Health Center
722 Laurel Ave
Butte Falls, Oregon 97522

Siskiyou Community Health Center
1701 NW Hawthorne Ave
Grants Pass, Oregon 97526

Siskiyou Community Health Center - Cave Junction
25647 Redwood Hwy
Cave Junction, Oregon 97523

SmileKeepers - Medford Childrens
925 Town Centre Drive, Suite B
Medford, Oregon 97504

SmileKeepers - Salem Childrens
1880 Lancaster Drive NE, Suite 109
Salem, Oregon 97305

SmileKeepers - Medford
826 E Main Street
Medford, Oregon 97504

Waterfall Clinic - North Bend Clinic
1890 Waite St # 1
North Bend, Oregon 97459

Waterfall Clinic - Marshfield Clinic
826 S 11th Street
Coos Bay, Oregon 97420

[1] Oregon's Coordinated Care Organizations Advancing Health Equity, Ignatius Bau. Jan 2019 (pg. 4)

Additional Supplemental Document B – Cohorts

Cohort 1
Estimated Start of Academic Training: Fall 2019

Willamette Dental Group - Bend
62968 O.B. Riley Rd, Suite 12
Bend, Oregon 97703

Willamette Dental Group - Eugene
2703 Delta Oaks Dr, Suite 300
Eugene, Oregon 97408

Willamette Dental Group - Gresham
1107 NE Burnside Rd
Gresham, Oregon 97030

Willamette Dental Group - Hillsboro
5935 SE Alexander St
Hillsboro, Oregon 97123

Willamette Dental Group - Milwaukie
6902 SE Lake Rd, Suite 200
Milwaukie, Oregon 97267

Willamette Dental Group - Portland - Stark 2
405 SE 133rd St
Portland, Oregon 97233

Willamette Dental Group - Portland - Weidler
220 NE Weidler Street
Portland, Oregon 97232

Pacific University Dental Hygiene Clinics
222 SE 8th Ave
Hillsboro, OR 97123

Galloway Family Dental
324 SE 9th Ave, Suite C
Hillsboro, Oregon 97123

Cohort 2
Estimated Start of Academic Training: Fall 2020

Willamette Dental Group - Medford
773 Golf View Dr
Medford, Oregon 97504

Willamette Dental Group - Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97471

Pacific University Dental Hygiene Clinics
222 SE 8th Ave
Hillsboro, OR 97123

Lohring Miller, DMD
1310 Coburg Rd
Suite 2
Eugene, Oregon 97401

AllCare
Location TBD

Virginia Garcia
Location TBD

SmileKeepers
Location TBD
(2 Supervising Dentists and 2 Dental Therapists)

Cohort 3
(Optional – Pending Additional Funding)

Additional Supplemental Document C – Population and Site Additional Information

The dentists participating in this pilot are among a small percentage of providers in Oregon who have dedicated more than 25% of their practice to patients with OHP dental insurance. The pilot sites are located in rural and urban areas that reach members who have a variety of economic and social determinants that can be barriers to care.

The pilot sites listed in this application for WDG are uniquely situated to provide care to members who meet the target population criteria. There are over 18,000 people in the target population currently being seen in these offices.

As of July 31, 2019, there are over 19,000 Medicaid patients assigned to the 9 proposed Willamette Dental Group pilot sites.

Additional Supplemental Document D – Populations and Sites

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
Willamette Dental Group - Bend 62968 OB Riley Road, Suite 12 Bend, Oregon 97701	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 20.6%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Seasonal Farmworkers/Homeless** - Deschutes County ID: 6412066407 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 08/21/2013 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Willamette Dental Group - Eugene 2703 Delta Oaks Drive, Suite 300 Eugene, OR 97408	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 24.2%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Lane County ID: 6417102319 **Designation Type: HPSA Population** Status: Designated **Score: 19** Designation Date: 03/27/2001 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	NHSC Approved Site Approved: 7/31/2018 Expires: 12/31/2021

[1] https://data.hrsa.gov/tools/shortage-area/hpsa-find
[2] List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties, Updated Census 2010, HRSA
[3] https://www.hrsa.gov/rural-health/about-us/definition/index.html
[4] National Health Service Corps (NHSC) Approved Sites
[5] https://nhsc.hrsa.gov/downloads/nhsc-sites/nhsc-site-reference-guide.pdf

