NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Dental Directors Meeting - 2026

NORTHWEST TRIBAL DENTAL SUPPORT CENTER
A Project of NPAIHB

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Thank You

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Northwest Portland Area Indian Health Board

Northwest Tribal Dental Support Center (NTDSC) and Indian Health Service (IHS) Updates

AGENDA (Part I)

- NPAIHB Overview
- Needs Assessment
- Site Visits
- NTDSC Roster
- IHS Directory and CDE
- EFDA Courses
- Dental Health Aide Update
- IHS OHS
- GPRA

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Northwest Portland Area Indian Health Board

Established in 1972, the Northwest Portland Area Indian Health Board (NPAIHB or the Board) is a non-profit tribal advisory organization serving the forty-three federally recognized tribes of Oregon, Washington, and Idaho. Each member tribe appoints a Delegate via tribal resolution, and meets quarterly to direct and oversee all activities of NPAIHB.

"Our mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare."

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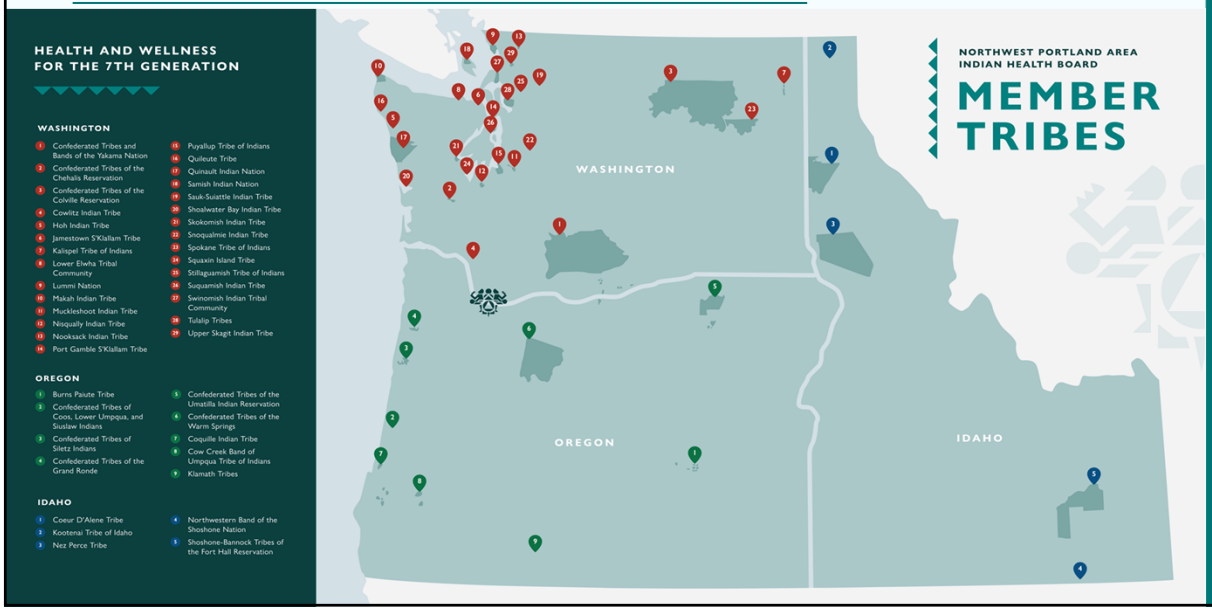
Northwest Portland Area Indian Health Board



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NTDSC and IHS Updates

Staff and Consultant

Ticey Mason, MAOL
NTDSC Director

Hilary Flaming, NDMA
NTDSC Coordinator

Dr. Sean Kelly, DDS, MSHS
NTDSC – Dental Consultant

CAPT Lori Snidow, DDS
IHS Area Dental Officer

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Northwest Portland Area Indian Health Board

Map of Dental Clinics in the Portland Area

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Needs Assessment

Most Helpful Services

- CDE
- Site Visits
- Prevention Supplies
- Northwest Tribal Dental Meeting
- Connecting to a larger network
- Initiatives

Most Requested CDE Topics

- Minimally Invasive Dentistry
- Medical/Dental Integration
- Traditional Foods/Nutrition
- Pediatrics and Elders
- Infection Control
- Disease Prevention
- Innovations in Dental Care
- Working in AI/AN Communities
- Leadership Training-Stress Management

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Site Visits

- Infection Control
- Prevention Program
- Continuing Dental Education (CDE)
- Clinical Efficiency
- Transitioning your Clinic
- Records and Data
- Peer Review and Chart Audits
- Quality assurance/improvement
- Prepare for Accreditation

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NTDSC Roster

Northwest Tribal Dental Support Center
Dental Roster

Jennifer Myers, EFDA Heather Reppeto, Chief Health and Wellness Officer			hreppeto@naranorthwest.org
Siletz (Confederated Tribes of Siletz Indians)			
Ashely Taylor, Dental Director Rachel Meek, DMD Teresa Carpenter, RDH Alison Noble, RDH Misty Reed, CDA David "Dion" Napolean, CDA Keisha Metcalf, CDA Vacant, Patient Care Coordinator Vacant, DA Vacant, Office Manager Vacant, Sterilization Tech Miranda Williams, Executive Health Director	**Siletz Dental Clinic** PO Box 320 Siletz, OR 97380 200 Gwee-Shut Rd NextGen AAAHC accredited	541-444-1030 **Tribal Clinic**	ataylordental@gmail.com RachelM@ctsi.nsn.us teresac@ctsi.nsn.us alisonn@ctsi.nsn.us mistyR@ctsi.nsn.us dionn@ctsi.nsn.us kiesham@ctsi.nsn.us mirandaw@ctsi.nsn.us
Vacant, Dentist (Siletz) Vacant, Dental Assistant II Vacant, Dental Assistant III	**Dan' ch'aa-may-yvlh-srii-dvn** **(Meaning: North doctor place (clinic)).**		

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Northwest Tribal Dental Support Center
Dental Roster

IDAHO			
Coeur d'Alene Tribe			
Taylor Wilkens, DDS, Director Frank Allen, DMD Matthew Johnson, DDS Adam Holecek, DDS Darrin Rich, DMD (PT) Kirk Bean, DDS (Ortho/PT) Rachel Davidson, DDS Fill- in Kim Legaspi, RDH Cathleen Bourque, RDH Elisabeth Goltz, RDH Connie Shryock, RDH Ellie Brown, CDA, Office Mgr. Lin Abson, CDA Chris Holecek, CDA Amber Hawkes, CDA Felicia Sines, CDA Janai Sjostrom, DA Shenelle Sines, Treatment Coord. Paulina David, Treatment Coord. Jennifer Degravio, DA Jayson Hall, DA Alexia Fuller, DA	**Marimn Health Center** 427 North 12th Plummer, ID 83851 NextGen AAAHC Accredited Provide Services to All Community Members	208-686-1931 **Tribal Clinic**	twilkens@marimnhealth.org fallen@marimnhealth.org mjohnson@marimnhealth.org aholecek@marimnhealth.org drich@marimnhealth.org kbean@marimnhealth.org rdavidson@marimnhealth.org klegaspi@marimnhealth.org cbourque@marimnhealth.org egoltz@marimnhealth.org cshryock@marimnhealth.org ebrown@marimnhealth.org labson@marimnhealth.org cholecek@marimnhealth.org ahawkes@marimnhealth.org fsines@marimnhealth.org jsjostrom@marimnhealth.org ssines@marimnhealth.org pdavid@marimnhealth.org jdegravio@marimnhealth.org jhall@marimnhealth.org afuller@marimnhealth.org

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WEAVE-NW Project

Good Health and Wellness in Indian Country

- Tobacco Cessation
- Diabetes
- Nutrition
  - Food Sovereignty
  - Physical Activity
  - Breastfeeding

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Oral Health Newly Added To 3rd Cycle…

Plan for FY3 (09/30/2026 – 09/29/2027

- Recruit two or three subawards for oral health projects
- Up to around $20,000 per subaward
  - Can be used for wages
  - Can be used for advocacy and support of program.
  - Cannot be used for equipment
  - See handout for restriction list

Requirements and steps

- Federally recognized Tribe
- Complete performance measurements
- Get a contract in place
- Prepare a budget/SOW
- Prepare a workplan
- Meet monthly with team
- Turn in an evaluation around performance measures at end of FY.

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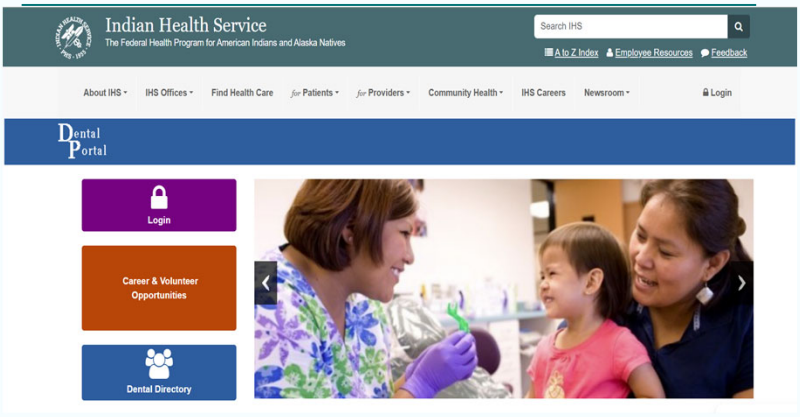
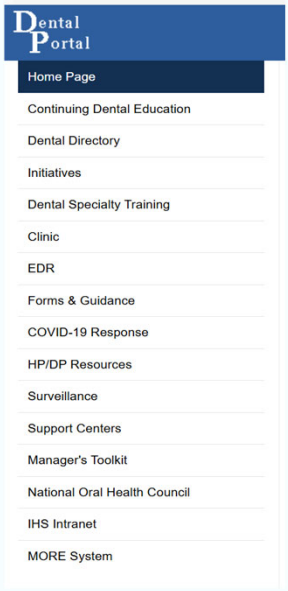
IHS CDE and Directory (DOH Dental Portal)





https://www.ihs.gov/doh/

IHS DIVISION OF ORAL HEALTH

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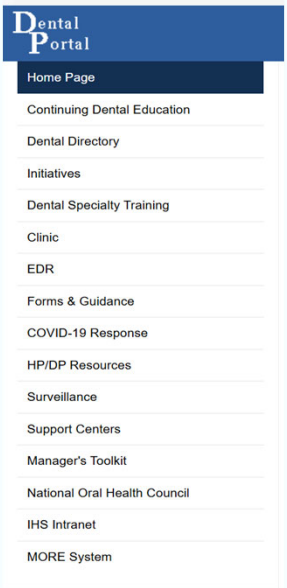
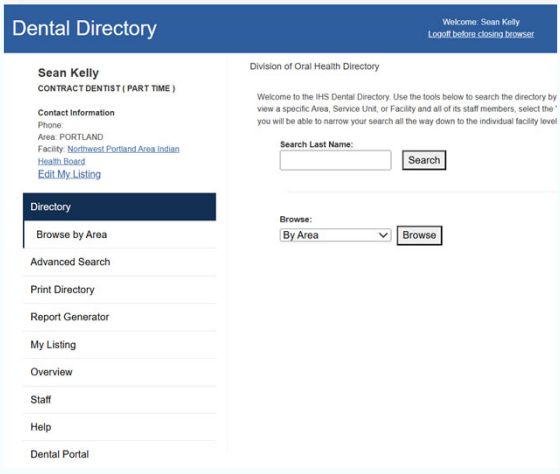
IHS CDE and Directory (DOH Dental Portal)





