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**Dental Pilot Project Application #100  
Oregon Tribes Dental Health Aide Therapist Pilot Project  
Technical Review Board Meeting Notes  
December 10, 2015**

The Oregon Health Authority’s Dental Pilot Project Technical Review Board (TRB) convened on December 10, 2015 to review the Dental Pilot Project Application #100: Oregon Tribes Dental Health Aide Therapist Pilot Project. The TRB for DPP #100 was held on December 10, 2015 from 9:00 am-4:00 pm at space donated by the Oregon Oral Health Coalition in Wilsonville, Oregon. The meeting was not open to the public.

**Technical Review Board Members Present:**

William S. Ten Pas, DMD	Oregon Dental Association
Gail L. Aamodt RDH, MS	Oregon Dental Hygiene Association
Tony Finch, MPH	Oregon Oral Health Coalition
Kenneth Wright, DMD, MPH	Kaiser Permanente
Shannon English, DDS	Willamette Dental
Kyle House, DDS	Private Practice, Pediatric Dentist
Richie Kohli, BDS, MS	Oregon Health Science University

**Technical Review Board Members Not Present:**

Maxine L. Janis, RDH, MPH, ABD	Heritage University
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**Subject Matter Experts Present:**

Maria Castro, MS	Office of Equity & Inclusion
Paul Kleinstub, DMD	Oregon Board of Dentistry
Bruce Austin, DMD	Oregon Health Authority

**Oregon Health Authority Program Staff Present:**

Sarah Kowalski, RDH	Oregon Health Authority
Laurie L. Johnson, DHSc, MA, RDH	Oregon Health Authority
Amy Umphlett, MPH	Oregon Health Authority
Cate Wilcox, MPH	Oregon Health Authority

## **Welcome**

Sarah Kowalski, Dental Pilot Project Coordinator, welcomed the meeting attendees. Ms. Kowalski provided background information on the Dental Pilot Project Program and its origins in Senate Bill 738 enacted in 2011. The goal of the Dental Pilot Projects is to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care. Ms. Kowalski asked all members of the Technical Review Board (TRB) to introduce themselves. All individuals present completed a sign-in sheet. The agenda for the day was reviewed.

## **Dental Pilot Project Program Background**

Ms. Kowalski reviewed the Oregon Health Authority's (OHA) role in the Dental Pilot Projects. OHA is responsible for approving projects, monitoring approved projects through progress reports and site visits. OHA is responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations. OHA monitors approved dental pilot projects for patient safety and protects the public by assuring that the citizens of Oregon receive the highest possible quality oral health care inside the confines of the approved pilot projects.

Ms. Kowalski reviewed the purpose of the program and projects. The Dental Pilot Projects are intended to evaluate the quality of care, access, cost, workforce and efficacy by achieving one of the following:

1. Teaching New Skills to Existing Categories of Dental Personnel
2. Developing New Categories of Dental Personnel
3. Accelerating the Training of Existing Categories of Dental Personnel
4. Teaching New Oral Health Care Roles to Previously Untrained Persons

Ms. Kowalski reviewed the actions that OHA is not responsible for which include not developing projects, not promoting one type of model, and not funding projects. The goals of the Dental Pilot Project Program are to ultimately make recommendations for best practice approaches and report back to the legislature at the conclusion of each project.

Ms. Kowalski reviewed the role of the Technical Review Board. Each project application will be reviewed by a Technical Review Board comprised of stakeholders and subject matter experts. The role of the Technical Review Board is to determine if the project meets the minimum standards as prescribed in OAR 333-010-0400 - 333-010-0470.

## **Project Approval:**

Ms. Kowalski reviewed the project approval process. The Technical Review Board (TRB) will include appropriate community-level personnel and key individuals, who can provide subject matter expertise, including: local dental public health managers; dental providers; and experts on state Medicaid policies, data, and quality improvement. In addition, Board members may include, but will not be limited to, representatives from the professional and private organizations. Pursuant to OAR 333-010-0445, no individual who has contributed to or helped prepare an application will be permitted to review the corresponding application. The Technical Review Board does not authorize or approve projects. The role of the board is to provide a recommendation to the Statewide Dental Director based upon review of the project application. The Technical Review Board does not have final decision making authority, the Statewide Dental Director has this responsibility.

**Application Overview**

TRB members were supplied with a printed and bound copy of DPP #100. Prior to the December 10, 2015 meeting, TRB received the application via electronic mail on October 19, 2015. TRB reviewed the application and submitted their comments on November 20, 2015.

Ms. Kowalski reviewed the application chronology.

**Application Chronology**

<b>Application Submitted:</b>	October 6, 2015
<b>Application Approved for Completeness:</b>	October 19, 2015
<b>Application Received by Technical Review Board:</b>	October 19, 2015
<b>TRB Application Review Comments Due:</b>	November 20, 2015
<b>TRB Board Meeting:</b>	December 10, 2015

**Facts of the Project:**

Ms. Kowalski reviewed the facts of the proposed project.

- **Title:** Oregon Tribes Dental Health Aide Therapist Pilot Project
- **Purpose:** Develops new categories of dental health care personnel
- **Proposed Project Period:** 6/1/2016 – 12/31/2025
- **Training Sites:** Anchorage, Alaska & Bethel, Alaska
- **Utilization Sites:** CTCLUSI’s Dental Clinic & CITCHC Health Clinic
- **Funding Sources:** Kellogg Foundation grant
- **Costs:** \$544,600 first two years

**Need for the Project:**

Ms. Kowalski reviewed the statistical rates of decay amongst Alaskan Native and American Indian children in the US as shared in the application. In addition, information from the 2012 Oregon Smile Survey was shared with regards to the decay rates of Oregon children ages 6-9. A review of the Centers for Medicaid and Medicare Oral Health Strategy from 2011 was shared around the principal barriers identified for dental care for children.

**A discussion amongst the TRB members followed.**

**Dr. House:** Important to impact the rampant and untreated decay, not the “had a cavity”.

**Dr. Ten Pas:** Need to measure the specific population—not use the Smile Survey data.

**Dr. Kohli:** They will be collecting baseline data for comparison.

**Mr. Finch:** Also look at the geographic area population, not just the native community. Overall, we need to look at collecting race/ethnicity data better.

**Ms. Castro:** Impact of social determinants of health.

**Dr. House:** Agrees—transportation is a huge problem in terms of access to care.

**Dr. Wright:** Delivery care model needs to change—hours, weekend, transportation, language access, etc.

**Ms. Castro:** Need willingness from providers to adapt practices to improve access.

**Ms. Aamodt:** These projects need to improve access to care.

### **Application Review:**

TRB Members were supplied with a worksheet to review the application upon. Their comments were due and submitted on November 20, 2015 to the OHA. The DPP then compiled the comments of each TRB member into one document. This document was then submitted to the applicants (NPAIHB) to allow them to respond to comments and questions by the TRB. A PowerPoint presentation was developed for the TRB meeting to allow members to follow along as the application was reviewed point-by-point.

