

**EXPANDING DENTAL HEALTH CARE IN INDIAN
COUNTRY;
PROMISES MADE, PROMISES BROKEN: THE
IMPACT OF CHRONIC UNDERFUNDING OF
CONTRACT HEALTH SERVICES**

HEARING

BEFORE THE

**COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE**

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

DECEMBER 3, 2009

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EXPANDING DENTAL HEALTH CARE IN INDIAN COUNTRY

THURSDAY, DECEMBER 3, 2009

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:41 p.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We will now convene the hearings. We have two hearings, and as I indicated previously, we thank all of you.

The first hearing is on expanding dental health care in Indian Country. And what we are going to do is begin with the witnesses for that hearing.

Dr. Ronald Tankersley is with us, a dentist from the American Dental Association, President, actually; Ms. Evangelyn "Angel" Dotomain, the President and CEO of Alaska Native Health Board; Dr. Patricia Tarren, Staff Pediatric Dentist, Department of Dentistry at Hennepin County Medical Center in Minneapolis.

If the three of you will take your seats, we will begin testimony. When it is required for us to be present at the vote, we will go to the end of the first vote, then cast the beginning of the second vote and be back as quickly as we can.

We have two items on our hearing list today. The first is on dental health care and the second is on contract health services. So we want to try to get through these in reasonable time, and I appreciate the cooperation of everyone.

Dr. Tankersley, you are President of the American Dental Association. We are pleased that you are here and your entire statement will be a part of the permanent record, so you may summarize. Why don't you proceed?

STATEMENT OF RONALD L. TANKERSLEY, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION (ADA)

Dr. TANKERSLEY. Mr. Chairman and Members of the Committee, I am Ron Tankersley, President of the American Dental Association, which represents 157,000 dentists across the Country. I am a practicing oral and maxillofacial surgeon in Newport News, Virginia.

Let me begin by thanking you for your efforts to reauthorize the Indian Health Care Improvement Act which contains so many important provisions to improve the health of American Indians and Alaska Natives. Enactment is long overdue.

I have been asked to appear before you to discuss our position on whether to expand the new dental health aide therapist position, which is currently being tested in frontier Alaska, into other areas of the Country.

You know from our previous testimony that the ADA does not support delegating surgical procedures to those without the comprehensive education of dentists. So we are opposed to Congress expanding the Alaska therapist model.

To us, it is not a matter of whether similar providers exist in other countries. The U.S. has higher education standards than many other countries, and currently in this Country, surgical services are not delegated to any health care provider with just two years of post-high school education. Even nurse practitioners who have six years of higher education and training are not given surgical privileges.

The real question is whether establishing such a position, with the attending challenges of recruiting, educating, training, supervising and regulating such providers, is the best solution for improving access to oral health in the tribal areas.

Furthermore, we believe that recent events make expanding that model even less necessary than in the past. Specifically, the drastic shortage of dentists in the Indian Health Services is finally being addressed. This year alone, there will be 70 additional dentists providing care in tribal areas. With one more year of similar recruiting success, the shortage of dentists in IHS could actually be eliminated. No other action could have more significant impact upon increasing access to surgical oral health care in tribal areas with profound needs.

The ADA has played a critical role in this success. Working with the Indian Health Service to create a fund for dental summer extern programs and lobbying to increase student loan repayments for dentists hired by the Service or the tribes. Last year, over 300 dental students applied for 150 openings for the extern program.

This year, the ADA successfully advocated for increased funding to double the number of summer dental externs in 2010. We believe that this will lead to more young dentists choosing to work in tribal areas, reducing even further the need to look for other models to provide surgical dental care.

That said, we agree with many others that innovations in the dental team could help increase access to dental services in under-served areas, including tribal lands. For example, the expanded function dental assistant model has been used with great success in the United States military. We also strongly support the creation of new innovative dental workforce models that parallel that of medical community health aides.

The ADA is currently funding and pilot testing such a model, the Community Dental Health Coordinator. We call that the CDHC. Our initial classes of CDHCs will work in rural, urban and tribal areas. These allied dental personnel come from the under-served communities in which they will work. They are trained to provide

community-focused oral health promotion, prevention and coordination of care.

And importantly for this discussion, the CDHC Program will be independently evaluated during the pilot phase before the program is actually replicated in other areas.

We all agree that American Indians and Alaska Natives deserve access to the same oral health care as the rest of the population. Accordingly, the ADA asks Congress to focus on eliminating dentist shortages and supporting workforce innovations that increase efficiency and focus on prevention, while still ensuring that the people who need surgical care receive that care from fully trained dentists.

Thank you. I appreciate the opportunity to speak.

[The prepared statement of Dr. Tankersley follows:]

PREPARED STATEMENT OF RONALD L. TANKERSLEY, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION (ADA)

Mr. Chairman and Members of the Committee:

I am Dr. Ron Tankersley, president of the American Dental Association (ADA), which represents 157,000 dentists around the country. I am a practicing oral and maxillofacial surgeon from Newport News, Virginia.

Let me begin by thanking you for your efforts to reauthorize the Indian Health Care Improvement Act. Enactment of this legislation, which contains so many important provisions to improve the health of American Indians and Alaska Natives, is long, long overdue.

I have been asked to appear before you to discuss our position on whether to expand the new dental health aide therapist position currently being tested in frontier Alaska into other areas of the country. You know from previous ADA committee testimony that the ADA does not support delegating surgical dental procedures to those without the comprehensive education of dentists. So, we are opposed to Congress expanding the Alaska therapist model.

To us, it's not a matter of whether similar providers exist in other countries. The United States has higher educational requirements than many other countries. Currently in this country, surgical services are not delegated to any healthcare providers with just two years of post-high-school training. Even nurse practitioners, with six years of education and training, are not given surgical privileges.

The real question is whether establishing such a position, with the attending challenges of recruiting, educating, training, supervising, and regulating such providers, is the best solution for improving access to oral health care in tribal areas.

Furthermore, we believe that recent events make expanding that model even less necessary than in the past. Specifically, the drastic shortage of dentists in the Indian Health Service (IHS) is finally being addressed—this year alone there will be 70 additional dentists providing care in tribal areas. With one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated. No other action could have a more significant impact upon increasing access to surgical oral healthcare in tribal areas with profound need.

The ADA has played a critical role in this success, working with the IHS to create and fund a dental summer extern program and lobbying to increase student loan repayments for dentists hired by the Service or tribes. Last year, over 300 dental students applied for 150 openings in the extern program. This year, ADA successfully advocated for increased funding to double the number of summer dental externs in 2010. We believe that this will lead to more young dentists choosing to work in tribal areas, reducing even further the need to look for other models to provide surgical dental care.¹

We agree with many that innovations in the dental team could help increase access to dental services in underserved areas, including tribal lands. For example, the expanded function dental assistant model that has been used with great success by the U.S. military. We also strongly support the creation of new innovative dental workforce models that parallel that of medical community health aides. The ADA is currently funding and pilot testing one such model, the Community Dental Health Coordinator (CDHC).

¹See attachment for additional ADA activities on behalf of IHS/tribal oral health.

Our initial classes of CDHCs will work in rural, urban, and tribal areas. These allied dental personnel come from the underserved communities in which they will work and who will provide community-focused oral health promotion, prevention, and coordination of dental care. And importantly, for this discussion, the CDHC program will be independently evaluated during the pilot phase before the program is replicated in other areas.

To qualify for a CDHC credential, an individual will have to be a high school graduate and complete a 12 month series of classes, with 3–6 months of on-site practice depending on the student's prior experience. The individual will have to be trained at a Commission on Dental Accreditation (CODA) approved training site. Working under a dentist's supervision in health and community settings (such as schools, churches, senior citizen centers, and Head Start programs) and with people who have similar ethnic and cultural backgrounds, CDHCs will:

- Provide individual preventive services, such as screenings, fluoride treatments, placement of sealants, and simple teeth cleanings.
- Place temporary fillings in preparation for restorative care by a dentist.
- Help patients and/or their caregivers navigate through the maze of health and dental systems to assure timely access to care and to help prevent reoccurrence of the Deamonte Driver tragedy.
- Collect information to assist the dentist in the triage of patients, which will enhance delivery system effectiveness and efficiency.
- Overcome the barriers to seeking care by working with community leaders to promote oral health literacy and nutritional literacy and to address additional social and environmental barriers, such as assistance with transportation issues and enrollment in publicly funded programs.

We all agree that American Indians and Native Alaskans deserve access to the same oral health care as the rest of the population. Accordingly, the ADA asks Congress to focus on eliminating dentist shortages and supporting workforce innovations that increase efficiency and focus on prevention while still ensuring that people who need surgical care still receive that care from fully trained dentists.

Thank you.

Attachment

American Dental Association's American Indian/Alaska Native Activities

The ADA is the founding member of the "Friends of Indian Health", which works to ensure adequate funding for the Indian Health Service and tribal health programs, including oral health care services. And each year the ADA aggressively lobbies the United States Congress to ensure the dental health programs funded by the Indian Health Service (IHS) receive adequate appropriations dollars. In addition:

American Indian/Alaska Native (AI/AN) Dental Placement Program

In 2005, the ADA hired a full time staffer to develop a volunteer dentist program for Indian Country. To date, volunteer dentists have served at 13 sites in eight states, including North Dakota.² In Minnesota we have sent 17 dentists on 19 trips. In November 2009, the ADA sponsored a team of eight prosthodontists, who travelled to Taos-Picuris Health Center (NM) for one week to provide full and partial dentures to local patients. The ADA continues to recruit, assign and coordinate volunteer dentists and dental students to serve at Indian Service (IHS) and/or tribal clinics.

Indian Health Service Externship Program Support

Since 2008, the ADA has financially sponsored 18 dental students who provided practical support for upper classmen who are participating in the IHS externship program. This provided the chance for more dental students to participate in the IHS dental extern program, a key recruitment activity. The current vacancy rate for IHS dentists has dropped from 140 last year to 67 today. We believe that some of that success is due to the IHS summer extern program. Last year over 300 dental students applied for 150 openings. The IHS has reported that their positive summer experience makes them great ambassadors to their dental school colleagues. As a

²Alaska (Bristol Bay Area Health Corporation/Togiak), Arizona (Hopi Health Care Center/Pollaca), Maine (Presque Isle), Minnesota (Cass Lake, Red Lake and White Earth Health Centers), New Mexico (Taos-Picuris Health Center), North Dakota (Belcourt and Fort Yates), South Dakota (Pine Ridge, Rosebud and Wagner) and Wisconsin (Menominee Tribal Clinic/Keshena).

result of this program the ADA successfully advocated for additional funding in FY 2010 to double the number of summer dental externs.

Summit on American Indian/Alaska Native Oral Health Access

In 2007, the ADA hosted the Summit, which included more than 100 participants, public and private interests, from tribal organizations, local communities, state dental societies, dental educators, specialty organizations, the U.S. Public Health Service, philanthropy and the Association.³ The Summit focused around the question, “What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaskan Native people?”

At the conclusion of the Summit, all participants agreed to work on activities related to the following seven AI/AN oral health focus areas:

1. Creating a new paradigm for improving the dental workforce;
2. developing collaborative strategies for lobbying, funding, policy making, etc.;
3. designing research and implementing “best practices” for the prevention of oral disease, including early childhood caries;
4. fostering broader community involvement to identify oral health issues and their solutions;
5. advocating for a fully funded IHS/Tribal/Urban (ITU) dental program;
6. building trust among the partners/communities of interest; and
7. encouraging meaningful tribal empowerment in oral health policy making.

American Indian/Alaska Native Strategic Workgroup

The AI/AN Strategic Workgroup is comprised of leaders for the action team areas identified during the 2007 Summit. The Workgroup continues to meet two times per year to foster and maintain collaborations for effective advocacy, research, policies and programs at the local, regional and national levels, resulting in: (1) increased access to oral health care, (2) reduced oral health disparities, and (3) improved prevention of oral disease. One outcome of this continued effort was a FY 2009 joint appropriations request seeking \$1 million for research into the unique causes and needed new treatments for tooth decay among AI/AN children. The Strategic Workgroup also identified a long term funding plan for the IHS dental program. The ADA conveyed that message in an April 2009 letter to President Obama. Tribal members of the AI/AN Strategic Workshop planned to work with their organizations to send similar letters to the Administration.

Symposium on Early Childhood Caries in American Indian and Alaska Native Children

In October 2009, the ADA co-hosted, with the IHS, the Symposium on Early Childhood Caries (ECC) in American Indian and Alaska Native (AI/AN) Children. The Symposium was attended by national and international ECC experts; Indian Health Service dental, pediatric and child development personnel; and local tribal representatives. There was a consensus among Symposium participants that early childhood caries among AI/AN children represents a different disease from that experienced by other populations of children: it starts earlier, follows a more aggressive course, results in a much higher burden of disease for the children and their families, and has been refractory to many years of determined efforts to control it using intervention strategies found effective in other populations. Control of ECC among AI/AN children thus requires new approaches which are likely to be multimodal in nature with an enhanced emphasis on the infectious etiology of the disease. It will also require development of new metrics with which we can better characterize the disease and measure the effectiveness of new prevention approaches. Symposium participants intend to present a research agenda to the National Institute of Dental and Craniofacial Research and similar entities.