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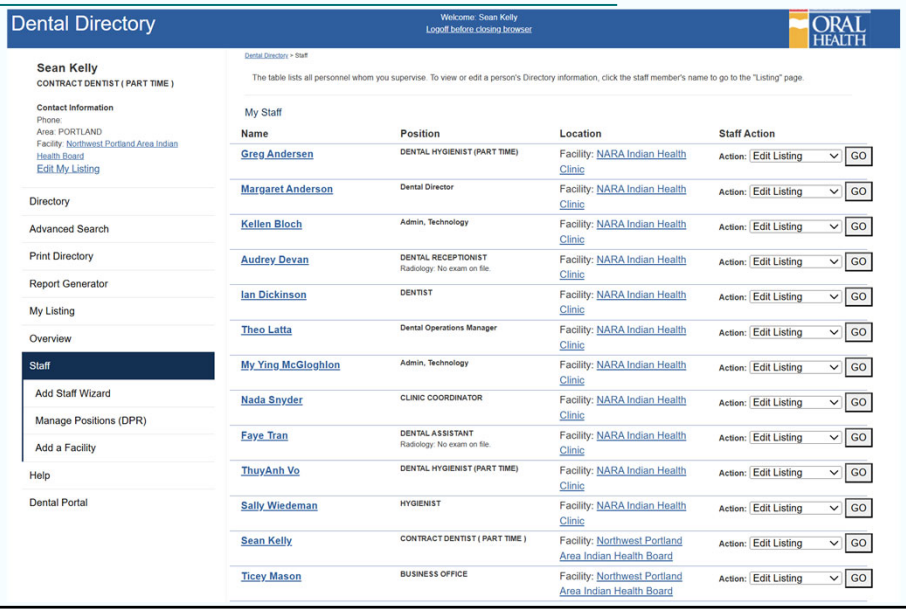

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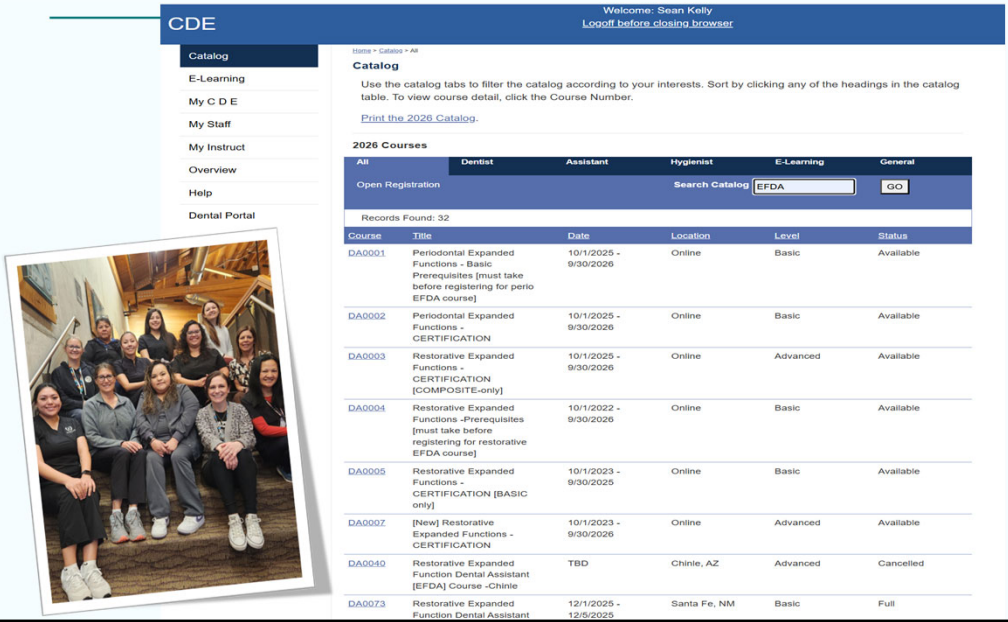
EFDA Courses



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EFDA Courses

Course	Title	Date	Location	Level	Status
DA0001	Periodontal Expanded Functions - Basic Prerequisites [must take before registering for perio EFDA course]	10/1/2025 - 9/30/2026	Online	Basic	Available
DA0002	Periodontal Expanded Functions - CERTIFICATION	10/1/2025 - 9/30/2026	Online	Basic	Available
DA0003	Restorative Expanded Functions - CERTIFICATION [COMPOSITE-only]	10/1/2025 - 9/30/2026	Online	Advanced	Available
DA0004	Restorative Expanded Functions -Prerequisites [must take before registering for restorative EFDA course]	10/1/2022 - 9/30/2026	Online	Basic	Available
DA0005	Restorative Expanded Functions - CERTIFICATION [BASIC only]	10/1/2023 - 9/30/2025	Online	Basic	Available
DA0007	[New] Restorative Expanded Functions - CERTIFICATION	10/1/2023 - 9/30/2026	Online	Advanced	Available

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EFDA Courses

DA0073	Restorative Expanded Function Dental Assistant [EFDA] Course -Santa Fe	12/1/2025 - 12/5/2025	Santa Fe, NM	Basic	Full
DA0075	Restorative Expanded Function Dental Assistant [EFDA] Course - Chinle	TBD	Chinle, AZ	Basic	Full
DA0084	Periodontal Expanded Function Dental Assistant [EFDA] Course - Parker Health & Wellness Center	2/9/2026 - 2/13/2026	Parker, AZ	Basic	Full
DA0091	Restorative Expanded Function Dental Assistant [EFDA] Course - Whiteriver	9/14/2026 - 9/18/2026	Whiteriver, AZ	Basic	Full
DA0095	NEW Restorative Expanded Function Dental Assistant [EFDA] Course - PIMC]	10/6/2025 - 10/10/2025	Parker, AZ	Basic	Full
DA0096	Periodontal Expanded Function Dental Assistant [EFDA] Course - Tuba City	6/1/2026 - 6/5/2026	Tuba City, AZ	Basic	Full

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EFDA Courses

3. .When the DA has satisfactorily completed the post-course cleanings, the dental chief/director under whose license the DA will be working should then e-mail the IHS EFDA Coordinator [IHSEFDA@ihs.gov] to inform them that post-course requirements have been met and that the record is on file at the local clinic. This should be done using this format only:
"_____ [name of DA] has satisfactorily completed the post-course requirements as a periodontal EFDA. He/she took course ____ [course number] on _____ [date] at _____ [location]. A copy of his/her evaluation form is being maintained in this office. Please issue instructions for certification."
4. Once this is done, the IHS EFDA Coordinator will provide the student with instructions on how to receive their CDE certificate and their EFDA certificate.
5. After the 20 cleanings done under direct supervision by the dentist/hygienist, the DA should NOT perform any further cleanings unless CERTIFIED by the IHS EFDA Coordinator. Following certification, the new EFDA may perform cleanings under indirect supervision [dentist/hygienist in the facility but not directly overseeing the work until a final check is needed].

Annual Competency:
1. The Dental Director/Dental Chief is encouraged to complete an annual competency evaluation on the periodontal EFDA to ensure high quality care is being delivered.
2. The annual competency evaluation can be found on the IHS Dental Portal under the Clinic Tab - Competencies

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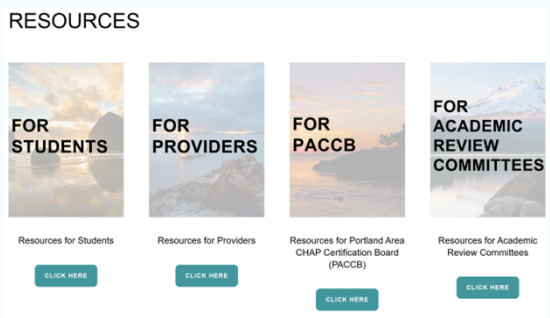
Dental Health Aide (DHA) /CHAP Update

Pamela Ready, MSDH, RDH
(Puyallup Tribe), (she/her)
DHA Education Director
pready@npaihb.org
C: (360)-461-1149
www.tchpp.org

Katie J. Denny
Northwest Portland Area Indian Health Board (NPAIHB)
Tribal Community Health Provider Program (TCHPP) Manager
KDenny@NPAIHB.org
(971) 430-2693 Office



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

TCHPP
TRIBAL COMMUNITY HEALTH PROVIDER PROJECT
NPAIHB

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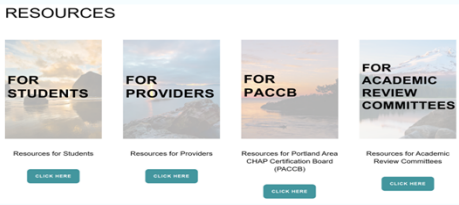
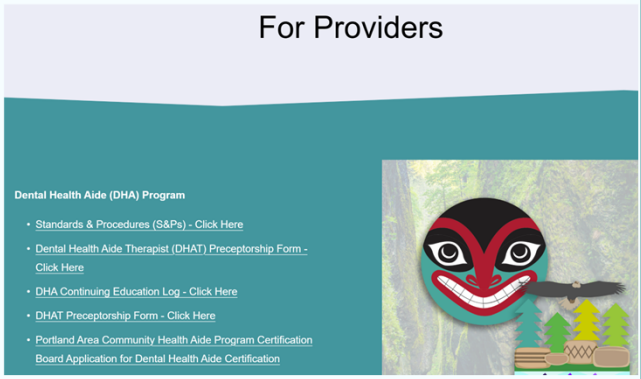
Dental Health Aide (DHA) /CHAP Update



Dental Health Aide (DHA) Program

- Standards & Procedures (S&Ps) - Click Here
- Dental Health Aide Therapist (DHAT) Preceptorship Form - Click Here
- DHA Continuing Education Log - Click Here
- DHAT Preceptorship Form - Click Here
- Portland Area Community Health Aide Program Certification Board Application for Dental Health Aide Certification



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IHS Oral Health Survey

Indian Health Service Data Brief ❖ November 2025

The Oral Health of American Indian and Alaska Native Dental Clinic Patients Aged 1 to 5 Years: Results of the 2024–2025 IHS Oral Health Survey

Kathy R. Phipps, DrPH, Nathan P. Mork, DDS, MPH, Samuel A. Mortensen, DMD, and Timothy L. Lozon, DDS

Key Findings

1. Since 1999, the oral health of AI/AN dental clinic patients aged 2 to 5 years has improved, but the pace of progress remains slower than that seen in other racial and ethnic groups.
2. The prevalence of early childhood caries increases with age; by the age of 5, over 80 percent of AI/AN dental clinic patients have ECC.
3. Over 40 percent of AI/AN preschool children receiving care at IHS or Tribal dental clinics have untreated tooth decay requiring restorative treatment, such as a filling, crown, or extraction.
4. Dental sealants on primary molars are an underutilized preventive measure, with only 11 percent of AI/AN dental clinic patients aged 3 to 5 years having at least one protective dental sealant.

https://www.ihs.gov/doh/documents/surveillance/Data_Brief_IHS_1-5_Year_Olds_2025.pdf

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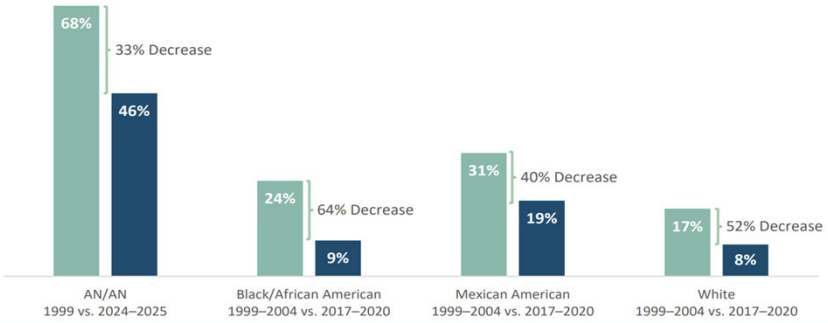
IHS Oral Health Survey

Indian Health Service Data Brief ❖ November 2025

Key Finding 1: Since 1999, the oral health of AI/AN dental clinic patients aged 2 to 5 years has improved, but the pace of progress remains slower than that seen in other racial and ethnic groups.

