Saskatchewan Dental Therapists Association

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Position Paper

In Response to

The Proposed New Community Based Dental Program
Announced by Premier Grant Devine
November, 1987

January, 1988

TABLE OF CONTENTS

BACKGROUND:

In 1974 the first graduates of the Dental Therapy (originally called Dental Nurse) program at Wascana Institute commenced employment with the Department of Health in the Saskatchewan Health Dental Plan. Dental therapists were trained in the two year program to provide basic restorative and preventive dental care. Examples of restorative care include: restore permanent and deciduous teeth with silver amalgam and composite resin fillings; place stainless steel crowns and space maintainers; perform pulpotomies and extractions on deciduous teeth. Preventive services provided by the therapists include: clinical, classroom and community dental health education; simple oral prophylaxis and fluoride treatments; application of pit and fissure sealants; and nutritional counselling. Some of the other general services provided by the therapist are to diagnose dental caries; expose and develop dental radiographs; intra oral administration of local anesthetic; and, recognition and referral of abnormalities and health related problems.

All of the services listed were provided by the therapist working in the Saskatchewan Health Dental Plan using a team approach. Each team consisted of a dental therapist, a certified dental assistant, and a supervising dentist. The supervising dentist usually supervised approximately 8 to 10 dental therapy teams.

From 1974 until the enactment of The Dental Professions Act 1978, dental therapists were only permitted to be employed in public health. The Saskatchewan Dental Therapists Association and the College of Dental Surgeons of Saskatchewan had sought the changes to legislation necessary to permit the employment of therapists in private practice. At that time there was a demand for dental therapists in private practice and an insufficient number of positions available to them in the Saskatchewan Health Dental Plan.

In December of 1987 another change was made to regulations under The Dental Professions Act effecting employment of dental therapists in private practice. This change allowed a dentist to employ two therapists instead of only one. Dental therapists practiced under the general supervision of a dentist while employed by the Department of Health as compared to direct (on site) supervision while employed in private practice.

In recent years, dental therapists noticed a significant change in the

dental status of their patients. The nature of treatment required changed from urgent to maintenance. Consequently the Saskatchewan Dental Therapists Association established an Ad Hoc Committee to: 1) investigate the impact that the changes in the dental disease incidence would have on the practice of dental therapy; 2) pursue an appropriate expansion of the role of dental therapists and, 3) pursue employment opportunities consistent with the changing dental disease incidence and population age. The emphasis was on preparing for the future by identifying the dental problems which would benefit most from the dental therapists care. A review of the dental literature confirmed anticipated assumptions.

It was obvious from both discussions and research, that dental therapists and hygienists do have a significant role to play in the delivery of care to children and senior citizens, the two groups most in need of dental education and treatment.

This message was shared with Mr. Walter Podiluk, Deputy Minister of Health in January, 1987.

At that meeting representatives of the Saskatchewan Dental Therapists Association expressed the desire to participate in a program which delivered care to those who are underserviced, primarily preschoolers and seniors. Mr. Podiluk informed the Saskatchewan Dental Therapists Association representatives of the governments satisfaction with the performance of dental therapists in the Saskatchewan Health Dental Plan and suggested also that the future of dental therapy was secure. (See Appendix A)

Later that year, in May 1987, rumors were circulating of drastic cuts to the Saskatchewan Health Dental Plan, no confirmation or denial of these rumors was given to the Saskatchewan Dental Therapists Association. On May 12, 1987, the Department of Education announced the Dental Therapy training program at Wascana Institute would be discontinued as of June 1988, until further notice. This gave dental therapists reason to take the threatening rumors very seriously. In response to threatened cutbacks a petition was distributed province wide, attempting to solicit public support for the maintenance of both the school based dental plan and the private practice adolescent dental plan. In approximately one week almost 7000 names were collected, from over

250 communities representing most areas of the province. The signed petitions and a map representing the distribution and size of support was presented to the Minister of Health's office June 8, 1987. The goal was to have public support influence the Minister of Health to keep the dental plans intact.