#### ***1. Minimum Standards: Application Page Numbers: Pg. 63, 72***

Ms. Kowalski presented the Minimum Standards to which a project must adhere. The TRB was tasked with determining if the project met the standards as required. In addition, the TRB was asked to review whether the project provided for patient safety as required in OAR 333-010-0410.

#### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: I had some initial concerns in regards to extractions and pulpal therapy on permanent teeth. According to the CHAP Standards and Procedures 2.30.610 (p 135 of Appendix A) it is up to the discretion of the supervising dentist. Are there set limitations in the training of the supervising dentist or is it based on the skill of the therapist? Also in regards to diagnosing/treatment planning I had some concerns also, but According to Appendix C- DHAT Training, the Supervising Dentist advises and is consulted in regards to treatment planning.
- Comments: Item (1) (c) is not adequately described as to how patients currently receiving treatment will be provided or arranged emergency care if needed.
- Comments: All other criteria were met in PN 13, and page 72.

#### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- Supervising dentists have standing orders with the DHAT, which gives them discretion to limit scope of practice if there are any concerns.
- DHATs do not graduate unless they can show competency in every procedure in their scope.
- Relationship with the supervising dentist is close, and ongoing communication about treatment planning is critical.
- Emergency care will be provided in the same manner as any emergency at the utilization site.

#### **A discussion amongst the TRB members followed:**

**Dr. Wright:** there is a robust review process between DHAT and supervising dentist.

**Dr. Finch:** Competency, scope of practice, standing order differences as authorized by supervising dentist.

**Ms. Kowalski:** This is not the Minnesota model.

## ***2. Qualified Instructors to Prepare Trainees, Application Page Numbers: Pgs. 26-27***

Ms. Kowalski reviewed the requirements in OAR 333-010-0410. The TRB was tasked with determining if the project met the requirements of providing for qualified instructors to prepare the trainees.

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: p. 26-27, p. 63, Appendix B
- Comments: The use of the Alaska group well meets this criteria.
- Comments: Page 26
- Comments: Variety of expertise from well qualified instructors with the DENTEX program, which is well established and recognized for educating quality providers of Dental Therapy. CV's show experience in education, research, publication and practice.
- Comments: Yes, instructors are qualified and aligned with an accredited institution.

### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.

### **A discussion amongst the TRB members followed:**

**Dr. Ten Pas:** Are all dentists calibrated? Concerned about same quality of care for all,

**Ms. Aamodt:** Care will be as good as the dentist they have their standing orders with.

**Ms. Kowalski:** Faculty are calibrated, training component to faculty,

## ***3. Minimum level of competency, Application Page Numbers: 41-57, 63, 71-75***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the project met the requirements that there are assurances that trainees will have achieved a specified level of competence before entering the employment/utilization phase of the project.

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 41-57, p. 63, pp. 71-75
- Comments: I have checked yes on this but do have concerns that there does not appear to be an evaluation provided by independent Dentist and Hygienist. Though treatment is initially to be provided to members of the respective tribes the purpose is to evaluate this for possible deployment into the general populous. With that being the end goal, I would prefer to see some independent review of the competence levels of the providers done by either members of the Oregon Board of Dentistry and Hygiene or by members they select to assure the transparency needed in a project of this scope.
- Comments: Page 63
- Comments: Appendix C
- Comments: No: There is concern that the application states if trainees are not able to do certain procedures, they would not be allowed to do them in the clinics. This leads me to believe trainees

may be graduated and not have certain skills necessary. This happens in dental schools also, but they are retained in school until they are proficient and then graduate.

### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- DHAT Educational Program is a competency-based educational program.
- Students' competency in each area is assessed continually through their education. Demonstrate competency to the minimum standards (which are based on the standards used in dental schools) prior to moving on to the next skill set.
- Faculty is all calibrated to the same standards.
- Faculty conducts quarterly meetings to discuss each student's progress and remediation is handled immediately if indicated.
- No student is graduated if the faculty does not concur that they are competent in the entire scope of practice.
- The type of independent review that is being asked sounds like there is a desire for the therapists to sit for a clinical board exam. The students could do this, but it is actually a very poor process to determine competency because by definition competency is determined over time, a one day board exam is never going to be able to assess competence.
- This highly competent faculty is very capable of determining competency. Students have been retained in order to attain minimum standards of competency, and some have not been able to successfully graduate. Only 64% of the students graduate.

### **A discussion amongst the TRB members followed:**

**Ms. Aamodt:** Why are the DHATs being reviewed every two years when other providers are not—not a standard practice? The licensure should be sufficient with the system of supervising dentists.

**Dr. Wright:** When the DHATs were first being socialized, they want the more stringent oversight to assure competency concerns.

**Mr. Finch:** confirmed

**Dr. Kleinstub:** Disciplinary action on 15% of 250 complaints per year.

**Dr. House:** The purpose of this group is how applicable is this model in the general populous. Tribes can do this on their own land with their own people without this pilot. Not about a tribal decision, rather a question about the overall Oregonian population. Are their independent eyes on this? Shouldn't be deployed through tele-dentistry. Will there be independent review?

Concerns about behavior management.

**Dr. Wright:** Evaluation committee for OHA?

**Ms. Kowalski:** Yes—it will evaluate all of these aspects. Behavior management—don't use nitrous. It is in the supplemental document.

**Ms. Aamodt:** Their curriculum covers it.

**Ms. Castro:** What is the population profile of those who graduate—the 64% in Alaska. Is there any disparity? Why didn't they graduate? What are they doing to help students be successful? It is an unacceptable rate. Will this be an issue in Oregon?

**Ms. Aamodt:** High mentoring process—31 of 32 graduated. Every program is different.

**Dr. Kohli:** Same for dentistry school.

**Dr. Austin:** 64% is misleading. Usually family issues and not due to poor performance.

**Mr. Finch:** Dynamics of being away from family, children, etc. Attrition higher for those coming from far away—1 year training away from family.

#### **4. Sufficient Staff to Monitor Trainee, Application Page Numbers 30, 63**

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants demonstrated that the project has sufficient staff to monitor trainee performance and to monitor trainee supervision during the employment/utilization phase.