Figure 1: Percentage of children aged 2 to 5 years with untreated decay by race/ethnicity and percentage reduction from baseline to current
1999/1999–2004 vs. 2024–2025/2017–2020



https://www.ihs.gov/doh/documents/surveillance/Data_Brief_IHS_1-5_Year_Olds_2025.pdf

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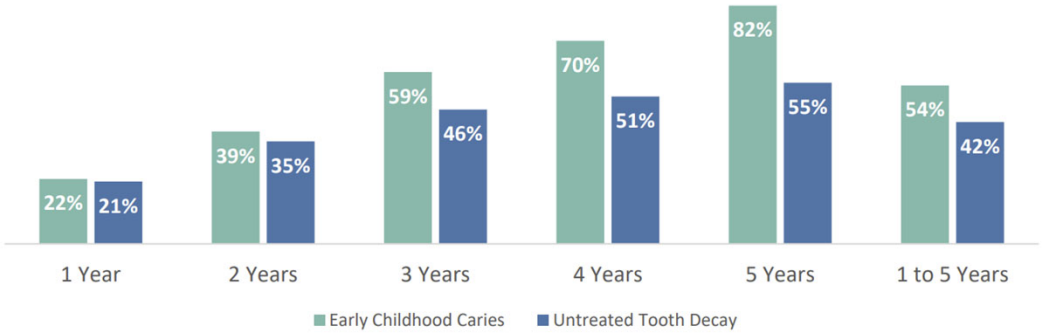
IHS Oral Health Survey

Figure 2: Percentage of AI/AN dental clinic patients with ECC and untreated tooth decay by age, 2024–2025



Key Finding 3: Over 40 percent of AI/AN preschool children receiving care at IHS or Tribal dental clinics have untreated tooth decay requiring restorative treatment, such as a filling, crown, or extraction (Figure 2).

https://www.ihs.gov/doh/documents/surveillance/Data_Brief_IHS_1-5_Year_Olds_2025.pdf

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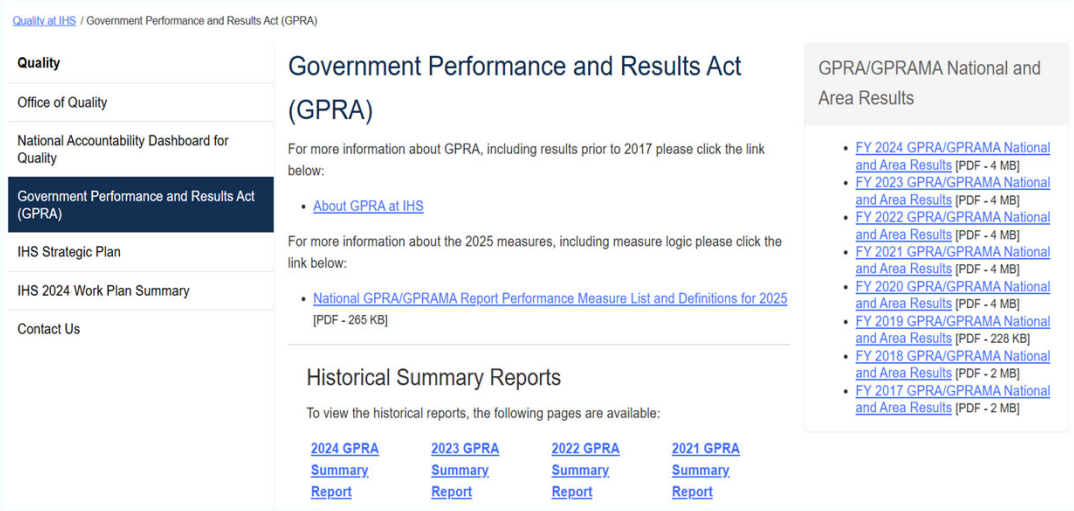
Government Performance and Results Act (GPRA)



Quality at IHS / Government Performance and Results Act (GPRA)

Quality

- Office of Quality
- National Accountability Dashboard for Quality
- Government Performance and Results Act (GPRA)
- IHS Strategic Plan
- IHS 2024 Work Plan Summary
- Contact Us

Government Performance and Results Act (GPRA)

For more information about GPRA, including results prior to 2017 please click the link below:

- About GPRA at IHS

For more information about the 2025 measures, including measure logic please click the link below:

- National GPRA/GPRAMA Report Performance Measure List and Definitions for 2025 [PDF - 265 KB]

Historical Summary Reports

To view the historical reports, the following pages are available:

2024 GPRA Summary Report | 2023 GPRA Summary Report | 2022 GPRA Summary Report | 2021 GPRA Summary Report

GPRA/GPRAMA National and Area Results

- FY 2024 GPRA/GPRAMA National and Area Results [PDF - 4 MB]
- FY 2023 GPRA/GPRAMA National and Area Results [PDF - 4 MB]
- FY 2022 GPRA/GPRAMA National and Area Results [PDF - 4 MB]
- FY 2021 GPRA/GPRAMA National and Area Results [PDF - 4 MB]
- FY 2020 GPRA/GPRAMA National and Area Results [PDF - 4 MB]
- FY 2019 GPRA/GPRAMA National and Area Results [PDF - 228 KB]
- FY 2018 GPRA/GPRAMA National and Area Results [PDF - 2 MB]
- FY 2017 GPRA/GPRAMA National and Area Results [PDF - 2 MB]

https://www.ihs.gov/quality/government-performance-and-results-act-gpra/

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Government Performance and Results Act (GPRA)

GPRA SUMMARY REPORT 2025

DENTAL

A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of American Indian/Alaska Native people.

The IHS dental health measures support Healthy People 2030 oral conditions objectives.

Access to dental services is a prerequisite for the control of oral disease in susceptible or high-risk populations.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay.

	FINAL RESULT	NATIONAL TARGET
ACCESS TO DENTAL SERVICES	24.8%	27.0%
DENTAL SEALANTS	11.4%	11.8%
TOPICAL FLUORIDE	25.3%	27.4%

https://www.ihs.gov/sites/quality/themes/responsive2017/display_objects/documents/FY%202025%20IHS%20GPRA%20Summary%20Report.pdf

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Government Performance and Results Act (GPRA)

Portland Area

DENTAL

Measure	Administrative Area	2025 Target	2025 Official	2026 Target	2026 Draft	2026 Result
Dental: General Access	PORTLAND	27.00%	34.99%	27.80%	18.12%	NOT MET
Sealants	PORTLAND	11.80%	13.85%	11.80%	8.14%	NOT MET
Topical Fluoride	PORTLAND	27.40%	32.71%	28.40%	16.42%	NOT MET

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2:30 BREAK

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Northwest Portland Area Indian Health Board

AGENDA (Part II)

Quality Assurance/Quality Improvement

- Staffing/Peer Review
- Clinic Management

Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs
- Staffing/Continuity of operations

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Northwest Portland Area Indian Health Board

Quality Assurance/Quality Improvement

- Staffing/Peer Review

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Quality Assurance/Quality Improvement

- Staffing/Peer Review
  - Staffing using IHS DOH Efficiency and Effectiveness Data Indicators Worksheet (Resources).
  - Need to know your **User Population**.
  - Review data periodically to evaluate the program, especially in view of QA/QI and goals set for the clinic.

CHAPTER 8 | Appendix V: *Efficiency and Effectiveness Data Indicators Worksheet*

Appendix V: Efficiency and Effectiveness Data Indicators Worksheet

	Indicator	Calculation	2016	2024
Resources	Population to Dentist Ratio	User population/# of FTE dentists[1]	1200:1	1,200:1
	Population to Staff Ratio	User population/# of FTE staff	500:1	500:1
	Assistant to Dentist Ratio	# of FTE DAs/# of FTE dentists	2:1	2:1
	Operatory to Dentist Ratio	# of non-RDH chairs/# of FTE dentists	2:1	2:1

https://www.ihs.gov/doh/clinicmanagement/efficiencyeffectiveness/Chapter%208%20Appendix%20V%20Efficiency%20and%20Effectiveness%20Data%20Indicators%20Worksheet%20-%202024.pdf

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	Assistant to Dentist Ratio	# of FTE dentists	2:1	2:1
	Operatory to Dentist Ratio	# of FTE DAs/#of FTE dentists	2:1	2:1
Services	Services per Dentist per Year	# of services/#of FTE dentists	4,505	5,097
	Services per Hygienist per Year[2]	# of services/#of FTE hygienists	1,592	2,902
	Services per Facility per Year[3]	# of services of all providers/#of FTE dentists only	6,497	6,604
Relative Value Units	RVUs per Dentist per Year	# of RVUs by dentist/#of FTE dentists	7,092	7,175
	RVUs per Hygienist per Year[2]	# of RVUs by hygienist/#of FTE hygienists	2,788	3,640
	RVUs per Facility per Year[3]	# of RVUs by all providers/#of FTE dentists	9,880	9,083
	RVUs per Staff per Year	# of RVUs (clinic)/#of FTE dental staff	2,770	2,860
	RVUs per Visit per Year	# of RVUs (clinic)/#of 0000-0190 codes	5.0	5.8
	RVUs per Patient per Year	# of RVUs (clinic)/#of 0000 codes	11.2	13.6
	RVUs per Operatory per Year	# of RVUs (clinic)/#of operatories	3,293	3,442
Patient Visits	Visits per Dentist per Year	# of 0000-0190/# of FTE dentists	1,879	1,645
	Visits per Dentist per Day	# of 0000-0190/# of FTE dentist/218 days	8.62	7.6
	Visits per Hygienist per Year[2]	# of 0000-0190 (hygienists)/#of FTE hygienists	1,357	1,056
	Visits per Hygienist per Day[2]	# of 0000-0190 (hygienists)/#of FTE hygienists/218	6.40	5.0
	Visits per Facility per Year[3]	# of 0000-0190 (all providers)/#of FTE dentists	3,236	2,206
	Visits per Operatory per Year	# of 0000-0190 (clinic)/#of operatories	721	691
Quality	Broken Appointment Rate[4]	9986/(0000-0190+9986-9170)	≤21%	≤17%
	% of Patient Treatment Planned[5]	(0150+0145)/0000 x 100	≥53%	≥44%
	% of Patients Completing Treatment[6]	9990/(0150+0145) x 100	≥46%	≥41%
	% of Level I-III (Basic) Services	# of Level I, II, III Services/#of Levels I-V Services	≥80%	≥90%

The IHS Division of Oral Health (DOH) recommends that Area Dental Officers, Dental Support Centers, or Dental Chiefs/Dental Directors assess these indicators once every one to two years. Please refer to the online training "Understanding Clinical Efficiency & Effectiveness Indicators" for more detail about these references. The above indicators on services, RVUs, visits, and quality are based upon an average of 12 selected IHS, Tribal, and urban dental programs using FY 2023 data, while the resource indicators are long-standing DOH recommendations. Collectively, these indicators serve only as recommendations for assessing clinical productivity, efficiency, effectiveness, and quality of care provided.