Pathways Into Health

In 2008 and 2009, the ADA co-sponsored the Pathways Into Health (PIH) annual conference. PIH is a grassroots collaboration of more than 150 individuals and organizations dedicated to improving the health, health care and health care education of American Indians and Alaska Natives. PIH recognizes that an important factor

³Stakeholder Groups: (1) Indian Health Service Area Dental Officers and Headquarters Personnel, (2) State Dental Societies, (3) Local Tribal Health Programs, (4) American Dental Association, (5) Indian Health Service Dental/Clinical/Preventive Support Programs and Other Local Programs, (6) Specialty and Special Interest Oral Health and General Health Care Organizations, (7) Regional Health Boards and Philanthropic Organizations, (8) Dental Education.

to improving the number of health care providers serving in Indian country is to “grow your own” and has developed distance education and mentoring programs to ensure that AI/AN students succeed in becoming health care providers. ADA personnel serve on the PIH advisory committee.

Society of American Indian Dentists (SAID)

Dr. Lindsey Robinson, ADA CAPIR Council chair represented the ADA at the Society of American Indian Dentists’ annual meeting, April 30-May 3, 2009 at University of California, Los Angeles. Dr. Robinson gave a presentation about ADA access to care activities, highlighting advocacy and programs for AI/AN populations.

ADA Institute for Diversity in Leadership

Two Summit participants; Dr. Alyssa York, dental director, Inter Tribal Council of Arizona and Ruth Bol, secretary/treasurer, SAID; were accepted to participate in the ADA’s Institute for Diversity in Leadership, a three-part personal leadership training program designed to enhance the leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been traditionally underrepresented in leadership roles in the profession.

The CHAIRMAN. Dr. Tankersley, thank you very much.

Evangelyn Dotomain? Thanks for being here and you may proceed.

**STATEMENT OF EVANGELYN “ANGEL” DOTOMAIN,
PRESIDENT/CEO, ALASKA NATIVE HEALTH BOARD**

Ms. DOTOMAIN. Good afternoon and thank you for the opportunity to testify today. I am honored to be here. My name is Angel Dotomain. It is much easier. I am President and CEO of the Alaska Native Health Board.

In response to extensive dental health needs and high dental vacancy rates, the Alaska Dental Health Aide Therapist Program began in 2003. It is part of the Community Health Aide Program, which is authorized under Section 119 of the Indian Health Care Improvement Act.

Following the CHAP model, the DHAT Program selects individuals from rural Alaska communities to be trained and certified to practice under general supervision of dentists in the Alaska Tribal Health System.

Alaska Native children and adolescents suffer dental caries rates at 2.5 times greater than the general U.S. child and adolescent population. This, combined with a vacancy rate of 25 percent and 30 percent turnover rates in dentists, has developed into a serious problem in Alaska dental care.

Indian Country, in fact, has about half the number of dentists per capita, at 33 per 100,000. With the number of dentists expected to decline, there is clearly not an adequate supply in the distribution of dentists to meet the basic dental health needs of America’s first people. Dental therapists can help to fill the gap to provide desperately needed services where dental services are limited or do not exist at all.

At a time when Indian Country lags behind the rest of the Country in access to service, isn’t it time for us to be at the forefront of the health care delivery model? The DHAT Program, if expanded, would allow for that to happen in our Country, and for the first time, American Indians and Alaska Natives would be the first to benefit from a positive health care change.

The Alaska DHAT Training Program is modeled after the New Zealand National School of Dentistry in Otago. New Zealand’s den-

tal therapists have been highly valued for over 80 years. In fact, over 14,000 dental therapists operate in over 53 countries worldwide, including Canada, The Netherlands, Australia, Great Britain and Malaysia. The United States is the only industrialized nation without a mid-level dental provider available to its citizens.

Alaska's DHATs receive extensive training, certification, continuing education and clinical reviews to ensure that their skills are of the highest quality. In 2007, the Alaska Native Tribal Health Consortium and the University of Washington's MEDEX Program opened DENTEX, the first DHAT training center in the United States.

The DENTEX Program is extremely rigorous. Students receive 2,400 hours of training over two years, spending one year in Anchorage and one year in Bethel. They utilize the same textbooks as dental students. DHATs are trained with the same high quality level of care dentists would, within their limited scope.

DHATs are trained to provide oral health education, preventive services, fillings, and uncomplicated extractions to preserve function and address pain and infection. In addition to their two-year training, DHATs are required to perform at least a 400-hour preceptorship program with their supervising dentist.

Only after the DHAT completes that clinical preceptorship are they eligible for certification. Each DHAT must apply for and receive certification to the Indian Health Service Community Health Aide Program Certification Board. DHATs must be recertified every two years, which includes multiple direct observation of skills and complete 24 continuing education hours per two-year period.

There are currently 10 practicing DHATs who were trained in New Zealand, and three who were trained at the DENTEX Program. There are 14 in DENTEX training and on December 11th will graduate seven more.

In recent independent studies, DHAT skills were assessed to determine if they are on par with dentist-provided services and quality of care. The results of an early study noted that the program deserves not only to continue, but to expand. In a recent pilot study, there was found to be no significant difference between irreversible dental treatment provided by DHATs in comparison to dentists, and no significant difference in reportable events.

Like the community health aide, the DHAT has become an essential part of dental health delivery in the Alaska Tribal Health System. Their ability to provide culturally appropriate high quality care has increased Alaska Native access to proper dental services and prevention activities.

It is exciting to see that other parts of the United States are looking at a dental mid-level model. DHATs are an innovative solution to the inadequate numbers of licensed dentists practicing in under-served areas, not just in rural Alaska. Because of this, we respectfully recommend this Committee urge the Indian Health Service to include DHAT Program funding in their funding request for future years.

In addition to seeing DHATs provide services, the Alaska Native Health Board is excited to see upcoming preliminary results of a study commissioned by philanthropic organizations which will determine the DHATs Program implementation integrity and conduct

a health outcome assessment addressing safety, quality and patient-oriented outcomes. The study started in the spring of 2009 and preliminary results are expected in the summer of 2010.

It has come to our attention that the current philanthropic evaluation meets all but one evaluation request set aside for review by the Secretary of Health and Human Services. Thus, we also respectfully recommend that the Committee utilize the current study for all of the needs of evaluation noted, rather than commissioning a new study.

With that, I thank you for your time and I am open for questions.

[The prepared statement of Ms. Dotomain follows:]

PREPARED STATEMENT OF EVANGELYN "ANGEL" DOTOMAIN, PRESIDENT/CEO, ALASKA
NATIVE HEALTH BOARD

Good afternoon and thank you for the opportunity to testify today. I am honored to be here. My name is Evangelyn "Angel" Dotomain and I am the President/Chief Executive Officer of the Alaska Native Health Board (ANHB). ANHB was established in 1968 and represents twenty-five tribal health organizations across the state of Alaska who collectively employ over 7,000 individuals and serve approximately 130,000 American Indians/Alaska Natives. Our purpose is to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people.

I am of Cupik and Inupiaq descent from the villages of Mekoryuk, Shaktoolik, and Mary's Igloo. I have been blessed to have previously worked for the Alaska Native Tribal Health Consortium (ANTHC) for approximately nine years in Education & Development, Recruitment, and in the Alaska Native Medical Center Administration office.

My testimony will address expanding dental health care in Indian country and Alaska's dental health aide therapist program. I appreciate the privilege and opportunity to share the Alaska Tribal Health System experience with the DHAT program. The DHAT program has provided high quality care that meets all the standards of care as that of a dentist within their scope of practice and exists as another example of innovations to ensure access to high quality care in Alaska.

Background

In response to extensive dental health needs and high dental vacancy rates, the Alaska Dental Health Aide Therapy (DHAT) program began in 2003. The DHAT program is part of the Community Health Aide Program (CHA Program), which is authorized under Section 119 of the

Indian Health Care Improvement Act, 25 U.S.C. § 1616*l*. The CHA Program started in the 1960s by the Indian Health Service to provide emergency, clinical, and preventive services under general supervision of physicians. Following the CHA Program model, the DHAT program selects individuals from rural Alaska communities to be trained and certified to practice under general supervision of dentists in the Alaska Tribal Health System.

The Alaska DHAT program was created in part due to the high rates of dental caries and overall lack of access to dental services in rural Alaska villages. Alaska Native children and adolescents suffer dental caries rates at 2.5 times greater than general US children and adolescents.¹ This, combined with a vacancy rate of 25% and 30% annual turnover rates in dentists has developed into a serious problem in Alaska dental care.²

Nationally, with the number of dentists declining from 60 per 100,000 currently to an expected 54 per 100,000 in 2030 (ADA), there is clearly not an adequate supply and/or distribution of dentists to meet the basic oral health needs of America's First People. The great unmet need for dentists or other oral health providers in Indian Country, where there are, on the average, about half the dentist-to-population ratio of the national average, is well-documented.³ According to the Indian Health Service: "The fact that dental decay affects more than 75 percent of AI/AN people presents a major challenge requiring a large-scale public health approach."⁴ Based on our experiences in Alaska, we could not agree more. Dental Therapists can help to fill the gap to provide desperately needed services where dental services are either limited or do not exist at all.

Dental Therapists Worldwide

The Alaska DHAT training program is modeled after New Zealand's National School of Dentistry in Otago. New Zealand's Dental Therapists have been highly valued for over 80 years and are providing high quality care. In fact, over 14,000 dental therapists operate in over 53 countries worldwide. The United States is the only industrialized nation without a midlevel dental practice available to its citizens.

Dental therapists have been in practice for many years world wide especially in

¹ Smith EB. Dental therapists in Alaska: addressing unmet needs and reviving competition in dental care. *Alaska Law Review*. 2007;24(1):105-43. Nash DA, Nagel RJ. Confronting oral health disparities among American Indian/Alaska Native children: the pediatric oral health therapist. *Am J Public Health*. 2005;95(8):1325-1329. One-third of school-age children in rural Alaska miss school because of dental pain, and a quarter report avoiding laughing or smiling because of the appearance of their teeth. *Ibid*. Oral Health disparities plague not only Alaska Natives, but all of Indian Country. According to the Department of Health and Human Service's Agency for Healthcare Research and Quality (AHRQ), AI/AN children between the ages of 2 and 4 have the highest rate of decay in the U.S.—five times the national average. <http://www.innovations.ahrq.gov/content.aspx?id=1840>. According to the Indian Health Service, 79 percent of AI/AN preschool children from 2 to 5 years old have a history of dental decay, 68 percent have untreated dental decay, and more than 50 percent have severe childhood cavities. http://www.ihs.gov/headstart/index.cfm?module=hs_providers_oral_health.

² Nash, DA. *Ibid*.

³ Agency for Healthcare Research and Quality, <http://www.innovations.ahrq.gov/content.aspx?id=1840>.

⁴ Indian Health Service, http://www.ihs.gov/headstart/index.cfm?module=hs_providers_oral_health.

children's oral health services and have shown they provide high quality care. For example, since 1963, Canadian dental therapists have been providing excellent care equal to or exceeding the quality of care of dentists and they have been more cost-effective.⁵ In the Netherlands, there is greater investment in a dental therapist/dental hygienist combination and a 20% reduction in dental school numbers to improve access to care and decrease care cost.⁶ With no litigation or malpractice suits in over 50 years, Malaysian dental therapists have proven their worth in the treatment of children's dental needs.⁷ Dental therapists have proven their ability through high quality care worldwide.

DHAT Program Information

Alaska's DHATs receive extensive training, certification, continuing education, and clinical reviews to ensure their skills are of the highest quality. Alaska's first DHATs received their training New Zealand's National School of Dentistry in Otago. The first DHATs graduated in 2004. In 2007, the Alaska Native Tribal Health Consortium in partnership with the University of Washington's MEDEX Northwest Physician Assistant Training Program opened DENTEX, the first DHAT training center in the United States. The DENTEX goal is to provide culturally sensitive patient-centered care to optimize prevention to ensure that patients feel comfortable enough to return for continued care and treatment.

The DENTEX program is extremely rigorous. Students receive two years of training in biological science, social science, pre-clinic, and clinic training. The students receive 2400 hours of training and clinical experience during their first year in Anchorage and during their second year in Bethel, Alaska. Utilizing the same textbooks as dental students, DHATs in training are trained to provide the same high quality level of care a dentist would within their limited scope. The DENTEX faculty, most from dental schools, ensures that the students meet all skill requirements throughout their training. The training also consists of extensive clinic training. In fact, 20% of the first year of training and 78% of the second year of training consists of clinical components.

DHATs are trained to provide oral health education, preventive services, fillings, and uncomplicated extractions to preserve function and address pain and infection. DHATs are able to provide atraumatic restorative technique, placement of temporary restorations, simple restorations, simple extractions, lab processed crowns, pulpotomy, and pulp capping just to name a few. In addition, DHATs provide community education, many times in schools for young children and to families who visit the clinics.

An additional requirement of participating in the program is for each student to have a sponsor agreement with a tribal health organization for which they will work after graduation and certification. The sponsoring tribal health organization covers the costs of the student's training for the two year program in return for four years of service. In addition, the sponsoring organization provides a supervising dentist for the DHAT.

⁵ Nash, DA. Dental Therapists: A Global Perspective, *Int'l Dental Journal*, 58:61-70 (2008).

⁶ *Ibid.*

⁷ *Ibid.*

In addition to the agreement and extensive training, the student must complete a preceptorship of at least 400 hours with their supervising dentist. Since the DHAT will be practicing under the general supervision of the supervising dentist, it is during this preceptorship time that the supervising dentist and DHAT agree on the DHAT's scope of practice. The preceptorship time also allows the dentist and DHAT to develop a rapport as they will be in constant communication once the DHAT is at their permanent station many times talking telephonically three to six times per day, communicating via e-mail and/or telemedicine consultations regarding patient needs.