#### **TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:**

- Comments: pp. 30, 41ff, 63
- Comments: In the initial phases I believe they have. I am a bit concerned about the need for the DHAT Coordinators. They seem to be hired one to one with the DHATs, and I am left unsure of their role and why the need for an additional coordinator with each hire. Could this function not be overseen by routine managerial staff from the clinics?
- Comments: Pg 30
- Comments: What is the availability of experienced DHAT's for the pilot program? Also in regards to the Supervising Dentist role, should the Supervising Dentist terminate employment during the process of the pilot? How hard is it to recruit a replacement?
- Comments: I think the supervision is good. I have concerns with the relative value system as a measure. It overstates and bloats results. I do not have OR Laws 2011 Ch 716.

#### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- DHAT coordinators are not hired one to one with DHATs. There will be one 0.5 FTE DHAT coordinator at each site. Their role is critical in staffing this project within each site, for administrative and communications functions. There are experienced DHATs not working, and some who have moved out of Alaska, and we will approach those candidates first.
- Recruiting and retaining dentists in rural and tribal settings is often a challenge, which is why having DHATs provide continuity of care is one improvement to the delivery system. While there is disruption for the time of re-hire, once the new dentist is hired there is still a primary provider that is familiar and trusted in the community. Building the workforce to a point where there are multiple supervising dentists that can collaborate in these situations is a goal of the pilot. That said, the supervising dentist at CTCLUSI is both committed to the community and to this pilot project, and is looking forward to expanding services with the addition of the DHATs.
- Even though the RVU system is not perfect, it is standard in this setting when measuring the workloads of staff. It can be one measure that allows for comparison between work sites, individuals, etc.

#### **A discussion amongst the TRB members followed:**

**Ms. Aamodt:** I'm a coordinator. Hire, ensure calibration, assign sites, monitor evaluation forms, etc. Not necessary to have a clinical background. The coordinator doesn't have to provide the training. Makes sure everything is in order—they are a facilitator.

**Dr. House:** Do they need a DHAT coordinator per DHAT? Perhaps for one for a site.

**Ms. Kowalski:** 0.5 FTE per site. Don't know the scope of the coordinator.

**Ms. Aamodt:** Does care stop if supervising dentist leaves? Can't continue when supervising dentist isn't there.

**Mr. Finch:** Alaska had staff to backfill. Enough other people on staff who can backfill supervision role?

**Dr. House:** they have to stop clinical work—can still do community outreach. What is the system that would provide the consistent depth of practice to continue the local supervision role? Private providers may or may not do that once the program is in the community.

**Dr. Ten Pas:** Do they use RVUs? Easy to bloat the system of reimbursement. It breaks out each piece of the procedure to get maximum reimbursement.

**Dr. Wright:** Composite RVUs are now used more that protects against the bloating.

**Dr. Kohli:** moving away from RVUs.

**Ms: Aamodt:** credit by being able to do a procedure, not by quantity of procedure.

### *5. Dental Care Delivery System, Application Page Number 13*

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants demonstrated that the project possesses the potential for developing new or alternative roles for dental health care personnel or for developing a reallocation of health care tasks which would improve the effectiveness of the dental care delivery system.

#### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: Pg 13
- Comments: I have checked “yes” here only because there is not a “possibly” or “maybe”. Having been involved with the DHAT program in Alaska with my role there as Regional Oral Health Consultant for Head Start, I have seen the program work in specific regions under very specific conditions on a specific population. This project repeats that process. What this project may be lacking is attempting to integrate it into the broader dental and health arenas. If it cannot be a primary focus of this project, then I believe a second phase will need to be attempted to honestly see if the program can be effectively integrated into the more public delivery space.
- Comments: I believe these items are addressed, but the evaluation of quality of care, access, cost, workforce and efficiency could be improved. The patient satisfaction survey is weak.
- Comments: It develops new roles, but the improvement or effectiveness of the dental care system has yet to be proven.

#### ***NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:***

- The Alaska DHAT model expands access to consistent, routine, high-quality oral health care. Recruiting, training and employing DHATs in areas of the state that face a dental provider shortage (33 out of 35 counties) is not limited to a unique population. Having a mid-level provider to work under general supervision (to allow services in remote and varied locations) that can deliver the most routine and preventive services will be beneficial wherever there are people that cannot find a dentist within a reasonable distance to see them; wherever dentists are not accepting Medicaid payments; and wherever the disease burden is disproportionate.\

- This model has increased the number of AI/AN oral health care providers serving AI/AN communities. Expanding the model statewide would offer workforce opportunities to rural and lower income communities. The key is that recruitment starts in the communities with high needs, and services and economic development go back to that community. Lower costs of employing the mid-level provider stretch third party billing to allow more Medicaid, uninsured, and underinsured patients to be seen.

**A discussion amongst the TRB members followed:**

**Ms. Kowalski:** potential to go to where people are—e.g. SBHCs.

**Mr. Finch:** How are they collaborating with the community services, such as transportation, food bank, etc.? Prepare community for new model—has the ground work been done? The collective group can address the issues—e.g. reducing ED visits because the community system is working together.

**Ms. Kowalski:** Did they do that in Alaska—how?

**Dr. House:** Community brought the answer. Buy in was to not fly clients to Anchorage every time. Cannot look at what happened in Alaska to Oregon. It is different. It works on tribal land. We need to see how this works in the general population. How does it integrate into the CCOS/DCOs/greater Oregon society?

**Ms. Castro:** The legwork has been done. CCO Community Needs Assessments (CNA), dental access is in the top 10 of every CNA. They are ready. Buy-in should be there. Maybe not in every community, but many are ready. CCOs collective impact work will play in favor of programs like this. School Based Health Center (SBHC) ideal Community Health Improvement Plans (CHIPs) would facilitate the deployment of this type of program.

**Dr. Ten Pas:** Need to take care we do this right, gather the data, and shows it increases access. Lots of eyes on this.

**Ms. Castro:** How do we measure this? Why do we not see who we are seeing? The dental pilot needs to articulate/illustrate the population better. If you move the disparity of a population on one issue in a positive way, you move the disparity on many populations. The legislature needs to understand that if we are successful with this population, most likely we will be successful with other populations.

**Dr. Kohli:** Let's review page 59-61 to ensure this point.

**6. Timeline, Application Page Numbers 2-8**

Ms. Kowalski reviewed the legislative language and intent behind Senate Bill 738. Pilot Projects are designed to run 3-5 Years. SB 738 “(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project.” Pilot Projects can apply for a modification to extend the project timeline if needed. The project has applied to operate from June 1, 2016 to December 31, 2025.

**TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:**

- Comments: Detailed in FS2
- Comments: Pages 2-6

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.

**A discussion amongst the TRB members followed:**

**Ms. Kowalski:** Ending in 2025 is a problem. They are supposed to run 3-5 years or time for validity of project. We can approve for 5 years, and then they can petition for more years later.

