Capitol Dental Care, Inc.
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February 2, 2015

Senate Committee on Health Care and Human Services
900 Court Street NE
Salem, Oregon 97301

RE: SB301

Chair Senator Monnes-Anderson and Members of the Committee,

For the record my name is Deborah Loy, I am the Executive Director of Government Programs for Capitol Dental Care (CDC). We are a dental care organization that provides care to hundreds of thousands of Oregon Health Plan enrollees. I am here to testify against SB301 which would amend ORS 680.205 (3) (d) by removing 'overall dental risk assessment and referral parameters' from the services that may be performed as described by an expanded practice dental hygienist (EPDH) in an agreement with a dentist.

The above language originated from SB738 which was passed by the 2011 Oregon Legislature. This legislation related to dental workforce and approaches to expansion. CDC supported SB738 then and continues to do so today. One of SB738's workforce expansion approaches was an EPDH and dentist being able to enter into a (collaborative) agreement. The agreement (which requires approval by Oregon Board of Dentistry) would allow a hygienist to do any one of the services as described in paragraph ORS 680.205 (3) (a) through (d) if it was included in the agreement. The agreement does not have to include all four additional services but can be limited to one or more of them. As an organization, Capitol Dental Care is especially interested in the agreement and the options it provides.

We are very committed to increasing access and capacity by expanding the dental team. The dental office and dentist becomes the HUB to the dental team and the community sites where the EPDHs deliver services are the spokes. CDC currently financially supports EPDHs (with dentist agreements) going into Head Starts, Women Infant and Children sites, nursing homes and schools. Additionally we are piloting EPDHs being co-located in medical offices. It is our belief that this model of care affords an opportunity of keeping many of our members healthy in their community. A long running pilot in California found ⅔ of children they saw using this model could be maintained in the community by the EPDH and never had to come into the dental office to see a dentist.

ORS 680.205 (2) states at least once each calendar year an EPDH shall refer each patient or resident to a dentist who is available to treat the patient or resident. It is this requirement that we believe 'overall dental risk assessment and referral parameters' was intended to address. In an agreement if (d) was to be included, the dentist would be able to establish the risk and referral parameters for when an EPDH needed to refer to him/her. A patient with low risk and no decay or treatment needs would not necessarily be referred based upon the individual dentist's parameters. Such a patient might simply be placed in recall with the EPDH versus being advised to see a dentist.

The law does not require an EPDH to ensure a patient actually sees a dentist just to say and document the above. ORS 680.205 (3) should be clarified to allow in an agreement that includes (d), that risk and referrals parameters criteria be established by the dentist in the agreement with the EPDH. Doing otherwise confuses a patient by referring him/her to a dentist if there is no need. Also it places CDC and the CCOs we contract with at risk for duplication of services. CDC wants to cover the right services, at the right time, by the right provider. Referring a member to a dentist without a need to be seen by the dentist would not be a prudent use of limited resources. Nor would it be supporting the dental team model with all providers working at the top of their scope of practice.

We would ask that ORS 680.205 (3) (d) not be removed but clarified. I am happy to answer any questions the committee may have and thank you all for the opportunity to testify.

Sincerely,

Deborah Loy

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