Only after the DHAT completes this clinical preceptorship are they eligible for certification. Each DHAT must apply for and receive certification to the Indian Health Service's Community Health Aide Program Certification Board. This independent federal board serves to credential providers and respond to issues and patient complaints. In addition, this board ensures standards for discipline, suspension or revocation of a certificate are met.

Once DHATs are trained, complete their preceptorship, and are certified, they begin work at their respective tribal health organization. However, their review and education does not stop there. DHATs must be recertified every two years and complete continuing education hours. A DHAT review consists of direct observation of each service performed eight times every 2 years. They are also required to complete 24 hours of continuing education per two year cycle.

Current DHATs

There are currently ten practicing DHATs who were trained in New Zealand and three who were trained at DENTEX. These DHATs work for the following tribal health organizations: Norton Sound Health Corporation (NSHC), Maniilaq Association (Maniilaq), Yukon Kuskokwim Health Corporation (YKHC), SouthEast Alaska Regional Health Consortium (SEARHC), Bristol Bay Area Health Corporation (BBAHC), Metlakatla Indian Community (MIC), and Mount Sanford Tribal Consortium (MSTC). In addition to these tribal health organizations having current DHATs practicing, the following tribal health organizations are sponsoring DHATs in their second clinical year of DENTEX: YKHC, BBAHC, Tanana Chiefs Conference (TCC), and Aleutian Pribilof Islands Association (APIA). The following tribal health organizations are sponsoring DHATs in their first year of DENTEX: Council of Athabascan Tribal Governments (CATG), YKHC, Eastern Aleutian Tribes (EAT), Maniilaq, and BBAHC. In total, there are thirteen DHATs currently practicing and fourteen in DENTEX training. Please see map of DHAT location information attached.

In recent independent studies, DHAT skills were assessed to determine if they are on par with dentist provided services and quality of care provided by DHATs.⁸ The results of an early study noted that the "program deserves not only to continue by to expand" and that suggestions that dental therapists "cannot be trained to provide competent and safe primary care for Alaska Natives is overstated."⁹ In a recent pilot study, there was found to be no significant difference between irreversible dental treatment provided by DHATs or dentists and no significant

⁸ Agency for Healthcare Research and Quality, <http://www.innovations.ahrq.gov/content.aspx?id=1840>.

⁹ Louis Fiset. *A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives* (Seattle, WA: University of Washington School of Dentistry, 2005).

difference in reportable events.¹⁰ Dr. Bolin noted:

One of the main objections to the solution of expansion of duties to nondentists was the issue of quality of care. Some who are opposed to treatment provided by DHATs have suggested that it is “second-class care” or, since DHATs do not have dental licenses, that they are practicing dentistry without a license and, therefore, could be “unsafe.”

...
The opposition has occurred despite study results showing that DHATs can perform primary care procedures comparably to dentists, and that DHAT trainees perform equally well compared with dental students.

Id. (citations deleted).

Next Steps

Like the Community Health Aide, the DHATs have become an essential part of the dental health care delivery model in the Alaska Tribal Health System. Their ability to provide culturally appropriate, high quality care has increased Alaska Native access to proper dental services and prevention activities. In addition, these individuals have become role models for young people sharing and teaching them there are options and careers available to them. DHATs continue to thrive and prove their worth just as dental nurses and therapists have worldwide.

It is exciting to see other parts of the United States are looking at a dental mid-level model. The Alaska Native Health Board believes that dental therapists can be extremely helpful in combating dental disease and increase the level of oral health throughout Indian country and the nation. DHATs are an innovative solution to the inadequate numbers of licensed dentists practicing in underserved areas, not just rural Alaska. Recently, the Minnesota Legislature approved the Oral Health Practitioner consisting of the Dental Therapist and the Advanced Practice Dental Therapist with graduates expected in summer of 2011.¹¹

In addition to seeing DHATs provide services, the Alaska Native Health Board is excited to see the preliminary results of a study commissioned by philanthropic organizations (Rasmuson, W.K. Kellogg, and Bethel Community Services Foundations) who are covering all costs of the evaluation which will determine the DHAT program’s implementation integrity and conduct a health outcome assessment addressing safety, quality, and patient-oriented outcomes. The study is being conducted under extensive review by two advisory committees; one national and one state. The national advisory committee selected RTI International to conduct the evaluation. RTI International is the second largest non-profit research group in the United States and has experience in program evaluation and health services research. The study started in the Spring of 2009 and preliminary results are expected in Summer of 2010.

DHAT Program Needs

Major issues addressed include program funding shortfalls and evaluation needs. We respectfully recommend that this Committee urge the Indian Health Service include DHAT program funding in their funding requests for future years. It has come to our attention that the current philanthropic evaluation meets all but one evaluation request set aside for review by the Secretary of Health and Human Services. Thus, we also respectfully recommend that the Committee utilize the current study for all other needs of evaluation noted rather than commission a new study.

¹⁰ Kenneth A. Bolin. *Quality Assessment of Dental Treatment Provided by Dental Health Aide Therapists in Alaska*. Paper presented at the National Oral Health Conference; 2007 May 1.

¹¹ Minnesota Board of Dentistry Newsletter 24:2 (September 2009).

Senator FRANKEN. Thank you, Mr. Chairman.

I want to introduce Dr. Patricia Tarren.

Thank you, Dr. Tarren, for traveling all the way from Minnesota. I know it is a great hardship. I am kidding about that. It is not so bad and I do it all the time.

Dr. Tarren is a pediatric dentist at the Hennepin County Medical Center, which is a great safety net hospital about four blocks from my house. And you have first-hand experience supporting mid-level dental providers and serving patients who face serious barriers to dental care, and we thank you for being here today.

STATEMENT OF PATRICIA TARREN, STAFF PEDIATRIC DENTIST, DEPARTMENT OF DENTISTRY, HENNEPIN COUNTY MEDICAL CENTER

Dr. TARREN. Good afternoon, Chairman Dorgan, Members of the Committee. My name is Patricia Tarren. I am a pediatric dentist at Hennepin County Medical Center.

I am here to testify regarding the amendment that Senator Dorgan had proposed restricting further expansion of dental therapists on Indian lands and prevent the Indian Health Services from providing or covering dental therapist services.

I am really glad to hear that he is going to be working with Senator Franken on the amendment that he had proposed, but is now withdrawn, to remove that restriction.

Hennepin County Medical Center is a large safety net hospital in Minneapolis, Minnesota. We provide dental care for patients who are medically compromised, those with special needs, and the socio-economically disadvantaged. We see the medical complications that arise from dental neglect, causing considerable pain, suffering, as well as costly hospitalizations.

When I graduated from dental school in England in 1974, I worked with four dental therapists and recognized their ability to provide safe, high quality dental treatment for our patients. I was a member of the Oral Health Practitioner Work Group that reported to the Minnesota legislature to facilitate enactment of Minnesota's dental therapy law this year.

I serve on the Curriculum Advisory Committee for Metropolitan State University's Advanced Dental Therapy Program. In my hospital position, I observe the professionalism of the dental hygienists I have trained in expanded functions, delivering local anesthetic and placing fillings.

Since the inception of the dental therapist in 1921, they have been evaluated worldwide. Dozens of peer-reviewed studies have shown that they improve access, reduce costs, provide excellent quality of care, and do not put patients at risk.

They provide commitment to their community and can work under general supervision of the dentist, who need not be present. Their scope of practice is limited to certain procedures which they are trained to perform to the same level of clinical competence as a dentist.

The benefit of a dental therapist improving access to care may well depend on them working in places impossible to recruit and staff permanently with dentists. This is particularly evident on Indian lands. For example, on the Red Lake Indian Reservation in

Minnesota, the dental hygienist struggles to find care for children with extreme dental neglect. Various intermittent volunteer and training programs using private dentists and dental students have not provided an effective solution.

Further, it has been demonstrated that American Indians have better health outcomes when culturally appropriate services are available. The dental health aide therapists, DHATs, who provide dental care in the bush for Alaska tribes have had a positive impact on oral health and are appreciated by their patients. They triage patients so the neediest are prioritized for the dentist's arrival. They are instrumental in directing patients who need evacuation by air for emergency care.

Dr. Bolin, a consultant and instructor with the DENTEX Anchorage Training Program, supervises DHAT students in the bush where he continues to see very good technical work as they perform simple procedures within a narrow scope of practice. The results of his pilot study are reported in the *Journal of the American Dental Association*. A full evaluation of the DHAT Program is currently underway, funded by the Kellogg Foundation.

So, given the successful introduction of the Alaska DHATs, tribes in other States should be allowed to evaluate the data when published, and determine for themselves whether to utilize DHATs, rather than using this restrictive legislation to deny them that possibility.

For the benefit of all members of society, the mark of a true medical professional is to advance the science of their profession. We should, therefore, be open to the possibility of different models of allied dental professionals, just as our medical colleagues have done with nurse practitioners and physician assistants, for example.

In conclusion, to increase access for under-served patients, allow us to follow our medical colleagues and expand our dental workforce to include well trained professional dental therapists who will provide appropriate care within their scope of practice, and allow their supervising dentist to practice at the top of their license. Please do not perpetuate the status quo where the best care is reserved for those with means and there is little or no care for the rest.

I urge you to support Senator Franken's amendment to remove the restrictive language and allow the option of dental therapists to improve dental care in Indian Country.

And thank you for this opportunity to testify.

[The prepared statement of Dr. Tarren follows:]

PREPARED STATEMENT OF PATRICIA TARREN, STAFF PEDIATRIC DENTIST,
DEPARTMENT OF DENTISTRY, HENNEPIN COUNTY MEDICAL CENTER

Good afternoon Chairman Dorgan, members of the committee. My name is Patricia Tarren. I am here to testify regarding an amendment by Sen. Dorgan which restricts further expansion of dental therapists on Indian lands and prevents the Indian Health Service (IHS) from providing or covering dental therapist services.

I support Sen. Franken's amendment to remove this restriction from the legislation thus allowing potential expansion of the dental therapist's important and cost-effective role in improving oral health on Indian lands.

I am a staff pediatric dentist at Hennepin County Medical Center, a large safety net hospital in Minneapolis, Minnesota. We provide dental care for patients who are medically compromised, those with special needs, and the socioeconomically disadvantaged. We see the medical complications that arise from dental neglect, causing considerable pain, suffering, as well as costly hospitalizations.

When I graduated from dental school in England in 1974, I worked with four dental therapists, and recognized their ability to provide safe, high quality dental treatment for our patients. I was a member of the Oral Health Practitioner Work group that reported to the Minnesota legislature to facilitate enactment of Minnesota's Dental Therapy Law this year. I serve on the curriculum advisory committee for Metropolitan State University's Advanced Dental Therapy Program. In my hospital position, I observe the professionalism of the dental hygienists I have trained in expanded functions – delivering local anesthetic and placing fillings.

Since the inception of the dental therapist in 1921 they have been evaluated worldwide. Dozens of peer-reviewed studies have shown that they improve access, reduce costs, provide excellent quality of care and do not put patients at risk. They provide commitment to their community, and can work under general supervision of the dentist who need not be present. Their scope of practice is limited to certain procedures which they are trained to perform to the same level of clinical competence as a dentist.^{1,2,3}

The benefit of the dental therapist – improving access to care – may well depend on them working in places impossible to recruit and staff permanently with dentists. This is particularly evident on Indian lands: For example on the Red Lake Indian Reservation in Minnesota the dental hygienist struggles to find care for children with extreme dental neglect. Various intermittent volunteer and training programs using private dentists and dental students have not provided an effective solution. Further, it has been demonstrated that American Indians have better health outcomes when culturally appropriate services are available.

The dental health aide therapists (DHATs) who provide dental care in the bush for Alaska tribes have had a positive impact on oral health and are appreciated by their patients.⁴ They triage patients so the neediest are prioritized for the dentist's arrival. They are instrumental in directing patients who need evacuation by air for emergency care. Dr. Bolin, a consultant and instructor with the DENTEX Anchorage training program, supervises DHAT students in the bush where he continues to see very good technical work as they perform simple procedures within a narrow scope of practice. The results of his pilot study are reported in the Journal of the American Dental Association.⁵ A full evaluation of the DHAT program is currently underway, funded by the Kellogg Foundation.⁶

So, given the successful introduction of the Alaska DHATs, tribes in other states should be allowed to evaluate the data when published and determine for themselves whether to utilize DHATs, rather than using this legislation to deny them that possibility.

For the benefit of all members of society, the mark of a true medical professional is to advance the science of the profession. We should therefore be open to the possibility of different models of allied dental professionals, just as our medical colleagues have done with nurse practitioners and physician assistants, for example.

In conclusion, to increase access for underserved patients, allow us to follow our medical colleagues and expand our dental workforce to include well trained, professional dental therapists who will provide appropriate care within their scope of practice and allow their supervising dentist to practice at the top of their license. Please do not perpetuate the status quo where the best care is reserved for those with means and there is little or no care for the rest.

I urge you to support Sen. Franken's amendment to remove restrictive language and allow the option for dental therapists to improve dental care in Indian Country.

Thank you.

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<http://www.wkcf.org/default.aspx?tabid=1147&CID=432&NID=259&newsitem=4>

The CHAIRMAN. Ms. Tarren, thank you very much. We appreciate your coming to testify.

