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ON THE COVER

2013 ODA Board of Trustees

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FRONT ROW: Dr. Barry Taylor, Dr. Sean Benson, Dr. Steve Timm, Dr. Jill Price, Dr. Judd Larson, Dr. David Dowsett, Dr. Rick Asai

NOT PICTURED: Dr. Matthew Biermann, Dr. Jeff Dryden, Dr. Randall Glenn, Dr. Allen Methven, Dr. Mike Murat, Dr. Lee Sharp, Dr. Jeff Stewart, Dr. Chris Walker

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Oregon Dental Association
503.218.2010 • 800.452.5628 • Fax: 503.218.2009
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PO Box 3710, Wilsonville, OR 97070-3710

Street address
8699 SW Sun Pl, Wilsonville, OR 97070

Dentist Health & Wellness Hotline 503.550.0190


Social networks
Look for the Oregon Dental Association group on:

facebook  LinkedIn  NewDocs

Twitter
Follow ODA President, Jill M. Price, DMD: @ODAPrez
Blog www.TheToothOfTheMatter.org

Jan 25 1:00 PM Executive Committee mtg (ODA)
Feb 2 8:00 AM Board of Trustees mtg (ODA)
Feb 27 8:00 AM Dental Day at the Capitol (Salem)
Apr 2 6:00 PM Executive Committee mtg (conference call)
Apr 4–6 Oregon Dental Conference (Oregon Convention Center)
May 31 7:00 AM Executive Committee mtg (The Allison Inn—Newberg)
Jun 1 8:00 AM Board of Trustees mtg (The Allison Inn—Newberg)
Jun 21 3:00 PM Executive Committee mtg (ttb)
Jul 27 8:00 AM Board of Trustees mtg (ODA)
Sep 5 12 NOON Executive Committee mtg (Sunriver Resort)
SEPT 6–7 ODA House of Delegates (Sunriver Resort)
SEPT 7 12 NOON Board of Trustees mtg (Sunriver Resort)
Nov 24–27 Oregon Mission of Mercy IV (Oregon Convention Center—Portland)

COMPONENT CE CALENDAR
compiled by Mehdi Salari, DMD
Send your component’s CE courses to bendsalari@yahoo.com.

Tues, Jan 8 Marion & Polk CE HRS: 2
What a dentist needs to know about cancer
Bud Pierce, MD, PhD
LOCATION: West Salem (Roth’s)
INFO: www.mpidentalce.com, mpidentalce@qwestoffice.net

Fri, Jan 11 Central Oregon CE HRS: 4
Medical Emergencies
Drs. Steve Rogers, Keith Krueger & Don DeLisi
LOCATION: Eagle Crest Resort
INFO: www.centraloregondentalsociety.org

Tues, Jan 15 Washington County CE HRS: 1.5
Differential Diagnosis of Jaw Lesions
Jeffery Stewart, DDS, MS
LOCATION: Beaverton (Stockport Boiler)
INFO: www.wacountydental.org, wcddskathy@comcast.net

Wed, Jan 16 Multnomah CE HRS: 1
Medications My Patients Take; Major Systemic Disease Processes & Patient Treatment Considerations, Brandon Reher, DDS
LOCATION: Portland (McMenamin’s Kennedy School)
INFO: www.multnomahdental.org, lora@multnomahdental.org

Fri, Jan 22 Clackamas County CE HRS: 1
Diagnosis & Management of Oral Mucosal Disease, Dr. Cindy Kleinegger
LOCATION: Oregon City (Prov. Willamette Falls Community Ctr.)
INFO: www.clackamasdental.com

Tues, Feb 5 Rogue Valley CE HRS: 2
Pediatric Dentistry Dr. John Washack
LOCATION: Grants Pass Country Club
INFO: ian.m.erickson@gmail.com or dr.sten.erickson@gmail.com

Tues, Feb 12 Marion & Polk CE HRS: 2
Endo Stuff: Some Stuff You Might Find Interesting Dr. Brian Whitten, OHSU
LOCATION: West Salem (Roth’s)
INFO: www.mpidentalce.com, mpidentalce@qwestoffice.net

Wed, Feb 20 Multnomah CE HRS: 1
Pearls About TMD & Complicated Oral Facial Pain Diagnosis and Treatment Considerations Kimberly Wright, DMD, MAGD
LOCATION: Milwaukie (ODS Plaza)
INFO: www.multnomahdental.org, lora@multnomahdental.org

Sat, Feb 23 Lane County* CE HRS: 4
Medical Emergencies
Dr. Steven Beadnell (*presented with the OHSU 500 Alumni Assn.)
LOCATION: Eugene (Downtown Athletic Club)
INFO: www.lanedentalociety.org

Tues, Feb 26 Clackamas County CE HRS: 4
Medical Emergencies Dr. Erik Richmond
LOCATION: Oregon City (Prov. Willamette Falls Community Ctr.)
INFO: www.clackamasdental.com

Tues, Mar 5 Rogue Valley CE HRS: 2
Indications for Early Ortho Intervention Dr. Jon Robinson
LOCATION: Grants Pass Country Club
INFO: ian.m.erickson@gmail.com or dr.sten.erickson@gmail.com

DBIC RISK MANAGEMENT COURSES

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<tr>
<td>April 6</td>
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<td>Oregon Dental Conference®</td>
<td><a href="http://www.oregondental.org">www.oregondental.org</a></td>
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<td>May 14</td>
<td>6 PM</td>
<td>Southwestern OR (Coos Bay)</td>
<td>Anne Mills at Dr. Roger Sim’s office, 541.267.5867</td>
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<td>Dec 6</td>
<td>9 AM</td>
<td>Multnomah (Portland)</td>
<td>Lora Mattson, 503.513.5010</td>
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<td>Dec 13</td>
<td>9 AM</td>
<td>Central Oregon (Bend)</td>
<td><a href="http://www.centraloregondentalsociety.org">www.centraloregondentalsociety.org</a></td>
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EVENTS & INFORMATION

Letters to the Editor
Letters to the editor are welcomed.
All letters and other submissions to this publication become the property of the Oregon Dental Association. Send submissions to:

Editor, Membership Matters
Oregon Dental Association
PO Box 3710
Wilsonville, OR 97070-3710
beavertondentist@yahoo.com

Articles
Are you interested in contributing to Membership Matters?
For more information, please contact editor, Dr. Barry Taylor:
beavertondentist@yahoo.com

Contact Us
“RED SKY AT NIGHT, SAILORS DELIGHT. RED SKY IN MORNING, SAILOR TAKES WARNING” is an old seaman’s adage. In Oregon, when one sees red sky in the middle of the day, we think forest fire. Forest fires are destructive, but, in the right conditions, contribute to a forest’s health.

On the horizon now, there is a red sky; but few, if any, of us know what the outcome will be. Some of that red sky is the glow of Coordinated Care Organizations (CCOs) that are being created in Oregon in response to the Patient Protection and Affordable Care Act. CCOs are health plans that, according to the State of Oregon website, “must be accountable for health outcomes of the population they serve. They will have one budget that grows at a fixed rate for mental, physical, and, ultimately, dental care.” While much has been written about the new health insurance exchanges that states will be implementing, most dental providers are not aware of CCOs. There are currently 15 CCOs.

As Melody Finnemore writes in her article on page 20, “Cover Oregon & CCOs,” “the objective is to improve health and lower costs by emphasizing prevention, reducing waste, improving efficiencies, and eliminating disparities in quality of care and outcomes.” These are ambitious objectives and one would hope that, indeed, CCOs do help the state of Oregon save the estimated $1 billion in health care costs over the next three years.

How dental care will be delivered under this umbrella is yet to be determined and should be of great concern for dentists. Some dental providers have already expressed concern about the inclusion—or exclusion—of dentistry in CCOs. CCOs in Oregon began providing care August 1 of this year, yet the legislation confusingly states that dental care does not have to begin until 2014, but CCOs want to include it now. In addition, there are not any dental benefits currently defined. Dental Care Organizations (DCOs) are rightly concerned that they are not always being included in conversations about how CCOs will use their set amount of funding. DCOs and Oregon Health Plan providers have not received an increase in their capitation rates from the state of Oregon in over a decade. These providers are being forced to provide less dental care to those in need.

