

10 December, 2008

Dear Oral Health Practitioner Work Group,

I am a dentist in general practice in Bemidji, Minnesota. I have practiced here for 25 years. Over that entire period of time I have been involved in addressing the issue of access to dental care of the people living in this area and region – from seeing total numbers of Medical Assistance recipients in excess of the recent incentive of increased reimbursement when designated as a Critical Access provider long before the concept was ever conceived, to refugee resettlement, to working to establish a dental access clinic accepting public assistance recipients only. The Northwestern District Dental Association region of Minnesota has been defined as the area of the state with the largest geographical area of all dental districts and at the same time containing the fewest number of dentists. Of the counties identified by the state of Minnesota as the poorest in the state, historically 3 to 4 of the 5 poorest counties lie within the district or region. With three Indian reservations in the region, few and distant large communities, a smaller and more widely dispersed population than many other areas of the state, plus numerous other factors which exist to make simply travelling to the dentist difficult, I am very aware that access to dental care is an issue for a significant portion of the population. I submit to you the following comments regarding the establishment of a dental mid-level practitioner called an Oral Health Practitioner (OHP):

- *First and foremost, it does not make any sense in my mind to go to all the effort of establishing a newly created type of dental worker unless by incentive or requirement they see and treat the underserved populations for which the legislature established this work group. In a very practical sense, nothing else in this letter matters with regard to addressing the issue of the difficulty in accessing dental care by a significant portion of our state population if a newly created type of dental worker will not care for those people. Working in all clinical settings, including private practice settings, would be possible. But without the OHP caring for a significant proportion of this reported underserved population, “What’s the point?”*
- *Secondly, to better meet the needs of the underserved, the scope of practice for an OHP should focus not so much on surgical procedures and extractions but on preventative services. These services, however, can currently be provided by Registered Dental Assistants and Dental Hygienists. While creation of another type of dental practitioner may be feasible, it will take years to implement and further years to evaluate if it is actually doing what it was intended to do. The legislature and Board of Dentistry have already authorized and established ways of addressing the issue of access to dental care through Restorative Expanded Function duties available to dental assistants and hygienists, as well as*

- collaborative dental hygiene practice agreements. These are relatively new creations and have not been in existence long enough that anyone has taken the time to assess their effect. I believe that many people do not fully understand the potential effectiveness of these two approaches. They should continue to be promoted as avenues to reduce access to care issues and rigorously evaluated to learn how well they do so. To establish another type of worker may simply be putting a very expensive cart before the horse.*
- *While there is no question that there exists to a lesser or greater degree a genuine access to dental care issue for many needy persons, two facts exist:*
 - *There has not been to my knowledge (or to the knowledge of any of my colleagues to whom I've spoken) in this entire process an agreed upon definition of "access" and what constitutes lack of access to care. Because of this lack of an agreed upon definition of the situation it has not always been possible to propose, discuss or evaluate comparisons, arguments or solutions as they are not necessarily equivalent. Let's talk apples to apples based upon agreed upon definitions and facts.*
 - *Having said that it is generally accepted that dental access is difficult or not possible for some percentage of our population, it would be wise to not be confused or seduced by the thought that all who are provided "access" will utilize it. Access does not equal utilization. I mention this to encourage realistic expectations and solutions to match the reality of level of need.*
 - *Footnote: Minnesota has been chosen as one of a select few states to receive federal monies to study and determine the state of the state's oral health. Let's use that money and opportunity over the next few years to learn the true status of Minnesota's oral health. By conducting rigorous studies that include the use of control groups, random chart audits and clinical examinations within a blind review process, the state of oral health can be determined and quality of care can be preserved. Then let us make informed decisions on needs and best solutions.*
 - *Careful study of the OHP concept that is being proposed by the work group shows that the mid-level practitioner being proposed for Minnesota would be unlike anywhere else in the world. While the reasons and desires for establishing such a position may be similar (provide access to dental care for those currently unable to attain it), the conditions in Minnesota are unlike any of the other models studied. I therefore urge that we move deliberately and more slowly toward the goal of increasing access by adding another level of practitioner.*
 - *It is my opinion and experience that a mid-level practitioner would be capable of performing certain procedures as recommended in the OHP proposal. However, I believe that it is in the best interests of all parties (first, the patient and public;*