Let me just say at the outset, my notion of this is that we have responsibilities to provide health care for Native Americans. I have never been very interested in saying to the IHS it is okay if you don't provide full dental service. You can do something less because we are short of money, so hire people that aren't qualified to be dentists to do bona fide dental work. So that has been my notion. Why let them off the hook? Why not say let's spend the money necessary to give the First Americans the kind of dental treatment that we have said that they would get in trust agreements and treaties and so on?

On the other hand, I recognize that in Alaska, you won't find a dentist around population centers, so they have created a separate kind of dental health aide therapist and apparently quite successful for providing services in the areas where there would be no service.

So the question I have is this. The testimony by Dr. Tankersley, you talk about your support of the creation of a new innovative

dental workforce that parallels the medical community health aides. You are pilot testing a community dental health coordinator. How does that particular position that you are now training, how does that relate to the DHAT, the dental health therapist that exists in Alaska? What might be the difference between those two levels?

Dr. TANKERSLEY. Well, the community dental health coordinator is more like a medical model. You know, like a physician's assistant or whatever. In other words, they are not doing surgical services, but there are many, many services that they do which are preventive, triage, and that sort of thing.

The DHAT model in Alaska, and once again, one of the problems is with multiple DHAT models. But the DHAT model in Alaska is doing surgical services. They are extracting teeth and doing things like that, and that is the problem.

As a surgeon, I can tell you there is no such thing as a routine extraction until it is done. You just never know what you are going to run into. You know, you can run into the area around a nerve. You can get excessive bleeding and that sort of thing. So that is our concern is having unsupervised surgery done by someone, you know, who admittedly could have good technical training.

The CHAIRMAN. All right.

Let me call on Senator Murkowski and then call on Senator Franken.

Senator Murkowski?

**STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA**

Senator MURKOWSKI. Thank you, Mr. Chairman. I appreciate the hearing.

I want to welcome you, Angel. It is good to see you and I appreciate your leadership on this issue and your leadership as the CEO of the Alaska Native Health Board.

Some of the comments that have been made here today, Dr. Tankersley has indicated that the effort that is underway now within the ADA is to help eliminate the shortage that we all acknowledge exists out there in terms of the dentists, the practitioners. And you have indicated that as many as 70 additional dentists may be in the pipeline coming into IHS.

Angel, I am going to ask you this question because so much of our problem is not that there not dentists that are being trained on a daily basis coming out of dental school. It is our ability to get them into these villages on a more than once a year for one week or two week basis. And this has been our challenge and how we as a very remote, very large State have come to this mid-model that has been developed, the DHAT model.

Your family comes from Shaktoolik. How many folks live in Shaktoolik now?

Ms. DOTOMAIN. As of last week, probably about 212.

Senator MURKOWSKI. About 212. How often do the people of Shaktoolik see a dentist come to the village?

Ms. DOTOMAIN. Once a year.

Senator MURKOWSKI. And how long would that individual be there to care for the residents?

Ms. DOTOMAIN. One week.

Senator MURKOWSKI. So you get one week. So your five-year-old child or your 23-year-old young woman or you are an elder, and you have dental care that is provided to you for one week. I shouldn't say dental care provided for one week because you get your time slot with the dentist that is there. Our challenge has always been how we get these professionals.

Now, earlier in the audience there were three friends from Kotzebue, and I was asking them as we took our break. I said, how many DHATs do we have in Kotzebue now? And I am told that we have two, and I was also reminded that both of these individuals were born and raised in Kotzebue. We have now trained them and they have come back home.

I have had a chance to visit with the DENTEX program and the individuals there that are going through there. You ask them where they are from, and one is from Chevak and one is from Hooper and one is from Quinhagak. And their desire is to go back to their village.

So what we are doing is we are not sending people out to a dental school in Oklahoma or Minnesota, and hoping that they come back home. We are growing our own. And I think this is one of the facets of the DHAT Program that I think is resulting in a level of success.

Dr. Tankersley, you mentioned the concern about the unsupervised surgery. And I think we have all recognized that that is kind of where the angst comes. When you are extracting teeth, that is a permanent issue, as opposed to putting fluoride on a child's teeth.

Can you explain, Angel, how the mentoring process works within the program? If you have a DHAT in a village who does have to work a procedure, are they totally on their own? Can you just explain for the panel here?

Ms. DOTOMAIN. Absolutely not. They are in constant contact and communication with their supervising dentist.

Senator MURKOWSKI. And what does that mean? Tell us.

Ms. DOTOMAIN. What happen is the dental health aid therapist actually works under the license and supervision of their supervising dentist, usually someone located, for instance, in Unalakleet, which is 40 miles from my home town of Shaktoolik, there is a dental health aide therapist, Aurora Johnson. Born and raised in Unalakleet, she was able to go to the program in New Zealand and come home.

And she works under the license of a dentist in Nome, with the Norton Sound Health Corporation. They are in constant communication with their supervising dentist, and the agreement between the supervising dentist and the dental health aide therapist actually can sometimes limit the already limited scope of practice of the dental health aide therapist.

So they come out of the DENTEX Program with a certain scope of training, and then they spend at least 400 hours with their supervising dentist in the preceptorship program. And during that time, they can either continue to limit the scope of practice so there is an agreement between the supervising dentist and the DHAT of what their scope of practice will be, based on how the supervising dentist feels their skills are.

Aurora Johnson could be in contact with her supervising dentist three to six times a day, either on the phone, via email, or through the Alaska Federal Health Care Axis Network Telemedicine Program. She is able to send films to her supervising dentist if she is unsure of or wants to just refer, consult with her supervising dentist. She has the option and opportunity to do that at any point in time during her day.

Senator MURKOWSKI. Thank you.

Dr. Tarren, I think you used the words “culturally appropriate” services, and you indicated that you think American Indians have better outcomes, and you have also cited to the DHAT Program in Alaska, where we have seen the benefits.

How significant do you feel that is as we are trying to develop these mid-levels to respond to what clearly is a need in my State and in the Lower 48 with American Indians?

Dr. TARREN. I think it is extremely important for the practitioner to develop the trust of their patients. And for example, if I came into Alaska and worked for two weeks in one of the villages, I would probably be viewed with some suspicion, and I know that my giving, for example, advice to a family about diet and their child would not be received as well as if Angel were giving them the exact same information.

And in our hospital at Hennepin County Medical Center, we see many patients of different ethnicities. For example, I have learned to speak Spanish so that I can more readily gain the trust of my Spanish-speaking families so that they will believe me when I am trying to divert their dietary practices from harmful practices, for example.

Senator MURKOWSKI. I appreciate you bringing that up because I think one of the things that we have recognized, particularly with children, is that if it is somebody that is in your village, someone that is in your community who is giving you guidance, giving you counsel, telling you, you know, are you brushing, who sees you in your school or in the store, that is kind of a constant reminder.

You mention the issue of trust, which is so important, but I think also just having that presence within the community on a daily basis, somebody that lives there, someone that is one of us I think makes such a big difference.

And Dr. Tankersley, I so appreciate what the American Dental Association is doing and their efforts. And I truly believe that there has been a greatly stepped up effort to get more dentists out into all aspects of rural America, and I applaud you on that.

I think that the example that is underway in Alaska does demonstrate that we can be working cooperatively to fill in some of these gaps, so I appreciate your willingness to work with us on that.

I have well exceeded my time, Mr. Chairman. I appreciate your indulgence.

The CHAIRMAN. Thank you very much.
Senator Franken?

**STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA**

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you, Senator Murkowski, for talking about the DHAT Program in Alaska and a lot of the successes of it.

I would like to ask Dr. Tarren, in your career as a dentist, and I knew you were a pediatric dentist. I just said pediatrician. Have you seen a dental therapist give substandard care?

Dr. TARREN. I have not. I was in England last year and visited two training programs, and continue to be very impressed by the level of education that is received, the competence, the commitment, the dedication among the students, who are learning dental therapy, and then going out in to the community to a practice situation, a community clinic, and again seeing the high level of professionalism.

And the fact that their patients really appreciate the standard of care that they are getting to the point where a dental therapist who recognizes that a procedure would be beyond her scope of capability and wants to refer that patient to the supervising dentist, the patient is a little bit disappointed and would rather have the dental therapist provide the care.

Senator FRANKEN. And I think that I would argue the most substandard is offering no care at all. Would you agree with that?

Dr. TARREN. Completely.

Senator FRANKEN. Now, have you worked on Red Lake Reservation?

Dr. TARREN. Unfortunately, no.

Senator FRANKEN. Do you know anyone who has?

Dr. TARREN. I know the dental hygienist that works there, and I know that they are desperately short of access to dental care. For example, they send patients down to the Twin Cities, children who need care, who have extensive dental needs and would most benefit from care under general anesthesia. And that is 250 miles. It is a long way to bring a small child.

Senator FRANKEN. Ms. Dotomain, do you see any reason why other locations that are suffering from a lack of dental care shouldn't use a mid-level dental provider model similar to what you use in Alaska?

Ms. DOTOMAIN. No, none at all.

Senator FRANKEN. Dr. Tankersley, shouldn't everyone have access to dental care?

Dr. TANKERSLEY. We believe they should.

Senator FRANKEN. Okay. In your testimony, you said something interesting. You said this year alone, there will be 70 additional dentists providing care in tribal areas. That was your recruitment. And then you went on to say, with one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated.

Dr. TANKERSLEY. Yes.

Senator FRANKEN. Do you know how many dentists there are in the IHS?

Dr. TANKERSLEY. I don't know the total, but I think the number that the IHS, you know, wants is low, as it is in some military situations.

Senator FRANKEN. I am sorry. I didn't understand.

Dr. TANKERSLEY. Yes, I don't know the total of dentists in IHS. No, I don't.

Senator FRANKEN. Well, the numbers don't seem to make any sense to me. Do you know what the shortage is?

Dr. TANKERSLEY. Well, the IHS has a quota just like military does for how many posts they have. And for years, there has been an inability to recruit dentists in IHS. In the last short period of time, we have been much more successful because of some of these programs that we have instituted in getting dentists to—

Senator FRANKEN. Okay. Well, if you don't know how many dentists there are in the IHS, and you said that recruiting 70 more could eliminate the shortage, I don't know how you could make that statement.

Dr. TANKERSLEY. Because there are—

Senator FRANKEN. There are 600 dentists in the IHS. Do you how much of a shortfall there is?

Dr. TANKERSLEY. Yes, the shortfall at this point is about another 70 dentists, and they have—

Senator FRANKEN. No, it is not. The shortfall that I have seen is about 25 percent.

And do you know what the turnover rate is?

Dr. TANKERSLEY. I don't know the statistics, but the turnover rate is high.

Senator FRANKEN. So when you said that with one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated, why did you use the word "could"?

Dr. TANKERSLEY. Because there is no way we know that it will be eliminated.

Senator FRANKEN. Why did you even bother to say it? Because the turnover rate is about 30 percent, sir.

Dr. TANKERSLEY. Yes, but because there is a—for the first time in many years, there is a positive trend to actually get dentists into the Indian Health Service.

Senator FRANKEN. Well, your positive trend was 70, which to my calculation is like 11 or 12 percent. And if we have a 24 percent shortfall and we have a 30 percent turnover, I don't see how 70 new recruits can possibly eliminate the shortage. And so it just bothers me that—I mean, I think we agree that people need dental care.

Dr. TANKERSLEY. We do.

Senator FRANKEN. And I understand that the ADA represents dentists and you want people who you represent to do this work, and I applaud dentists who do this. But we have a model here that seems to be working, and we have a shortfall in Indian Country. And it could do a lot of people a lot of good. And I wouldn't mind if you could meet that shortfall. I would love it. But it doesn't seem to me that from your testimony that your testimony is convincing at all.

And what I want to do is make sure that kids in Indian Country don't have rotting teeth. That is my responsibility.

Thank you.

Thank you, Mr. Chairman.

[The prepared statement of Senator Franken follows:]

PREPARED STATEMENT OF HON. AL FRANKEN, U.S. SENATOR FROM MINNESOTA

Thank you Mr. Chairman. It is an honor to be here today, and I thank you for holding this hearing on such a critical and timely topic for our nation and particularly Minnesotans.

Last summer, Minnesota became the first state to pass legislation to create a training option for mid-level dental health practitioners to be licensed. The goal was providing more basic services to underserved rural populations in the state. Underserved areas including reservations where there are teeth literally rotting in the mouths of children because they don't have dentists to take care of them.

Physician assistants and nurse practitioners have become accepted and valuable parts of the health care model. There is no reason that areas other than Alaska shouldn't have the option to add dental health aid therapists to the dental care model. Particularly in locations where there has been such a historically hard time in getting dentists to work. The bill we craft today should be permissive to reasonable options, not dictating because of special interests.

Over 50 countries, such as England, Canada and Australia are using mid-level dental practitioners to improve access and lower costs. Research has shown these programs are both safe and effective. Not a single study has shown these programs to be unsafe. Yet the American Dental Association has repeatedly tried to block efforts to have mid-level providers help Americans improve their dental health. The ADA fought the Alaska program. When the program was implemented they filed a lawsuit to stop it. The ADA was vehemently against the Minnesota legislation. And now they are lobbying to take away the chance to duplicate a good program in places where it's needed most.

We are talking today about teeth rotting in the mouth of children because of a lack of dental care. How can this possibly be acceptable?