Also of concern is who will be able to contract with a CCO to provide dental care. The implementation plan states that “each CCO is to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside.” Does ‘any’ mean that the CCO contracts with just one DCO in its area? For a DCO to maintain its business model, it needs to have fair access to the patient pool. Will individual providers who are not members of a DCO be unable to provide care unless they join a DCO? If a CCO was to contract with just one DCO, that would limit a patient’s options for providers, and could mean financial failure for a non-contracted DCO.

The OHSU Department of Pediatric Dentistry relies heavily on the OHP patient pool; 95% of their patients are enrolled in OHP. But since it is not a DCO, will it be cut out of this patient pool? The implementation plan for these CCOs is going to have to allow accommodations for academic programs. To exclude an academic program would be of benefit to no entity.

Dental Care Organizations, individual Oregon Health Plan providers, and educational programs such as the OHSU Department of Pediatric Dentistry play a vital role in treating OHP and Medicaid patients. As the State of Oregon goes through monumental health care changes, it is important that such potential problems are considered now rather than after the 2014 implementation date. ●
Save the Date

ODA Dental Day at the Capitol

February 27, 2013
8 AM – 3 PM
Oregon State Capitol

Join your ODA colleagues in a march to the Capitol to help educate legislators and the public about the importance of oral health.

Talk to legislators or staff one of our education tables in the lobby to share your expertise in the field of Dentistry.

If you are interested in being involved, please contact us at 800.452.5628 or cswartz@oregondental.org.

WHO: You and your dental colleagues
WHAT: Dental Day at the Capitol
WHEN: Wed., February 27, 2013
WHERE: Oregon State Capitol
RSVP: 800.452.5628 or cswartz@oregondental.org

ADA’s 2013 Dental Code Check App Available for Apple, Android Mobile Devices

Dental codes are now available at the touch of a button with the 2013 Dental Code Check app. The app is available for $19.99 for Apple via the iTunes Store and Android mobile devices via Google Play.

The new CDT Code Check 2013 app contains all of the CDT Codes, and is an especially handy practice management tool for dentists and dental staff who travel between offices. It is also ideal for working on claim forms and looking up procedure codes when the CDT Manual is unavailable. The app was created from the American Dental Association’s CDT 2013: Dental Procedure Codes book. The CDT Code, which is another name for the Code on Dental Procedures and Nomenclature, a standard for recording dental services in patient records, on paper claim forms, and on HIPAA standard electronic claim transactions.

The CDT Code Check 2013 app’s features include:

- A complete listing of 2013 CDT Codes including category of service, subcategory, procedure code, nomenclature, and descriptor.
- A list of new, revised and deleted codes with tracked changes so you can see exactly what was changed.
- Maximum portability. The codes go where you go without the need for a bulky book or an internet connection.
- Searchable by three categories: code number, keyword and category of service.
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Eugene • Lane County

ALEX H. VO, DMD
Salem • Marion & Polk

Do you know someone who is interested in joining the Oregon Dental Association?

Take them to lunch, and ODA will buy!

When they sign up for membership, ODA will reimburse you for the cost of the lunch. For details, contact Margaret Torgeson at 503.218.2010 or mtorgeson@oregondental.org.

WCDS Meeting

Washington County Dental Society members enjoyed their first meeting after a summer break, on September 18.

The evening’s speaker, James Beckerman, MD, is a cardiologist with the Providence Heart and Vascular Institute in Portland, home of the world-famous “Pink Glove Dance.”

Dr. Beckerman has appeared on the Today Show and Doctor Oz, and authored a book, The Flex Diet. He shared his expertise and encouraged members that getting heart healthy can be flexible by offering tools for a lifetime of success.

Mission of Mercy IV
Portland, Oregon
November 24–27, 2013
Call to Volunteer

These leadership positions are open. To be reviewed by the nominating committee prior to election, please submit materials 45 days prior to election. Interested applicants should submit a letter of interest and a one-page resume to:

ODA Leadership Development Committee
Chair, Nominating Sub-Committee
PO Box 3710, Wilsonville, OR 97070
or email:
leadership@oregondental.org

Please cc: William E. Zepp, CAE
Executive Director,
at bzepp@oregondental.org

COUNCILS & COMMITTEES

The following ODA Councils and Committees need volunteers:

- Annual Meeting Council
- Membership Council
- New Dentist Committee
- Public and Professional Education Council
- Publications Advisory Committee

For more information, please call 503.218.2010.

Howard Faran, DDS
Dr. Faran’s One Day Dental MBA
How to build a meaningful and profitable dental practice that will make a difference to your community.

Friday, January 25, 2013 8:00 a.m. - 3:30 p.m.
details and registration at lanedentalsociety.org

Downtown Athletic Club, Eugene
breakfast & lunch included

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Dentist Health & Wellness Hotline

ODA volunteers are on call, 24 hours a day to provide confidential, caring assistance for help in dealing with substance abuse and addiction, disability, litigation stress, and mental health challenges.

ODA member dentists recognize the essential human dignity of all those who suffer from chemical dependency or mental disorders. Our services are available to all Oregon dentists and OHSU dental students in need of help, regardless of their affiliation with the ODA.

503.550.0190
24-hour support

ODS Board

Health Services Group (HSG) board member, Dr. David Howerton (center) was present on November 3, as the ODA Board of Trustees re-elected board chair, Dr. Jay Lamb, and lay member, Jill Eberwein.
To guide our legislative priorities for the coming years, and to provide partner organizations with ODA-endorsed solutions to oral health issues, the Government Relations Council created a work group to create answers to the question, “How can we improve the oral health of all Oregonians?” After hours of meetings, the workgroup produced the ODA Oral Health Initiative. The Initiative outlines five areas where there is room for development in the oral health arena. It is designed to ensure that ODA and its members are the thought-leaders for infrastructure and funding improvements to the oral health delivery system.
SECTION 1 Oral Health Prevention Programs

- Prenatal Programs (such as WIC)
  - Provide maternal oral screening and care
  - Provide parental diet and wellness education as it relates to the oral health

- Early Childhood Programs (such as First Tooth, Early Head Start and Head Start)
  - Conduct screening and anticipatory guidance
  - Provide preventive fluoride therapies
  - Provide dental care

- Comprehensive School Oral Health Program
  - Implement a school screening program
  - Expand the school sealant program for 1st and 2nd permanent molars
  - Provide culturally sensitive oral Hygiene education
  - Provide culturally sensitive diet and wellness education as it relates to oral health
  - Provide preventive fluoride therapies
  - Provide dental care

- Appropriate oral health education and prevention programs for adults and seniors
  - Provide culturally sensitive diet and wellness education as it relates to oral health
  - Provide preventive fluoride therapies
  - Provide education for senior care providers, and including involving their families

- Provide an Oral Health Coordinator position to support the above oral health programs

- Implement state-wide community water fluoridation

SECTION 2 The Oregon Health Plan

- Integrate oral health into healthcare transformation and Coordinated Care Organizations
  - Ensure dental representation in the CCO Governance Models
  - Dedicated dollars for oral health in the global budget
  - Increase inter-professional collaboration between oral health care providers and other health professionals to address patient health

- Establish dedicated funding for oral health care for Healthy Kids Program

- Establish the importance of adult oral health in OHP
  - Increase the reimbursement rate to 70% of UCF (usual and customary fee) to cover cost of care
  - Establish an adult dental benefit that includes preventive care.

SECTION 3 Support Dentists and Dental Auxiliaries to Improve Access

- Increase the availability of Dentist Education Loan Repayment Programs (tax incentives)

- Create deferred compensation plans of Medicaid reimbursements for OHP Providers

- Increase the ethnic and cultural diversity in the dental workforce
  - Tuition Subsidies for under-represented individuals from ethnic minorities for dental education programs
  - Facilitate preparation for dental career opportunities

- Facilitate the integration of electronic dental and health records
  - With tax incentives, tax deductions, etc.

SECTION 4 Oral Health Leadership

- Strengthen leadership in the oral health field by hiring a state dental director that oversees OHA and DMAP dental programs
  - Create a state dental advisory board to coordinate state oral health affairs, pro-bono dental programs, and oral health education programs.

- Increase funding for the state oral health program
  - Improve our eligibility for CDC funding for oral health initiatives and other funding opportunities.

SECTION 5 Surveillance and Evaluation

- Ensure appropriate funding for relevant health surveillance reports* that identify oral health issues.
  - Expand the Smile Survey to:
    - Include more data such as comparative data between fluoridated and non-fluoridated areas.
    - Include demographic information
  - Perform a needs assessment on the oral health of elderly and Oregonians with disabilities.