**Ms. Aamodt:** There will be 2 years of training, but the additional 3 years should provide enough time to prove effectiveness.

**Ms. Kowalski:** They already have someone training in Alaska, which is fine.

**Dr. Kohli:** When we approve the project, what time?

**Dr. Austin:** 5 seems reasonable.

**Dr. House:** agreed.

**7. Training & Utilization Project Sites,**

Ms. Kowalski reviewed the locations of both the training sites in Alaska and utilization sites in Oregon. The utilization sites in the application included the Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians: CTCLUSI Dental Clinic and Coquille Indian Tribe: Coquille Indian Tribal Community Health Center (CITCHC). The applicants have indicated they are working on other site locations with other tribes in Oregon. Ms. Kowalski reviewed the requirements in OAR 333-010-0410. The TRB was tasked with determining if the applicants included a detailed narrative of the Training & Utilization Project sites.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 7-8
- Comments: Yes to me, but I am very aware of the program and its training protocols. In this narrative it states the affiliation with DENTEX and MEDEX, but there is not much information on what those programs provide. What is the training curriculum, how many procedures are done and under who's instruction and assessment, etc.? This leaves a large hole in the available data for most folks not aware of the program, so some supplemental information would be appreciated.
- Comments: No
- Comments: page 8. Only the 1st site fulfills this requirement. The 2nd site does not yet have a clinic. Additional sites have not been identified.
- Comments: Page 7&8
- Comments: Some areas TBD, which leaves opportunity for increased outreach.
- Comments: No: It does for CTCLUSI but does not for Coquille. The Coquille agreements is tentative and was submitted in February. CTCLUSI is more recent and more complete.

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- Appendices B and C contained CVs of instructors, and curriculum description in detail. Clinical year is done in Bethel, AK, not at the utilization site. 400 hour preceptorship is done at the utilization site.
- There is broad interest in the state among the 9 tribes. If and when tribal leadership of our potential future sites have made commitments, we will amend our application.

- The Coquille Indian Tribe (CIT) is committed to improving access to oral health through the DHAT Pilot Project. The CIT is planning to partner with the CTCLUSI in the initial phases of this project to share dental clinic space and supervising dentist. The CIT and CTCLUSI are also exploring the feasibility of mobile dental services, with DHAT's, as a member of the oral health team, to improve access and deliver care to tribal members throughout the six counties that are part of the tribes' service area. The CIT is expanding its current community health center facility to include dental services. A proposal for funding this facility expansion was recently approved by the Coquille Tribal Council and submitted to the funder. Construction is planned to begin March 2017 and open January 2018.

**A discussion amongst the TRB members followed:**

**Ms. Kowalski:** In Alaska—Anchorage Year 1, Bethel Year 2. Year 2 flying to villages for community service projects and training. In the future, they would like to have the training in Oregon. Sites are Coos/LU/Siuslaw and Coquille. Additional sites that have been brought up are possibly Cow Creek and Umatilla if they can afford it. If they want to bring them on board, that would be a modification of the project.

**Ms. Aamodt:** Gail: Don't see the infrastructure built into the project- e.g. a dental clinic. No site yet. Can they answer that?

**Ms. Kowalski:** Curriculum in detail is in the Appendix—400 pages.

**Dr. English:** How far apart are the two sites? Could there be a common clinical site or do they need 2 clinics?

**Ms. Kowalski:** See responses. They had to get tribal agreement to participate.

**Dr. Ten Pas:** Mobile service only is problematic versus a bricks and mortar site.

**8. *Criteria Used to Select Utilization Site, Application Page Numbers: 36, 37, 61***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants included a detailed narrative of the Training & Utilization Project sites and criteria used to select the sites.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 7-8
- Comments: Yes to me, but I am very aware of the program and its training protocols. In this narrative it states the affiliation with DENTEX and MEDEX, but there is not much information on what those programs provide. What is the training curriculum, how many procedures are done and under who's instruction and assessment, etc.? This leaves a large hole in the available data for most folks not aware of the program, so some supplemental information would be appreciated.
- Comments: No: Comments: page 8. Only the 1st site fulfills this requirement. The 2nd site does not yet have a clinic. Additional sites have not been identified.
- Comments: Page 7&8
- Comments: Some areas TBD, which leaves opportunity for increased outreach.
- Comments: No: It does for CTCLUSI but does not for Coquille. The Coquille agreements is tentative and was submitted in February. CTCLUSI is more recent and more complete.

## **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.

### **A discussion amongst the TRB members followed:**

**Dr. Ten Pas:** See pages 36-37, 61 of application; and please ask them.

## ***9. Schools, Health Facilities, Colleges, Application Page Numbers: 79-82***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had provided evidence that demonstrates a liaison has been established with participating agencies. (Schools, health facilities, colleges, etc.)

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 79-80, DENTEX/ANTHC/UW-MEDEX
- Comments: SPPT 1 though unsigned on some of the agreements. Looks like the pilot is well covered from the Tribal side.
- Comments: SPPT1
- Comments: pg. 79-82
- Comments: Pg 13 AB1 and pg 32 PN5

## **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- DHAT program will be cutting ties with DENTEX.
- “We are going to partner with a local tribal college. UW has been a great partner, but never intended to be with us for the long haul. This is an amicable parting and one that is very bitter sweet, but we need to be able to provide our students with an Associate degree in order to be able to qualify for accreditation, so it is time to move on.”

### **A discussion amongst the TRB members followed:**

**Ms. Kowalski:** They will be discontinuing the relationship with DENTEX. Rather they will partner with a local school in Alaska to move forward in providing an AA degree.

**Dr. Ten Pas:** I have concerns. UW is accredited, big faculty with lots of training. Severing relationship with School X—who are they? Training? Worked with CODA? Quality?

**Dr. Austin:** In a remote part of Alaska, didn't know them.

**Ms. Kowalski:** Do they provide other types of training?

**Dr. Wright:** Did DENTEX provide AA degree?

**Ms. Kowalski:** Only a Certificate.

**Mr. Finch:** Tied to the Nurse Practitioner school—more mid-level training.

**Ms. Aamodt:** Talked with CODA. A key point is the education is transferable. Must be! If not, that is a huge issue for the sake of the students and trust of the community. Needs to be an accredited program. We need to know more.

**Mr. Finch:** They are talking about meeting CODA requirements, then it must be an accredited school. It probably will be okay, but we need to ask.

**Ms. Aamodt :** Mary may not know what accredited means. It takes time and is arduous. We need to say to be viable in Oregon, it must be an accredited program.