I am looking forward to hearing from the people who have come here to testify on this crucial topic, particularly Dr. Patricia Tarren, from the Hennepin County Medical Center in the great state of Minnesota. But I'd also like to point out that we won't be hearing today from the people who have the most to lose. People on the reservations who have some of the worst dental health of anyone in our country. People who, at the same time, have some of the worst access to dental care. Those are the people that will continue to have poor dental health and poor access to dental care if we deny them this opportunity.

The CHAIRMAN. Senator Franken, thank you very much.

This is an issue that has had some previous attention by this Committee, again thanks to the work of Senator Murkowski and others. Senator Franken has brought the issue to us again, and I think caused us to have a discussion that is probably long overdue.

I appreciate the testimony by all three of you. We are going to work on this Committee to think our way through this in a way that reaches a good result.

My interest, I think the interest of everyone on this Committee, is for good dental care for American Indians who have been promised good dental care. I have seen circumstances myself of one dentist working in an old trailer house serving 5,000 people on an Indian reservation. That is not good dental care. Most of the dental care there was to simply have a patient show up and pull the tooth. So we expect better, demand better, and I think this discussion will be helpful going forward.

And Senator Franken, I appreciate you requesting this hearing.

Senator MURKOWSKI. Mr. Chairman?

The CHAIRMAN. Yes, Senator Murkowski?

Senator MURKOWSKI. Can you let me ask one quick question of Dr. Tankersley?

Is there an effort within the ADA to specifically recruit American Indians, Alaska Natives into the dental profession? Do you have a specific outreach to them, and if so could you speak to that?

Dr. TANKERSLEY. You know, we have pipeline projects, and that is difficult and there is an effort to do that, and it is meeting with some success.

Senator MURKOWSKI. Can you define when you say it is meeting with success? How far along are you in the process?

Dr. TANKERSLEY. Well, you know, it is a low percentage. I don't know, do you know the percentage? We can supply it. I know it is an—

Senator MURKOWSKI. I would be curious to know what that is.

Dr. TANKERSLEY. The reason I know is because our Board of Trustees deals with this all the time, and it is a major issue, not just with Indians, but with other ethnic groups, too.

And if I have permission to say something, I would like to say most of the conversation of what has been done is exactly what our community dental health coordinator does—you know, the cultural competence, the prevention, they can get people out of pain. And the difference in approach probably is that we would like to see the Indian Health Service have better resources so that they could have dentists to come in to do the actual surgical procedures.

Now, we are aware of stories like a dentist shows up once a year, but that is not necessary. I mean, if you have proper resources in medicine and dentistry, there are lots of people that can come into areas once a week or once a month. And so it is just a matter of having the appropriate resources to get the dentist in to do the surgical procedures.

Thank you.

The CHAIRMAN. Dr. Tankersley, thank you.

Angel Dotomain, thank you.

Patricia Tarren, we appreciate your being here.

That closes this portion of the hearing.

[Whereupon, at 3:48 p.m., the Committee was recessed, to reconvene the same day.]

A P P E N D I X

PREPARED STATEMENT OF THE PEW CHILDREN'S DENTAL CAMPAIGN

The Pew Children's Dental Campaign would like to thank the Committee Chairman for holding this important and timely hearing.

The Pew Children's Dental Campaign is working to ensure that more children receive dental care and benefit from policies proven to prevent tooth decay. We are mounting a national campaign to raise awareness of the problem, recruit influential leaders to call for change, and showcase states that have made progress and can serve as models for pragmatic, cost-effective reform.

Pew believes children should see a dentist when needed, and when possible. However, we recognize it is not always possible. Therefore, Pew supports state innovations that show promise in improving access to preventive and restorative services for children who cannot access care. Pew supports state efforts to expand the existing dental health care team with new providers, as well as using current providers to the extent of their training.

The Campaign supports dental workforce innovations based on five key principles:

- 1.) Proposals for new workforce models should be **based on research and evidence**.
- 2.) Models should be based on a **careful analysis** of the state's particular experience and needs.
- 3.) The **duties and scope of practice** of new providers should be designed to address the needs and problems identified in the state's analysis.
- 4.) New dental providers should be **adequately educated** to perform their scope of services competently.
- 5.) States should adopt the **least restrictive level of supervision** that maintains patient safety.

The DHAT program in Alaska meets each of these criteria.

To prevent tribes in the other 49 states—who have the legal standing as sovereign nations—from even assessing the viability of this model as a solution to their lack of access to dental care is counterproductive.

Our country is facing a critical lack of access to dental care. A shortage of dentists—especially in low-income, inner-city and rural communities—constitutes a national crisis, particularly for children.

There is a consistent shortage of dentists in rural and underserved areas, including tribal lands. The ADA has acknowledged a geographic maldistribution of dentists, with too few locating in rural, isolated, and underserved areas.

During economic downturns, it is always easier to recruit dentists for the IHS and other safety net settings. However, once the economy improves, the vacancy rate always goes up. Generally speaking, about one quarter of rural safety net clinic openings for dentists are unfilled, and the percentage is higher in rural areas.

Expanding the dental workforce to include therapists is a cost-effective investment that can help extend essential health services to all Americans. Therefore, the Pew Children's Dental Campaign supports the DHAT program and does not support preemptively restricting the tools available to communities in the other parts of the United States to address their dental health needs.

Attachment

MAY 2009

THE PEW CENTER ON THE STATES

NATIONAL ACADEMY FOR STATE HEALTH POLICY

W.K. KELLOGG FOUNDATION

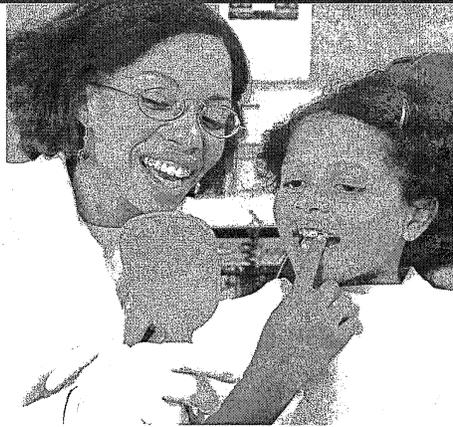
Help Wanted:

A Policy Maker's Guide to New Dental Providers

By Shelly Gehshan, Mary Takach, Carrie Hanlon and Chris Cantrell

Access to oral health care is becoming an increasingly serious problem for many people in the United States, particularly for children. The tragic death of 12-year-old Deamonte Driver in 2007 from complications of untreated tooth decay gave the nation a sobering reminder of the grim consequences that can result from a lack of dental care availability.¹ The National Academy for State Health Policy and the Pew Center on the States, with funding from the W.K. Kellogg Foundation, conducted a comprehensive literature review and interviewed leading experts in several states to learn about options for expanding available care.

Limited provider supply and increased demand for care are combining to create the growing national problem. Shortages of private dentists—especially in low-income, inner-city, and rural communities—and limited availability of government-supported dental care restrict patient access. The supply of private dentists who participate in public health insurance programs and who serve young children, the elderly, people with disabilities and immigrants is also acutely constrained. Dentists are also poorly distributed, with too few in many communities that need them and too many in others. At the same time,



Americans are living longer and doing so with more of their natural teeth than past generations, putting additional strain on an already taxed system of care.²

It is not surprising that dental problems disproportionately affect low-income families, children, and racial and ethnic minorities. Nearly 80 percent of dental caries occur among 25 percent of children, many of whom are from lower income families.³ While states are required to provide dental care to Medicaid-enrolled

¹ Deamonte Driver, a 12-year-old Maryland boy, died from a tooth abscess that spread to his brain. He spent six weeks in the hospital prior to his death, at a cumulative bill totaling over \$250,000. See "For Want of a Dentist," *The Washington Post*, February 28, 2007. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html>

² R. L. Ettinger, "Oral Health and the Aging Population," *Journal of the American Dental Association* (Sept., 2007), 138.

³ L. M. Kaste, et al., "Coronal caries in the primary and permanent dentition of children and adolescents 1–17 years of age," *Journal of Dental Research* 76 (1996), 631–641.

low-income children, only one in three of these children received services in 2006.⁴ Racial and ethnic minorities, independent of income, have more serious problems accessing dental care than whites and have poorer oral health as a result.⁵

The current economic crisis likely will further limit access to dental health services but, at the same time, the crisis gives states an opportunity to explore new, cost-effective models that can safely provide the care patients need. As a result, many states are considering adding new types of dental providers such as community dental health coordinators, dental therapists and advanced dental hygiene practitioners to the existing oral health care team.

Recognition is growing in the United States that such alternative providers can competently and safely deliver basic dental care. These additional providers can supply urgently needed oral health services, especially essential preventive care in areas and settings where dentists are scarce. By improving access to primary care for all patients, not only those in underserved communities, these new providers can potentially reduce the overall demand for care, actually making it easier for patients needing more complex treatment to get in to see a dentist.

Many other countries, including Canada, Great Britain, Australia and New Zealand, have had alternative dental providers for decades who function similarly to nurse practitioners and physician assistants. A substantial body of research exists that establishes the quality of care, cost effectiveness and health outcomes associated with the

use of alternative providers, and this extensive research can guide the United States in looking at similar models.⁶

This guide is intended to provide policy makers with objective information and the tools they need as they consider developing new providers. It reviews three proposed providers—dental therapist, community dental health coordinator and advanced dental hygiene practitioner—along with implementation steps policy makers can consider.

Why Develop New Providers?

A number of factors have spurred interest in developing new dental providers.

- **Shortages of private dentists persist.**⁷ By the year 2014, the number of dentists reaching retirement age will outpace new dentists entering the workforce, and the ratio of dentists to population (a common measure of supply) will begin to decline.
- **People who cannot afford private dentists have limited options.** Community health centers and clinics operated by dental and hygiene schools, hospitals and public schools comprise the dental safety net for individuals who cannot afford private care. Community centers and clinics, however, have the capacity to serve only about 10 percent of the 82 million low-income people who need them.⁸ Hospital emergency rooms—often a last resort for uninsured patients—can treat only for pain and infection, not underlying dental problems.

4 Centers for Medicare and Medicaid Services, *Annual EPSDT Participation Report: Form CMS-416 (National), 2006* (Baltimore, MD: U.S. Department of Health and Human Services, 2008). Retrieved January 29, 2009. http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrnr/03_StateAgencyResponsibilities.asp

5 GAO, *Oral Health, Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149, September, 2000, 6.

6 Minnesota Safety Net Coalition, *Highlight of the Research Literature Review on Mid-Level Oral Health Practitioners*, January, 2009, 107-111 http://www.healthstate.mn.us/healthreform/oralhealth/FinalReport_OHP.pdf

7 B. Mertz and E. O'Neill, "The Growing Challenge of Providing Oral Health Services to All Americans," *Health Affairs*, v. 21, no. 5 (2002), 73.

8 H. Bailit, et al., "Dental Safety Net: Current Capacity and Potential for Expansion," *Journal of the American Dental Association* 137, no. 6 (June 2006), 807-815.

- **Expanding public dental coverage alone will not sufficiently increase access.** In fact, coverage expansions might lead to growing waiting lists for providers who participate in Medicaid and Children's Health Insurance Program (CHIP).⁹ Public insurance programs rely primarily on private practitioners to deliver care. The majority of dentists, however, do not participate in Medicaid and the CHIP.¹⁰ Extending public dental coverage under the current inadequate Medicaid financing structure will not address the core problem of limited provider supply and could exacerbate access problems, putting additional pressure on the delivery system.

Proposals for New Providers

In the United States, most dental care is delivered in private practices by a dental team that consists of dentists, dental hygienists and dental assistants.

Recognizing the successes of other models throughout the world, innovative proposals for new providers have emerged that would expand the dental team and increase access to care. Currently, three principal proposals for new dental care providers are being discussed by policy makers, dental professionals and other stakeholders: the dental therapist, community dental health coordinator and the advanced dental hygiene practitioner. Key characteristics of these three providers are highlighted below.

Dental Therapist

Dental therapists deliver basic educational, preventive and restorative services. For cases that require more extensive care, dental therapists refer patients to a dentist. In other countries, dental therapists focus on care for children in schools and public health settings. Many, however, also work in private practices with dentists.

The dental therapist model has not been adopted in the United States, with the exception of the Alaska Native Tribal Health Consortium, which introduced what the Consortium called dental health aide therapists (DHATs) as a way to deliver care to some of the most isolated tribal regions.

In the Alaska model, dentists who supervise DHATs are not usually on-site. DHATs practice under standing orders issued by their supervising dentist that spell out what treatment DHATs can provide and when they must refer

As of 2007, 10 dental therapists have provided care to thousands of residents in 20 Alaskan villages, many of whom might never have received care otherwise. Since dental therapists are not under the direct supervision of dentists, they are able to practice in remote areas not often visited by dentists. Two initial studies found that the care provided by dental therapists in Alaska is of high quality.¹¹

⁹ K. I. azar, "Dental Benefits Widen, Waiting Lines Grow, Some Balk at Giving Care, Call Subsidized Rates Too Low," *Boston Globe*, August 7, 2008.

¹⁰ P. Cunningham and J. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change, Tracking Report no. 16, August 2006.

¹¹ K. Bolin, "Assessment of Treatment Provided by Dental Health Aide Therapists in Alaska: A Pilot Study," *JADA* 2008; 139, no. 11, 1530-1535; L. Fiset, "A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives," University of Washington School of Dentistry (September, 2005).

