

Oregon Health Authority
Pat Allen, Director
Cate Wilcox, MPH, Maternal and Child Health Section Manager
Dana Hargunani, MD, MPH, Chief Medical Officer
Jeremey Vandehey, Director Health Policy and Analytics
Bruce Austin, DDS, Chief Dental Officer
500 Summers St NE
Salem, Oregon 97301

May 4, 2018

Re: Dental Pilot Project #100

Dear Director Allen, Ms. Wilcox, Dr. Hargunani, Mr. Vandehey and Dr. Austin:

Practicing dentists and officers of the Oregon Dental Association (ODA) have been engaged in the progress of the current Oregon Dental Pilot Projects. We are a strong supporter of the pilot project model and advocate for well-designed studies that produce meaningful data while ensuring quality, safe care for Oregonians. A great example of this process is Pilot Project #200, which is well-constructed and producing tangible data by which to evaluate a new scope of practice for an oral health provider. Unfortunately, Pilot Project #100 has not been well-defined, raising concerns in many areas.

This letter is not a statement on the merit of a new mid-level provider in Oregon; instead, the recent report from the Oregon Health Authority (OHA) on the failed Pilot Project #100 site visit raises serious public safety issues, and we want to convey concerns regarding the lack of oversight and accountability from OHA. These safety and oversight issues cannot be condoned by the state because it would establish unequal safety standards for tribal members.

Key Issues Within Report

Informed Consent

The issue of lack of informed consent is a serious matter. The OHA report finds “74% of the 23 charts reviewed in the randomized sample had a signed form consenting to treatment by the DHAT trainee on the initial date of service.” Health care providers have ethical and legal obligations to obtain proper consent. Informed consent ensures that the patient understands diagnosis and treatment options prior to receiving care.

OAR 330-010-0440 requires the project to obtain written informed consent for each patient. This rule was drafted specifically to ensure that patients being seen by this new provider type have been informed of the role and status of the trainee, and to provide the patient assurances that they can refuse care from a trainee without penalty for such a request. The chart review showed over a quarter were lacking this critical component.

Practicing Outside of Scope of Approved Practice

We are alarmed that the Pilot Project trainees were allowed to practice beyond their approved scope of practice. Approved scope of practice reflects limitations on a provider type based on education, training and, in this case, agreed upon requirements within the approved application. Scope limitations protect both the patient and the provider. The chart review, which found three instances of trainees attempting tooth extractions outside of their scope of practice, included

only a sample of the work performed by the trainees. We are genuinely concerned about what else is happening in the clinic that was not reflected within these 23 cases.

Incomplete and Inaccurate Record Keeping

Accurate chart records are not optional when treating patients. Only 35% of the charts reviewed were accurately represented in the detailed data report. Performed procedures were simply missing. There were examples of not recording weight while administering analgesics to minors. Not only is the lack of accurate records concerning for pure documentation and follow-up purposes, but it places the patient in unnecessary danger. The provider cannot accurately track a patient's care, complications or necessary follow-up without proper documentation. Further, the outcome of this project cannot be evaluated fairly without accurate data fully representative of the patients treated and outcomes of those treatments.

Moving Forward

We were concerned that at a Pilot Project Advisory Committee meeting on April 23, 2018, the Pilot Project staff did not convey that they felt there were any real patient safety issues identified, despite the numerous flags raised in the report. Without acknowledgement of these critical errors, it's unclear how changes can effectually be made to ensure patient safety.

If this program is to succeed, these problems must be taken very seriously, and there must be accountability. We believe that the Oregon Health Authority (OHA) needs to play a greater role to ensure appropriate regulatory oversight on the pilot project providers, facilities, and project, safeguarding patient safety at all times. We recognize that OHA is not expected to license DHATs; however, stakeholders in this process reasonably expected OHA to hold the project to standards that would similarly be expected by other oral health providers and ensure general oversight of the project. We do not believe that the OHA has been holding Pilot Project #100 practitioners to the same standard of care that every other dental provider would be required to meet under the Dental Practice Act.

Oregon dentists are dedicated to ensuring that patients are protected. We hope OHA holds the Pilot Project to clear, relevant standards developed in partnership with licensing boards and professional societies. We urge you to re-evaluate the project for patient safety.

Sincerely,



Bruce Burton, DMD,
President



James McMahan, DMD,
President-Elect



Scott Hansen, DMD,
Treasurer

CC:

Senator Fred Girod
Representative Mitch Greenlick
Representative Cedric Hayden
Senator Laurie Monnes-Anderson
Senator Elizabeth Steiner-Hayward
Oregon Board of Dentistry
Tina Edlund
Portland Area Indian Health Board