### ***10. Supporting Statistics Describing the Need, Application Page Numbers: 18, 101-103***

Ms. Kowalski presented statistics from the Indian Health Service 2014 Oral Health Survey which contained National Area and Clinic Level Results. Links and supporting information is contained in the Technical Review Board DropBox. Ms. Kowalski indicated that the supporting documents will also be emailed to TRB members who have chosen not to access the DropBox. Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had provided evidence with supporting statistics that describes the need for this pilot project.

#### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 101-103
- Comments: They have supported the need to look at this for the children at the Tribal sites. I do not see supporting documents for the broader populous.
- Comments: SPPT2
- Comments: pg. 101-103
- Comments: Significant need within pilot population.
- Comments: No: The statistics are national and not for the areas proposed.

#### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.
- NPAIHB supplied follow-up links to the “Oral Health of AI/AN Preschool Children 2014 Indian Health Service 2014 Oral Health Survey” which contained National Area and Clinic Level Results.

#### **A discussion amongst the TRB members followed:**

**Ms. Kowalski:** In Dropbox—2014 survey, demographic data (need this updated from 1999) Baseline data will be critical for site-specific data.

**Mr. Finch:** Tony: What baseline data is required?

**Ms. Kowalski:** We don't tell them. We can tell them what we want to see. See OARs.

### ***11. Demographic Data of Population, Application Page Numbers 62, 104***

Ms. Kowalski indicated that the NPAIHB supplied a link to the study “An Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons.” Links and supporting information is contained in the Technical Review Board DropBox. Ms. Kowalski indicated that the supporting documents will also be emailed to TRB members who have chosen not to access the DropBox. This study was published in 1999 and is close to 200 pages in length.

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had provided demographic data to support the oral health status and the unmet oral health needs of the targeted population that will be served by the proposed project.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: SPPT3
- Comments: p. 104 – not site specific but by association/reflection. P. 62 some baselines to be identified prior to project implementation.
- Comments: No: The statistics are national and not for specific areas.
- Comments: SPPT3
- Comments: I did not see demographic data specific to oral health status of Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians.

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.
- NPAIHB supplied follow up links to the study “An Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons.”

**A discussion amongst the TRB members followed:**

**Mr. Finch:** Would like more data specific to Coos.

**Dr. House:** Agrees.

***12. Purpose and Objectives of the Project, Application Pages 5-7, 15-17***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had clearly stated the purpose and objectives of the project with specific time frames.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp.5-7, 15-16 – New category of dental personnel in Oregon modeled after the Alaska DHAT.
- Comments: Well stated and defined.
- Comments: No: Comments: The time frame is weak: “In the first 3 years we will evaluate our pilot sites.” Goals and objectives have not identified numbers or percentages of improvement noted; how will the project coordinators know if the goals and objectives were met?
- Comments: Pages 15-17
- Comments: It states the purpose and objectives clearly.

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- In the short term, our objectives are to:
  - Increase the efficiency of the dental clinic and dental team;
  - Increase the ability of tribal health programs to meet unmet need; and

- Increase provider job satisfaction and patient satisfaction.
- In the long term, our objectives are to:
  - Increase the number of Native providers serving Native communities;
  - Increase patient education at the community level;
  - Increase treatment of decay and decrease decay rates in pilot populations;
  - Improve overall understanding of oral health in relation to overall health; and
  - Improve oral care behaviors in pilot communities.
- Our short term objectives are more easily measured, and we will be working closely with our tribal sites to ensure that the specific measure and the individual site coordinators would be able to track the progress of the site in terms of meeting goals and objectives. For example, what does it mean for a tribal health program to meet unmet need? Is it decreased wait time, increased percentage of children receiving oral health exams per year, increased percentages of their adult population etc.?
- When we finalize our relationship with an evaluation team, we will better be able to provide specific measures that we believe will be possible to measure within the short timeframe of this project that will demonstrate success toward long term objectives.

**A discussion amongst the TRB members followed:**

**Ms. Aamodt:** They explained this well last week at the symposium. One question—decreased decay rates. The baseline may be higher due to providing care to those who never had care. Be prepared to see the numbers go up due to touching new populations.

**Ms. Castro:** We saw that across the board—saw it in CCOs—with expanded access.

***13. Demonstrate Feasibility, Application Pages 15-17***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had described how the proposed project will demonstrate feasibility for achieving the objectives.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 15-17
- Comments: For this targeted population they have.
- Comments: 27-29
- Comments: pg. 16 & 17
- Comments: Availability of experienced DHAT's? Will the DENTEX program expand in the number of students accepted to accommodate the Oregon Pilot or will the number remain the same and fewer Alaskan students? (Or does the program base its acceptance numbers on application and interest?)
- Comments: I am still concerned about cost effectiveness.

**NPAlHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- Students pay out-of-state tuition—that is part of the short term sustainability plan for the DHAT ED Program. AK students will still have priority, but to date they have only entered a max of 8 AK students and have the capacity to select 12.

**A discussion amongst the TRB members followed:**

- No Comments

***14. Description of the Skills Trainees are to Learn, Application Page Number 18***

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: p.18 – Mirror the Alaska DHAT program with full collaboration, training, and implementation monitoring.
- Comments: Appendix A
- Comments No: pg. 18 A more a general statement rather than clearly describing the skills trainee will learn.
- Comments: Comments: This is weak in the narrative section, but is well stated later in the proposal.
- Comments: Specifically in Appendix A and C.

**NPAlHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- The Alaska DHAT model expands access to consistent, routine, high-quality oral health care. Recruiting, training and employing DHATs in areas of the state that face a dental provider shortage (33 out of 35 counties) is not limited to a unique population. Having a mid-level provider to work under general supervision (to allow services in remote and varied locations) that can deliver the most routine and preventive services will be beneficial wherever there are people that cannot find a dentist within a reasonable distance to see them; wherever dentists are not accepting Medicaid payments; and wherever the disease burden is disproportionate.
- This model has increased the number of AI/AN oral health care providers serving AI/AN communities. Expanding the model statewide would offer workforce opportunities to rural and lower income communities. The key is that recruitment starts in the communities with high needs, and services and economic development go back to that community. Lower costs of employing the mid-level provider stretch third party billing to allow more Medicaid, uninsured, and underinsured patients to be seen.

**A discussion amongst the TRB members followed:**

- No Comments

***15. Relationship to the Sponsor, Application Page Numbers 20-21***

Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had described the project's relationship to the sponsor.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: p.p. 20-21, NPAIHB
- Comments: Very thorough on pg. 20.
- Comments: Page 21
- Comments: 20
- Comments: Would like to see the “need proposal” submitted to Kellogg on April 3rd as referenced in the Kellogg letter of support.

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.