TABLE 1
NEW DENTAL PROVIDERS — HOW DO THEY COMPARE?

	PROPOSED COMMUNITY DENTAL HEALTH COORDINATOR	DENTAL THERAPIST	PROPOSED ADVANCED DENTAL HYGIENE PRACTITIONER
History	First proposed by the American Dental Association in 2006 First 12 CDHC candidates began training in 2009	Introduced in 1921 in New Zealand Now used in 53 countries and Alaska.	Developed by the American Dental Hygienists' Association to be a new licensed dental provider
Post-secondary education	Twelve months of training program followed by a six-month internship	Two years of training followed by clinical training in practice sites (Other countries are moving toward a three-year program that combines dental therapy and dental hygiene)	A 2-year master's degree for people with a 4-year degree in dental hygiene
Regulation	Certification	Certification Recertification required every two years	Licensure
Supervision	Direct supervision by a dentist for clinical services; general supervision for education	General supervision under standing orders by a dentist	General supervision under standing orders by a dentist or collaborative agreement with a dentist
Practice settings	Private practices, WIC offices, Head Start programs, community clinics, schools, churches, nursing homes, federally qualified health centers	Private practices, community-based clinics, rural settings, Indian Health Service (IHS) clinics in Alaska, schools, nursing homes	Private practices, community-based clinics, rural settings, IHS, schools, nursing homes
Scope of services	Assist patients in locating providers who accept the patients' insurance, perform education, preventive services, and limited restorations	Perform basic preventive, diagnostic and restorative services	Perform basic preventive, diagnostic and restorative services

patients elsewhere. These orders can vary depending on the dentist and dental therapist. Typically, the dentist practices in a "hub clinic" while providing supervision to dental therapists at satellite clinics in remote areas.

Dental therapists undergo training that is designed to resemble the last two years of dental school but includes more hours of education and experience treating children than dentists receive.¹²

¹² D. Nash and R. Nagel, "Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Oral Health Therapist," *American Journal of Public Health* 95 no. 8 (August 2005), 1325-1329. Retrieved March 17, 2009. <http://www.ajph.org/cgi/reprint/AJPH.2005.061796v1>

Community Dental Health Coordinator (CDHC)

Following the model of community health workers, the community dental health coordinator position (CDHC) is designed to supplement the services already provided by dentists, dental hygienists and dental assistants. CDHCs will act most often as a facilitator in communities by helping patients navigate the health care system and obtain access to oral health care, but CDHCs may also perform preventive and restorative services, such as applying fluoride varnish. Direct supervision by a dentist would be required when performing clinical procedures, while general supervision would be necessary for community and educational support.

CDHC candidates must have a high school education. The first group of CDHC candidates is in training at press time, so a fully implemented model is not yet available for evaluation. CDHCs may undergo voluntary certification but are not required to be licensed under the current proposal. This is controversial considering the proposed CDHC model includes performing temporary restorations. All other providers who perform restorations are licensed, which is a stricter process.

Advanced Dental Hygiene Practitioner (ADHP)

The advanced dental hygiene practitioner would be able to perform basic preventive, diagnostic and restorative services. This model is comparable to a nurse practitioner in the ADHP's function and relationship to dentists. Under the proposed model, the ADHP would work under general supervision with standing orders from a dentist. This would allow ADHPs to provide basic services and case management with a high degree of autonomy

while still reserving the more complex procedures for the expertise of the dentist.

The American Dental Hygienists' Association has developed a master's degree curriculum for training these new providers. The program is intended to recruit existing dental hygienists who would like to further their education and qualify as an ADHP. Upon completion of the program, ADHPs will be licensed by states. While no ADHP program is currently in place, training programs are being planned by hygiene education programs at community colleges in several states.

Developing a New Type of Dental Provider

Mid-level providers such as nurse practitioners and physician assistants have existed in the medical community for years and have been successfully integrated into the health care workforce. State policy makers looking to introduce similar providers in dentistry to their states require thorough data to determine what types of professionals would best integrate with the existing dental workforce. Policy makers need to:

- **Collect baseline data** to document the extent to which people have untreated oral health problems or difficulty accessing routine dental care and to determine which populations, institutions or communities the new provider could serve. Data sources include: State Dental Directors,¹³ State Oral Health Coalitions, State Health Policy Institutes,¹⁴ and the U.S. Department of Health and Human Services, Health Resources and Services Administration.¹⁵

¹³ An overview of information provided to the Centers for Disease Control and Prevention (CDC) by state dental directors is available at <http://apps.nrc.cdc.gov/synopsis/index.asp>.

¹⁴ National Network of Public Health Institutes, "National Network of Public Health Institutes" (2008). Retrieved December 23, 2008. <http://nnpbi.org/home/>

¹⁵ Health Resources and Services Administration, "Shortage Designation: HPSAs, MUAs & MUPs," 2008. Retrieved December 23, 2008. <http://bhpr.hrsa.gov/shortage/mauguide.htm>

TABLE 2
KEY CHARACTERISTICS OF PROPOSED AND CURRENT PROVIDER MODELS

	PROPOSED COMMUNITY DENTAL HEALTH COORDINATOR	DENTAL THERAPIST	PROPOSED ADVANCED DENTAL HYGIENE PRACTITIONER
Unique features	Educators, community health workers focused on supporting the proper use of dental services by low-income populations.	Primary care providers focused on delivering basic preventive and restorative care to isolated and underserved populations.	Case managers and primary care providers who could assess risk, educate, provide preventive services and basic restorations.
Potential political/implementation challenges	<ul style="list-style-type: none"> • Training to do temporary restorations with a hand instrument is controversial for an unlicensed practitioner. • Although the CDHC model is designed to increase access to care by helping patients find dental providers, it does not address the fact that most dentists do not accept Medicaid patients. 	<ul style="list-style-type: none"> • Trained to perform restorative procedures under general supervision, which is controversial among segments of organized dentistry in the U.S. 	<ul style="list-style-type: none"> • Trained to perform restorative procedures under general supervision, which is controversial among some members of organized dentistry. • Training may be excessive and expensive, given the limited expansions gained in scope of practice. • Salaries would be higher than that of dental therapists for a similar scope of practice. • It may be difficult to persuade dentists to collaborate with and accept referrals from ADHPs.
Potential limitations of the scope of service	<ul style="list-style-type: none"> • Includes a mix of skills and services that may not be realistic. • Very limited clinical services would make them difficult to support through reimbursements and of limited use in most practice settings. • To perform clinical procedures, CDHCs must be under a dentist's supervision and so could not help in the many areas where there are no dentists. 		<ul style="list-style-type: none"> • Recruiting from current pool of hygienists would limit cultural competence since most are white women.
Advantages	<ul style="list-style-type: none"> • Could be useful in prevention programs. • Supported by the American Dental Association. • Candidates would be drawn from the communities they will serve, increasing their ability to provide culturally competent care and overcome barriers. 	<ul style="list-style-type: none"> • A proven model, with a solid research base on quality of care from Alaska and other countries. • Ability to practice under general supervision makes them useful in many areas without dentists. • Two-year education makes them cheaper to train, reimburse, and employ. • Can mirror, and be sensitive to, the population served. 	<ul style="list-style-type: none"> • The public is familiar with dental hygienists and might feel comfortable receiving care from them. • A higher education level may help gain the confidence of dentists that they can perform restorative functions. • ADHPs could perform case management for underserved patients and help staff safety net clinics, which lack sufficient dentists.

- **Assess the current dental workforce and educational infrastructure** to determine: which dental providers currently work in the state; where provider shortages exist; how many providers are enrolled in Medicaid; how many providers serve patients with special needs; and whether existing educational institutions can be expanded to train new providers or if new institutions need to be created. Data sources include: state medicaid agencies, state dental associations, and dental schools.
- **Identify potential funding streams**, such as Medicaid and CHIP, to ensure that the new provider model will be sustainable and supported by reimbursement policies linked to the populations and settings to be served. State Medicaid and CHIP agencies are good places to obtain information regarding financing questions. Also, comprehensive information on each state's economic, budget, demographic and uninsured rate can be found at Kaiser State Health Facts.¹⁶
- **Appraise the political landscape and identify who is likely to support and oppose the plan and why**—and include both sides in stakeholder discussions. The political landscape may present opportunities to advance a new model. For instance, tight state budgets or state health goals promoting dental homes for all children may give policy makers the opportunity to take a fresh look at potentially less costly and more accessible dental provider options. Policy makers will also need to determine if any statutory or regulatory changes are needed to establish a new dental provider.

Implementation Steps for Developing New Provider Models

Experiences from states show that developing new dental providers requires careful planning.

Implementation steps include:

- **Create a strong, broad-based partnership of stakeholders.** The group's leader must keep stakeholders focused on the central, mobilizing objective—improving access to oral health for the underserved—and away from perceived limits or threats to any professional group's practice.¹⁷ Involving and developing leadership roles for dentists who serve Medicaid patients or practice in safety net settings have also proven helpful.¹⁸ Other stakeholders to consider are: dental, dental hygiene and medical professional associations; state colleges and universities with public health programs; oral health coalitions; local and national experts; legislative champions; organizations serving vulnerable populations, such as consumer advocacy groups and federally qualified health centers; state policy makers; and Medicaid and state health agency representatives. Transparency in the process builds trust and collaboration among stakeholders.
- **Obtain legislative approval** (required in most states for a new dental provider). Where possible, work with the state Board of Dentistry to permit implementation of a new provider under existing regulations.¹⁹ States also can amend the dental practice act to explicitly

¹⁶ See <http://www.statehealthfacts.org/>

¹⁷ Many lessons about consensus-building, particularly adhering to the group objective, were evident in North Carolina's experience with physician assistants. See E. Harey Estes, Jr. and Reginald D. Carter, "Accommodating a New Medical Profession: The History of Physician Assistant Regulatory Legislation in North Carolina," *North Carolina Medical Journal* 66, no. 2 (March/April 2005), 103-107

¹⁸ For discussion about the importance of support among dentists for new dental workforce models, see L. Nolan et al., *The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children* (Washington, DC: Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University, January 17, 2003).

¹⁹ *Ibid.* Although the authors discuss the option to "reinterpret" law, it is unclear whether any states have done it.

allow for the new provider or enact legislation to establish the new provider scope of practice and supervision level.

- **Handle regulatory issues.** After legislation has been passed, state regulatory agencies (e.g., health professions' boards) write and enforce the regulations that implement the law.²⁰ Regulations are needed for credentialing or licensing new provider types, licensing exams and renewal and continuing education requirements. States must determine whether an existing board will be responsible for regulating the new provider or if a new committee must be established. Most states regulate dental practice through a dental board; a few states have separate dental hygiene committees that make recommendations to the dental board.²¹ Consensus stakeholder group involvement will help ensure that regulations are not designed to block competition.
- **Develop an appropriate educational framework** so that students can obtain the licensing or credentialing required for the new provider type. A curriculum must be developed and faculty must be hired or trained. Funding may be required for program courses, faculty and equipment. Consideration should be given to joint education and training with dentists to foster constructive working relationships. An educational institution within the state (or region) will need to create a program that incorporates the curriculum, and the program will need to be accredited by the Council on Dental Accreditation, which provides accreditation to dental and hygiene education programs.²² If the Council declines, it is the state's responsibility to provide accreditation. This process takes time, but it can be undertaken concurrently with consensus building and legislative initiatives.
- **Identify and make necessary systemic modifications.** Consider whether the ways oral health care is delivered and providers are supervised and/or reimbursed will need to be changed for the new provider type to be successful. States must determine where new providers will work and what types of assistance they may need. For specific settings, such as nursing homes or schools, leaders of those systems need to be involved in the planning. Clinical rotations to those sites can be built into the curriculum and funding and reimbursement plans can be made. New providers may require help marketing their services to patients, dentists and institutions; negotiating contracts; or developing collaborative agreements with dentists. States may consider adding case review or consulting fees to reimbursement rates to compensate dentists for their time providing supervision.

Tools for Developing New Providers

States' experiences, such as those in California, Colorado, Iowa and Minnesota, also show that several tools can facilitate progress in implementing new types of dental providers. To help policy makers assess needs and make informed decisions related to workforce changes, states can:

- create a department or unit that enables new workforce models to be piloted;
- develop regulations and review processes to ensure that workforce changes are based on evidence and in the best interests of the public; and/or
- carry out workforce planning either across all health professions or specific to oral health professions.

20 C. Dower, S. Christian and E. O'Neil, *Promising Scope of Practice Models for the Health Professions*, (San Francisco: Center for the Health Professions, University of California, San Francisco, 2007), 1.

21 *Ibid*, 14.

22 The Council is technically independent of the American Dental Association, but organized dentistry does exert some indirect influence over the Council's functions.

Piloting New Approaches: California

The California legislature established the Health Workforce Pilot Projects Program (HWPP) in 1972 to allow organizations to demonstrate and evaluate new provider models before requesting changes in professional practice laws.²³ Pilot projects are intended to help the state avoid spending the money and time on legislative battles over untested models.²⁴ Through the HWPP, the Registered Dental Hygienist in Alternative Practice (RDHAP) model—specially trained hygienists working in underserved communities—was tested in 1980. And, after a protracted process that highlights the need to include all stakeholders throughout the planning stages, legislation to create these providers was passed in 1997. Approximately 230 licensed RDHAPs now practice in California.