*Among relevant questions to be answered:

- How many people are showing up at hospital emergency rooms for dental related problems, and why did they go there?
- Where have the oral health initiatives in the past succeeded or failed? (ie LAP hygienists, increasing the scope of work of dental auxiliaries)
- How many people in the state don’t have dental insurance/lack access to care? What are the characteristics of this group?
The Oregon Dental Association: DENTIST ADVOCATES of Oregon

By Daniel Saucy, DMD

It is our job to educate our elected officials about the best practices for dentistry and to present our solutions to access to care issues.

IF WE DON’T, THEN WHO WILL?

You may not realize it, but what elected officials do affects many aspects of dentistry. From Medicaid reimbursement rates to clinic ownership, the business of dentistry is changed every legislative session by lawmakers and administrative rule writers. But you have an ally in your corner—the Oregon Dental Association.

With nearly 70% of the dentists in Oregon as our members, the ODA is committed to helping dentists provide the best level of care to all Oregonians and advance the oral health care system for all Oregonians. By working to increase access to preventative care and by increasing the prevalence of oral health literacy, we are working to prevent disease and educating the public about how to get healthy and stay healthy. But we also know that we can only help our patients for as long as we are in business, so ODA also advocates for dentistry to those making laws and regulations which impact the patient, the practice and the profession of dentistry.

You cannot achieve overall health without good oral health. And although many Americans have access to oral health care and enjoy excellent oral health, there are still tens of millions who do not. Factors, such as poverty, geography, lack of oral health education, language or cultural barriers, fear of dental care, and the belief that people who are not in pain do not need dental care, can all play a role in preventing care for those individuals. We need lawmakers who understand the importance of oral health and will listen to our concerns. It is our job to educate our elected officials about the best practices for dentistry and to present our solutions to access to care issues. If we don’t, then who will?
The ODA’s Government Affairs department and the Government Relations Council, along with a network of grassroots dentists, have championed many political issues for our members and the community at large including:

- Sponsoring a bill that requires insurance companies to cover medically necessary dental procedures for Oregonians who are born with craniofacial abnormalities, such as cleft lip and palate;
- Advocating to keep dental coverage a part of the Oregon Health Plan for those individuals on Medicaid;
- Maintaining the highly trained dentist as the head of the dental team;
- Keeping insurance companies out of the dentist/patient relationship;
- Advocating to increase the number of communities served by community water fluoridation—a safe and cost effective way to prevent dental carries in both children and adults.

The ODA is continuously watchful for bills and regulatory action that could be harmful to the dental professional and to the health of Oregonians, while constantly striving to work toward solutions for issues such as the lack of access to care, Medicaid, and improved wellness for the most vulnerable.

Dr. Dan Saucy, a general dentist in Salem, is chair of the ODA Government Relations Council. He can be reached at ddsdmd@teleport.com.
The Importance of Giving

Trying to make your mark on a specific issue, or in a specific area, as an individual person may seem like a daunting task. But the collective power of even a medium-sized political action committee can create a great deal of clout. Did you know that in five years, Dentists of Oregon Political Action Committee (DOPAC) has gone from being nearly insignificant to one of the largest healthcare PACs in the state of Oregon?

Money is the lifeblood of a political action committee. Five years ago, when DOPAC contributions were added to membership dues, we all made a commitment to our profession. And that commitment has paid off. With the expertise of our lobbyists, the help of DOPAC board members from around the state, and our healthy PAC funds, the ODA is finally able to make a big splash in the political arena.

DOPAC works to help elect candidates who understand the importance of dentistry and the link between oral health and overall health. Representing the “Tooth Party,” ODA leadership spends every fall meeting with candidates on both sides of the aisle, conveying the importance of prevention, and showing how much dentists care about the oral health of Oregon. We are looking to make a difference, so building these relationships early is the key to being at the table when the important decisions are made. Working to maintain the dentist as the head of the dental team is imperative to the safety of our patients. Regardless of party affiliation, DOPAC supports candidates who will be strong advocates for dentists and the patients they serve. Initiating conversations and building relationships with our elected officials has allowed us to communicate our legislative priorities like never before.

Whenever an elected official has a question about oral health, we want to make sure that we are the ones they go to for solutions. DOPAC has opened the door, now it is up to each and every one of us to walk through it. We have a captivated audience that is willing to learn more about the importance of oral health; teach them, and get involved today.

DOPAC COMMITTEE MEMBERS

Patrick Hagerty, DMD, DOPAC Chair
Daniel Saucy, DDS, GRC Chair
Dennis Clark, DMD
Weston Heringer, Jr, DMD
Sheena Kansal, DDS
Lonn Robertson, DMD
Jeff Timm, DMD
Theresa Tucker, DDS
Kim Wright, DMD
Sean Benson, DDS, Ex-Officio
Jill Price, DMD, Ex-Officio
William Zepp, CAE
Five years ago, when DOPAC contributions were added to membership dues, we all made a commitment to our profession.

AND THAT COMMITMENT HAS PAID OFF.

**DOPAC Giving Strategy**

DOPAC’s giving follows a 3-tier approach as outlined below and approved by the ODA Board of Trustees in 2009. These three tiers have proven successful, as we have developed close allies and friends in the legislature. The tiers focus on (1) legislative and caucus leadership, (2) Senate and House Health Care Committee members and tough open seat races, and (3) safe incumbents who are supportive of our issues (pro-dentist legislators).

**TIER 1**

This group of donations is the most important. Legislative leadership influences their caucuses, develops messaging around issues, assigns bills to committee, schedules bills for a vote, and communicates with the other chamber and the governor’s office. This group is the beginning and end for a bill’s life; they pick committee assignments, and they plan which bills will be debated on the floor. Even if a chair passes a bill out, this group has the ability to suspend debate on, and kill the bill.

**TIER 2**

This category of contributions includes current House and Senate Health Care Committee members, strong dental supporters in tough re-election races, and open-seat races where DOPAC seeks to make a positive first impression (create a pro-dentist candidate).

**TIER 3**

This final tier is made up of safe-incumbents who are supportive of our issues and who play important roles in their caucuses. They don’t fit into one of the other two tiers, but they are a good vote when the bill comes to the floor, or they serve other important purposes. They could be hidden leadership members (those who influence party leaders), those with close ties to the Health Care Committees (co-chair of Human Service committee), and or general pro-dentist legislators.

Dr. Pat Hagerty, a general dentist in Albany, is chair of Dentists of Oregon Political Action Committee (DOPAC). He can be reached at patrick@patrickvhagertydmd.com

Election night was a good night for Democrats all across the country. President Obama won reelection, Democrats maintained control of the U.S. Senate, and here in Oregon, Democrats took back the majority in the House, after Republicans forced a 30-30 tie in 2010 when they picked up six seats of their own. All of the seats Democrats picked up in the Oregon House had Democratic registration edges over Republicans. Several states also legalized marijuana and gay marriage. 2012 was a far different election than 2010.

National
Polls leading up to Election Day showed a virtual tie in the popular vote between Governor Romney and President Obama, with Obama maintaining slim leads in crucial battleground states like Ohio and Virginia. In 2008, President Obama won in a landslide with 365 electoral votes. The President didn’t win reelection with quite the same numbers but only lost two states (Indiana and North Carolina) from his 2008 Electoral College victory.

Democrats had a lot of seats to defend in the U.S. Senate, but picked up Republican-held Senate seats in Indiana with Joe Donnelly’s upset over Richard Murdock and Elizabeth Warren’s defeat of incumbent Senator Scott Brown. However, Democrats lost in Nebraska, the seat held by retiring Senator Ben Nelson, but they held on to hotly contested seats in Montana, with incumbent Senator Tester squeaking out a win over Congressman Reyberg, and Heidi Heitkamp pulling off the upset win of the night over Congressman Richard Berg in North Dakota. Also, Tammy Baldwin made news by being the first openly gay candidate elected to the Senate. Baldwin beat former governor Tommy Thompson to keep Wisconsin a blue state.

In the U.S. Congress, Democrats picked up six House seats. Notable Republicans Alan West and Joe Walsh lost. Here in Oregon, all five incumbents were reelected by comfortable margins. Oregon will be returning a Congressional Delegation of Peter DeFazio, Greg Walden, Kurt Schrader, Earl Blumenauer and Suzanne Bonamici.