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
Willamette Dental Group - Gresham 1107 NE Burnside Gresham, OR 97030	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 29.7%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Willamette Dental Group - Hillsboro 5935 SE Alexander Street Hillsboro, OR 97123	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 23.7%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Willamette Dental Group - Medford 773 Golf View Drive Medford, OR 97504	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or	Medicaid %: 22.8%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Seasonal Farmworkers**-Jackson County ID: 6417694621 **Designation Type**: **HPSA Population** Status: Designated **Score: 18** Designation Date: 12/26/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	NHSC Approved Site Approved: 7/31/2018 Expires: 12/31/2021

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	moderate to high risk for caries		Last Update Date: 12/26/2017		
Willamette Dental Group - Milwaukie 6902 SE Lake Road, Suite 200 Milwaukie, OR 97267	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 26.8%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Willamette Dental Group - Roseburg 2365 NW Stewart Parkway Roseburg, Oregon 97471	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 6.07%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Douglas County ID: 6414631750 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 09/28/2001 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	NHSC Approved Site Approved: 7/31/2018 Expires: 12/31/2021
Willamette Dental Group - Stark 2 405 SE 133rd Street Portland, Oregon 97233	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low	Medicaid %: 77.37%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Mid-Multnomah ID: 6414480423 **Designation Type: HPSA Population** Status: Designated **Score: 14** Designation Date: 11/30/1999	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	income (i.e. Medicaid) and/or moderate to high risk for caries		Last Update Date: 10/28/2017		
Willamette Dental Group - Weidler 220 NE Weidler Street Portland, OR 97232	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 27.2%	In a Dental Health HPSA: Yes HPSA Name: **Low Income**-North/Northeast Portland ID: 6413534196 **Designation Type: HPSA Population** Status: Designated **Score: 20** Designation Date: 07/23/2018 Last Update Date: 07/23/2018	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Galloway Family Dental 324 SE 9th Avenue, Suite C Hillsboro, OR 97123	• Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are moderate to high risk for caries • People with disabilities • People who are uninsured	Medicaid %: 0%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Lohring Miller, DMD 1310 Coburg Road, Suite 2 Eugene, Oregon 97401	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 75%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Lane County ID: 6417102319 **Designation Type: HPSA Population** Status: Designated **Score: 19**	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
SmileKeepers Corvallis 1769 NW Kings Blvd. #8 Corvallis, Oregon 97330	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Benton County ID: 6414065144 **Designation Type: HPSA Population** Status: Designated Score: 19 Designation Date: 09/06/2006 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants	
SmileKeepers DUC 1880 Lancaster Dr. NE Ste. 104 Salem, Oregon 97305	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Marion/Polk ID: 6414940200 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/14/1999 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants	
SmileKeepers Eugene 1680 Chambers Rd. Suite 204 Eugene, Oregon 97402	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Lane County ID: 6417102319 **Designation Type: HPSA Population** Status: Designated Score: 19 Designation Date: 03/27/2001 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	moderate to high risk for caries				
SmileKeepers Gateway 948 NE 102nd Ave, Ste. 105 Portland, Oregon 97220	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Mid-Multnomah ID: 6414480423 **Designation Type: HPSA Population** Status: Designated Score: 14 Designation Date: 11/30/1999 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Grants Pass 1201 NE 7th St., Ste. A Grants Pass, Oregon 97526	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Josephine County ID: 6414221673 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 05/06/2004 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Lebanon Main 165 Main St. Lebanon, Oregon 97355	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Linn County ID: 6416954626 **Designation Type: HPSA Population** Status: Designated **Score: 16**	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	income (i.e. Medicaid) and/or moderate to high risk for caries		Designation Date: 05/08/2008 Last Update Date: 10/28/2017		
SmileKeepers Lincoln City 2825 W. Devils Lake Rd. Lincoln City, Oregon 97367	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Lincoln County ID: 6415613792 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 06/15/2006 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
SmileKeepers McMinnville 510 E 8th St. McMinnville, Oregon 97128	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name**: Low Income/Migrant Farmworker/Homeless** - Yamhill C ID: 6413125912 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/23/1978 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
SmileKeepers Medford Children 925 Town Centre Drive, Ste. B Medford, Oregon 97504	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Seasonal Farmworkers**-Jackson County ID: 6417694621 **Designation Type: HPSA Population** Status: Designated	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	• Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		Score: 18 Designation Date: 12/26/2017 Last Update Date: 12/26/2017		