On June 11th it was obvious the petition and other efforts were unsuccessful. On that date, dental therapists, dental assistants, dentists and administrative staff of the Saskatchewan Health Dental Plan were informed of the governments decision to: 1) change the delivery of dental care for children from a public service school based plan to a private practice delivery model; 2) discontinue the adolescent program and services to teens aged 14 to 17; and, 3) lay off the majority of the Saskatchewan Health Dental Plan staff (approximately 400). The dentists were laid off immediately, the dental auxiliaries by the end of June. Without the benefit of supervision, dental therapy teams did their best to finish the treatment required by their patients before the June 30th deadline.

Although the school based dental plan was over as of June 30, 1987 the controversy surrounding the delivery of dental care was far from settled. Dental plan staff were not the only ones upset by the changes to the dental care delivery system for children. The public in general, parents, teachers, and children, voiced strong opposition to the changes to the dental plans. Dissatisfaction was also expressed by many organizations, schools boards, health care associations, womens groups, church groups, farm groups, political parties, town councils, etc.

Almost every week, since June 11th, the media has reported on the impact that dismantling the school based program has had in Saskatchewan.

Another major announcement was made by Premier Devine in November at the Progressive Conservative Convention in Saskatoon. At the convention he announced that the government would soon implement a new community based dental program. This new program, he said, would see everyone in a win/win situation. The Saskatchewan Dental Therapists Association, encouraged by this announcement, requested a meeting with government officials to share ideas related to the planning, implementing and evaluating of the new community based dental plan.

A preliminary meeting with the Deputy Minister of Health, Walter Podiluk, to discuss the proposed plan was held December 22, 1987. At this meeting Mr. Podiluk requested the Saskatchewan Dental Therapists Association prepare a report outlining suggestions for the new dental program, and that it be submitted to the Department of Health in January, 1988.

The following report was prepared in response to Mr. W. Podiluk's request.

GENERAL RECOMMENDATIONS:

The new dental program should feature the following characteristics.

I. PROVIDE COMPREHENSIVE PREVENTION ORIENTED DENTAL CARE

Nearly all dental disease, including tooth decay and periodontal disease can be prevented. The prime focus of any dental program should therefore be health promotion and prevention of disease.

II. REMOVE INEQUALITIES INHIBITING ACCESS TO CARE

As the new program continues to be provincially funded, accessibility to care is therefore a right of all eligible recipients. Efforts must be made to remove barriers to care.

III. FOCUS ON HIGH RISK AND UNDERSERVICED GROUPS

In Saskatchewan, the high risk groups are children ages 3 to 16 and seniors 65 and over. The underserviced are seniors in general and individuals living in rural areas many kilometers from a dental office.

IV. DELIVER COST EFFECTIVE DENTAL CARE EFFICIENTLY

Saskatchewan's tax base is shrinking and its deficit growing, this demands restraint and responsible use of public funds. Creative planning and flexible ideas will be necessary to design the most cost effective program.

V. MAXIMUM UTILIZATION OF EXISTING HUMAN RESOURCES

There is considerable expense and time required to educate and recruit dental health personnel. Programs must be designed to make the best possible use of all types of dental health personnel already available in the community.

VI. ENSURE QUALITY CONTROL

The quality of dental services provided must be monitored to provide optimal patient care. Quality control also serves to minimize the duplication of services, and therefore the duplication of expenses, associated with poor quality care.

VII. DETER PROGRAM ABUSE

A method of abuse control is essential to deter patients and practitioners from taking advantage of the system.

VIII. ONGOING PROGRAM EVALUATION

Program evaluation is an essential element of all public health programs. It must be carried out continually in order to determine if the goals of the program are being achieved.

ENABLING FACTORS

I. LEGISLATION:

Amend current legislation governing the practice of dentistry and dental therapy:

a) To permit dental auxiliaries in private practice to function under the general supervision of a dentist.

b) To permit the employment of dental auxiliaries by agencies, responsible for the delivery of dental care programs, provided they also have a dentist employed/contracted for the purpose of providing general supervision and service.

c) To remove restrictions limiting the number of dental therapists that may be employed by each dentist.

d) To remove restrictions prohibiting dental therapists from charging directly for services rendered.

e) To permit dental therapists the opportunity to enter into a contract with a dentist for the purpose of providing dental therapy services.