Notes:

1. FTE is Full Time Equivalent. To calculate the FTE of a position, divide the total hours worked per week by 40 hours. For instance, to determine the FTE of a dentist working 2 8-hour days per week, one would divide 16 hours by 40, which would equal 0.4 FTE.
2. Includes community-based services and visits, and RVUs generated from those services.
3. If dentist and dental hygienist data cannot be obtained, use facility standards.
4. For previous years prior to 2015, 9130 should be substituted for 9986.
5. The proportion or percentage of patients treatment planned is contingent upon the program using D150 or D145 (age 3 and under) codes each year. If the clinic only uses these codes every three years, this indicator would need to be calculated in three-year increments. Use of D120 is not recommended as it will provide a >100% rate as patients often have multiple recall exams in a year.
6. The proportion or percentage of patients completing treatment is dependent upon the program using the 9990 code. If the clinic does not consistently use this code when a patient completes Level I-III services (note that all services do not need to be completed, only Levels I-III), this indicator would not produce reliable results. Use of D120 in the denominator is not recommended as it will significantly lower the completion rate.
7. These clinical productivity and efficiency indicators should be analyzed in total to gain a thorough understanding of a dental program. Individual indicators may fluctuate significantly and, if analyzed individually only, they may or may not indicate productivity or efficiency issues in the program.

Quality Assurance/Quality Improvement

- Staffing/Peer Review
  - Staffing using IHS DOH Efficiency and Effectiveness Data Indicators Worksheet (Resources).
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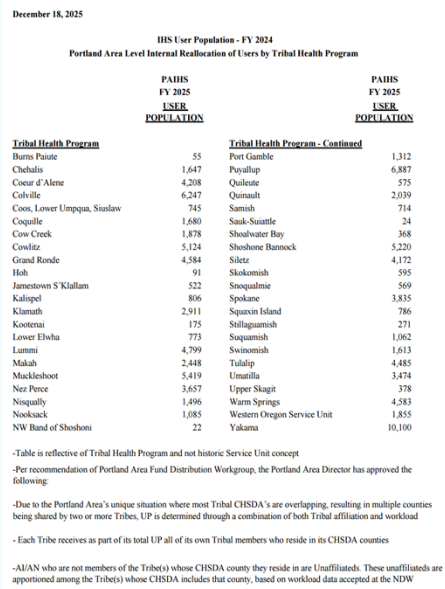
	Operatory to Dentist Ratio	# of non-RDH chairs/# of FTE dentists	2:1	2:1

https://www.ihs.gov/doh/clinicmanagement/efficiencyeffectiveness/Chapter%208%20Appendix%20V%20Efficiency%20and%20Effectiveness%20Data%20Indicators%20Worksheet%20-%202024.pdf



December 18, 2025

IHS User Population - FY 2024
Portland Area Level Internal Reallocation of Users by Tribal Health Program

Tribal Health Program	PAIHS FY 2025 USER POPULATION	Tribal Health Program - Continued	PAIHS FY 2025 USER POPULATION
Burns Paiute	55	Port Gamble	1,312
Chehalis	1,647	Puyallup	6,887
Coeur d'Alene	4,208	Quileute	575
Colville	6,247	Quinault	2,039
Coos, Lower Umpqua, Siuslaw	745	Samish	714
Coquille	1,680	Sauk-Suiattle	24
Cow Creek	1,878	Shoalwater Bay	368
Cowlitz	5,124	Shoshone Bannock	5,220
Grand Ronde	4,584	Siletz	4,172
Hoh	91	Skokomish	595
Jamestown S'Klallam	522	Snoqualmie	569
Kalispel	806	Spokane	3,835
Klamath	2,911	Squaxin Island	786
Kootenai	175	Stillaguamish	271
Lower Elwha	773	Suquamish	1,062
Lummi	4,799	Swinomish	1,613
Makah	2,448	Tulalip	4,485
Muckleshoot	5,419	Umatilla	3,474
Nez Perce	3,657	Upper Skagit	378
Nisqually	1,496	Warm Springs	4,583
Nooksack	1,085	Western Oregon Service Unit	1,855
NW Band of Shoshoni	22	Yakama	10,100

-Table is reflective of Tribal Health Program and not historic Service Unit concept

-Per recommendation of Portland Area Fund Distribution Workgroup, the Portland Area Director has approved the following:

-Due to the Portland Area's unique situation where most Tribal CHSDA's are overlapping, resulting in multiple counties being shared by two or more Tribes, UP is determined through a combination of both Tribal affiliation and workload

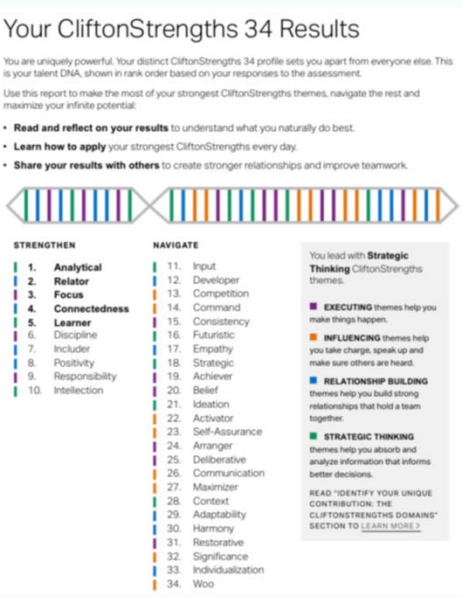
- Each Tribe receives as part of its total UP all of its own Tribal members who reside in its CHSDA counties

-AI/AN who are not members of the Tribe(s) whose CHSDA county they reside in are Unaffiliateds. These unaffiliateds are apportioned among the Tribe(s) whose CHSDA includes that county, based on workload data accepted at the NDW

Quality Assurance/Quality Improvement

- Staffing/Peer Review
  - Clifton Strengths/Team Building
    - A tool to help determine staff strengths and assignments.

	EXECUTING								INFLUENCING								RELATIONSHIP BUILDING									STRATEGIC THINKING							
	Leaders with dominant strength in the Executing domain know how to make things happen. When you need someone to implement a solution, these are the people who will work tirelessly to get it done. Leaders with a strength to execute have the ability to "catch" an idea and make it a reality.								Those who lead by influencing help their team reach a much broader audience. People with strength in this domain are always selling the team's ideas inside and outside the organization. When you need someone to take charge, speak up, and make sure your group is heard, look to someone with the strength to influence.								Those who lead through Relationship Building are the essential glue that holds a team together. Without these strengths on a team, in many cases, the group is simply a composite of individuals. In contrast, leaders with exceptional Relationship Building strength have the unique ability to create groups and organizations that are much greater than the sum of their parts.									Leaders with great Strategic Thinking strengths are the ones who keep us all focused on what could be. They are constantly absorbing and analyzing information and helping the team make better decisions. People with strength in this domain continually stretch our thinking for the future.							
Team	Achiever	Arranger	Belief	Consistency	Deliberative	Discipline	Focus	Responsibility	Restorative	Activator	Command	Communication	Competition	Maximizer	Self-Assurance	Significance	WOO	Adaptability	Connectedness	Developer	Empathy	Harmony	Includer	Individualization	Positivity	Relator	Analytical	Context	Futuristic	Ideation	Input	Intellection	Learner	Strategic
Samantha Arneson	7	4						9										6	1						3		2				10	5	8
Sean Kelly						6	3	9										4					7		8	2	1				10	5	
Ticey Mason						8			5	9		3					6			4	2	1		7	10								
Total by Theme	0	1	1	0	0	2	1	2	1	1	0	1	0	0	0	0	1	0	2	2	1	1	1	2	2	1	1	0	0	0	2	2	1
Total by Domain									8								3								12								7



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Quality Assurance/Quality Improvement

- Staffing/Peer Review

PEER REVIEW:

IHS Oral Health Program Guide

In the context of this manual, the term peer review refers to the process of assessing the quality of clinical care provided by an employee, contractor or volunteer. In this context, it is a process in which the dentist must participate as a condition of employment.

The peer review can be a direct clinical evaluation, a review of dental charts or a combination of the two.

It can be conducted on a regularly scheduled basis as part of the Quality Assurance/Quality Improvement (QA/I) program or as a focused review in response to a patient complaint or other adverse occurrence.

When and how the peer review is conducted should be defined clearly in the clinic's Policy and Procedure Manual and all employees should be apprised of the peer review process and standards during their initial orientation.

https://www.ihs.gov/doh/clinicmanagement/ohpgpdf/Chapter%207/12IHS-OPHS790-DEN_HNB_Chapter7_SectionC.pdf

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Quality Assurance/Quality Improvement

•Staffing/Peer Review

PEER REVIEW:

According to the AMA "peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care"

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Quality Assurance/Quality Improvement

•Staffing/Peer Review

PEER REVIEW:

As productivity and efficiency measures assist with a QA/QI program, using peer review is also important. Organizing a rotating schedule of Dentist/DT/RDH in assessing patient charts for one another helps identify discrepancies that when corrected will provide quality assurance. It may later also lead to improvement as workflows may be identified that can be changed for the better. The peer review process helps both to ensure quality while also providing a tool to identify areas that need improvement. Quality Assurance/Improvement should be implemented in other areas as well, whether it is patient broken appointments, staff absenteeism or radiograph retakes, a robust dental program is always looking for ways to improve and provide the best care for their patients.

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Quality Assurance/Quality Improvement

•Staffing/Peer Review

PEER REVIEW:

Dr. Kelly's Summary of Peer Reviews

- To help providers achieve a common focus of dental care knowing we all come from different experiences and training.
- Such reviews guide our dental program to keep moving in a unified direction.
- The process aides in recognizing what works and what doesn't.
- Such are not meant to be adversarial. They should be as objective as possible.
- Professional peer review focuses on the performance of professionals, with a view to improving quality and upholding standards. Which is something we all must desire.