- the dentist, as the responsible party; the mid-level practitioner; and the educational institution) to ensure that the OHP receive the same high quality dental education as do dental students by having them be integrated into an accredited dental educational program. (This means that an OHP program be taught in an educational institution that is accredited by the Commission on the Dental Accreditation of the American Dental Association – CODA). The highest quality third-party unbiased oversight then is therefore in place to assure the highest possible standard of care deliverable by this level of practitioner. Surgical procedures and other procedures beyond the current scope of dental hygiene taught in this way allows the OHP to receive their dental education along with dental students, providing for education within an integrated dental team environment. (i.e. If they learn together and confidently know what each other can do they will be more likely to successfully make the entire concept work when they are out in the real world!)*
- *I believe that certain procedures performed by a mid-level practitioner are of a nature such that the ongoing decision-making which must occur during the performance of the procedure (intra-operative decision making) make it advisable (i.e. necessary) to have a dentist available for onsite supervision, and furthermore, only after a dentist has completed an examination, diagnosis and treatment plan.*
 - *Because dentistry believes that an OHP should be minimally under indirect supervision (i.e. a dentist needs to be in the building) when performing surgical procedures, a so-called “collaborative management agreement” is not necessary. (Tremendous confusion exists in the use of the term “collaborative management agreement” which is not the same as “collaborative dental hygiene practice agreement” .) Furthermore, one can say that there is no such thing as a “regular” procedure to drill or pull teeth. There are many complications that can arise during the performance of surgical procedures which may or may not be foreseen. A dentist is properly trained to adapt and make ongoing diagnoses and treatment plan changes to deal with complications (such as broken root tips, uncontrolled bleeding, tooth nerve or pulp exposure and others) whereas an OHP not under direct supervision will not be able to complete the patient’s care.*
 - *I agree that an OHP may be allowed to do evaluations, assessments, and data collection (i.e. preliminary examination) to assist a dentist. However, only the dentist should be allowed to do examination, diagnosis and treatment plan.*
 - *Because underserved patients often exhibit a greater degree of complication and other systemic health conditions, the use of unsupervised, lesser-educated providers risks jeopardizing the patient’s health and safety.*
 - *Acknowledging that there appears to be a concern with the finances of the state, the fact remains that it has been proven that the best way to improve access is to increase reimbursement rates and create incentives to encourage dentists to*

branch out to underserved areas and populations (please research Michigan and Tennessee). Given that fact, I agree with the concerns of the MDA that the OHP is not the best way to resolve the access problem and will make only a small impact.

- *Finally, while I do not differ on the desire to address the issue of access to dental care for the needy, I do not believe a better understanding of the problem and proposal of solutions has been generated than those of the Minnesota Dental Association. The MDA is recognized as a leader in organized dentistry for the nation, and because the U.S. leads the world in quality and delivery of dental care, for the world. The MDA has the support and the resources of the American Dental Association to help solve this problem. I do know that the Minnesota Dental Association - while originally opposed to the concept of OHP – has worked harder than any other group to research, propose and support workable solutions. The MDA has put forth practical, solid, workable plans and means of addressing the issue. (For one example, refer to the Minnesota Dental Association Recommendations: Oral Health Practitioner.) The MDA has been at the forefront and proactive with recommendations for solutions that ensure that, if instituted, the economic impact of the Oral Health Practitioner is positive in a variety of practice settings while improving the oral health of patients and keeping the cost of care the same or decreasing it.*

Please be clear about the issues to be solved by an OHP.

Then make fully informed decisions about whether or how to proceed.

There are already sufficient legislatively-approved solutions in statute to address dental access-to-care concerns. As they are relatively recent enactments they need time to continue their effectiveness and grow. Their success is measurable now. There are numerous stakeholders at the dental access table. The Minnesota Dental Association is a leader in the nation in solving dental access issues and has successfully worked collaboratively with all the other stakeholders to achieve the successes already in place. Utilize their commitment to the problem, their expertise and that of the greater organized dentistry community, and collaboratively we can solve the access to dental care issue.

Respectfully submitted,

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Bemidji, MN