SmileKeepers Medford Main 826 E. Main St. Medford, Oregon 97504	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Seasonal Farmworkers**-Jackson County ID: 6417694621 **Designation Type: HPSA Population** Status: Designated Score: 18 Designation Date: 12/26/2017 Last Update Date: 12/26/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Milwaukie 15121 SE McLoughlin Blvd. Milwaukie, Oregon 97267	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Newberg 710 E. Foothills Dr., Ste. 710A Newberg, Oregon 97132	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Yamhill C ID: 6413125912 **Designation Type: HPSA Population** Status: Designated	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	• Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		Score: 13 Designation Date: 05/23/1978 Last Update Date: 10/28/2017		
SmileKeepers Salem Capitol 408 Lancaster Dr. NE Salem, Oregon 97301	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Marion/Polk ID: 6414940200 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/14/1999 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Salem Childrens 1880 Lancaster Dr. NE Ste. 109 Salem, Oregon 97305	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Marion/Polk ID: 6414940200 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/14/1999 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Salem Lancaster 1251 Lancaster Dr. NE, Ste. A Salem, Oregon 97301	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Marion/Polk ID: 6414940200 **Designation Type: HPSA Population**	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	• Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		Status: Designated Score: 13 Designation Date: 05/14/1999 Last Update Date: 10/28/2017	Rural Health Grants.	
SmileKeepers Sheridan 411 W. Main Street Sheridan, Oregon 97378	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name**: Low Income/Migrant Farmworker/Homeless** - Yamhill C ID: 6413125912 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/23/1978 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
SmileKeepers Springfield 227 Q. St. Springfield, Oregon 97477	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Lane County ID: 6417102319 **Designation Type: HPSA Population** Status: Designated **Score: 19** Designation Date: 03/27/2001 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
SmileKeepers Stark 13908 SE Stark Street, Ste. E Portland, Oregon	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Mid-Multnomah ID: 6414480423 **Designation Type: HPSA**	HRSA – Rural Designation – No Location: This location is not in an	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
97233	moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		**Population** Status: Designated Score: 14 Designation Date: 11/30/1999 Last Update Date: 10/28/2017	area that qualifies for Rural Health Grants.	
SmileKeepers Stayton 151 W. Washington Street Stayton, Oregon 97383	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 95%	In a Dental Health HPSA: Yes HPSA Name**: Low Income/Migrant Farmworker/Homeless** - Marion/Polk ID: 6414940200 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/14/1999 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Beaverton Wellness Center 2725 SW Cedar Hills Blvd, Suite 200 Beaverton, Oregon 97005	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Cornelius Wellness Center	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low	Medicaid %: 100%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Western Washington ID: 6416342887	HRSA – Rural Designation – No	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
1151 N. Adair St. Cornelius, Oregon 97113	income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		**Designation Type: HPSA Population** Status: Designated Score: 10 Designation Date: 01/31/1995 Last Update Date: 10/28/2017	Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Hillsboro Clinics 226 SE 8th Ave. Hillsboro, Oregon 97123	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic McMinnville Clinics 115 NE May Lane McMinnville, Oregon 97128	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Yamhill C ID: 6413125912 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/23/1978 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Newberg Clinics	• Low-Income Adults as determined by patients Medicaid eligibility	Medicaid %: 100%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker/Homeless** - Yamhill C	HRSA – Rural Designation – No	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
2251 E Hancock St, Suite 103 Newberg, Oregon 97132	• Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		ID: 6413125912 **Designation Type: HPSA Population** Status: Designated Score: 13 Designation Date: 05/23/1978 Last Update Date: 10/28/2017	Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Women's Clinic 333 SE 7th Ave, Suite 5500 Hillsboro, Oregon 97123	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Beaverton School District 13000 SW 2nd St Beaverton, Oregon 97005	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic	• Low-Income Adults as determined by patients	Medicaid %: 100%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant**	HRSA – Rural Designation – No	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
Forest Grove School District 1715 Nichols Lane Forest Grove, Oregon 97116	Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		**Farmworker -** Western Washington ID: 6416342887 **Designation Type: HPSA Population** Status: Designated Score: 10 Designation Date: 01/31/1995 Last Update Date: 10/28/2017	Location: This location is not in an area that qualifies for Rural Health Grants	
Virginia Garcia Dental Clinic Hillsboro School District 1998 SE Century Blvd. Hillsboro, Oregon 97124	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Tigard High School 9000 SW Durham Road, Building 7110 Tigard, Oregon 97224	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