II. EDUCATION:

a) Continue to provide dental therapists the opportunity to enroll in the Dental Hygiene Program at the Saskatchewan Institute of Applied Science and Technology.

b) Develop modules to provide education for dental auxiliaries in the following areas: Geriatrics, Administration, Research, Education, Public Health, Orthodontics, as well as general refresher courses as required.

c) Reorganize dental auxiliary education so that an individual can progress through various levels without barriers and repetition of previous education.

III. OTHER GROUPS:

a) Employ more dental personnel in Saskatchewan Health for the purpose of conducting research and program evaluation, as well as contributing to the current role of dental health promotion.

b) Initiate discussions between the Department of Health and dental health professional associations, and consumer representatives aimed at facilitating a cooperative approach and a workable solution to the dental health problems facing Saskatchewan.

GENERAL RECOMMENDATIONS DISCUSSED:

I. PREVENTIVE ORIENTED COMPREHENSIVE CARE PROGRAM

Preventive dentistry encompasses all aspects of dental treatment, public health measures, and efforts towards behavioural change which brings about a state of dental health in an individual.

A dental health public awareness program should be initiated to promote individual responsibility in the prevention and treatment of dental disease.

Public dental health promotion should be aimed at the needs of the entire population, not just the needs of plan participants. Information promoted through a public education campaign could cover such topics as nutrition, plaque control, denture care, oral cancer, mouth protection, fluorides, harmful habits, as well as promote the need for regular professional care.

Water fluoridation is the most effective and efficient caries preventive public health measure currently available and should be implemented in all communities where feasible.

Fissure sealants constitute a valuable preventive measure, sealing off the pits and fissures on all teeth which favor the initiation of dental caries. Fissure sealants are successful on surfaces where plaque control and fluorides are not. Sealants should be a preventive service provided through the program wherever indicated.

Plaque control measures including home care instruction by health care providers, must be reinforced in the clinic, classroom, and community.

In order for the program to provide comprehensive care, periodontal and restorative treatment needs must also be met. Treatment along with good oral health practices are necessary to achieve and maintain a healthy dentition.

II. REMOVE INEQUALITIES INHIBITING ACCESS TO CARE

Efforts made at removing barriers to care and achieving high utilization must focus on regional, patient, and manpower factors.

A community dental program could take a variety of forms; school based, hospital based, community center based, seniors home based, institution based, dental office based or a combination of the above, depending on the services being provided as well as the community, patients and health care providers involved. The hundreds of school based clinics available for use in Saskatchewan represent the most convenient and cost efficient means of delivery.

Regional challenges vary. Availability of facilities, population distribution, and consumer trading patterns are factors which should significantly influence program design. Programs may vary in delivery design from community to community, but should be consistent with the general recommended characteristics.

Another challenge is to reduce the inequities that occur between the health of the low- versus high-income groups. There is disturbing evidence which shows peoples health remains directly related to their economic status. Within the low income bracket some groups have a higher incidence of poor health than others. Older people, welfare recipients, single parent families headed by women, natives, and immigrants require special consideration in order to deal with this disparity.

The poor distribution of dental manpower has been a long standing problem in Saskatchewan. With the exception of dental therapists and certified dental assistants who were employed in public health caring for school children in almost 600 clinics province wide (including the remote north), the majority of the dental manpower serve the needs of the urban population. In the case of dental hygienists, the demand for hygiene services in the cities has been greater than the supply of hygienists. Dental hygienists have <u>not</u> had to seek opportunities in rural Saskatchewan in order to secure employment. Currently many hygiene positions remain vacant and

patient needs remain unmet due to a lack of qualified personnel in cities and rural areas alike.

The poor distribution of dentists coupled with a minimum acceptable ratio of dentists to population has left rural residents severely underserviced. Better distribution and an increase in the number of dentists and auxiliaries would help meet manpower challenges.

The new dental program should promote the optimum allocation of services to dental auxiliaries within their scope of qualifications. Many qualified dental auxiliaries, distributed throughout the province, are currently seeking employment opportunities. Approximately one hundred dental auxiliaries (fifty certified dental assistants, thirty dental hygienists, sixteen dental therapists) and sixteen dentists will graduate this spring, contributing significantly to the dental manpower pool. The goal to provide equitable access to dental care will be greatly enhanced if human and physical resources are permitted to be utilized to their full potential.