Oregon Senate
There were really only two competitive Oregon Senate races this year, and, unfortunately for dentistry, Democrats won both of them to maintain their slim 16-14 majority. East Multnomah County Senator Monnes-Anderson fended off a tough challenge from local dentist Dr. Scott Hansen. And, in a rematch from 2010 House District 9, Rep. Arnie Roblan beat Dr. Scott Roberts to replace retiring Sen. Verger.

Oregon House
Democratic voters came home and gave the Democrats back control of the Oregon Legislature. The conventional wisdom was that Democrats were likely to pick up one to two seats. Instead, Democrats picked up four seats, beating four incumbent freshmen. The fact that Democrats had voter registration edges in all four of the districts they won back from Republicans clearly helped. Democrats voted Democratic this year. East Multnomah County challenger Chris Gorsek beat incumbent Rep. Matt Wand; challenger Shemia Fagan beat incumbent Rep. Patrick Sheehan; challenger Ben Unger beat Rep. Katie Eyre; and the upset of the night was challenger Joe Gallegos knocking off Rep. Shawn Lindsay. Democrats also retained control of two hotly contested seats, with Brent Barton beating Steve Newgard and John Lively beating Steve Fishioneri to keep House Districts 40 and 12, respectively, also in Democratic control. With Democrats back in control with a 34-26 margin, look for Rep. Tina Kotek of North Portland to be the next Speaker of the House.

Oregon Statewide Races
Oregon Labor Commissioner Brad Avakian (D) beat back a tough challenge from Sen. Bruce Starr (R). This was a race that many thought might break the Republicans’ way because the race was non-partisan. Avakian simply outworked Starr, and the results showed on Election Day. This also means Sen. Starr will be returning to the Oregon Senate.

Oregon Secretary of State Kate Brown (D) also won reelection against opponent in Knute Buehler. Buehler outraised Brown by a sizable amount, nearly swept the major newspaper endorsements, and ran a very sophisticated campaign. Brown was able to win largely with the help of outside labor groups.
Oregon Ballot Measures

Ballot Measure 77, which proposed to amend the Oregon Constitution and grant the governor and lawmakers greater, temporary powers in case of a major natural disaster or terrorist event passed with 58% of the vote. This ballot measure was largely uncontested and received very little attention from the media.

Ballot Measure 78, which proposed to amend the Oregon Constitution and change the constitutional language describing governmental system of separation of powers, as well as making grammatical and spelling changes, also passed, with 72% of voters approving the measure. This measure was largely a technical fix and was uncontested.

Ballot Measure 79, which proposed to amend the Oregon Constitution and prohibit real estate transfer taxes, fees, and other assessments, except those operative on December 31, 2009, passed with 59% of the vote. This was a fairly controversial ballot measure, with the realtors pumping millions of dollars into the race. Several newspapers took the realtors to task, saying that the realtor’s argument of this preventing another tax was disingenuous. Despite the criticism and poor polling numbers, the ballot measure prevailed.

Ballot Measure 80, which was to legalize marijuana, failed 45% to 55%. However, voters in Colorado and Washington approved similar bills. They became the first two states in the nation to legalize marijuana. This will be a contentious issue for years to come, because it is still prohibited under federal law. Look for supporters of legalizing marijuana to try again in a few years.
Ballot Measure 81 proposed to prohibit commercial, non-tribal fishing with gillnets in Oregon “inland waters.” Several months ago, both sides of the ballot initiative agreed to a proposal by the Governor that would limit—but not ban—gillnetting in inland waters. Because of the deal, both sides urged their supporters to vote no on the ballot measure and support the Governor’s plan instead. Voters listened and rejected the ballot measure 66% to 34%.

Ballot Measures 82 and 83 would have amended the state constitution to allow private companies to build and operate casinos. The group behind the measures wanted to build a casino in Wood Village. The Native American Tribes fought against it. Both sides spent millions on the measures. And about three weeks before Election Day, the proponents of the measures announced they were suspending their campaign due to a lack of support among voters. Voters repeated that message by voting down Measure 82 (72% to 28%) and Measure 83 (71% to 29%).

Ballot Measure 84 proposed to phase out existing inheritance taxes on large estates, and all taxes on intra-family property transfers. Proponents of the measure argued that the high income taxes hurt job creation, while opponents argued that such a measure would blow a huge hole in the budget and effectively end capital gains taxes for the wealthy in Oregon. Voters rejected the measure 54% to 46%.

Ballot Measure 85 proposed to amend the Oregon Constitution and eliminate the corporate kicker, instead allocating such monies for K through 12 public education. Voters approved the measure 59% to 41%, but it is unlikely to have any immediate effect on schools. It will likely be several years at least before the Corporate Kicker kicks again.

Portland Ballot Measures

In Multnomah County, voters approved the library measure, which creates a permanent rate to fund library services. In theory, now the County won’t have to go back to voters every couple of years to ask them to reauthorize bonds. Voters approved this measure 68% to 32%.

In Portland, voters also approved a new school bond to improve the infrastructure of Portland schools. The District tried in 2010, but the bond narrowly failed. The bond will raise an additional $482 million for schools from property taxes. Voters approved of the measure 65% to 35%.

Also in Portland, voters approved a permanent $35 income tax on all Portland residents that will put more money into arts programs in schools and the community. The tax will raise about $12.8 million for arts education, of which, about $3.8 million will go to arts organizations. The measure passed 60% to 40%.

Portlanders also approved changes to the City’s Fire Police Disability Retirement System. Currently, fire and police officers can schedule their retirement for a month that has five weeks in it and thus lock in a higher rate of retirement pay. The ballot measure changes that. The measure is expected to save the City millions of dollars over the years in police and fire pension costs. Voters approved of the measure 75% to 25%.

Portland Elections


Amanda Fritz will be returning to City Hall after beating Mary Nolan, 58% to 41%. The margin of victory was somewhat shocking, as the two of them were separated by just a few thousand votes in the Primary. Pre-election day polls had Fritz winning, and she nearly swept the newspaper editorial endorsements. With newcomers Hales and Novick, City Hall will be an interesting place over the next few years.

Notable Events from Washington

Democrats will hold onto the Governor’s mansion in Washington. In Washington, ballots must simply be postmarked by Election Day, so it often takes several days to count all the ballots, but former Congressman Jay Inslee beat Attorney General Rob McKenna (R).

Washington voters approved Referendum 74, which legalizes gay marriage in the state. They, along with Maryland and Maine, became one of the first states in the nation to approve gay marriage through the initiative process. Look for a similar measure on the ballot in Oregon in 2014.

In contrast to Oregon, Washington and Colorado approved their measures legalizing marijuana. As noted above, it remains to be seen how this will turn out as marijuana is still illegal for personal consumption under federal law.

George Okulitch, president of State Street Solutions, is ODA’s contract lobbyist. He can be reached at george@statestreetsolutions.com.
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Cover Oregon & Coordinated Care Organizations

Dentists as providers, employers, & consumers

By Melody Finnemore

COVER OREGON

The Oregon Health Insurance Exchange

The Oregon Health Insurance Exchange, mandated by the federal act and established by the state legislature, is designed to provide coverage for the state’s estimated 636,000 uninsured people and offer affordable insurance options for small businesses. Recently rebranded as Cover Oregon, the exchange will begin enrolling members in October 2013 and coverage will begin January 2014. Grants provided startup funding for the exchange, and an administrative fee paid by enrollees will fund its operations.

Individual enrollees, most of whom do not have access to coverage at work, can use the exchange to make “apples-to-apples” comparisons of health insurance plans and costs. The plans offered through the exchange will meet specific requirements and will be graded on quality, care coordination, and network adequacy. Through one application process, people will be able to enroll in either commercial insurance plans or the Oregon Health Plan, and they will be able to find out whether they are eligible for tax credits to help them pay for coverage, according to Cover Oregon’s business plan.

Companies with fewer than 50 employees can use the exchange to provide health plan options to their employees. Under a defined contribution model, employers could contribute a set amount to premiums and allow their employees the choice of all plans offered on the exchange. The exchange also provides employers with administrative efficiencies by coordinating premium payments, the business plan states.

Lisa Morawski, a spokesperson for Cover Oregon, said the exchange will offer dental coverage as well and is gathering input from dental insurance carriers about the best way to implement those plans. In mid-November, Cover Oregon presented a webinar for dental carriers interested in participating in the exchange. Cover Oregon also revised its Intent to Apply form for dental carriers and made it available Dec. 1. The deadline to apply was Dec. 15.

