OREGON DENTAL ASSOCIATION

OREGON ORAL HEALTH COALITION

ROHC

improving general health through oral health for all Oregonians

In December of 2010, at the request of Senator Monnes-Anderson, the Oregon Dental Association and the Oregon Oral Health Coalition began mediation to work on the topic of Access to Care. Over the course of the last several months, our mediation group worked hard (at considerable time and expense to those involved) to come up with a bill that maintains the integrity of the dental team and gets to the root of access barriers in Oregon. We have come to agreement that due to multi-faceted barriers to access, multiple ways to address those barriers are necessary, and ODA and OrOHC agree on the attached amendments to Senate Bill 738. As a result of our agreement, we also respectfully ask the committee to remove SB 227 and SB 232 from Monday's agenda.

- We agree that no ONE solution by itself will solve the problem as we understand it. Therefore, we believe that the access to care problem will require a multimodal solution.
- We agree that dental disease is preventable and therefore prevention should play the greatest long-term role in managing oral health care costs and incidence of disease.
- We agree that if a new dental team member is to be considered, there should be pilot projects developed to demonstrate what may or may not work in Oregon.
- We agree that all pilot programs should have metrics built into them, to determine the level of success each has had on improving oral health, cost savings and access to care.
- We agree that in order to properly compare the metrics of new providers, we must first establish a baseline of access issues in order to show the effectiveness of any and all pilot projects.
- We agree that all pilot project language should include sunset provisions to insure that pilot programs will be adequately reviewed and shown to be effective before adopting permanent changes.
- We agree that LAP dental hygienists should be allowed to enter into employee/provider agreements with insurance companies and be reimbursed for authorized procedures within the scope of their license and permit.
- We agree that Expanded Practice Dental Hygienist is a good descriptor of the expanded scope of practice for these dental hygienists.
- We agree that dental hygienists (2-4 years of college) are trained to be a part of the dental team, under the supervision of a dentist (8-13 years of college and professional school). If Expanded Practice Dental Hygienists want to practice beyond the CODA standards, they should be required to complete additional training and experience beyond the standard dental hygiene education. There are two distinct pathways to obtain this credential.
- We agree that the dentist is the head of the dental team and needs to remain that way as we move towards a model of community coordinated care organizations to deliver care and manage chronic diseases through the use of health care teams.
- We agree that as the head of the dental team, the dentist must have some role in coordinating care for all team members, up to and including general supervision (need not be in the office), whether that be a collaborative agreement to outline the parameters of that general, direct or indirect supervision.

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