III. FOCUS ON HIGH RISK UNDERSERVICED GROUPS

Current fiscal constraints dictate the necessity to target on select high risk groups, progressing toward universal care if and when feasible or desirable.

Children and seniors experience a high incidence of dental disease and a limited ability to independently pursue professional care. Tooth decay plagues the younger generation, while root caries and periodontal disease attack seniors.

The optimal time to prevent dental decay in children is soon after the teeth erupt. Children have all of their deciduous teeth years before they reach school age. Three is an ideal age to begin dental care. At this age the patient, parent and health care provider have a good opportunity to contribute to the prevention of dental problems, as well as contributing to the development of a healthy dental attitude.

Teens exhibit an increased rate of decay coinciding with the eruption of their permanent teeth. The new dental program must continue to serve adolescents during this critical time to maximize on the preventive benefits of the program. It is not until many children reach their teens that they can fully comprehend and apply preventive techniques necessary to prevent oral disease. Age 12-13 is the 'worst' time for care to be discontinued.

Seniors are one of the most dentally underserviced groups in our society. This has occurred for a multitude of reasons including: lack of perceived need of dental care; economic barriers inhibiting care; negative attitudes of dental health care providers to delivering care; lack of transportation or assistance; the list goes on. The facts are, that there is a definite need for care, there is an increasing number of seniors in our population, there are more seniors with natural teeth, there is an increasing awareness of the need for care, on both the part of the seniors as well as the profession.

Young and middle aged adults have been omitted from the target groups as they are most likely able to practice preventive techniques and seek dental care. They are the most likely group to benefit from other third party dental insurance coverage.

IV. DELIVER COST EFFECTIVE DENTAL CARE EFFICIENTLY

Resources to consider when designing a cost effective dental care program can be divided into three categories; human, physical, and material resources. The most cost effective use of human resources is achieved when personnel are utilized to their full potential. Task assignments should be allocated to capitalize on qualifications, not minimize them. Regulations under The Dental Professions Act and Saskatchewan Dental Therapists Act outline the services that can be provided by the various levels of dental health personnel. These services were designated with public protection in mind, and can be used as a reliable guide to assign duties for personnel within the new program.

To enhance reader understanding of the roles of various dental auxiliaries, a definition and description of each is presented in Appendix B.

Some of the benefits that can be expected from the optimal use of dental auxiliaries were demonstrated in the Saskatchewan Health Dental Plan. Benefits included:

- an extremely high utilization rate of approximately 90%
- a high level of patient/parent acceptability
- a decrease in cost/patient/year trend
- a decrease in decay/patient/year trend
- a high level of quality care
- equivalent accessability to care in all areas of the province
- a stable workforce, an attrition rate of a low 5-7%
- promotion of prevention in the clinical, classroom and community settings

The cooperative participation of dentists cannot be under-estimated. Dental auxiliaries can independently perform many duties but rely on the dentists for guidance and assistance with complicated aspects of dental treatment.

General supervision of dental therapy teams, providing basic dental care to school age children, has been proven effective and cost efficient. A continuation of this type of supervision is essential to keep costs at a

reasonable level.

Physical resources refer to clinical facilities. The use of existing facilities is the most cost effective and acceptable method of delivering care.

Creating new clinical facilities in communities where adequate facilities are already present is a waste. Therefore, facilities such as those found primarily in many schools, as well as some hospitals, community buildings and private dental offices should be utilized for maximum benefit.

Material resources referred to include equipment and dental supplies. Much of the equipment required is already available and should be redistributed back to communities throughout the province. Dental supplies purchased by a central purchasing agent will result in plan participants being able to purchase supplies at the lowest possible price. Volume purchasing also contributes to consistently high standards of care by ensuring only quality supplies and products are utilized.

V. MAXIMUM UTILIZATION OF EXISTING HUMAN RESOURCES

Currently in Saskatchewan, there are many highly motivated, dedicated and experienced dental therapists and assistants distributed throughout the province. Many of these auxiliaries are unemployed due to the lack of opportunities in their communities. The affects of the lack of income for these individuals goes beyond the individual or the immediate family. Individuals living, working and spending in the community have a positive affect on the community as a whole. When opportunities for work disappear from a community, then often so do the individuals effected.