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Quality Assurance/Quality Improvement

•Staffing/Peer Review

PEER REVIEW:

IHS National Dental Program Review Tool

(new 2024 version)

3. Chart Documentation (from Sections A & B of the IHS Indirect Review of Clinical Services, plus selected sections)	
1) A health questionnaire completed by the patient and signed by the provider within the past 12 months is present and documentation exists that it was reviewed at each visit. Positive responses followed up with documentation.	
2) Appropriate measures have been taken to ensure patient safety and appropriate treatment. (eg- blood pressure for HTN patients, blood sugar for diabetic patients).	
3) Appropriate ADA codes are recorded (including tooth number, surface, or pocket depths when appropriate) and documentation exists in the progress note to justify all codes. Miscellaneous codes and limited exam codes are explained.	
4) Dental Progress Notes include: a. date of treatment b. signature of the provider(s) – legible signature c. if signature is illegible, printed or stamped name of provider(s) d. degree of the provider(s) e. If the patient was an emergency or exam, the SOAP (or similar) format used	
5) Dental progress notes include a disposition (what the patient needs next) at the end of each visit.	
6) Informed consent contains risks, benefits, and alternatives in language the patient can understand.	
7) The informed consent form is signed by the dental provider and patient/parent/guardian. This includes the examination record/treatment plan.	
8) Pain documentation is included on the progress note. Documentation is consistent with the facility policies. If pain is indicated, additional information on the management, treatment, or referral for treatment is included.	
9) All hard tissue findings (normal, pathology, or abnormalities) are recorded in the dental record.	
10) Documentation that radiographs have been read exists in the patient record. This may be either in the progress note or on the Exam Form.	
11) Evidence of soft tissue exam is present, either by listing of abnormalities or designation of "STN" (Soft Tissues Normal) or "WNL."	
12) Periodontal status (CPI or PSR) and diagnosis for patients age 15 and older is noted on the exam.	
13) Orthodontic status (for patients ages 6 to 20) is noted on the dental exam sheet.	
14) Written treatment plan exists for all patients receiving initial or recall dental exams. a. Treatment plan is easily understood b. Follows a logical sequence c. Is revised as needed, revisions are dated and initialed	
15) If a full scope of services is not available at the facility, a chart notation is made that the patient has been informed of his/her need for treatment at another facility.	
16) The patient is placed in a recall program based on his/her individual risks (caries/perio target group) and clinic resources, rather than arbitrary time intervals.	
17) Pre-operative x-rays are evident as appropriate (oral surgery, endo, etc.)	
18) Documentation of the behavior for all children under the age of 6 is documented.	
19) Behavior management techniques used and their level of effectiveness are documented.	
20) When definitive periodontal therapy is planned for patients with CPITN/PSR of 2 "3's", a periodontal work-up is conducted. This includes probing pocket depths, furca involvement, mobility, and occlusal features, with documentation.	
21) The dental record contains an individualized prevention assessment that includes oral hygiene, preventive regimens recommended, etc.	
Overall Score ("Passing" score is 80%)	

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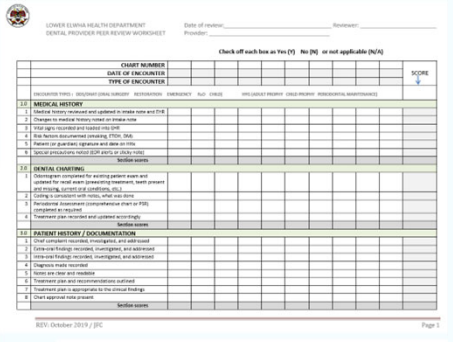
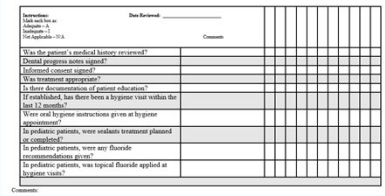
Quality Assurance/Quality Improvement

- Staffing/Peer Review

PEER REVIEW:

Others available to share among the Portland Area Clinics

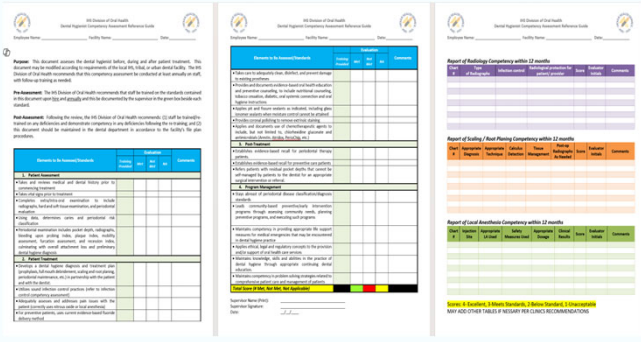




Quality Assurance/Quality Improvement

- Staffing/Peer Review

PEER REVIEW: Dental Hygienist



https://www.ihs.gov/doh/index.cfm?fuseaction=clinicmanagement.comp

Purpose: This document assesses the dental hygienist before, during and after patient treatment. This document may be modified according to requirements of the local IHS, tribal, or urban dental facility. The IHS Division of Oral Health recommends that this competency assessment be conducted at least annually on staff, with follow-up training as needed.

Pre-Assessment: The IHS Division of Oral Health recommends that staff be trained on the standards contained in this document upon hire and annually and this be documented by the supervisor in the green box beside each standard.

Post-Assessment: Following the review, the IHS Division of Oral Health recommends: (1) staff be trained/re-trained on any deficiencies and demonstrate competency in any deficiencies following the re-training; and (2) this document should be maintained in the dental department in accordance to the facility's file plan procedures.

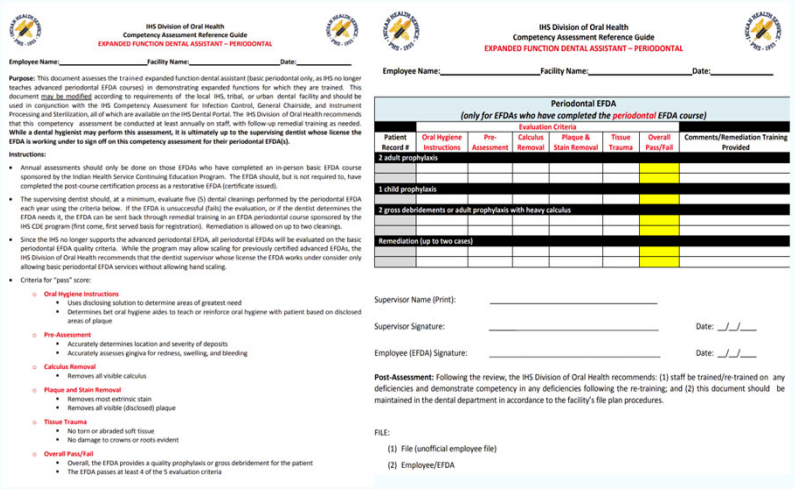
Quality Assurance/Quality Improvement

•Staffing/Peer Review

PEER REVIEW: **Perio EFDA**

Annual Competency:
1.The Dental Director/Dental Chief is encouraged to complete an annual competency evaluation on the periodontal EFDA to ensure high quality care is being delivered.
2.The annual competency evaluation can be found on the IHS Dental Portal under the Clinic Tab - Competencies.

https://www.ihs.gov/doh/documents/Annual%20Competency%20Assessment%20-%20Periodontal%20EFDA.pdf



IHS Division of Oral Health
Competency Assessment Reference Guide
EXPANDED FUNCTION DENTAL ASSISTANT – PERIODONTAL

Employee Name:_____Facility Name:_____Date:_____

Purpose: This document assesses the trained expanded function dental assistant (basic periodontal only, as IHS no longer teaches advanced periodontal EFDA courses) in demonstrating expanded functions for which they are trained. This document may be modified according to requirements of the local IHS, tribal, or urban dental facility and should be used in conjunction with the IHS Competency Assessment for Infection Control, General Chairside, and Instrument Processing and Sterilization, all of which are available on the IHS Dental Portal. The IHS Division of Oral Health recommends that this competency assessment be conducted at least annually on staff, with follow-up remedial training as needed. **While a dental hygienist may perform this assessment, it is ultimately up to the supervising dentist whose license the EFDA is working under to sign off on this competency assessment for their periodontal EFDA(s).**

Instructions:

- Annual assessments should only be done on those EFDAs who have completed an in-person basic EFDA course sponsored by the Indian Health Service Continuing Education Program. The EFDA should, but is not required to, have completed the post-course certification process as a restorative EFDA (certificate issued).
- The supervising dentist should, at a minimum, evaluate five (5) dental cleanings performed by the periodontal EFDA each year using the criteria below. If the EFDA is unsuccessful (fails) the evaluation, or if the dentist determines the EFDA needs it, the EFDA can be sent back through remedial training in an EFDA periodontal course sponsored by the IHS CDE program (first come, first served basis for registration). Remediation is allowed on up to two cleanings.
- Since the IHS no longer supports the advanced periodontal EFDA, all periodontal EFDAs will be evaluated on the basic periodontal EFDA quality criteria. While the program may allow scaling for previously certified advanced EFDAs, the IHS Division of Oral Health recommends that the dentist supervisor whose license the EFDA works under consider only allowing basic periodontal EFDA services without allowing hand scaling.
- Criteria for "pass" score:
  - **Oral Hygiene Instructions**
    - Uses disclosing solution to determine areas of greatest need
    - Determines bet oral hygiene aides to teach or reinforce oral hygiene with patient based on disclosed areas of plaque
  - **Pre-Assessment**
    - Accurately determines location and severity of deposits
    - Accurately assesses gingiva for redness, swelling, and bleeding
  - **Calculus Removal**
    - Removes all visible calculus
  - **Plaque and Stain Removal**
    - Removes most extrinsic stain
    - Removes all visible (disclosed) plaque
  - **Tissue Trauma**
    - No torn or abraded soft tissue
    - No damage to crowns or roots evident
  - **Overall Pass/Fail**
    - Overall, the EFDA provides a quality prophylaxis or gross debridement for the patient
    - The EFDA passes at least 4 of the 5 evaluation criteria

IHS Division of Oral Health
Competency Assessment Reference Guide
EXPANDED FUNCTION DENTAL ASSISTANT – PERIODONTAL

Employee Name:_____Facility Name:_____Date:_____

Periodontal EFDA
(only for EFDAs who have completed the periodontal EFDA course)

	Evaluation Criteria						
Patient Record #	Oral Hygiene Instructions	Pre-Assessment	Calculus Removal	Plaque & Stain Removal	Tissue Trauma	Overall Pass/Fail	Comments/Remediation Training Provided
2 adult prophylaxis							
1 child prophylaxis							
2 gross debridements or adult prophylaxis with heavy calculus							
Remediation (up to two cases)							

Supervisor Name (Print): _____

Supervisor Signature: _____ Date: __/__/____

Employee (EFDA) Signature: _____ Date: __/__/____

Post-Assessment: Following the review, the IHS Division of Oral Health recommends: (1) staff be trained/re-trained on any deficiencies and demonstrate competency in any deficiencies following the re-training; and (2) this document should be maintained in the dental department in accordance to the facility's file plan procedures.