**A discussion amongst the TRB members followed:**

**Dr. House:** What happens with the relationship with DENTEX?

**Ms. Kowalski:** Need more information.

**Dr. Kohli:** The need proposal.

**Ms. Kowalski:** Please ask them this afternoon.

**Mr. Finch:** Kellogg driving the need for mid-level provider. Who asked whom to participate?

**Dr. Wright:** Publishing could be part of the story.

***16. Curriculum Plan, Application Pages 41-61***

Ms. Kowalski provided an update regarding new accreditation standards for dental therapy programs. CODA standards published and implemented in August 2015. “The curriculum must include at least three academic years of full-time instruction or its equivalent at the postsecondary college-level.” Alaska DHAT Program is applying for CODA Accreditation. Ms. Kowalski reviewed the requirements in OAR 333-010-0410. The TRB was tasked with determining if the applicants had described a curriculum plan thoroughly which will prepare each trainee to meet specific competencies and project objectives.

***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: p. 40ff – existing DHAT with DENTEX
- Comments: Page 42-57
- Comments: Page 41-61
- Comments: More detail Appendix C
- Comments: It is thoroughly described, but the clinical is tentative for the Coquille pilot.

**NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- There were no response comments on the TRB worksheets submitted by the applicants on this point.

**A discussion amongst the TRB members followed:**

**Ms. Kowalski:** Not sure if CODA will approve their new school. Should be a 3-year program, but year round could be the work around to this and the 2-year program. Ask Dr. Willard.

**Dr. Austin:** Total hours made sense.

## ***17. Measurable Objectives, Monitoring, Evaluation & Data Plans, Application 59-64***

Ms. Kowalski asked TRB members to review pages 14 and 15 from the Dental Pilot Project Application Workbook which the applicants used to complete their application to the program. Ms. Kowalski reviewed the requirements in OAR 333-010-0400 - 333-010-0470. The TRB was tasked with determining if the applicants had provided a description of baseline data and project activity information to be collected. Plans must include a description of the method to be used in collecting and analyzing data about trainee performance, acceptance and cost effectiveness.

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: pp. 59-64 - more site specific baselines, p. 62
- Comments: page 62, PN12
- Comments: Page 62
- The data collection needs to be robust and detailed.
- Comments: pp. 59-74
- Comments: page 60
- Comments: Page 62
- Comments: What will the researcher evaluate in the blind study of dentist/DHAT comparison?
- Comments: I have concerns with the relative value system. It may not be a true picture of the trainees and programs performance. I am not assured with the cost effectiveness by what has been submitted.

### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- We believe that the blind study would show that trained DHATs with comparable years of practice deliver the same (and sometime higher) quality of care as a dentist for the procedures a DHAT is trained to perform.
- We are still finalizing our evaluation system and are willing to use other systems of measure to evaluate the trainees and program performance.

### **A discussion amongst the TRB members followed:**

**Ms. Aamodt:** When do the experienced DHATs come to Oregon? Baseline data on page 62 needed prior to them starting.

**Dr. Austin:** They will start June/July 2016 with community outreach.

**Dr. House:** What if they come forward with baseline that shows no need? Do we disapprove?

**Ms. Kowalski:** They have done some of that process to justify to this point. They don't want to invest in baseline if the project wasn't going to get approved.

**Dr. Kohli:** Why are they calling it a blind study? Dentist vs a DHAT?

**Dr. House:** What are they studying?

**Dr. Finch:** Are we measuring quality?

**Dr. Austin:** Pretty restoration or did it fail after a year? Measure lack of quality versus who is better—DHAT or Dentist.

**Dr. House:** What type of patient management system are they using? Never not want to study quality but not measuring who is the better provider.

**Dr. Austin:** We can gather a lot from the charts.

**Ms. Aamodt:** Recommend a simple inter oral photo—and maybe x-ray--of any restoration.

**Dr. Kohli:** What about cavity preparation?

**Ms. Aamodt:** Part of the training process.

**Mr. Finch:** Difference between training and production. Measuring should be different. Probably not needed in the production phase.

**Ms. Aamodt:** I agree.

**Dr. House:** I partially disagree. In training, everyone is on their best behavior. Once out in production, may not be at the same level. We can do chart reviews—not arduous. It would be remiss to not check the clinical work. Builds political confidence in the community. Need to ensure and quality institution behind it and metrics that prove quality services. Need independent look at this. No need for more xrays, for example.

**Dr. Austin:** Will help for scalability down the road.

**Dr. House:** Need an Oregon spin on it—not tribal, not Alaska, not Kellogg—Oregon.

**Dr. Kohli:** Measure Adverse Outcomes. Let's talk with them about this.

**Dr. Johnson:** Kellogg did a report on 1,100 studies over 54 countries that showed the quality of DHATs.

**Dr. Ten Pas:** Dentistry in US is different than other countries. Concerned about “developing evaluation system”. Isn't this too late to start an evaluation system?

## **18. More Information**

Ms. Kowalski stated that the Oregon Health Authority (OHA) program staff may request additional information from an applicant during the Technical Review Process. Ms. Kowalski presented a 5 year budget that was submitted by the applicants for review by the TRB.

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: Can the pilot, which is already based on and utilizer of a seasoned existing program, accomplish expected results in 3-5 years?
- Comments: 1) Will there be any oversight or monitoring of the project as it progresses from outside groups – OHA, Board of Dentistry and Hygiene, other stakeholders? 2) Will there be an opportunity for the Review Board to do site visits and/or get live updates as the project progresses? 3) Will we have the opportunity to interact with the DHATs over the coming year or so of their training and primary placement?
- Comments: The time frame is weak: “In the first 3 years we will evaluate our pilot sites.” This is vague. Is it long enough to provide accurate numbers? Students are slow in the beginning, will you have adequate data? How long will a student DHAT have been providing services at the site during this time? Will the numbers include the experienced DHAT production? Please be more specific.
- Goals and objectives have not identified numbers or percentages of improvement noted; how will the project coordinators know if the goals and objectives were met? Please be more specific.

- Only the 1st site is fully identified and has a clinic on site. The 2nd site does not yet have a clinic. Additional sites have not been identified. This will need more clarification. Has funding been identified to build a clinic at the 2nd site? It will also need personnel.
- Comments: What is the tribal population of the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians?
- Comments: 1) What happens if a pilot site does not continue? 2) Will additional sites go through the same process? 3) How will the project assure calibration of the pilot clinic dentists? 4) Kellogg allotted \$2,509,460 but the project allotted \$544,600. Why the discrepancy? 5) I would like each sponsoring Tribe's financials since they are responsible for clinics, etc. 6) Has recruitment of trainees begun prior to pilot approval? 7) I would like a list of the 94 dental health shortage areas in Oregon. 8) What is the definition of community used in this proposal? 10) How did the DHAT program wipe out decay in Alaska as stated on page 15, PN1. 111? Is this project creating new access or shifting access?