The viability of many rural communities and family farms is dependent on off-the-farm incomes.

Designing a dental care program aimed at providing employment for qualified individuals already available in the community will have financial benefits for both federal and provincial governments. The demand for Unemployment Insurance benefits would be reduced. The cost associated with retraining and the capital required to educate new personnel would be reduced. The tax base would also increase if those currently unemployed were given an opportunity to re-enter the workforce.

VI. QUALITY ASSURANCE

The development of written criteria and standards of practice are essential in an attempt to assess the quality of dental care. A review procedure should be set up prior to the implementation of the plan. Dental care providers then need to be informed of the standard of care they are expected to provide.

In a dental care program it is possible to examine the dental services provided by using profiling and chart review and clinical audits of work performed. The adequacy of processes, such as sterilization radiation safety, emergency protocol, and scheduling of patients can be readily determined by clinical visits.

A quality assurance system must possess the following characteristics: be transferable to all clinical settings; be systematic and sequential in approach; evaluate all levels of care; include evaluation of education aspects; and offer immediate feedback to dental care providers.

Quality assurance must be viewed as an integral part of the dental care system. Every component of the system (from the provider, the patient, the materials used, to the care rendered) including the interaction of these components, has a quality assurance dimension to be considered.

VII. DETER PROGRAM ABUSE

Another way in which a central agency could compliment the efforts of the community based dental program is by managing the data collection functions. A data system is a highly important feature of a provincial health care program accountable to the public. The data system would be able to: 1) assist in the control and evaluation of the program, and 2) assist with the administrative functions such as payments, identification of beneficiaries and efficiency of record keeping.

Practitioner and patient profiles of service patterns would be available and would help deter program abuse.

VIII. ONGOING PROGRAM EVALUATION

Program evaluation is extremely important, especially in large publicly funded programs. An ongoing evaluation process is necessary to determine if goals are being achieved.

Administrators of public programs are responsible to the public and must therefore monitor programs to ensure that needs are being met on an equal basis.

Evaluation has the added benefits of being able to establish the effectiveness of various methods and determine trends. This information is an invaluable tool when used for program planning and implementation.

PROPOSED OPTION #1

FINANCE:	Government of Saskatchewan
PROMOTION) EVALUATION) CONTROL)	Saskatchewan Health
ADMINISTRATION:	Saskatchewan Health
PARTICIPANTS:	Children ages 3 to 16 Seniors 65 years and older
PERSONNEL:	Government employed dentists, dental therapists/hygienists, certified dental assistants, denturists, dental equipment technicians, and administrative support staff.
FACILITIES:	School based clinics to provide care to children and mobile seniors. Seniors home based clinics to provide care for home-bound seniors. (*Clinics may be permanent or portable)
ADVANTAGES:	All the advantages of the previous, very successful Saskatchewan Health Dental Plan, with the added advantage of making dental care readily available to the elderly. Satisfy public needs and demands.
DISADVANTAGES:	Inconsistent with current government philosophy. Does not improve availability of care to all age groups.

PROPOSED OPTION #2

FINANCE: Government of Saskatchewan

PROMOTION)
EVALUATION) Saskatchewan Health
CONTROL)

ADMINISTRATION:
a) Saskatchewan Health - underserviced areas
b) College of Dental Surgeons of Saskatchewan - urban and semi-urban areas

PARTICIPANTS:
Children ages 3 to 16
Seniors 65 years and older

PERSONNEL:
a) Government employed dentists, dental therapists/ hygienists, certified dental assistants, denturists, dental equipment technicians, and administrative support staff.
b) Private practice dentists and staff.

FACILITIES:
a) School based clinics to provide care to children and mobile seniors.
Seniors home based clinics to provide care for home-bound seniors.
(*Clinics may be permanent or portable)
b) Private dental offices as well as those described above where necessary.

PROPOSED OPTION #2 (cont'd)

ADVANTAGES:

Makes care available to target groups in areas underserviced by private practice.

All the advantages of the Saskatchewan Health Dental Plan on a smaller scale.

