From: Jamie Sledd
Sent: Wednesday, December 10, 2008 4:44 PM
To: Kristine Gjerde (MDH)
Subject: Letter to OHP Workgroup

Thank you to the work group for their commitment to discussing workforce changes to address the oral health disparities in Minnesota. As one who has practiced in Canada and continues to have contacts with practitioners in the region and as another who participated in the site visits to Canada, New Zealand and England, we would like to remind the work group of several issues that have been demonstrated to be a concern as you move forward in your thoughtful deliberation of the Oral Health Practitioner.

The Saskatchewan and Northwest Territories experience is difficult to compare to Minnesota on several fronts, but much can be learned from their history. The remoteness of the region is vastly different from the geography of Minnesota, where a road leads us to every town and it does not take several plane rides to see a dentist. Nor do we have communities to which supply ships can travel only a few months out of the year when the ice has melted. Indirect supervision in these remote areas may result in a geographic deterrent to care, but in Minnesota it is still feasible and desirable to have this level of care.

The scope of practice in Canada does not emphasize prevention like we do in Minnesota and the data shows that the dental therapist workforce has not impacted the rate of disease. The trend in the work group discussion has been to emphasize treating disease while overlooking the successes that have been demonstrated with prevention. Ignoring the success of prevention measures is a short-sighted view that will cost Minnesota taxpayers more in the future.

The Canadian model also demonstrates the difficulty of providing oral care in underserved areas. While there are more than 200 dental therapists in Canada, only 37 practice in underserved areas.

Educators in New Zealand have stated that diagnosis is and should continue to be exclusively in the dentist's scope of practice. The dental therapists have the important role of recognizing and identifying findings, but the ability to diagnose goes deeper into the understanding of the causes and conditions of the disease and developing a rationale for treatment. You cannot drill, fill and pull teeth based purely on recognition and expect to consistently come out with safe and effective care.

New Zealand dental therapists are trained in a dental school, alongside dentists. This creates a strong foundation and familiarity for both the therapist and the dentist once they begin clinical work after graduation. Dental therapists must be an integrated member of the dental team to provide the highest quality care to patients.

In England, the dentist always sees the patient first to make a diagnosis and formalize the treatment plan. Should anything unexpected arise during treatment, intra-operative diagnosis and decisions must be made. This is a frequent occurrence. The ability to make these decisions during irreversible treatment requires the dental therapist be under the indirect supervision of a dentist to assist in this process.

Like New Zealand, dental therapists in England are also trained alongside dentists in a dental school. At the University of Sheffield, the dental students and dental therapy students took many of the same courses. The significance of this integrated education is the importance of the dental therapist to receive the same level of training as the dental student and build the foundation for a strong, integrated dental team.

Lastly, as a result of our many conversations with educators and practitioners from nations with dental therapists, we have found that these programs have some level of success due to the tremendous funding from the government for educational costs and treatment payment. The inability to keep these providers in underserved areas demonstrates the economic difficulties that a Minnesota program will have in the long term.

Success is defined by the standards of the profession in the society in which it resides. Minnesota has enjoyed a high level of care supported by quality educational institutions, as we see represented in the work group. We hope you will take these items listed above into consideration as you move forward. This letter does not claim to address all of our concerns with the position, but addresses the most critical items to us. We look forward to a mid-level position that will serve Minnesota's needs and provide the quality of care that all Minnesotans expect and deserve.

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