### **NPAIHB (Applicants) Response to Compiled Comments from TRB Worksheet:**

- Grant funding (which is supplementing Tribal resources) is through March 2018.
- After that, the Tribes are committed to continuing this program through third party billing and their own resources if necessary.
- They are expanding their oral health programs, and the pilot using a new provider is concurrent with that—not separate from.
- It is possible we will have continued grant funding after March 2018, but would look to expand to more sites, expecting the first two sites to be self-sustaining.
- The initial phases of the pilot are funded in full—training of DHATs, employment of experienced DHATs and DHAT coordinators. The ability for this pilot to continue past private funding sources relies on a commitment from the Tribes to support expansion of their oral health care delivery systems and third party billing. There is substantial evidence that DHATs cost \$0.30 for every dollar earned--both in AK and MN models.
- Page 22 TRB Worksheet
- Please refer to the tasks of the OHA Evaluation Committee for questions about evaluation outside of our internal program evaluation.
- The measurable outcomes were divided into short term and long term objectives. We feel confident those included in the short term objectives will have evidence in our evaluation timeframe. The data collected will show real results by which decision-makers can use at any point in time. Our project has outlined what we see as projected successes in our Tribal communities and have based our data collection to corroborate or refute those endpoints.

### **A discussion amongst the TRB members followed:**

**Ms. Kowalski:** Page 17... Concerns of timing (2 years) and funding. After 2018 they expect the sites to be self-sustaining. \$2.5 million is for other things happening not just in Oregon—we suspect. There is a DHAT site in Washington State on tribal land operating under tribal sovereignty.

**Ms. Castro:** Who will do the paperwork on the reimbursement for Medicaid?

**Ms. Aamodt:** Supervising Dentist. Are they guaranteed this portion of money for their project? Or will the \$2.5 million be distributed across projects across the region?

**Ms. Kowalski:** We are only concerned with if they can fund the two Oregon sites.

**Dr. Ten Pas:** We are depending on the tribes to have a financial buy-in in the site. What happens after 3 years out? That is only 1 year of practicing to be self-sustaining—not sufficient. We need this information. We need the full picture. We can approve with answers to these requests.

**Mr. Finch:** There is language that they do get the \$500K. That is what concerns us. Do we need to know more? The tribes have hired their own folks and other work.

**Ms. Aamodt:** Our concern is if they have enough to fund this project.

**Ms. Kowalski:** We need the full 5 year funding plan.

**Dr. Ten Pas:** Look at pg. 9—references “the project” at \$2.5 million. Want to find out if there is an issue now, not later. What is the use of the remaining \$2 million?

**Ms. Aamodt:** \$0.30/DHAT can't be interpreted—not enough info.

### *19. Evaluation Committee*

Ms. Kowalski explained the process of the Evaluation Committee. Evaluation Committee Members are tasked with reviewing progress reports, conducting site visits, and participating and attending Evaluation Committee Annual Meetings. Members are requested to attend at least one site visit during each year of the pilot project. Applications and instructions are available online at the Dental Pilot Project Program Website, <http://healthoregon.org/dpp>.

### *20. Presentation by Applicants*

The members of the TRB were each asked if they felt an in-person presentation by the applicants would be constructive. Most TRB members indicated they wanted a presentation by the applicants.

**Presentation:** Northwest Portland Area Indian Health Board

#### **Applicant representatives present in person:**

Pam Johnson

Christina Peters

#### **Representatives on the phone:**

Mary Williard, DDS, ANTHC DHAT Education Program

Vicki Faciane, Tribal Health Director, CTCLUSI

Kelle Little, Tribal Health Director, Coquille Indian Tribe

#### **NPAIHB:**

- 46 Procedures in DHAT Scope of Practice compared to over 500 of a dentist.

**Dr. House:** Retention problems with supervising dentist. What efforts are in tandem to grow local dentists to support the system, and the DHAT program?

#### **NPAIHB:**

- Continuity of care will come from the DHATs. Where DHATs are practicing, there is usually a more stable dental team, which is attractive to dentists. They have a new, FT

dentist—Dr. Sara Ann Roberts (CTCLIUS). Committed to providing dental care within tribes.

- Two PT dentists are also committed.
- DHAT was started because of problems with dentists staying in rural areas. Organizations have MOAs to allow dentists from neighboring programs to provide the backfill. There is work done to assure the relationship between DHAT and backfill dentist. DHATs actually provide the stability and consistent care when dentists leave.
- Also provide a role model for children in tribal communities and encourage dentistry as a possible career for native children.

**Ms. Castro:** How to ensure credits DHATs receive can transfer to Oregon.

- Currently they are not. The vision is to create that through the community college system.
- Current contract with UW for the training and supports—gain a certificate. Credits transfer to general education credits, which are not that helpful in the ladder towards a BA and beyond. Barrow, Alaska creates a pathway. Associates of Science and transferable credits for what the courses truly are. The community college is a tribal college called Iisagvik located in Barrow, Alaska. It is accredited.

**Ms. Castro:** Are the credits transferable from the new college?

- Yes, they should be in the same way any other tribal college is. It is an accredited tribal college.

**Dr. Ten Pas:** When do you anticipate transferring from UW to the tribal college?

- UW will end February 2016. Working with Iisagvik. Enroll in July 2016.

**Ms. Aamodt:** Do they have other health careers at Iisagvik?

- Training of Medical Assistant type providers; basic nursing training for oil industry in Barrow region.

**Ms. Aamodt:** Are there certifications that go along with those disciplines? Looking for a track record.

- They offer associates degrees. The UW program is not part of UW per se. It is not offered in Seattle. Much ability to transfer the program. Currently contract with UW for administrative work. They have their own faculty in AK. Anticipate to keep this the same, just a new contract for that institutional support. We will become a larger part of their institution and expand—behavior health aids, nursing aids, etc.
- UW never intended to be the final resting place for this program. This situation would be able to be CODA accredited.
- UW won't ever make this an accredited program. We need this commitment to move the DHAT program forward.

**Dr. Ten Pas:** What are the numbers of faculty at the tribal college?

- Don't know the number yet. They have been functional for a while.

**Dr. Ten Pas:** This sounds like this is an administrative relationship than a clinical?

- Yes. We supply the faculty and clinical sites, they provide the administrative support. The program will remain where it is, instructors and curriculum will remain

the same. Will take time for CODA—next few years. CODA is predicting program accreditation visits in 2017.

**Dr. Ten Pas:** What entity will be seeking CODA accreditation?

- CODA provides programmatic accreditation. It will be the program that applies. They require that they be in an accredited institution.