Promotes private dental practices.

Consistent with government philosophy to reduce civil service.

DISADVANTAGES:

Inconsistent with public demand to return dental plan to the schools province wide.

Establishes two standards of accessibility to care.

Debate surrounding which communities are to be serviced by which method.

PROPOSED OPTION #3

FINANCE:	Government of Saskatchewan
PROMOTION) EVALUATION) CONTROL)	Saskatchewan Health
ADMINISTRATION:	College of Dental Surgeons of Saskatchewan
PARTICIPANTS:	Children ages 3 to 16 Seniors 65 years and older
PERSONNEL:	Agency (i.e. hospital, nursing home, school boards, municipality, town council, etc.) employed dentists and auxiliary personnel. Self employed dentists, dental therapists and/or hygienists and denturists.
FACILITIES:	School, hospital, town office, community health center, seniors home, institutions, dental office clinics, either permanent or portable.

PROPOSED OPTION #3 (cont'd)

ADVANTAGES:

Community participation in program delivery is encouraged.
Extremely flexible, able to meet a variety of community needs.
Removes dental market monopoly from single group.
Consistent with government philosophy to reduce civil service and promote private enterprise.
Increase availability of dental care to all ages, as individuals not eligible for provincial program are able to access care at their own expense.

DISADVANTAGES:

Inconsistent with the goals of the College of Dental Surgeons of Saskatchewan.
Increase complexities associated with program administration.

CONCLUSION:

Saskatchewan Dental Therapists have proven their ability, availability and desire to deliver dental care to all areas of the province. The public in return has shown their overwhelming support of therapists providing care. There are many dental problems in Saskatchewan which remain unresolved because dental therapists are restricted from delivering care.

The implementation of Option #1 is the best way to solve most of these problems.

The Saskatchewan Dental Therapists Association strongly urges Saskatchewan Health to design a community based program that will take full advantage of the quality care dental therapists have to offer.

APPENDIX A

Saskatchewan Dental Therapists Association

Presentation to Mr. W. Podiluk and Mr. E. Gaschler on January 28th, 1987

Issue I - Reintroducing the four year olds into the Saskatchewan Health Dental Plan

Withdrawal of the four year olds from the Saskatchewan Health Dental Plan is a major concern of Saskatchewan Dental Therapists (Not that their withdrawal affected or cost us anything personally). Our concerns stem from what we have observed since their withdrawal from the plan.

First, we have noticed that most of the parents put off dental care for their children until their children are eligible for the Dental Plan. The erroneous impression which we are concerned that parents are receiving, is that dental care is not necessary until children reach school age. If treatment was required, they may conclude, services would not have been withdrawn.

Secondly, we observe that treatment "is" required and for some urgently. Many children require extensive restorative treatment. The average child entering the Saskatchewan Health Dental Plan has 2.69 decayed, extracted or filled teeth. Decayed teeth account for 2.16 of the total 2.69, and although these teeth can usually be restored to function as normal, it is not the best way to introduce a child to dental care. As Dental Therapists we try not only to prevent dental disease, but as well we try to foster a positive attitude towards dental health and dental treatment in the patients and parents we care for. The odds of being successful on both counts would be increased if patients could be seen before they require restorative dental treatment. If the current trend in the decay rate of the general population continues its decline, and if children are seen at an early age, then a relatively caries free generation may soon become a reality. This is an exciting possibility for Saskatchewan.

The Saskatchewan Health Dental Plan and its employees have endeavored for more than a decade to work together with Saskatchewan residents to improve both dental health and dental attitudes. We feel great progress has been made, as seen by a steady decrease in the decayed, extracted, filled rates of Saskatchewan children and by the high (89.9%) acceptance rate of eligible dental plan recipients.

More significant than impressive statistics to Dental Therapists, is our rewarding personal experiences with the children, parents and teachers. We feel well accepted and appreciated. We see every day the positive influence the Dental Plan has had on Saskatchewan people. We would like to see the positive effects of the Dental Plan extend to reach the four year olds. We could then further prevent or minimize treatment and trauma. Children would then be more likely to have a very positive first experience in the dental chair, being seen before dental disease becomes a major problem.