CCOS

Coordinated Care Organizations

CCOs began treating patients covered by the Oregon Health Plan and Medicaid last August 1. CCOs are health plans that bring a range of practitioners—including oral health professionals—from a particular community together to provide more comprehensive care for low-income patients. The objective is to improve health and lower costs by emphasizing prevention, reducing waste, improving efficiencies, and eliminating disparities in quality of care and outcomes.

According to a description from the Oregon Health Authority: “(CCOs) have one budget that grows at a fixed rate for mental, physical, and, ultimately, dental care. CCOs are accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.”

Under the program, OHP benefits remain the same, and people covered under the plan continue to see their
There is no doubt the Patient Protection and Affordable Care Act is going to impact dentists and their practices.

The big question is what those impacts will look like once health insurance exchanges and coordinated care organizations (CCOs) have been fully implemented.

same providers. Following an initial enrollment period, more OHP patients were enrolled between September 1 and November 1, 2012.

The CCOs are scheduled to work collaboratively with dental care organizations (DCOs) by 2014. A petition filed with the Oregon Health Authority in October requests that CCOs would be required to contract directly with DCOs to provide dental services through 2017. The petition was filed by Dr. Mike Shirtcliff of Advantage Dental, Senator Alan Bates and Rep. Tim Freeman.

According to the Oregon Health Authority, a third-party analysis found that CCOs could help Oregon save $1 billion in health costs over the next three years and more than $3.1 billion over the next five years. The state received $1.9 billion in federal funding earlier this year to implement the CCOs.

Melody Finnemore is a freelance writer for ODA and a partner in Precision Communications (www.precomwords.com). She can be reached at precisionpdx@comcast.net.
Cover Oregon Health Exchange and Dental Benefits

As per the Affordable Care Act, state-based exchanges are intended to provide “competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality and other factors.” This paper voices the concerns of the Oregon Dental Association in Cover Oregon’s approach to offering dental coverage for Oregonians.

Adult Dental Benefit Plans should be offered within the exchange

• Overall health is directly related to oral health, therefore, stand alone adult dental plans should be offered within the health exchange.
• Oral pain is one of the most common reasons people go to the emergency room, where they can’t receive the care they need anyway. Not including adult dental as an essential health benefit only guarantees that these people will continue to go to the emergency room for oral pain.
• Although offering adult dental as an essential health benefit would increase cost, at first, the dental model is a preventative one and only serves to reduce cost, pain, and suffering in the long run.

Pediatric Dental Benefits should be offered as standalone plans

• The exchanges are distinct from the outside market because consumers—many of them purchasing insurance for the first time without the guidance of a broker—need all the tools they can get, including pricing transparency, to make the choices that work best for them. They should not be forced to purchase a dental plan they don’t want because of the medical plan they have selected.
• 98% of Americans with dental coverage have a dental benefit policy that is separate from their medical policy. Carving out dental benefits from medical benefits is recognized as the preferred method of providing dental benefits in the private and public markets.
• No peer reviewed studies show that embedding or integrating dental benefits into medical benefit payment systems will result in more coverage or improve the quality of dental care.
• Embedding dental benefits eliminates the consumer’s choice and goes against the intention of the health exchange. It removes the individual’s ability to compare dental products because they are mixed in with other medical products.
• Separate offer and pricing of dental benefits empowers consumers and increases transparency. Embedded pediatric dental benefits can hide within the much larger medical package, which can be confusing to consumers.
• The technology, systems and human resource infrastructure required to administer medical and dental benefits are entirely separate and non-redundant.
• Consumers should be able to compare and contrast existing family dental coverage with pediatric dental benefits offered in the Exchange. Embedding the pediatric dental benefit makes this comparison impossible and could cause coverage changes that might result in less dental benefit coverage.
• The Affordable Care Act specifically calls for standalone dental plans to be offered as a separate selection. We only ask that Oregon follow this guideline.
As the Governor has expressed his intention to expand the Coordinated Care Organization (CCO) delivery model to all public employee contracts, members of the ODA have a continued vested interest in how the integration of dental benefits will be handled. However, there are too many decisions left to be made for ODA to make a formal opinion at this time. This paper voices the Association’s concerns.

Concerns with moving forward with integration without a MOU:
- Historically, dental is the very first thing on the chopping block when hard cuts have to be made. The way the global budget is set up, there is nothing to guarantee that a dental benefit will be secured.
- The reimbursement rate for Medicaid patients is already too low for many of our members to cover the overhead cost of seeing the patients. We are concerned that complete integration will see a further reduction in reimbursement as the global budget is spent on more expensive medical benefits, and more dentists will be unable to see those patients that need the care the most.
- The dental delivery model is very different than the medical delivery model. We have concerns that CCOs aren’t currently equipped to deal with the differences without adversely affecting patient care.

Concerns with the DCO Petition:
- We have concerns about what allowing only CCOs to contract with DCOs might mean for some alternative clinic settings, such as the dental school and other safety net clinics. The unintended consequences of the petition on these clinic settings could be detrimental to the dental workforce if it puts the accreditation of the dental school into question.
- Member dentists who are interested in becoming providers for a CCO would have to become a provider for a DCO, which some do not wish to do.
An estimated 3 million children will gain dental benefits by 2018 through health insurance exchanges, roughly a 5 percent increase over the number of children with private benefits currently, the American Dental Association said in a report on potential effects of the Affordable Care Act (ACA) on dentistry.

To read this story, please see the original on the American Dental Association’s website:
To read this story, please see the original on the American Dental Association’s website:
The legislative process is governed by rules, laws and procedures, making it somewhat mechanical in nature. Although the legislative process is long and complex, all laws begin as ideas.

An idea for a law can come from anyone; an individual or group of citizens, a legislator or legislative committee, the executive or judicial branch, or a lobbyist. By statute state agencies must pre-session file bills. Legislators or legislative committees may file an unlimited number of measures within established timelines set by rule.

If deadlines are missed, the Senate Rules Committee must approve requests for drafting and/or introduction to the Senate. Appropriation or fiscal measures sponsored by the Joint Committee on Ways and Means are exempt from filing deadlines and may be introduced at any time.

Types of Measures

The Legislative Assembly can accomplish tasks in addition to creating, amending or repealing laws. It can honor a distinguished Oregonian, propose an amendment to the Oregon constitution, or send a message on behalf of the Oregon legislature to the President of the United States. In these instances, a bill is not the appropriate form of measure.

There are six types of measures: a bill, joint resolution, concurrent resolution, resolution, joint memorial, and memorial.

A bill, the most common type of measure, is a proposal for a law. All statutes, except those initiated by the people or referred to the people by the Legislative Assembly, must be enacted through a bill.

The path of a bill, from the time it is just an idea to the time it arrives at the Governor’s desk for approval, is paved with many detours. In order for a bill to become law, it must be passed by both houses in the identical form. A bill may be introduced in either the Senate or the House with the exception of revenue bills which must originate in the House.

This is achieved through the following step-by-step process, using the House of Representatives, for example, as the house of origin.

1. An idea to change, amend or create a new law is presented to a Representative.
2. The Representative decides to sponsor the bill and introduce it to the House of Representatives, and requests that the attorneys in the Legislative Counsel’s office draft the bill in the proper legal language.
3. The bill is then presented to the Chief Clerk of the House, who assigns the bill a number and sends it back to the Legislative Counsel’s office to verify it is in proper legal form and style.
4. The bill is then sent to the State Printing Division, where it is printed and returned to House of Representatives for its first reading.
5. After the bill’s first reading, the Speaker refers it to a committee. The bill is also forwarded to the Legislative Fiscal Officer and Legislative Revenue Office for determination of fiscal or revenue impact the measure might have.
6. The committee reviews the bill, holds public hearings and work sessions.
7. In order for the bill to go to the House floor for a final vote, or be reported out of committee, a committee report is signed by the committee chair and delivered back to the Chief Clerk.
8. Any amendments to the bill are printed and the bill may be reprinted to include the amendments (engrossed bill).
9. The bill, now back in the house of origin (House), has its second reading.
10. The measure then has its third reading, which is its final recitation before the vote. This is the time the body debates the measure. To pass, the bill must receive aye votes of a majority of members (31 in the House, 16 in the Senate).
11. If the bill is passed by a majority of the House members, it is sent to the Senate.

12. The bill is read for the first time and the Senate President assigns it to committee. The committee reports the bill back to the Senate where the bill is given the second and third readings.

13. If the bill is passed in the Senate without changes, it is sent back to the House for enrolling.

14. If the bill is amended in the Senate by even one word, it must be sent back to the House for concurrence. If the House does not concur with the amendments, the presiding officers of each body appoint a conference committee to resolve the differences between the two versions of the bill.