Virginia Garcia Dental Clinic Tualatin High School 22300 SW Boones Ferry Road Tualatin, Oregon 97062	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: No	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Virginia Garcia Dental Clinic Willamina School District 1100 NE Oaken Hills Drive Willamina, Oregon 97396	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 100%	In a Dental Health HPSA: Yes HPSA Name: **FQHC/Migrant Farmworker/Low Income** ID: 6419994166 Designation Type: HPSA Population Status: Designated **Score: 17** Designation Date: 2/25/2010 Last Update Date: -	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
Pacific University Dental Hygiene Clinics 222 SE 8th Ave Hillsboro, OR 97123	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or	Medicaid %: 10% Uninsured %: 90%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Western Washington ID: 6416342887 **Designation Type: HPSA Population** Status: Designated **Score: 10** Designation Date: 01/31/1995 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
	moderate to high risk for caries • People with disabilities • People who are uninsured				
AllCare CCO Coast Community Health Center 1010 1st St SE #110 Bandon, Oregon 97411	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Coos County ID: 6414318289 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 04/10/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes. Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Curry Community Health - 5th Street Clinic 615 5th Street Brookings, Oregon 97415	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Curry Community Health - School Based Health Center 629 Easy Street Brookings, Oregon	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population** Status: Designated	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
97415	• Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017		
AllCare CCO Curry Community Health - Gold Rush Center / Spicer Health Clinic 29692 Ellensburg Ave Gold Beach, Oregon 97444	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Curry Community Health - Clubhouse 29845 Airport Way Gold Beach, Oregon 97444	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Curry Community Health - Mental Health / Public Health 1403 Oregon Street	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population**	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
Port Orford, Oregon 97465	• Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		Status: Designated Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017	Rural Health Grants.	
AllCare CCO Curry Health Network 500 5th St Brookings, Oregon 97415	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income** - Curry County ID: 6419812922 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 01/04/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Rogue Community Health - Medford Health Center 19 Myrtle Street Medford, Oregon 97504	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income/Migrant Seasonal Farmworkers-**Jackson County ID: 6417694621 **Designation Type: HPSA Population** Status: Designated Score: 18 Designation Date: 12/26/2017 Last Update Date: 12/26/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
AllCare CCO Rogue Community Health - Butte Falls Health Center	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Seasonal Farmworkers-**Jackson County ID: 6417694621	HRSA – Rural Designation – Yes Location: This location is in an area	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
722 Laurel Ave Butte Falls, Oregon 97522	moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		**Designation Type: HPSA Population** Status: Designated Score: 18 Designation Date: 12/26/2017 Last Update Date: 12/26/2017	that qualifies for Rural Health Grants.	
AllCare CCO Siskiyou Community Health Center 1701 NW Hawthorne Ave Grants Pass, Oregon 97526	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income/Migrant Farmworker** - Josephine County ID: 6414221673 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 05/06/2004 Last Update Date: 10/28/2017	HRSA – Rural Designation – No Location: This location is not in an area that qualifies for Rural Health Grants.	
AllCare CCO Siskiyou Community Health Center - Cave Junction 25647 Redwood Hwy Cave Junction, Oregon 97523	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name: **Low Income/Migrant Farmworker** - Josephine County ID: 6414221673 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 05/06/2004 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Waterfall Clinic - North Bend Clinic 1890 Waite St # 1	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Coos County ID: 6414318289	HRSA – Rural Designation – Yes	

Site Address	Focus Population	Characteristics of Medicaid/OHP patients seen by site location, self-reported from project sponsor	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2, 3]	National Health Service Corp (NHSC) Approved Sites[4, 5]
North Bend, Oregon 97459	income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries		**Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 04/10/2008 Last Update Date: 10/28/2017	Location: This location is in an area that qualifies for Rural Health Grants.	
AllCare CCO Waterfall Clinic – Marshfield Clinic 826 S 11th Street Coos Bay, Oregon 97420	• Low-Income Adults as determined by patients Medicaid eligibility • Children ages 0-18 who are low income (i.e. Medicaid) and/or moderate to high risk for caries • Adults with diabetes ages 19-64 • Older adults ages 65+ • Pregnant women who are low income (i.e. Medicaid) and/or moderate to high risk for caries	Medicaid %: 60%	In a Dental Health HPSA: Yes HPSA Name**: Low Income** - Coos County ID: 6414318289 **Designation Type: HPSA Population** Status: Designated Score: 17 Designation Date: 04/10/2008 Last Update Date: 10/28/2017	HRSA – Rural Designation – Yes Location: This location is in an area that qualifies for Rural Health Grants.	