We are confident prevention of disease, as opposed to the treatment of disease, is a goal shared by both the Department of Health and ourselves.

Goals we realize cannot always be reached because of financial reasons.

Expanding a program usually means spending more money on the program. The expansion we are suggesting may be an exception; expanding the Dental Plan to accommodate the four year olds may not result in an added expense for the Government. Please consider the improved dental health of the majority of eligible patients and therefore the lower treatment requirements. Consider also, less than 20% of the decayed teeth in the preschool population are being treated before they enter the plan. Currently the cost of treating four year olds is not being avoided, it is just being deferred.

We therefore encourage the Department of Health to reintroduce four year olds into the Saskatchewan Health Dental Plan.

Issue II - Dental Education Review Committee

We understand that the Departments of Health, and Advanced Education and Manpower are working together with representatives from the College of Dentistry, Wascana Institute and Kelsey Institute on a committee with a mandate to examine a wide-range of issues related to the training of dental health personnel in Saskatchewan.

This committee, formed in 1985, has stimulated a lot of speculation, rumors and concern within the dental community. We contacted Ian Thomas in the spring of 1986 to express our interest in the work of the committee and to volunteer our input. Sid Smith later wrote to us, giving us an opportunity to respond to six statements by August 31st, 1986. We did that and were then invited to present our ideas in person to the committee, again as it related to the six statements. We have been unable to establish from the communications we have had with this group, 1) what are their goals, 2) what will likely happen as a result of their more than a year of work and meetings and 3) when they plan to draw up their conclusions and present them?

We appreciate that a committee of this type is necessary as many factors influencing supply and demand are changing significantly. Our main concern is that the viability of the Saskatchewan Health Dental Plan is not put in jeopardy by the committee's recommendations, and that Dental Therapists are allowed to continue to contribute to dental health success story that is unfolding in Saskatchewan.

Issue III - Improving Dental Care Opportunities for Senior Citizens

Dental Therapists were created originally to deliver quality preventative and restorative dental care to children in all regions of Saskatchewan. Prior to the creation of the Saskatchewan Health Dental Plan and dental therapists these services were not readily available in many rural communities. Presently dental therapists are located in approximately 75 communities throughout Saskatchewan, including locations in the remote north. We have accomplished what was expected of us, we now look forward to contributing to the successful accomplishment of other goals.

We anticipate that one of the goals of the Department of Health is to

increase the opportunities senior citizens have, to receive dental care. The Department of Health has done much to improve the health and well being of the Seniors in the past few years and making dental care more available would compliment this trend.

Dental Therapists feel by virtue of our accomplishments, specifically

1) Public acceptance
2) Delivery of quality care
3) Participation in continued education, willingness to learn new skills
4) Demonstration of a high level of professionalism
5) Stable work force - low attrition rate
6) Successful employment in Private Practice and Public Service

that we should be considered as potential dental health care providers if a Geriatric Dental Program, becomes a reality. Whether it be administered by the Department of Health or the College of Dental Surgeons. We accept the fact that further education would be desirable and that we would not likely work as indirectly supervised as we do in the children's program. We feel we have a lot to offer and want to be considered favorably should a program be created.

Issue IV - Rewriting of Health Professions Act

It is our understanding that the Department of Health is currently conducting a review of the Acts related to health professionals. As our Act requires some amendments, we welcome the review. The amendments, we with the aid of legal counsel, have requested be approved by the Minister, deal with the area of discipline.

Discipline has not been a major problem for our profession but should a case arise we are currently in a poor position to deal with it. We would like to know if possible when we might expect a response to our request for amendments and what type of response it might be.

5) Conclusion

Dental Therapists and the Saskatchewan Dental Therapists Association are a caring and concerned group of professionals. We have maintained and promoted a high standard of discipline of Dental Therapists. We are working for the well being of the public, in our chosen areas of dental expertise. The Saskatchewan Dental Therapists Association is striving to continue improving our profession by remaining open to change, and by welcoming opportunities to further our education, expand our functions and thus serve the population more effectively.

We understand this is a time of restraint! We realize that the Department of Health does have many concerns and issues to deal with, but we felt we should grasp the opportunity to talk with you in person. We greatly appreciate the time you've provided from your work schedule to meet with us.