15. After the bill has passed both houses in the identical form, it is signed by three officers: the Speaker of the House, the Senate President, and the Chief Clerk of the House or Secretary of the Senate, depending on where the bill originated.

16. The enrolled bill is then sent to the Governor who has five days to take action. If the Legislative Assembly is adjourned the Governor has 30 days to consider it.

17. If the Governor chooses to sign the bill, it will become law on the prescribed effective date. The Governor may allow a bill to become law without his/her signature, or the Governor may decide to veto the bill. The Governor’s veto may be overridden by a two-thirds vote of both houses.

18. The signed enrolled bill, or act, is then filed with the Secretary of State, who assigns it an Oregon Laws chapter number.

19. Staff in the Legislative Counsel’s office insert the text of the new laws into the existing Oregon Revised Statutes in the appropriate locations and make any other necessary code changes.

Effective Date of Legislation

In 1999, the Legislative Assembly adopted ORS 171.022, which reads, “Except as otherwise provided in the Act, an Act of the Legislative Assembly takes effect on January 1 of the year after passage of the Act.” Some bills contain a clause which specify a particular effective date. Still others may have emergency, sunset, or referendum clauses attached.
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Delivery date will be no later than May 15, 2013. Vehicle MSRP: $32,500. Winner is subject to all applicable taxes.
Raffles are considered games of chance by the IRS and do not qualify as a tax deductible donation.
STATE REP. TINA KOTEK has played an instrumental role in the health care reform underway in Oregon. As a member of the Joint Special Committee on Health Care Transformation, she worked closely with Gov. John Kitzhaber to integrate human services, education, and other programs for children via creation of the Early Learning Council. During the 2011 legislative session, Kotek focused on bringing down health care costs for small businesses and improving access for middle-class Oregonians, among other issues.

Before her first election to the Oregon House of Representatives in 2006, Kotek worked as the policy director for the non-profit Children First for Oregon and as the public policy advocate for the Oregon Food Bank. She earned a bachelor’s degree in religious studies from the University of Oregon and a master’s in international studies from the University of Washington. Kotek lives in North Portland with her partner, Aimee Wilson, and their dogs, Wickett and Rudy.

Now serving her third term in the Oregon House, Kotek is co-chair of the House Committee on Rules. She made history in November by becoming the nation’s first openly lesbian lawmaker to lead a state legislative chamber. As she was being named Speaker of the House, Kotek took time to share why Oregon’s oral health plays a key role in her advocacy work.

**Why did you choose to devote your career to public service?**

Kotek: I came to elected office by first advocating for low-income children and families in Salem. I believe in making Oregon a better state through smart public policy.

**Why is Oregon’s oral health important to you?**

Kotek: A healthy mouth is essential to one’s overall well being. Especially for people struggling to make ends meet, healthy teeth are important to one’s self-esteem and ability to have good nutrition. No one in Oregon or this country should need to live with tooth pain or have rotting, broken teeth.

**What would you say are some of your biggest accomplishments on behalf of oral health and organized dentistry in Oregon?**

Kotek: Two things immediately come to mind: First, maintaining some level of dental benefits in the Oregon Health Plan during many years of budget cuts. Oral health can’t be separated from physical and mental health. Second, community water fluoridation in Portland. I worked to help fund the public education campaign. We need to keep that effort moving forward.

**How can the state further improve the oral health of its citizens?**

Kotek: Make it a priority. Let’s fund a dental director in the Oregon Health Authority, someone who can coordinate both Oregon Health Plan and public health efforts. Provide some resources so every community can have fluoridated water. Focus on the oral health of pregnant women to reduce the spread of caries to newborns. Lastly, ensure the availability of dentists and other dental professionals so everyone has access to the care they need.

**What is your favorite thing about going to the dentist?**

Kotek: Leaving with shiny teeth and a new toothbrush.

**What is your least favorite part?**

Kotek: Oh, definitely the whir of the drill, if I have a cavity.

**What do you enjoy doing in your spare time?**

Kotek: My idea of a fun break is going to the movies and eating lots of popcorn. But I definitely floss when I get home!
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Workshops

The Oregon Dental Conference® is offering some wonderful workshops in 2013. Space is limited, so make sure to reserve your spot early. Registration forms and directions for online registration can be found in the conference Preview Program.

Preview Programs will be mailed in January to all Oregon and Washington dental offices, as well as to members of our partner groups. Please note that Drs. Trope and Low’s workshops have a fee in addition to the conference registration fee.

Update in Modern Endodontics—Workshop

PRESENTED BY Martin Trope, DMD
RECOMMENDED FOR: Dentists
ODA course
CE CREDITS: 3

COURSE LIMIT: 40 participants
ADDITIONAL FEE: $100
NOTE: Participants must also be registered for the ODC to attend.
MATERIALS/EQUIPMENT PROVIDED BY: Brasseler USA

Endodontic diagnostics, instruments and techniques have undergone revolutionary changes in the last few years. If the endodontic techniques you currently use are now outdated and obsolete. It is now scientifically proven that Nickel Titanium files, if used correctly, are safe and offer a better outcome for treatment. In addition, new filling materials allow bonding in the root canal with reduced leakage as a result.

This hands-on course will provide an opportunity to update and familiarize you with these up-to-date changes. Upon completing the course, you will be prepared to perform endodontic procedures in a more straightforward and predictably safe and successful manner.

Topics of discussion will include:
- Advances in endodontic diagnosis
- Nickel Titanium (NiTi) rotary instruments and irrigation protocols used in a simple sequence that results in clean canals free of cultivable microbes
- Bonded filling techniques
- Information on which teeth to refer and which to confidently and successfully treat

During this course, attendees will learn:
- To apply new principles of canal instrumentation and filling to appropriate cases
- How to select appropriate instruments to suit individual needs
- How to perform endodontic procedures in a successful and cost effective manner

The Art and Science of Micro-Ultrasonic Instrumentation in Periodontal Therapy

A Workshop

PRESENTED BY Sam Low, DDS, MS, MEd
RECOMMENDED FOR: Dentists and Hygienists
ODA course
CE CREDITS: 3

COURSE LIMIT: 30 participants
ADDITIONAL FEE: $100 for dentists; $50 for staff
NOTE: Participants must also be registered for the ODC to attend.
MATERIALS/EQUIPMENT PROVIDED BY: Hu-Friedy

Although the ultrasonic instrument was originally introduced as a device for removing gross supragingival calculus of tooth surfaces, it is only in the past few years that it has gained popularity as a credible approach to managing subgingival periodontal disease.

Incorporating power driven instrumentation into the periodontal component of the practice provides a time effective adjunct to definitive root planing and the deplaquing process of the periodic supportive maintenance.

At the conclusion of this course, attendees will be able to:
- Be familiar with the current literature justifying the use of power driven instrumentation
- Select the necessary instrumentation commercially available to achieve effective results
- Implement techniques unique to this modality, especially in the area of enhancing patient comfort
- Incorporate power driven instrumentation into the periodontal component of the practice

This workshop will acquaint the dental clinician with the versatility of using ultrasonic instrumentation in periodontal root planing and supportive maintenance procedures.

CPR for the Health Care Provider

PRESENTED BY Mary Ann Vaughan, RN, CEN, BSN
RECOMMENDED FOR: everyone
ODA course
CE CREDITS: 3.5

COURSE LIMIT: 50 participants
NOTE: Cost is free with ODC registration, but attendees MUST preregister for this course.

Course is offered six times:
THURSDAY, APRIL 4
9 AM - 12:30 PM
1:30 - 5 PM
FRIDAY, APRIL 5
9 AM - 12:30 PM
1:30 - 5 PM
SATURDAY, APRIL 6
8 - 11:30 AM
12:30 - 4 PM

This is an American Heart Association class emphasizing the CABs of resuscitation, including rescue breathing, use of bag-valve mask, AED, CPR and foreign body airway removal for all age groups. The workshop will include written and skills evaluations. Re-certification is for two years.

Please Note: The American Heart Association requires that each attendee who registers to attend this course, purchase and bring the following CPR book to class: 90-1038 BLS for Healthcare Providers Student Manual available from the following dealers: www.Laerdal.com, www.channing-bete.com and www.eworldpoint.com.
Recap from the ADA House of Delegates

Introduction
Gregory B. Jones, DMD

My responsibility as the immediate past-president of the ODA was to serve as the chair of the Oregon delegation for the ADA House of Delegates. After attending my last ADA House, I want to share some of my thoughts on how these experiences have changed me and my dedication to the dental profession.