FILE:
(1) File (unofficial employee file)
(2) Employee/EFDA

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Quality Assurance/Quality Improvement

•Clinic Management

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Quality Assurance/Quality Improvement

- Clinic Management (Quality)
  - Broken Appointment Rate, % of Patient Treatment Planned, % of Patients Completing Treatment and % of Level I-III (Basic) Services
  - Review data periodically to evaluate the program, especially in view of QA/QI and goals set for the clinic.

Quality	Broken Appointment Rate[4]	9986/(0000+0190+9986-9170)	≤21%	≤17%
	% of Patient Treatment Planned[5]	(0150+0145)/0000 x 100	≥53%	≥44%
	% of Patients Completing Treatment[6]	9990/(0150+0145) x 100	≥46%	≥41%
	% of Level I-III (Basic) Services	# of Level I, II, III Services/# of Levels I-V Services	≥80%	≥90%

https://www.ihs.gov/doh/clinicmanagement/efficiencyeffectiveness/Chapter%208%20Appendix%20V%20Efficiency%20and%20Effectiveness%20Data%20Indicators%20Worksheet%20-%202024.pdf

CHAPTER 8 | Appendix V: *Efficiency and Effectiveness Data Indicators Worksheet*

Appendix V: Efficiency and Effectiveness Data Indicators Worksheet

	Indicator	Calculation	2016	2024
Resources	Population to Dentist Ratio	User population/# of FTE dentists[1]	1200:1	1,200:1
	Population to Staff Ratio	User population/# of FTE staff	500:1	500:1
	Assistant to Dentist Ratio	# of FTE DAs/# of FTE dentists	2:1	2:1
	Operatory to Dentist Ratio	# of non-RDH chairs/# of FTE dentists	2:1	2:1
Services	Services per Dentist per Year	# of services/# of FTE dentists	4,505	5,097
	Services per Hygienist per Year[2]	# of services/# of FTE hygienists	1,992	2,902
	Services per Facility per Year[3]	# of services of all providers/# of FTE dentists only	6,497	6,604
Relative Value Units	RVUs per Dentist per Year	# of RVUs by dentist/# of FTE dentists	7,092	7,175
	RVUs per Hygienist per Year[2]	# of RVUs by hygienist/# of FTE hygienists	2,788	3,640
	RVUs per Facility per Year[3]	# of RVUs by all providers/# of FTE dentists	9,880	9,083
	RVUs per Staff per Year	# of RVUs (clinic)/# of FTE dental staff	2,770	2,860
	RVUs per Visit per Year	# of RVUs (clinic)/# of 0000+0190 codes	5.0	5.8
	RVUs per Patient per Year	# of RVUs (clinic)/# of 0000 codes	11.2	13.6
	RVUs per Operatory per Year	# of RVUs (clinic)/# of operatories	3,293	3,442
Patient Visits	Visits per Dentist per Year	# of 0000+0190/# of FTE dentists	1,879	1,645
	Visits per Dentist per Day	# of 0000+0190/# of FTE dentist/218 days	8.62	7.6
	Visits per Hygienist per Year[2]	# of 0000+0190 (hygienists)/# of FTE hygienists	1,357	1,056
	Visits per Hygienist per Day[2]	# of 0000+0190 (hygienists)/# of FTE hygienists/218	6.40	5.0
	Visits per Facility per Year[3]	# of 0000+0190 (all providers)/# of FTE dentists	3,236	2,206
	Visits per Operatory per Year	# of 0000+0190 (clinic)/# of operatories	721	691
Quality	Broken Appointment Rate[4]	9986/(0000+0190+9986-9170)	≤21%	≤17%
	% of Patient Treatment Planned[5]	(0150+0145)/0000 x 100	≥53%	≥44%
	% of Patients Completing Treatment[6]	9990/(0150+0145) x 100	≥46%	≥41%
	% of Level I-III (Basic) Services	# of Level I, II, III Services/# of Levels I-V Services	≥80%	≥90%

The IHS Division of Oral Health (DOH) recommends that Area Dental Officers, Dental Support Centers, or Dental Chiefs/Dental Directors assess these indicators once every one to two years. Please refer to the online training "Understanding Clinical Efficiency & Effectiveness Indicators" for more detail about these references. The above indicators on services, RVUs, visits, and quality are based upon an average of 12 selected IHS, Tribal, and urban dental programs using FY 2023 data, while the resource indicators are long-standing DOH recommendations. Collectively, these indicators serve only as recommendations for assessing clinical productivity, efficiency, effectiveness, and quality of care provided.

Notes:

1. FTE is Full Time Equivalent. To calculate the FTE of a position, divide the total hours worked per week by 40 hours. For instance, to determine the FTE of a dentist working 2 8-hour days per week, one would divide 16 hours by 40, which would equal 0.4 FTE.
2. Includes community-based services and visits, and RVUs generated from those services.
3. If dental and dental hygienist data cannot be obtained, use facility standards.
4. For previous years prior to 2015, 9130 should be substituted for 9986.
5. The proportion or percentage of patients treatment planned is contingent upon the program using 0150 or 0145 (age 3 and under) codes each year. If the clinic only uses these codes every three years, this indicator would need to be calculated in three-year increments. Use of 0120 is not recommended as it will provide a >100% rate as patients often have multiple recall exams in a year.
6. The proportion or percentage of patients completing treatment is dependent upon the program using the 9990 code. If the clinic does not consistently use this code when a patient completes Level I-III services (note that all services do not need to be completed, only Levels I-III), this indicator would not produce reliable results. Use of 0120 in the denominator is not recommended as it will significantly lower the completion rate.
7. These clinical productivity and efficiency indicators should be analyzed in total to gain a thorough understanding of a dental program. Individual indicators may fluctuate significantly and, if analyzed individually only, they may or may not indicate productivity or efficiency issues in the program.

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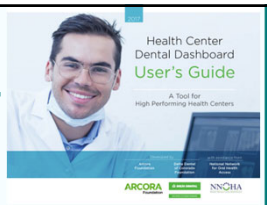
Quality Assurance/Quality Improvement

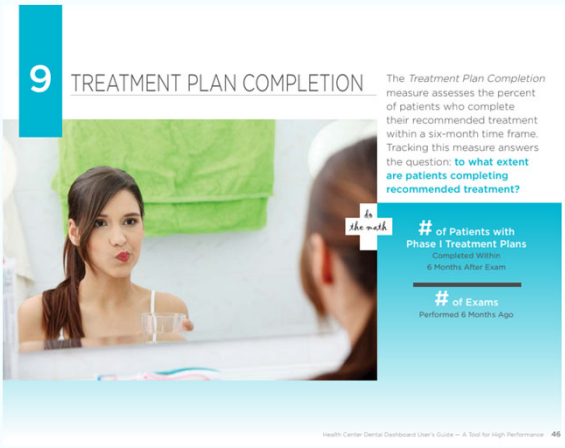


- Clinic Management

Measures the degree to which a patient's oral health treatment needs are being met. Completing treatment improves a patient's health, satisfaction with their Health Center experience, and allows them to focus on prevention rather than restoration.

  - % of Patients Completing Treatment

https://drive.google.com/file/d/1fiUHCnUN9HulhwEqhuEURpgk11NNHF1c/view



9 TREATMENT PLAN COMPLETION

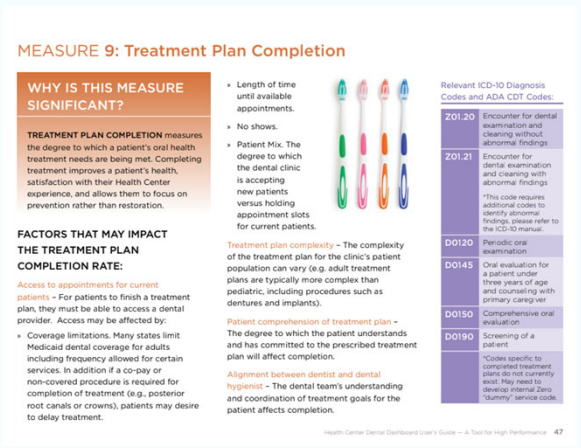
The *Treatment Plan Completion* measure assesses the percent of patients who complete their recommended treatment within a six-month time frame. Tracking this measure answers the question: **to what extent are patients completing recommended treatment?**

In the math

# of Patients with Phase I Treatment Plans Completed Within 6 Months After Exam

# of Exams Performed 6 Months Ago

Health Center Dental Dashboard User's Guide — A Tool for High Performance 46



MEASURE 9: Treatment Plan Completion

WHY IS THIS MEASURE SIGNIFICANT?

TREATMENT PLAN COMPLETION measures the degree to which a patient's oral health treatment needs are being met. Completing treatment improves a patient's health, satisfaction with their Health Center experience, and allows them to focus on prevention rather than restoration.

FACTORS THAT MAY IMPACT THE TREATMENT PLAN COMPLETION RATE:

Access to appointments for current patients – For patients to finish a treatment plan, they must be able to access a dental provider. Access may be affected by:

- Coverage limitations. Many states limit Medicaid dental coverage for adults including frequency allowed for certain services. In addition if a co-pay or non-covered procedure is required for completion of treatment (e.g., posterior root canals or crowns), patients may desire to delay treatment.
- Length of time until available appointments.
- No shows.
- Patient Mix. The degree to which the dental clinic is accepting new patients versus holding appointment slots for current patients.

Treatment plan complexity – The complexity of the treatment plan for the clinic's patient population can vary (e.g. adult treatment plans are typically more complex than pediatric, including procedures such as dentures and implants).

Patient comprehension of treatment plan – The degree to which the patient understands and has committed to the prescribed treatment plan will affect completion.

Alignment between dentist and dental hygienist – The dental team's understanding and coordination of treatment goals for the patient affects completion.

Relevant ICD-10 Diagnosis Codes and ADA CDT Codes:

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
	*This code requires additional codes to identify abnormal findings, please refer to the ICD-10 manual.
D0120	Periodic oral examination
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation
D0190	Screening of a patient
	*Codes specific to completed treatment plans do not currently exist. May need to develop internal Zero "dummy" service code.

Health Center Dental Dashboard User's Guide — A Tool for High Performance 47

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Quality Assurance/Quality Improvement

•Clinic Management

Reporting the proportion of patients completing treatment is an important tool to measure the general oral health of the community that you serve. The higher the rate of treatment complete, the more patients who have their urgent, preventive, and basic oral health services met, the greater the oral health of your community. A healthier dental population allows for a greater focus on prevention. A Dental Completion Code is very important, often used when all Level I-III services (link below for explanation of IHS Levels of care) are completed, or all dental diseases are treated.

https://www.ihs.gov/doh/clinicmanagement/ohpgpdf/Chapter%205/12IHS-OPHS790-DEN_HNB_Chapter5_SectionD.pdf

Quality	Broken Appointment Rate[4]	9986/(0000+0190+9986-9170)	≤21%	≤17%
	% of Patient Treatment Planned[5]	(0150+0145)/0000 x 100	≥53%	≥44%
	% of Patients Completing Treatment[6]	9990/(0150+0145) x 100	≥46%	≥41%
	% of Level I-III (Basic) Services	# of Level I, II, III Services/# of Levels I-V Services	≥80%	≥90%

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Quality Assurance/Quality Improvement

•Clinic Management

- PDSA (Plan, Do, Study, Act) Model
- Mini-experiments to identify strategies that increase access, decrease broken appointments, etc
- Use data to determine strategies' effectiveness
- Small-scale so participants don't make significant investments of time and resources until they can modify strategies to ensure they will be impactful.