Independent, Evidence-Based Review Policies: Colorado²⁵

To mitigate the impact of lobbyists and interest groups in the process, several states have established independent mechanisms to review proposals for changing scopes of practice for the health professions and then summarize that evidence for legislators or other policy makers.²⁶ The governor of Colorado issued an executive order in 2008 commissioning the study of the evidence for and value of expanding the scopes of practice of advanced practice nurses, physician assistants and dental hygienists.²⁷ The Colorado Health Institute (CHI)

systematically reviewed regulatory policies and relevant research in the state and produced an evidence-based study of the scopes of practice of the three health care professionals, their practice settings and the quality of care they provide. The report concluded that unsupervised dental hygienists can “competently” provide oral health care preventive services “within their scope of training, education and licensure in Colorado” and can do so with quality of care “at least comparable” to that of dentists.²⁸ The report also found that, as in other states, current Colorado statute prevents dental hygienists from making a diagnosis that falls within the full scope of their license and that some payers in Colorado do not directly reimburse dental hygienists for services authorized under their current scope of practice. The report calls for an evaluation of and recommendations for reimbursement policy options to “enhance the use of dental hygienists in areas where oral health access is lacking.”²⁹

Health Care Workforce Planning: Iowa³⁰

Iowa has designated a single state entity to address overall health care workforce planning across the state: the Bureau of Health Care Access within the Iowa Department of Public Health (IDPH). Bureau programs have provided grants to communities and educational institutions for tuition reimbursement, loan repayment, training and recruitment, and mentoring programs for

23 <http://www.oshpd.ca.gov/hwdd/HWPP.html>

24 <http://www.oshpd.ca.gov/hwdd/HWPP.html>

25 Unless otherwise noted, all information in this section comes from: Colorado Health Institute, “Colorado Collaborative Scopes of Care Study,” Retrieved November 21, 2008. <http://www.coloradohealthinstitute.org/resource/HotIssues/hotissuesViewItemFull.aspx?theItemID=43>

26 Dower, 10-13.

27 Governor Bill Ritter, Jr., Executive Order B 003 08 Commissioning the Collaborative Scopes of Care Study and Creating an Advisory Committee, February 7, 2008. Retrieved November 21, 2008. <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D784%2F835%2FB+003+08+%28Scopes+of+Care+Study%29.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1228676288785&ssbinary=true>

28 Colorado Health Institute, *Final Report of Findings: Executive Summary*, Prepared for the Scopes of Care Advisory Committee (December 20, 2008), 8. Retrieved January 23, 2009. http://www.coloradohealthinstitute.org/Documents/workforce/csoc/executive_summary.pdf

29 *Ibid.*, 9.

30 Doreen Chamberlin, “Iowa Strategies on Health Care Workforce Planning,” handout presented at the National Academy for State Health Policy’s 21st Annual State Health Policy Conference, Tampa, Florida (October 7, 2008). Unless otherwise noted, all information from this section comes from this source.

health professionals. Programs also have funded online training and curriculum for health education programs and supported improvements to a state worker registry. Legislation in 2007 built on these efforts and directed IDPH to project future workforce needs, coordinate efforts, make recommendations and develop new strategies. After participating in a multi-agency workgroup, conducting a literature review and convening a summit, IDPH issued a final report with workforce recommendations for health professions, including dental providers. Short-term recommendations include establishing an Iowa Health Workforce Center to provide state-level coordination of recruitment and retention of health professionals.³¹ Iowa passed legislation in 2008, which directs IDPH to take additional steps in workforce planning and development, such as seeing that relevant data is continuously collected and biennially delivering a strategic plan to the governor and legislature.³²

Oral Workforce Planning: Minnesota

In May 2008, Minnesota enacted the Omnibus Higher Education Policy Bill, which established the position of an oral health practitioner, a provider similar to an ADHP.³³ The legislation instructed the Commissioner of Health and the Board of Dentistry to convene an Oral Health Practitioner Work Group to make recommendations and propose legislation regarding the education, training, scope of practice, licensure and regulation of oral health practitioners.³⁴ The work group's co-conveners served important roles: The Department of Health provided logistical and project support, while the Board of

Dentistry offered technical expertise. The work group met several times throughout the fall of 2008. These facilitated meetings were open to the public, and information, materials and public feedback are available online.³⁵ The work group issued its report to the legislature in January 2009.³⁶ The report from the work group was used to develop legislation for a new provider that was amended, enacted and signed into law in May 2009.

Conclusion

New thinking and action is needed to respond to the serious dental access problems facing states. Demographic shifts are reducing the number and availability of dentists even as demand increases. As the most highly trained and educated dental providers, dentists will remain the leaders and experts in the field and the only providers who can perform the most complex and clinically difficult procedures. However, new dental providers offer a way for states to help ensure that vital primary dental care is accessible to constituents regardless of age, race, ethnicity, income, geographic location and/or insurance status. State examples and studies from around the world confirm that providers with a smaller scope of practice than dentists can efficiently and safely perform many components of dental care. States are working hard to gather data, build consensus, develop systems of care, and train and educate new types of providers who can join the dental team, supply basic primary dental care to underserved populations and expand the safety net.

31 Iowa Department of Public Health, "The Future of Iowa's Health and Long-Term Care Workforce: Health and Long-Term Care Workforce Review and Recommendations," December 2007. Retrieved November 21, 2008. http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf

32 Page 8, <http://iowahouse.org/wp-content/uploads/2008/04/bill-summm-house-health-care.pdf>

33 Minnesota Laws 2008, Chapter 298—S.F.No. 2942. <https://webh12.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id=298>
The Minnesota Dental Hygienists' Association (MDHA) describes the legislation as modeled after the ADHP model. See MDHA, "Legislative Reports," Retrieved November 5, 2008. <http://www.mdha.com/Legislative.html>

34 Minnesota Department of Health, "Oral Health Practitioner Work Group 2008: Project Summary and Timeline." Retrieved November 5, 2008. <http://www.health.state.mn.us/healthreform/oralhealth/projects/summary.pdf>

35 See Minnesota Department of Health, "Oral Health Practitioner Work Group." Retrieved 5 November 2008. <http://www.health.state.mn.us/healthreform/oralhealth/index.html>

36 Minnesota Department of Health and Minnesota Board of Dentistry, *Oral Health Practitioner Recommendations: Report to the Minnesota Legislature 2009*, January 15, 2009. Retrieved January 23, 2009. <http://www.health.state.mn.us/healthreform/oralhealth/FinalReport.pdf>

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For a copy of the full "Help Wanted" report, visit www.pewcenteronthestates.org/helpwanted and www.nashp.org.

PREPARED STATEMENT OF THE SHOSHONE-BANNOCK TRIBES—FORT HALL BUSINESS
COUNCIL, PREPARED STATEMENT

Fort Hall Indian Health Service Dental Department Needs

Guidelines for the development of the appropriate size for I.H.S. dental clinics for the purpose of this approximation are found in the 1998 I.H.S. Planning and Programming Manual, and from the I.H.S. Oral Health Program Guide. Appropriate size for an I.H.S. dental clinic is based on a workload projection formula that multiplies an estimated need for 95 Dental Service Minutes (DSM) per person in a user population per year. For the Fort Hall Indian Health Service, with an estimated user population of 6,100 the estimated workload projection is 6,100 (user pop) X 95 (service minutes) = 579,500 total service minutes provided annually.

Analysis of the construction program projected through the year 2005 foresaw the need for the development of 4 dental templates. The templates and their utilization/workload ranges are as follows:

<u>SERVICE LEVEL</u>	<u>WORKLOAD RANGES</u>
1) 8 Dental Treatment rooms	262,001 DSMS through 393,000 DSMS
2) 12 Dental Treatment rooms	393,001 DSMS through 588,000 DSMS
3) 16 Dental Treatment rooms	588,001 DSMS through 856,000 DSMS
4) 24 Dental Treatment rooms	856,001 DSMS through 999,999 DSMS

According to analysis template, the Fort Hall Service Unit Dental Clinic would have 12 Dental Treatment Rooms to accommodate the estimated workload projection of 579,500 service minutes. Currently, the Fort Hall Dental Clinic has 6 dental treatment rooms.

Referring to the I.H.S. Oral Health Program Guide page I-41, table 1, labeled Dental Staff and Facility Recommendations for Selected Ranges of Annual Service Minute Needs, a 12 dental treatment room facility should have 4 dentists, and 15 dental auxiliaries (includes dental hygienists, dental assistants, and clerks). Our current 6 chair facility has 3 dentists, and 5 dental auxiliaries. The additional staff for this model is obviously significant and the would require significant funding for salaries – far in excess of dental department budgeting which currently requires supplementation from third party collections to meet payroll on what is under the I.H.S. recommended 2:1 of dental assistant to dentist ratio.

I do not have accurate knowledge of what the actual construction cost of the physical expansion of the dental clinic to include 6 more treatment rooms would be. Some conceptual planning for expansion to a 10 chair clinic at the Fort Hall Service Unit has been done in the Portland Area Office, and Gene Kompkoff at the Area Office may be a resource for cost estimates on construction of additional treatment rooms. In 2005, loose estimates for this expansion included \$80,000 for a Pre-design-concept study, \$100,000 for actual design costs, and \$1,000,000 for the construction phase of the dental expansion. This was for the addition of 4 dental treatment rooms, and some additional office space in the dental area.

Relative to equipping the treatment rooms, however, I can approximate from recent purchases for the current clinic. To provide delivery systems, and patient treatment chairs, comparable to those we installed in 2005, it would cost \$13,000 to \$15,000 per operator, or between \$78,000 and \$90,000. Delivery and installation of comparable equipment in 2006 was \$8,600, thus one could anticipate such cost would be closer to \$10,000 at this time. Comparable X-ray systems for the each treatment room to those we installed in 2007 would cost approximately \$3,000 per

room, with an additional \$100 per room for wall plate mounts, and a one time installation fee in the range of \$1500 to \$2,000. Overhead treatment lights were not replaced in our operatories in 2006, so their cost would also need to be added as one per room at a cost of approximately \$1,300 each totaling \$7,800. Additionally, with the eventual need to initiate an Electronic Dental Record (EDR), each treatment room will need to be equipped with the appropriate Hardware (monitor/keyboards/mouse) to accommodate the use of EDR. The current cost to I.H.S. clinics for this hardware per treatment room is \$1,689 for a total of \$10,134. Thus, it could very easily cost in the neighborhood of \$140,000 to equip 6 new dental treatment rooms. This would not include cabinetry necessary as part of the construction.

In relation to the question of Orthodontic needs in our community, we don't have a dental code in our RPMS package to track the number of children who are in need of orthodontic services, so we have to speculate averages from looking to other sources for information. One Orthodontic Journal article we referenced speculated that 15% of the overall population of children 10 to 18 years old was receiving orthodontic therapy, and that an additional 16% were in need of such treatment for a total of 31%. I Contacted the I.H.S. Orthodontic Consultant, Dr. Mark McCollough of the Western Oregon Service Unit, and his estimation in the American Indian Population of this age range was anywhere from 75% to 90% exhibit an orthodontic treatment need. It should be noted that the range of need ranges widely from mild to severe involving significant functional problems to those that are strictly mild aesthetic concerns.

Dr. McCollough also included appropriately that patients can not even be screened and considered for orthodontic therapy unless they are highly motivated, and have excellent oral hygiene. Historically, this would eliminate a significant number of patients who otherwise present with orthodontic needs.

Even if you estimated trying to provide approximately 30% of the orthodontic therapy in this age range to our local youth, you would be looking potentially at a number in the range of 300 patients annually according to a PCC Management Report Visit Count Summary of the dates 12/09/08 – 12/09/09 - which reported 976 patient encounters in this age range at the Ft. Hall Service Unit. With an average cost approximating \$5,000 per case of comprehensive orthodontic therapy, an annual cost of 1.5 million dollars would be incurred for this number of patients. Orthodontic therapy is classified as a Level VI (6) service, a category of low priority due to the fact that many more critical and higher prioritized dental services are still not provided regularly due to lack of critical resources. This is why orthodontic services have historically been provided at very few locations nationally in the Indian Health Service.

PREPARED STATEMENT OF TERRY BATLINER, DDS, MBA

I am writing as a private citizen. The following opinions are strictly my own and not necessarily those of my employer, The University of Colorado Denver (UCD) or any other group with which I am affiliated.

I am a dentist and a member of the American Dental Association (ADA). I occupy the positions of Associate Dean at the UCD School of Dental Medicine and Associate Professor in the Colorado School of Public Health. More importantly, I am a member of the Cherokee Nation of Oklahoma and I care deeply about the health of Indian people. That is why I adamantly disagree with ADA's effort to thwart the expansion of the Dental Health Aid Therapist (DHAT) program outside of Alaska.

Earlier in my career I spent 8 years in the Indian Health Service, 5 years in South Dakota and 3 years in the Northwest. It was depressing to treat child after child with early childhood caries (ECC), knowing that there were at least 5 more kids needing care for every one we treated. My current work takes me back to the Pine Ridge reservation and to the Navajo Nation in Arizona. The situation has not improved and has, in fact, gotten worse. This is not merely my opinion. At a recent national meeting of ECC investigators it was agreed the problem has gotten far worse in Indian Country. The majority of kids at age 3 in Indian communities have significant and often severe untreated dental decay. Why? Well one reason is clearly the lack of access to preventive, restorative and even emergent dental services.