**Dr. House:** How many tribal members are eligible for pilot program?

- We serve any Native American—last year 633 individual; 86% were NA. We do see some Head Start kids. Total eligible—460 (CTCLUSI) tribal members in our 5 counties; and NA can go there.

**Dr. Ten Pas:** How many DHATs for the clinic?

- 2. Goal is to increase access.

**Dr. Ten Pas:** How many could be served?

- Provide medical primary care. 1,100 active user population—1 primary care visit. Also eligible for dental care. Can also include surrounding county areas—Coos, Curry, Jackson, Douglas counties. Increase capacity to address access issues. The pilot project is to start a new member of the team.

**Dr. Kohli:** What are the quality care metrics?

- The program is competency based. Supervised by licensed dentists. Know existing standards of care that are being provided. They can judge that for DHAT students work. Evaluation criteria standards, similar to a dental student lab at a dental school setting.
- Monitoring the “blind” study?
- We have an outline of what we want, but don’t want to put all the details together until we are approved.

**Dr. Ten Pas:** Do they have measures in AK?

- Some research has been done in AK. RTI did the evaluation for AK and they are willing to do it for this project. DHATs must be certified every 2 years, so some will come from the supervising dentist. We’ll get a sense of the type of care being delivered.
- A national evaluation plan is being developed. Aligning this evaluation with the national evaluation.
- Adverse Outcomes?
- Patient satisfaction, technical care, adverse outcomes. All will go into the evaluation piece.

**Dr. Ten Pas:** Why these two sites?

- Coquille has a medical facility that can facilitate integration of primary and dental care. They are ready. It is a lot of work—Vicki and Kelle have been great partners!

**Dr. Ten Pas:** Where will you potentially expand?

- Roseburg and Pendleton are interested. Lots of interest across the state. CTCLUSI’s Dental Clinic & CITCHC Health Clinic have a large land area, which is attractive. We want to see geographic diversity eventually.

**Dr. House:** How long does one wait to get seen—to help illustrate the need?

- We are looking at current wait times and current drive times. A lot of backlog, too.
- Fully staffed clinic, but 6-8 weeks out for scheduling. When no full-time dentists, seeing emergencies first. Prevention is put off, which then can progress into problems. 633 patients is not our caseload; a huge proportion are on significant treatment plans. Don't have 2015 numbers yet.
- CTCLUSI only NA dental clinic to serve the entire SW Oregon. They drive great distances. Next closest is Lincoln City, or northern California. Some come from all over Oregon.

**Dr. Ten Pas:** When is care available? Hours/Day to increase access?

- The provider will enable this service in better ways. Focus on efficient use of services and infrastructure. Providers are needed who can do the work.
- Always looking at hours of operation, etc. For the more local population, that helps. Those who drive the long distances it is less important. But we will be expanding our availability. Current model can't do it.
- They do put in 12 hour days! DHATs located out in the county, they will put in those hours.

**Dr. House:** How many chairs?

- Currently 3, looking to expand 2-3 more chairs.
- Currently 1 hygienist. Community College will bring on a Dental Assistant program— increase access to medical and dental care.

**Dr. Ten Pas:** Funding? Can you clarify the discrepancy with the grant award and your budget? Also, there is not an MOU with Coquille.

- In the process of getting an MOU with Coquille—have one with CTCLUSI. Kellogg supports region, regional staff, meetings, etc. This budget is only the Oregon portion.

**Dr. Ten Pas:** What happens if the sites are not self-sustaining by Year 3?

- Tribes signed on for funding. This supplements tribal funding. They have the commitment to continue the programs. This is an economically viable model. MN—opening a 2<sup>nd</sup> clinic with the expanded use of DHATs. NPIAHB is committed to oral health in the region. We don't anticipate that going away, including Kellogg support.
- A disconnect between funders on a 3 year schedule and project on a 5 year schedule. They are looking for more diverse funding. Bulk of expenses are the training and employment of DHATs. This can be paid for prior to end of funding. Employment—tribes committed to carrying that. Many tribal partners can also provide scholarships for students.

**Dr. Ten Pas:** Can you discuss the needs proposal submitted to Kellogg?

- We typically don't share full grant proposal.

**Dr. House:** Do you have more detailed information around the needs? Number of dentists in the area? Number of hygienists in the area? How many take OHP? Tribal coverage?

- Number of employees is very small, have the option to go anywhere and use their insurance. OHP is relevant—open card. No one taking open card anymore. Many don't have any insurance and get all their care from NA/IHS clinics. In addition, the non-Coquille/CTCLUTSI members rely on the tribal clinics. 51% of Coquille members are on Medicaid—open card. Very few providers who take open cards. This is culturally

competent care. This is where historical trauma is illustrated. Can also take services to the far-flung places/communities where unseen patients are. There is interest in other communities-e.g. FQHCs, etc.

**Ms. Kowalski:** Any information on CMS recognizing DHATs?

- In AK and MN. In recent legislation they can get reimbursed in OR.

**Dr. House:** How much will be general population/non-native use?

- Pretty low-- a few tribal employees, spouses, 38 patients who legacy from the community (insurance and private pay). Not looking to open up to general public beyond these patients.

### **Conclusion:**

In Conclusion, all members of the Technical Review Board indicated they would Recommend Approval or Recommend Approval with amendments as noted. No member of the TRB recommended Denial of the project application.

### ***TRB Compiled Comments from TRB Worksheet Submitted November 20, 2015:***

- Comments: Recommend that the Pilot Project be shortened to reflect the intent of the SB 738 legislation and the project's complete reliance/utilization of an established model to launch an Oregon specific project.
- Comments: 1) I would recommend that a measure outcome be the decrease, if any, in the disease load of the clients being served. The rationale is that if we are simply looking to promote another component for restoration, then we are not achieving the true long term goal of disease prevention. There are currently great measures in place for assessing access to care, but there is not a robust measure for the effect of DHAT education and intervention. Decayed Missing Filled Teeth needs to be DMFTS so that you can better measure disease decrease. Otherwise a small buccal pit is measured the same as a 4 surface lesion needing a root canal. There should be a set number of children assessed by each site (100 or more in each group) in order to measure impact versus the current statement of: "Select a group of patients randomly and assess their oral health".
- The recommended cohort of 50 random patients for cost study should be larger.

### **Follow-Up Items**

- Ms. Kowalski will follow-up with the TRB with a proposed summary of clarifying questions and/or issues to present to the applicants.
- Finalized meeting notes will be distributed and posted online.
- A closing summary of recommendations, with intent to approve DPP application #100 with noted requirements, will be submitted to the TRB.

The meeting was adjourned at 3:00 pm.