Quality	Broken Appointment Rate[4]	9986/(0000+0190+9986-9170)	≤21%	≤17%
	% of Patient Treatment Planned[5]	(0150+0145)/0000 x 100	≥53%	≥44%
	% of Patients Completing Treatment[6]	9990/(0150+0145) x 100	≥46%	≥41%
	% of Level I-III (Basic) Services	# of Level I, II, III Services/# of Levels I-V Services	≥80%	≥90%

CHAPTER 8 | Appendix V: Efficiency and Effectiveness Data Indicators Worksheet

Appendix V: Efficiency and Effectiveness Data Indicators Worksheet

	Indicator	Calculation	2016	2024
Resources	Population to Dentist Ratio	User population/# of FTE dentists[1]	1200:1	1,200:1
	Population to Staff Ratio	User population/# of FTE staff	500:1	500:1
	Assistant to Dentist Ratio	# of FTE DAs/# of FTE dentists	2:1	2:1
	Operatory to Dentist Ratio	# of non-RDH chairs/# of FTE dentists	2:1	2:1
Services	Services per Dentist per Year	# of services/# of FTE dentists	4,505	5,097
	Services per Hygienist per Year[2]	# of services/# of FTE hygienists	1,992	2,902
	Services per Facility per Year[3]	# of services of all providers/# of FTE dentists only	6,497	6,604
Relative Value Units	RVUs per Dentist per Year	# of RVUs by dentist/# of FTE dentists	7,092	7,175
	RVUs per Hygienist per Year[2]	# of RVUs by hygienist/# of FTE hygienists	2,788	3,640
	RVUs per Facility per Year[3]	# of RVUs by all providers/# of FTE dentists	9,880	9,083
	RVUs per Staff per Year	# of RVUs (clinic)/# of FTE dental staff	2,770	2,860
	RVUs per Visit per Year	# of RVUs (clinic)/# of 0000+0190 codes	5.0	5.8
	RVUs per Patient per Year	# of RVUs (clinic)/# of 0000 codes	11.2	13.6
	RVUs per Operatory per Year	# of RVUs (clinic)/# of operatories	3,293	3,442
Patient Visits	Visits per Dentist per Year	# of 0000+0190/# of FTE dentists	1,879	1,645
	Visits per Dentist per Day	# of 0000+0190/# of FTE dentist/218 days	8.62	7.6
	Visits per Hygienist per Year[2]	# of 0000+0190 (hygienists)/# of FTE hygienists	1,357	1,056
	Visits per Hygienist per Day[2]	# of 0000+0190 (hygienists)/# of FTE hygienists/218	6.40	5.0
	Visits per Facility per Year[3]	# of 0000+0190 (all providers)/# of FTE dentists	3,236	2,206
	Visits per Operatory per Year	# of 0000+0190 (clinic)/# of operatories	721	691
Quality	Broken Appointment Rate[4]	9986/(0000+0190+9986-9170)	≤21%	≤17%
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The IHS Division of Oral Health (DOH) recommends that Area Dental Officers, Dental Support Centers, or Dental Chiefs/Dental Directors assess these indicators once every one to two years. Please refer to the online training "Understanding Clinical Efficiency & Effectiveness Indicators" for more detail about these references. The above indicators on services, RVUs, visits, and quality are based upon an average of 12 selected IHS, Tribal, and urban dental programs using FY 2023 data, while the resource indicators are long-standing DOH recommendations. Collectively, these indicators serve only as recommendations for assessing clinical productivity, efficiency, effectiveness, and quality of care provided.

Notes:

1. FTE is Full Time Equivalent. To calculate the FTE of a position, divide the total hours worked per week by 40 hours. For instance, to determine the FTE of a dentist working 2 8-hour days per week, one would divide 16 hours by 40, which would equal 0.4 FTE.
2. Includes community-based services and visits, and RVUs generated from those services.
3. If dentist and dental hygienist data cannot be obtained, use facility standards.
4. For previous years prior to 2015, 9130 should be substituted for 9986.
5. The proportion or percentage of patients treatment planned is contingent upon the program using 0150 or 0145 (age 3 and under) codes each year. If the clinic only uses these codes every three years, this indicator would need to be calculated in three-year increments. Use of 0120 is not recommended as it will provide a >100% rate as patients often have multiple recall exams in a year.
6. The proportion or percentage of patients completing treatment is dependent upon the program using the 9990 code. If the clinic does not consistently use this code when a patient completes Level I-III services (note that all services do not need to be completed, only Levels I-III), this indicator would not produce reliable results. Use of 0120 in the denominator is not recommended as it will significantly lower the completion rate.
7. These clinical productivity and efficiency indicators should be analyzed in total to gain a thorough understanding of a dental program. Individual indicators may fluctuate significantly and, if analyzed individually only, they may or may not indicate productivity or efficiency issues in the program.

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Quality Assurance/Quality Improvement

- Clinic Management

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Example: PTC, make sure code is properly entered, EDR change? Use peer review to verify code is entered correctly. Low lying fruit? Have appointments available that allow immediate treatment like prophies, sealants (simple procedures) that will complete a patient's treatment.

Tabletop Exercise: Pick one and discuss how you may strategize for improvement, perhaps using past strategies that have made a difference. How would (did) you implement and study the strategy?

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Quality Assurance/Quality Improvement

- Clinic Management

An additional explanation of the Clinical Productivity and Efficiency measures is available through the IHS DOH Dental Portal via the Continuing Dental Education page. The course number is DE0389, found in the E-Learning section. It covers Clinical Efficiency and Effectiveness and Quality Assurance/Quality Improvement (QA/QI). It is also available via YouTube at the following link:

https://www.youtube.com/watch?v=ZZjrrcMkayg

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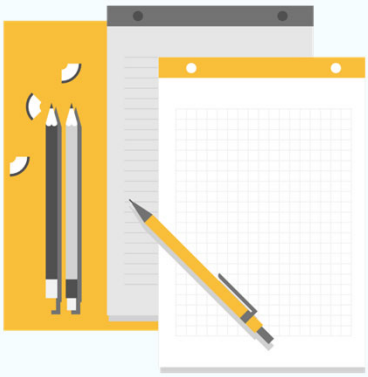
Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs
- Staffing/Continuity of operations



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Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs
  1. Policy & Procedures
     a. Organizational wide or Interdepartmental
     b. Require Governing Body approval
        i. Tribal Council or Health Board
  2. Protocols and Standard Operating Procedures (SOPs)
     a. Departmental
     b. Day to day activities
     c. Easier to update as new workflows are developed or new information is provided.
  3. No paper! **Central electronic access only!**
  4. IHS DOH Dental Portal Examples

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Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs

  Hierarchy approach to safe practices:

  1. Rules and Regulations (OSHA, FDA, EPA, FGI)
  2. State and Local requirements. (State & Local health department)
  3. Manufacturers Instructions for Use (IFUs)
  4. Evidence-Based Guidelines and National Standards (CDC)
  5. Consensus Documents (AAMI) (stricter, if you use AMMI for one aspect of IC, then you need to use it for all other aspects, can't pick and choose.)
  6. Organization's Infection Prevention and Control Policy

Credit for this outline to:
Damon Pope, DMD
IHS DOH National Dental Infection Control & Safety Coordinator
Indian Health Service HQ

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Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs

  Protocols vs. SOPs:

  From the point of view of regulatory frameworks, protocols are the official rules and standards set by an external regulating body, while procedures, including SOPs, are the methods used to achieve or comply with the protocols. Note that protocols are not necessary to have an SOP - you can write an SOP to do whatever you like, regardless of whether there is a protocol that needs to be satisfied - but in a regulation context, this is the distinction between protocol and SOP.
  Protocols are sometimes described as being goal-oriented or problem-oriented, in that they are designed describe what needs to be achieved. In contrast, SOPs are the practical instructions that an individual needs to follow to fulfill or achieve that goal. For example, a protocol might lay out the standard of accuracy or purity a test or process might require, whereas the SOP will spell out the specific procedure the laboratory will use to perform the test or process to that standard.

  https://www.quora.com/What-is-the-difference-between-an-SOP-and-a-Protocol-in-a-laboratory

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Tabletop exercise/discussion

- Policies & Procedures, Protocols and SOPs
  - **Exercise and Discussion**

1. **"Managing safety checks on dental equipment. As an example, providing safety checks for our mobile nitrous system to ensure it is working properly."**
2. **Caries Risk Assessments during an exam.**
3. **"Pain management, rarely prescribe a controlled med."**
4. **"Emergency Preparedness, I don't feel our dental clinic has clear plans outlined and we recently had power out at the clinic."**
5. **"No shows. Where is the line between too punitive and not putting enough onus on the patient."**
6. **"Office inventory management. How it would be best to ensure we have the supplies we need."**
7. **Dental exams and taking routine radiographs, or radiographs during an urgent care appointment.**
8. **Processing instruments for reuse, sterilization room and staffing.**

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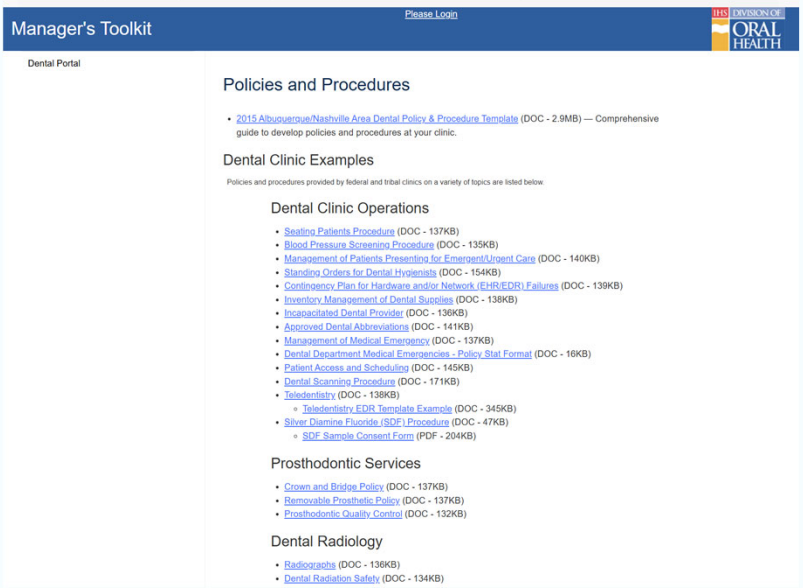
Policies & Procedures, Protocols and SOPs