In the U.S., it is generally agreed that a child with a painful and abscessed tooth is a dental emergency. That is simply not the case in Indian Country. I recently

learned the following fact from some current IHS dentists: A dental emergency is defined differently because there are just too many kids with these problems and too few dentists to treat them. Only kids with severe facial infections are considered true emergencies because the risk of dire complications is very high. In Indian Country, a child in pain is not an emergency. This must change!

The Indian Health Service cannot fill the large number of dental vacancies they currently have and even if they could, there would still be too few dentists to serve the needs of Indian people. The DHAT provides some hope for Indian communities. If local people can be trained and supported, they will be more likely to stay in their communities and provide needed emergent, preventive and restorative care to their fellow community members. This would help to reduce the number of children in pain and perhaps lead to some leveling in the definition of a dental emergency. If the DHAT program expands, perhaps more Indian children will grow up free of dental pain.

I respectfully urge you to act now to remove the language in the present draft of the Indian Health Care Improvement Act that would effectively restrict the expansion of the DHAT program for Indian communities outside of Alaska. It is sad that the ADA has taken a stand that places the economic concerns of dentists over the severe dental needs of Indian people. Please help those in the most need, our Indian children.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO
RONALD L. TANKERSLEY, D.D.S.

Question. Is there an effort within the ADA to specifically recruit American Indians, Alaska Natives into the dental profession? Do you have a specific outreach to them, and if so could you speak to that?

Answer. The ADA has been involved in a variety of activities to attract and recruit minorities, including American Indian/Alaska Native (AI/AN) students, to a career in dentistry. Knowing that just one approach is not enough, the ADA has employed a variety of strategies.

We formed the Committee on Career Guidance and Diversity Activities which is made up of representatives from the national and student chapters of the Society of American Indian Dentists (SAID), the National Dental Association (NDA), the Hispanic Dental Association (HDA), the American Dental Education Association (ADEA), the American Student Dental Association (ASDA), the National Association of Advisors to the Health Professions (NAAHP) and the Colgate-Palmolive Company.

Committee members collaborate on joint efforts to attract students from underrepresented groups including AI/AN students, such as:

- Attending and exhibiting at the annual SAID Conference to distribute career resources and materials aimed at attracting AI/AN students to careers in dentistry.
- Supporting and collaborating with community-based organizations such as Learning for Life Health Careers Exploring organization in their outreach activities promoting dentistry as a profession to students from diverse of backgrounds.
- Publicizing the need for a diverse profession. For example, Dr. George Blue-Spruce, former committee member and founder of the SAID, wrote an article titled, "The Need for American Indian Dentists", which is on the Career Resources landing page of ADA.org at <http://www.ada.org/public/careers/beadentist/index.asp#need>.

The ADA initiated the Student Ambassador Program which is made-up of representatives from the Society of American Indian Dentists (SAID) Student Chapter, National Association of Advisors to the Health Professions (NAAHP), the American Student Dental Association (ASDA), the Student National Dental Association (SNDA), the Hispanic Student Dental Association (HSDA), the American Dental Education Association (ADEA) Council of Students. The Ambassador Program is a student-driven recruitment process in which dental students take the lead in organizing and conducting introduction to dentistry get-acquainted programs with an emphasis on recruiting underrepresented students to the profession.

The five student representatives plan an annual meeting where they share information on their national student peer-to-peer recruiting outreach strategies and programs. Specifically, the 2009 SAID Student Chapter representative detailed the support and resources for AI/AN students interested in dentistry and encouraged other ambassadors (including AI/AN students) to model the best practices presented at

the meeting. A CD containing the recruiting programs presented at the 2009 Ambassador Meeting, including the information targeting AI/AN students, was made available to all participants at this year's program.

The ADA has established a mentoring program with information specifically for AI/AN students on the ADA webpage at <http://www.ada.org/public/careers/beadentist/college.asp> linking interested students with AI/AN students via the Arizona School of Dentistry and Oral Health SAID Student Chapter site. The site includes "A Day in the Life" series,⁷ a newly revised feature of ADA.org, which highlights an American Indian new dentist working at the Yukon-Kuskokwim Health Corporation Dental Clinic in Bethel, Alaska. A portrait of her day-to-day activities in working in the clinic and in the surrounding Alaskan villages is detailed at: http://www.ada.org/public/careers/beadentist/day_damon.asp. The ADA.org site also has information on IHS, scholarships and other resources to encourage AI/AK students to consider a career in dentistry.

In addition to peer—peer recruitment strategies, collaborative ventures with community organizations, dental societies are also encouraged to liaison locally with a variety of community resources/organizations across the country as exemplified in a resource kit highlighting "best practices" in dental society initiated outreach efforts.

The ADA is committed to these and future programs to increase the number of AI/AN dentists."

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO
PATRICIA TARREN, BDS

Question. During the hearing, it was said that opposition to the dental health aide therapist program in Alaska was related to concern about therapists performing irreversible procedures without the proper training. Can you recommend or describe ways that programs for mid-level dental health providers could address this concern? Do you think that there are advantages to having access to mid-level dental health providers even if the providers cannot do surgical procedures?

Answer. There have been 5 years of positive experience with Dental Health Aide Therapists (DHATs) in Alaska (as well as utilization of a similar model in New Zealand since 1921) where the education and experiential training received by the graduates prepares them to practice in the Alaskan bush **including performing extractions, with the authorization of their supervising dentist.** They are educated in a certified program with professional supervision in a narrowly focused, competency based, primary care curriculum. The DHAT must meet the same standard of care for procedures they perform as that expected of a dentist. Following graduation, they have 400 hours of direct supervision in preceptorship with their supervising dentist, and their scope of practice is based on their demonstration of clinical skill. They undergo continued quality assessment and assurance by their supervising dentist and receive annual education and recertification. Ongoing, independent evaluation of DHAT clinical competency has shown that DHATs provide competent, safe care.^{1, 2, 3, 4, 5, 6} They are well received and appreciated in their communities as highlighted in an editorial by Elise Patkotak in the Anchorage Daily News, June 2005: "People need ongoing treatment to take care of long- and short-term problems. A dentist in a village for a couple of weeks doesn't meet that need."⁷

It must be emphasized that the DHAT works under the license and supervision of a dentist. They have the constant ability for daily contact, as frequently as needed, by telemedicine with the supervising dentist, who retains control over proce-

¹Nash, D et al. Dental Therapists: A Global Perspective. *Int Dent J.* April 2008 58 (2): 61–70.

²Support for the Alaska Dental Health Aide Therapist and Other Innovative Programs for Underserved Populations. Policy date: 11/8/2006 <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1328>.

³Dental Health Aide Program Improves Access to Oral Health Care for Rural Alaska Native People. AHRQ Innovations exchange. June 2008, updated Nov. 2009; <http://www.innovations.ahrq.gov/content.aspx?i=1840>.

⁴Training New Dental Health Providers in the U.S.: Executive summary prepared for W.K.Kellogg Foundation, Burton L. Edelstein DDS MPH, Dec. 2009.

⁵Bolin K. Assessment of Treatment Provided by Dental Health Aide Therapists in Alaska: A Pilot Study. *J Amer Dent Assoc.* Nov. 2008; 139: 1530–1535.

⁶Evaluation to Measure Effectiveness of Oral Health Care Model in Rural Alaska Native Villages. W.K. Kellogg Foundation press release 7/15 2008 <http://www.wkkf.org/default.aspx?tabid=1147&CID=432&NID=259&newsitem=4>.

⁷Patkotak, E. Dental aides remedy lax care in villages. *Anchorage Daily News (AK): Voice of the Times.* June 8, 2005.

dures performed by the DHAT. Teledentistry, for example, utilizing intraoral cameras, digital x-rays, and electronic health records allow the dentist to view in “real-time” the patient’s medical history, any lab results, clinical and radiographic findings and consult with attending dentist to confirm the diagnosis, treatment plan, and authorize treatment as well as offer guidance throughout the procedure. The usefulness in utilizing teledentistry to support the services and minimize complications of DHATs or a similar model of mid-level practitioner, such as the dental therapist, is underscored by the published statement of RADM Halliday, chief dental officer USPHS, “The fact that many Indian Health Service dental facilities are in remote locations underscores the need for strong commitment to technology in delivering care. . . IHS has made large financial commitments over last several decades . . . in emerging technologies in the health field. . . IHS remote sites in Alaska often utilize telemedicine/teledentistry to consult with oral health providers. . . This is being increasingly integrated into remote facilities in the lower 48 states as well. All new clinics are equipped with digital imaging technology which IHS has used for many years.”⁸

It was interesting to hear Dr Yvette Roubideaux’s testimony (which followed ours), when questioned by Sen. Murkowski about **expanding the use of DHATs, she responded that the IHS “has not taken a formal position . . . but it is a great program.”**

It is noteworthy that in his testimony, Dr Tankersley stated, “Performing surgical services there’s no such thing as a routine extraction until it’s done, for example a root wrapped around the nerve or excessive bleeding. . .” This complication can be avoided by triaging the procedure with the supervising dentist, discussing potential complications before beginning the procedure, receiving authorization to carry out the procedure and having a robust system in place for management of any complication for example, stabilize the patient and transport them to a facility where treatment can be completed. **In his testimony Dr Tankersley stated, in regard to the DHAT, “Admittedly they could have good technical training.”**

In my opinion, removing the ability of the DHAT to perform nonsurgical extractions will dilute their potential benefit but will not negate their usefulness. According to Burton Edelstein in his report to the Kellogg Foundation “the primary goal of instituting dental therapists is to expand the availability of basic dental services to socially disadvantaged subpopulations who are now inadequately served. A second goal is to establish a diverse cadre of caregivers whose social, experiential and language attributes are a better match for targeted underserved populations than those of current dentists. The proportion of procedures now delivered exclusively by dentists that could potentially be delegated to dental therapists is substantial: 75 percent for general dentists and 79 percent for pediatric dentists”.⁴

A published on the IHS website, there are approximately 380 IHS dentists. As of 12/3/2009, there were 108 vacancies with 56 available for immediate employment now.⁹

According to Dr. Tankersley’s testimony, “The number of dentists that the IHS wants is low, as in the military . . . the inability to recruit for years . . . turnover rate is high . . . but we are showing a positive trend recruiting new graduates.” **In my opinion, this strengthens the argument for utilizing DHATs or other models of dental therapists in Indian country.** As Sen. Murkowski stated, (in Alaska) “we are growing our own DHAT graduates who return to their community, high level of commitment to serve.” They are a proven model providing safe, effective, culturally sensitive dental care for individuals who lack access to care.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO
PATRICIA TARREN, BDS

Question. Dr. Tankersley said during questioning that their Community Dental Health Aide Coordinator (CDHC) model is a better option than the Dental Health Aide Therapist (DHAT) currently being used in Alaska for improving dental care through the Indian Health Service. As a dentist, do you agree with that assessment? Dr. Tankersley also asserted that the CDHC is more similar to the medical model of a Physician Assistant. Again, as a dentist, do you believe this is true?

⁸Indian Health Service: IHS Impressions, Quarterly Newsletter Vol. 6, Issue 2. Public Health Dentistry—Creating Access for the Underserved: An interview with RADM Christopher G. Halliday, Chief dental Officer, USPHS.

⁹Indian health Service website: The Indian health Service Dental Program, and employment opportunities accessed 12/3/2009.

Answer. I disagree with Dr. Tankersley's assertions. While the Community Dental Health Coordinator (CDHC) may prove to be a useful adjunct in providing preventive dental services and coordination of dental care, it is **a new, untested model**. It is more comparable to the community health worker (CHW) and pales in comparison to the educational background and scope of services of the Physician Assistant (PA) which is a well proven model. **The CDHC cannot perform anywhere near the range of services of the PA or DHAT.** According to the ADA, the CDHC will work in health and community settings, assist the dentist in triaging patients, and address social, environmental and health literacy issues facing the community. They will educate community members on preventive oral health care and assist them in developing goals to promote and manage their personal oral health care. Helping patients navigate their way through the complex maze of health and dental care systems to obtain care will be an important role of the CDHC. **To date there have been no graduates of the ADA's CDHC program.**¹⁰

According to the U.S. Bureau of Labor Statistics PAs receive 2 years of training in accredited programs (admission to many programs requires at least 2 years of college and some health care experience. Most applicants have a bachelor or master's degree due to the competitive applicant pool). The PA passes a national exam to become licensed. Employment growth is high as PAs are increasingly utilized to contain costs. PAs practice medicine under supervision of physicians and surgeons: diagnostic, therapeutic, preventive. They treat minor injuries—suturing, splinting and casting, take medical histories, examine and treat patients, order and interpret lab tests, xrays and make diagnoses, record progress notes, instruct and counsel patients, order and carry out therapy. They have prescribing privileges. They may make house calls, work in hospitals and nursing homes. Also, those who specialize in surgery provide preoperative and postoperative care and may work as 1st or 2nd assistant during major surgery. **They may be the principle care providers in rural or inner city clinics** where the doctor is present 1 or 2 days/week. Their duties are determined by supervising doctor and state law.¹¹

The DHAT more readily resembles the PA or the nurse practitioner than the CDHC. The CDHC is envisioned to provide limited preventive and palliative care and extensive care coordination services—which will be a useful member of the oral health care delivery team, but with a very much limited scope of practice compared to the DHAT.

¹⁰ ADA website: The ADA CDHC Program: frequently asked questions. Sept. 2009.

¹¹ U.S. Bureau of Labor Statistics, Occupational Outlook handbook, 2008–2009 Edition.