APPENDIX B

DENTAL AUXILIARIES DEFINED

In an attempt to summarize and simplify the distinguishing roles of each of the three types of dental auxiliaries, the following definitions are presented.

A certified dental assistant is an individual who contributes to the dental health of patients by assisting the clinician in the performance of dental treatment. The services provided by the dental assistant which are unique to this profession are chairside duties, for example, preparation of dental materials and maintenance of a clear working field.

A dental hygienist is an individual who contributes to the dental health of patients by providing treatment and education aimed specifically at the prevention of dental disease. The procedures unique to the dental hygienist are the techniques necessary in the removal of deposits below the normal level of gingival attachment.

A dental therapist is an individual who contributes to the dental health of patients by providing basic preventive and restorative services. Duties unique to dental therapy are the preparation of teeth for restorations, including pulpotomies, pulp capping and stainless steel crowns, fitting and placing space maintainers, and extraction of primary teeth.

A dental therapist/hygienist is an individual who contributes to the dental health of patients by providing basic restorative care and periodontal treatment.

DENTAL AUXILIARIES DESCRIBED

In an attempt to acquaint the reader with the general services each of the three types of dental auxiliaries provide, the following descriptions are presented.

The Dental Assistant:

The dental assistant; referred to as a Certified Dental Assistant (C.D.A.) once they have graduated and have registered and licensed with the College of Dental Surgeons of Saskatchewan, perform specialized clinical and chairside assisting duties while assisting a dentist, dental therapist or dental hygienist. They also work independently providing patient care. Some of the services they provide directly to the patient are:

- taking of dental radiographs
- taking impressions
- diet counselling
- oral hygiene instruction
- polishing the teeth
- applying topical fluorides
- placing and removal of rubber dam
- application of fissure sealants
- polishing amalgam restorations
- taking and recording gingival and plaque indices

The Dental Hygienist:

The dental hygienist, referred to as a Registered Dental Hygienist (R.D.H.) once they have graduated and have registered and licensed with the College of Dental Surgeons of Saskatchewan, can work in the following capacities: clinical practitioner, health educator, faculty member, manager,

consultant or researcher. The majority of Registered Dental Hygienists are employed as clinical practitioners and in that capacity, provide the following general services to patients in the dental office under the supervision of a member of the College of Dental Surgeons:

- perform screening exams and record abnormal conditions
- take dental radiographs
- take impressions and make study models
- assess oral hygiene and provide oral hygiene instruction
- perform complete prophylaxis, root planing and curettage
- polish amalgam restorations and remove minor overhangs
- apply desensitizing agents, fissure sealants and topical fluorides
- business and general office duties
- take and record vital signs
- place and finish restorations
- perform surgical curettage
- administer local anesthetic
- fabricate mouthguards

The Dental Therapist:

The dental therapist, referred to as a Saskatchewan Dental Therapist (S.D.T.) once they have graduated and have registered and licensed with the Saskatchewan Dental Therapists Council, provides basic preventive and restorative services. They were employed primarily by the Saskatchewan Health Dental Plan to care for the dental needs of Saskatchewan children utilizing school based dental clinics, until July of 1987. They are also eligible to work in private practice providing dental treatment to patients of all ages.

The services dental therapists provide include the following general services:

- examination of patients including diagnosis and treatment planning
- application and removal of rubber dam
- intra oral administration of local anesthetic
- administration of first aid and handling of general dental emergencies
- recognition and referral of clinical and radiographic abnormalities and health related problems
- patient, classroom and community education in oral health
- removal of visible deposits and stains
- polishing of clinical crowns
- application of pit and fissure sealants; and topical fluoride
- oral hygiene instruction and diet counselling
- preparing for and placing of permanent restorations in primary and permanent teeth, including stainless steel crowns on primary teeth
- pulpotomy on primary teeth
- finishing and polishing of dental restorations
- extraction of primary teeth
- placement of space maintainers
- fabricating mouthguards
- taking impressions and fabricating dental study models

The Dental Therapist/Hygienist

The dental therapist/hygienist is a dental auxiliary educated and qualified to provide all the services outlined in the descriptions headed The Dental Therapist and The Dental Hygienist.