- Resources

https://www.ihs.gov/DOH/chiefs/index.cfm?fuseaction=duties.display



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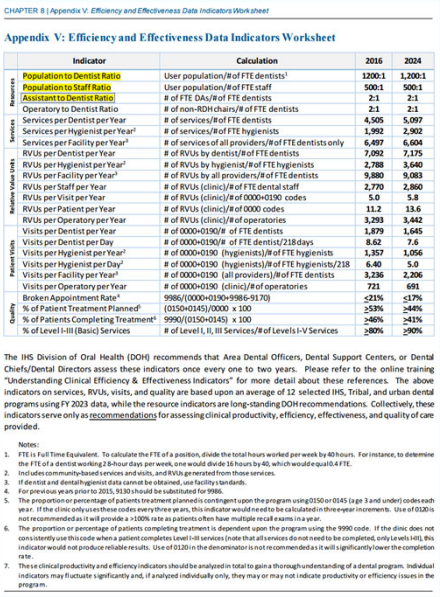
Staffing/Continuity of Operations

Tabletop exercise/discussion

•Staffing/Continuity of operations

The Population to Staff Ratio indicator is not as beneficial as using the Resource Requirement Methodology (RRM), which provides detailed staffing recommendations based on patient population. These criteria are used in concert with empirical data, such as workload or service population, called driving variables, to estimate the staffing requirements in full-time equivalents to provide comprehensive acute, chronic, and preventative health care services to Indian people.

https://www.ihs.gov/dper/planning/rrm-references/dental/



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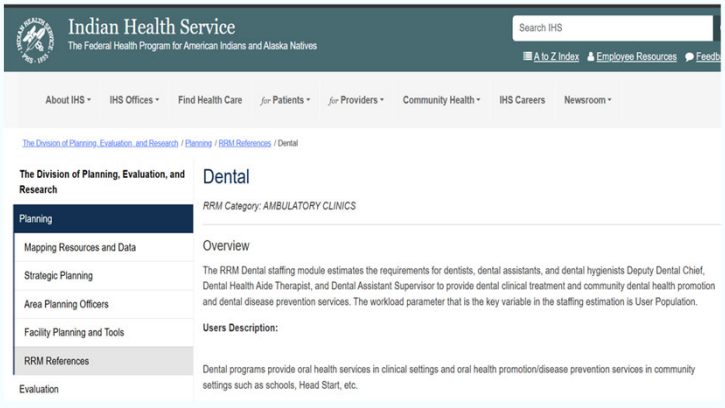
Staffing/Continuity of Operations

Tabletop exercise/discussion

•Staffing/Continuity of operations



https://www.ihs.gov/dper/planning/rrm-references/dental/

Resource Requirement Methodology (RRM)

Staffing Formulae

Driving Variables: **User Population**

Personnel Categories:
Dentist
Dental Assistant
Dental Hygienist
Clerical Support
Dental Health Aide Therapist (DHAT)
Deputy Dental Chief
Dental Assistant Supervisor

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Staffing/Continuity of Operations

Tabletop exercise/discussion

•Resource Requirement Methodology (RRM)

Based on this method (handout and next slides) discuss what your staffing should be to include the following questions:

1. Am I over or understaffed?
2. What staff positions am I short or exceed? Who do I need in my clinic?
3. If over staffed, how has this benefitted the clinic?
4. If understaffed, how has this affected the clinic?

https://www.ihs.gov/dper/planning/rrm-references/dental/

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Resource Requirement Methodology (RRM)

Staffing Criteria

- **Fixed Dentist staff** of 1.00 FTE for every facility with a User Population above 800, plus 1.00 FTE Dentist for every 1200 User Population (See below where DHATs are authorized.
- **Deputy Dental Chief** of 1.00 FTE for every 5.0 FTE Dental providers (dentist, dental hygienists, or DHATs).
- **Fixed Dental Assistant staff** of 2.00 FTE for every facility with User Population above 800, plus 2.00 FTE Dental Assistant for every 1200 User Population above 800 User Population.
- **Fixed Dental Hygienist staff** of 0.50 FTE for every facility with User Population above 800, plus 0.50 FTE Dental Hygienist for every additional 1,200 User Population.
- **Dental Assistant Supervisor** of 1.00 FTE for every 6.00 FTE non-supervisory dental assistants or for every facility with a User Population above 3,200, plus 1.00 FTE DA supervisor for every additional 6.00 FTE non-supervisory dental assistant staff or every additional 3,600 user population.
- **Fixed clerical support staff** of 0.50 FTE for every facility with a User Population above 800, plus 0.50 FTE for every additional 1,200 User Population.
- For programs contemplating **dental health aide therapists** (DHATs) under general supervision, fixed DHAT staff of 0.75 FTE for every facility with a User Population above 800 and a corresponding 0.25 FTE supervising dentist, plus 0.75 FTE for every additional 1,200 User Population and a corresponding 0.25 FTE supervising dentist.
- For programs contemplating dental health aide therapists (DHATs) under indirect or direct supervision, 0.25 FTE DHAT staff for every facility with a User Population above 2000 (with 1.75 FTE dentists), then 0.25 FTE DHAT staff for every additional 1,200 User Population (with 0.75 FTE dentists).

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Resource Requirement Methodology (RRM)

MINIMUM STAFFING LEVELS (fixed):

Personal Category	FTEs	per	Driving Variables	Min.	Max.
Dentist	1.0		User Population	800	
Dental Assistant	2.0		User Population	800	
Dental Hygienist	0.5		User Population	800	
Clerical Support	0.5		User Population	800	
Dental Health Aide Therapist	0.75		User Population	800	

plus, VARIABLE STAFFING LEVELS:

Personal Category	FTEs	per	Driving Variables	Min.	Max.
Dentist	1.0	1200	User Pop.	1200	n/a
Dental Assistant	2.0	1200	User Pop.	800	n/a
Dental Hygienist	0.5	1200	User Pop.	800	n/a
Clerical Support	0.5	1200	User Pop.	800	n/a
Dental Health Aide Therapist	0.25	1.75 Dentist	User Pop.	2000	n/a
Dental Health Aide Therapist	0.25	0.75 Dentist	User Pop.	1200	n/a
Deputy Dental Chief	1.0	5.0 FTE	Dentists		
Dental Assistant Supervisor	1.0	6.0 FTE	Dental Assistants or user Pop	3200	3600

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Staffing/Continuity of Operations

Tabletop exercise/discussion

- Resource Requirement Methodology (RRM)

What to do with this information? Along with revenues, this information may be used to present to your administration to justify staffing needs if understaffed. If over staffed, then may provide additional services and/or justify the need to increase in clinic size.

https://www.ihs.gov/dper/planning/rrm-references/dental/

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Staffing/Continuity of Operations

Update clinic "DPR" data; Dentist & RDH Vacancy announcement template and instructions for 2026 Inbox ×

K **Knutson, Joel (IHS/HQ)** 10:17 AM (1 hour ago)
to LISTSERV-IHS, ADO, Dental

ADOs, Dental Directors and Dental Support Center personnel,

It is anticipated there will be an update review of the IHS OCPS Continuity of Care and Operations (COCO) status in the coming months. (The last COCO reviews were in April, 2025.) Please update your clinic staffing so DOH can provide a reasonably accurate assessment of staffing across all IHS I/T/U clinics. This will be important to combine with other IHS initiatives to address staffing challenges.

Updating the Dental Directory information is becoming more important than ever before. The recent request for Vacancy information at the clinic level to justify IHS HR hiring action heightens the importance of having the most accurate information possible on very short notice. There is no other comparable database to track this information.

Attached is the [IHS Dental Portal] ADO Vacancy listing template updated for 2026-2032. (**Note: This template is updated for years through 2032. If the template you are currently using ends with 2019 or 2025, please use the new template**)

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Continuity of Operations

- If your clinic was damaged or destroyed, what would you need to resume operations?
- Does your facility have a COOP plan?
- If you have critical staff shortages, would you see fewer patients or would you limit services to basics?
- If you were incapacitated, who would take over? Are they ready?

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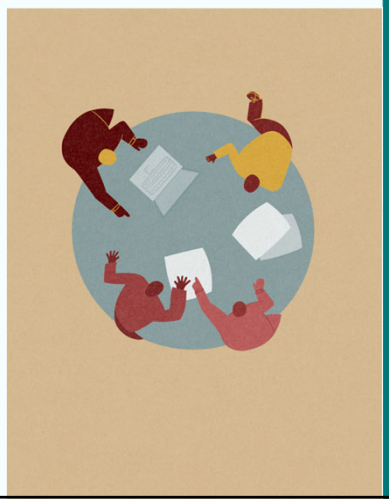
Hazards Vulnerability Analysis

- Every site has different hazards:
  - Fire
  - Flood
  - Train wreck
  - Financial resource loss
  - Staff loss
- HVA determines
  - What you are vulnerable to
  - How high is the risk?
  - How prepared are you to deal with it?



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Risk Assessment Matrix

Probability	Severity: Catastrophic - 4	Critical - 3	Marginal - 2	Negligible - 1
Frequent - 4	High (16)	High (12)	Serious (8)	Medium (4)
Probable - 3	High (12)	Serious (9)	Serious (6)	Medium (3)
Remote - 2	Serious (8)	Serious (6)	Medium (4)	Low (2)
Improbable - 1	Medium (4)	Medium (3)	Low (2)	Low (1)

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Tomorrow

Northwest Tribal Dental Support Center

Northwest Tribal Dental Meeting
June 2-4, 2026
Salishan Coastal Lodge

Northwest Tribal Dental Meeting (7.5 CDE)

Wednesday, June 3, 2026		**Long House**
7:00 am	Registration opens	
7:30 am - 9:00 am	Breakfast (Provided)	
8:15 am	Tribal Welcome	Crooked River, Siletz Drummers Naiya Mason, Little Miss Siletz
8:30 am	Northwest Tribal Dental Support Center	Ticey Mason, NPAIHB
8:45 am	Being an Ally in Indian Country	Jillene Joseph, Executive Director Native Wellness Institute
9:45 am	Break	
10:00 am	Infection Control	Amanda Hill, BSDH, RDH CDIPC
12:00 pm	Lunch (Provided)	
1:00 pm	Career Advancements in Dentistry	Dr. Sean Kelly, NTDSC Dental Consultant CAPT Lori Snidow, Portland Area IHS Area Dental Officer Dr. Chloe Craig, Director, Wy'east Dentistry Pathway, OHSU
2:30 pm	Break	
2:45 pm	Wellness in the Workplace	Jillene Joseph, Executive Director Native Wellness Institute
4:15 pm	Closing Remarks/Adjourn for the Day	Ticey Mason, NPAIHB
	HAVE SOME FUN Time	
6:00 pm - 9:00 pm	Reception (food provided)	

We would like to thank ***Arcora-The Foundation of Delta Dental of Washington*** for sponsoring the food and beverages at the Northwest Tribal Dental Meeting. Thank you!

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Questions!

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drkelly55@gmail.com

S

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NORTHWEST TRIBAL DENTAL SUPPORT CENTER
A Project of NPAIHB

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Thank you!

Northwest Tribal Dental Meeting CDE Information:

Course number will be **DE0993**

Completion Code will be: **Ally**

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