Starting this process, I was unaware of anything outside of my dental office—seeing my patients and running my business were my only concerns. Going down this path, I soon learned of the state and national efforts to protect and enhance the practice of dentistry. There is a great amount of time and work put in on our behalf for the advocacy of dentistry. The entire profession—members and nonmembers alike—benefits from the direction that occurs in state legislatures, federal laws, and regulations. Even though the ADA House may look slow and cumbersome to a new delegate and take several long days of tedious work, it really does have a positive effect on dentistry.

It is hard to say, but I will miss the ADA HOD. Not just because of being on top of all the current news and topics from around the country, but the friendships that I have made. Attending meetings in our state, regionally, and nationally has shown me that many other states have the same problems we face in Oregon.

As I go back to my rural dental office, I am reflecting on the fact that many of the things that dentistry fights for are those very things that make my dental practice so fulfilling and successful.

Historical perspective
Rickland G. Asai, DMD

I have been asked to write a short article on the changes in the ADA HOD over the years. I guess I was chosen for this article, because I have served as an alternate delegate or delegate for 14 years and on the ADA Standing Committee on Bylaws two additional years. I thank you for the opportunity to serve as your elected representative to the ADA HOD over the years.

In many ways, the HOD has not changed much at all, except that it is creeping up in size, from 435 members in 1996 to its current size of 473. I recall the 435 number, as it exactly matched the number in our US Congress my first year at the ADA HOD. So, is bigger better? Not in my opinion. Though efficiency and delegate engagement may not be directly related to size of the HOD, it is much more challenging to have 473 engaged delegates than 200 or 300. While there are touted advantages such as leadership development and raising ADPAC dollars, there are also disadvantages, such as costs to the constituents of sending these larger delegations to attend the HOD. In these times of tight budgets, this is a growing concern. It may very well be true that less diversity will occur with a smaller HOD (though the delegates are not very diverse now, as demonstrated below), but ultimately it is up to delegations to send a representation of their district.

One of the most disappointing aspects of the ADA HOD is the regular attempt to act more like a managing board than a HOD. By that I mean the HOD should focus on the broader policy statements and vision for the ADA, and leave the management functions to the Board of Trustees as the fiduciary agent. Additionally, committee work should be addressed by our councils, committees and task forces, not debated on the floor of the House. A clearer delineation of duties for the Board of Trustees as the fiduciary agent. Additionally, committee work should be addressed by our councils, committees and task forces, not debated on the floor of the House. A clearer delineation of duties for the Board of Trustees and the councils and committees would help clarify roles and expedite the business of the HOD.

Demographically, the HOD has become somewhat more diversified, although to a first time attendee, it might not appear to be so. It is still over 82% male and 90% Caucasian, with few minorities represented: such as the 22 Asian, 6 Black and 9 Hispanic delegates reported this year. The average age is 57.8. Seventy percent reported to be in practice full time, while 13% practiced part-time, 4% were dental faculty, and 5% were part-time faculty/part-time practice.

For alternate delegates, it was 79% male and 89% Caucasian, with 19 Asian, five Black and ten Hispanic. The average age for alternates was 55.1. Sixty-nine percent are in private practice full time, while 13% were part-time, 5% were dental faculty, and 4% were part-time faculty/part-time practice. There were only 417 alternate delegates registered.

The ADA and its HOD is like a very large ship. It changes direction slowly and deliberately, and many times we are only trying to maintain our course. If we are to...
keep up with the winds of change, avoid inclement weather and dodge incoming attacks, we may want to consider something other than a large wind powered sailing ship. Perhaps a nuclear-powered aircraft carrier would suffice.

**New Delegate**

**Steven E. Timm, DMD**

My first impression from the 2012 ADA House of Delegates was how well the process has been planned, organized, and executed. From credentialing, to the admission gates at the House, to the detailed agenda that was constantly adjusted for changes in resolutions, reports, motions, and amendments, and the infrastructure of audio and video and lighting, it reminded me of the complexity of a Hollywood awards special.

Our preparation actually began three weeks earlier at the 11th District Caucus meeting, with delegates from the five states in the district: Oregon, Washington, Idaho, Montana, and Alaska. The ADA HOD agenda was reviewed and discussed, with the most significant items singled out for additional study. I was struck by the great spirit of cooperation among the attendees at the caucus, which carried over to the ADA HOD as well.

Seeing and hearing our fellow dentists from across the country, with their high level of dedication and commitment as ADA officers, trustees, council members, and others, gave me a renewed level of appreciation for the vision we all share as dentists to enhance and advance the practice of dentistry.

While the process of governance can be tedious at times (not much difference between the ODA HOD and ADA HOD—just more items on the agenda at ADA), most discussion was truly offered in the pursuit of clarity and understanding.

Lastly, having the opportunity to listen to ADA staff members was an eye-opening experience. Each staff member I heard from displayed an exceptional dedication to our profession. Many of the ADA senior staff are world-class experts in their field, providing the ADA councils and committees and publications with up-to-date research and findings to allow the best decisions to be made. The field of dentistry is going to change without a doubt, but I have a renewed confidence that with the incredibly competent staff from the ADA, and from our own ODA as well, we can hope to minimize the impact to our chosen profession, and most importantly, to our patients.

**Budget Reference Committee**

**Judd R. Larson, DDS**

This year I had the opportunity to represent the 11th District on the nine-person Budget Reference Committee at the ADA House. It was an interesting and challenging experience. The Budget Reference Committee hears testimony from delegates and alternate delegates on resolutions pertaining to the budget; the committee then deliberates and makes their recommendations about each resolution. They take into consideration all of the testimony and what is in the best interest for the association as a whole, basing their recommendations on these key ingredients. This year we deliberated for almost eight hours after the budget hearing was completed.

I thought the Budget Reference Committee process went well this year, and we were able to put several items in place that are going to help drive this association forward in the future. One of those items was reestablishing a capital fund in the budget to fund depreciating items, such as the buildings we own in Chicago and Washington, D.C. We had a capital fund in the past but it has not been funded since 2005, so placing money in this fund will put us in a much better position going forward, as we are expecting approximately 10 million dollars’ worth of capital expenses in the next few years, for various things, including tenant lease hold improvements in our buildings. It also significantly decreases the possible need for any special assessments to our members to pay for these costs going forward.

The last item I wanted to share with you was that the ADA House did pass a $10 dues increase for the coming year. This was a great success in my opinion, since we were looking at a possible $30 dues increase and a $50 special assessment to each member as we headed into the House of Delegates. We were able to take a strategic look at all budget items and make some tough decisions that will benefit the ADA as a whole moving forward. The ADA is a very slow moving body, but it was nice to see us take some truly positive steps in the right direction that will
set us up for future success. I encourage you to talk with one of your Oregon delegates or alternate delegates if you have any questions, as they can be a great resource for you regarding any of the ADA House outcomes.

Reference Committee on Membership and Related Matters

Renee E. Watts, DDS

The Reference Committee on Membership and Related Matters recommended adoption of several housekeeping resolutions. One of the more significant actions taken by the 2012 ADA House of Delegates was the approval of Resolution 51H-2012, which addressed the dues paid by active life members. In previous years, active life members received a 50% reduction from full dues; going forward, the discount was reduced to 25%. There was a great deal of testimony in the House of Delegates, addressing timing of the change as well as the potential to “grandfather” current members paying active life dues. Ultimately, the House approved the change for all active life members beginning with the 2013 membership year.

The Committee recommended a ‘no’ vote on Resolution 167, which the House followed. This vote maintained the current policy of allowing the House final approval of sponsorship or endorsement of a national professional liability policy.

The final significant resolution, 173, called for the ADA to establish an action plan to collaborate with dental schools to promote the private practice of dentistry, with a cost implication of $200,000 for the first year and $76,000 for subsequent years. The committee recommended a ‘no’ vote, since dental school graduates enter a variety of careers after graduation, and there are many programs already in existence to assist graduates who are going into private practice. The House concurred and voted down this resolution.

Report on Governance

David J. Dowsett, DMD

The ADA, like the ODA, has once again been seriously examining their governance structure. While not the only hotly-debated group of resolutions, the reference committee on governance and the ensuing House discussions and actions reflected the sometimes polarizing and disparate ways we see our organization. The global questions we grapple with are: what is the most effective and efficient way to run our organization, what are the overarching roles of the House of Delegates vs. the Board of Trustees (BOT), and how do they work best together while adhering to the needs and desires of the members and advancing the vision of our association? In 2012, a comprehensive sturdy on governance was completed and presented to the ADA BOT by the Westman Group. Many of the recommendations were put forth as resolutions to the House. The House agreed with many of these, and adopted resolutions including creating and defining an election commission to oversee candidate procedures and conduct. The House has also adopted resolutions to change the term of office for the the Speaker of the House as well as to encourage all constituent societies to implement delegate term limitations with the goal of increasing diversity within the House.

A controversial Westman study recommendation was to sunset some of the councils at the ADA — specifically, the council on Members Insurance and Retirement Programs—and merge their business into other areas. The ADA Board concurred, but after spirited debate the House elected to not follow the suggestion, and thereby preserving the council on MIRP. Subsequently, the House passed a resolution to create an ad hoc task force to comprehensively investigate issues affecting councils based upon the Westman report suggestions (94 RC).

Resolution 97 and subsequent substitutions regarding “financial responsibility of the BOT and the HOD” created, once again, spirited testimony. This resolution would have placed budget authority with the BOT. The basis for the recommended change was to give the group with the most knowledge and understanding—the BOT, which has responsibility for budget development and implementation—more control over the process. This control is widely recognized in associations as ‘best practice.’ The HOD would have retained authority to set dues levels, thereby providing checks and balances to the process. The HOD did not agree to give up its current charge of approving the budget and thus defeated the resolution. This decision was widely seen as an issue of roles with concerns over checks and balances.
A second critical Westman Group suggestion involved reducing the size of the House from a maximum of 460 to a target of 300. The stated reasons were to increase efficiency and, more importantly, to increase engagement and effectiveness of the delegates. Additionally, having fewer delegates would reduce the financial burden of constituent societies who now fund attendance (the ADA does not fund delegate attendance; it is up to each constituent). Again, a majority of those on the reference committee and many districts, led by the 13th (California) and our own 11th, worked very hard to accomplish this goal while paying special attention to the desires of ASDA and the smallest constituents. After much debate, working and reworking, the resolutions failed. More than 50% of the delegates were in favor, but since the resolution was a bylaws change, a 2/3 majority vote was required.

As a result of mixed implementation and uncertainty over the strength and validity of the Westman study suggestions, the reference committee put forth a final resolution to reexamine the study itself. The House believed that the study needed to be reevaluated by the BOT. It is clear to this participant that many of these issues will be revisited in years to come, and I encourage all members to read the Westman Report on governance found at www.ada.org. Please contact any or all of your delegates with questions or concerns.

Summary of the Reference Committee on Dental Education, Science and Related Matters

Jeffery C.B. Stewart, DDS

The Reference Committee on Dental Education, Science and Related Matters heard testimony and presented recommendations for action to the House pertaining to 31 different resolutions. Those which generated the most interest and discussion are highlighted here.

Resolution 16 supported approval of dental anesthesiology as an ADA-recognized specialty of dentistry. The application for recognition had been submitted by the American Society of Dental Anesthesiologists. The application had previously been reviewed and approved by the ADA Committee on Specialty Recognition, the Council on Dental Education and Licensure (CDEL) and the ADA Board of Trustees. The reference committee heard considerable testimony

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both in favor and against approval of the application; they ultimately recommended that the House approve the application. However, after extensive debate on the floor of the House, the resolution was defeated. At the end of the House, additional resolutions were introduced and passed that essentially directed CDEL to undertake a comprehensive review of the entire specialty recognition application process.

There was also extensive discussion of Resolution 17, which attempted to provide clarifying language to the requirements of recognition of dental specialties in regard to membership status in sponsoring specialty organizations and the ability to hold office and vote in those organizations. Again, the reference committee heard passionate testimony on both sides of the issue and ultimately recommended that the existing wording in the resolution might have unintended consequences for some specialty organizations, including the possibility of creating a sense of disenfranchisement by many member dentists in the dental public health community. This resolution was therefore recommended for referral back to CDEL for further study of this issue and report to the 2013 House. The motion to refer this resolution was approved.

Resolution 29 proposed to amend the ADA policy, “Eliminating Use of Human Subjects in Board Examinations.” The original intent of this resolution was to unify two policies that address this subject. However there was some concern, especially from the American Student Dental Association (ASDA), that the amended policy still contained wording which stated that although use of human subjects in clinical licensure exams does raise certain ethical issues, the practice in and of itself is not unethical. ASDA favored removal of this wording, as it sends an ambiguous message regarding ADA’s policy on this issue as stated subsequently in existing policy as supporting the elimination human subjects in clinical licensure examinations. Ultimately the House voted to refer this resolution to appropriate ADA agencies for further study.

The reference committee heard a lot of testimony in support of Resolution 159, which proposed to restore financial support for the ADA library to the budget. The budget submitted by the Board of Trustees reduced funding by $660,000. The reference committee agreed with the Board and did not support the restoration of the funding but submitted a substitute resolution (159RC) to the House because they also heard some concern from members regarding the absence of a plan for the disposition of the library’s collection of dental resources. The reference committee resolution called for maintenance without disposition of the library collections and physical space until ADA appropriate agencies develop a transition plan to be reported to the 2013 House of Delegates. The reference committee resolution was approved.

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Research on the upswing for OHSU School of Dentistry faculty

By Sydney Clevenger

Despite the decline in NIH dollars nationally, funding for OHSU School of Dentistry faculty is off to a good start this fiscal year. “We have some brilliant scientists with powerful ideas for research studies,” said Interim Dean Gary Chiodo, DMD, FACD. “The first-time hit rate from all funding sources for our dental faculty is 49 percent, which, if you know anything about the current funding climate is really good.”

Recent research grants to OHSU School of Dentistry faculty include:

• $1.2 million from the NIH’s National Institute of General Medical Science to David Morton, PhD, professor and associate dean for research. The four-year grant is a basic science renewal grant now in its 21st continuously funded year, and will enable Dr. Morton to study cyclic GMP (or cGMP), an intracellular chemical messenger present in almost all cells.

• $500,000 from the NIH’s National Institute for Dental and Craniofacial Research (NIDCR). The two-year grant is an administrative supplemental grant to Jack Ferracane, PhD, chair of restorative dentistry and division director of biomaterials and biomechanics, Tom Hilton, DMD, MS, alumni centennial professor of operative dentistry, and John Mitchell, PhD, professor of restorative dentistry, for a mechanistic approach to cariogenic disease.

• $50,000 from the American Association of Orthodontists Foundation to David Covell Jr., DDS, PhD, associate professor and chair of orthodontics, for a two-year project to digitize growth study radiographs that date from the 1950s. OHSU School of Dentistry currently has one of the largest growth study collections in existence and the AAOF has provided funding for eight collections to pool their records and to make them accessible for teaching and research purposes at www.aaflegacycollection.org.

• $40,000 from the Medical Research Foundation of Oregon to Carmem Pfeifer, DDS, PhD, assistant professor of restorative dentistry. This is a one-year Early Career Investigator award to look at the synthesis of new and improved adhesive systems based on riboflavin.

The School of Dentistry also will benefit from a renewed training grant to OHSU’s department of medical informatics and clinical epidemiology (DMICE). Within DMICE’s new round of five-year funding, one pre-doctoral and two postdoctoral slots will be devoted to dental informatics for fully-funded (tuition, salary, research) training grants for individuals interested in oral health, dental, and/or craniofacial research.

The new dental informatics training grants, funded by the National Institute of Dental and Craniofacial Research, will be led by Mark Engelstad, DDS, MD, MHI, associate professor of oral and maxillofacial surgery (OMFS) and health informatics, and OMFS residency program director, and Denice Stewart, DDS, MHSA, senior associate dean for clinical affairs and professor of community dentistry. (For more information on the grants listed above, go to www.ohsu.edu/sod and click on the October 2012 and November 2012 Dental Bites.)

Because OHSU School of Dentistry is number 40 of 49 United States dental schools in National Institutes of Health research funding ($363,598 in 2011), and to give dental school researchers a leg up on competing for scarce dollars, Dr. Chiodo this fall created a Dean’s Fund for Research Support.

The Dean’s Fund for Research Support provides funds for preliminary studies, bridge funding, and core costs. The first awards were announced in November. “This will set the stage now for future research growth,” Dr. Chiodo said.
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