Alaska Native Dental Health Initiative

American Dental Association
www.ada.org

The 152,000 members of the American Dental Association (ADA) believe that all Americans deserve access to dental care. We are committed to working with all stakeholders to find short- and long-term solutions to providing that care, especially to low-income and geographically isolated populations for whom access to dentists is difficult and who, consequently, suffer a disproportionate degree and severity of dental disease.

However, the ADA unequivocally opposes allowing non-dentists to perform such irreversible procedures as extracting teeth, drilling cavities or performing pulpotomies (root canals in children's primary teeth). Doing so risks patients' safety and health and, over the long-term, would erode the quality of the nation's oral health care system.

Faced with a horrific level of disease, the Alaska Native Tribal Health Consortium has begun to train and deploy a multi-tiered system of dental health aides to provide services ranging from education to preventive care to restorative care. The consortium expanded the Alaska Community Health Aide Program (CHAP) several years ago to include dental health aides, who would provide a variety of services in underserved areas. **The ADA supports the Dental Health Aide program, with the exception of one component: the use of dental health aide *therapists* (DHATs)—to perform irreversible surgery that no non-dentist should perform.**

DHATs are sent out to treat dental disease and complications with only 18 to 24 months of training after high school. They are expected to perform procedures that can lead to serious—in some cases life-threatening—complications. By comparison, dentists, generally after earning a bachelor's degree, spend a minimum of four years in graduate-level training in dental school, and many dentists then continue on for specialty training.

Proponents of the DHAT program argue that theirs is the only viable solution because of the shortage of available dentists in remote villages. **But this argument ignores the best**

solution: ensuring that Alaska Natives, like all Americans, receive the best dental care available—care provided by licensed dentists.

The ADA and the Alaska Dental Society (ADS) are collaborating to create a lasting network of care for Alaska Natives. This must happen in stages—first by deploying volunteer dentists from Alaska and the rest of the nation to help get the epidemic of untreated disease under control. More than 100 ADA-member dentists have offered to treat Alaska Natives in their villages, at no charge, for periods of no less than two weeks, at any time of year.

Ultimately, a volunteer program cannot supplant a self-sustaining oral health infrastructure. The ADA/ADS proposal offers long-term solutions to create one, including:

- Placing a dental health aide in every village to provide educational and preventive services;
- Creating local training programs for dental auxiliaries so that Alaska Natives and others interested in dental careers need not leave the state for training;
- Securing full funding to enable the Indian Health Service to fill its vacant dental positions and prevent the Tribal health authorities from having to lay off additional dentists;
- Establishing an educational pipeline for qualified young Alaska Natives to attend dental schools, become fully qualified, licensed dentists and return to provide care in their home communities;
- Exploring new models for dental auxiliaries, like the community oral health provider; and
- Jump-starting the whole process by placing volunteer dentists in the villages immediately, while the other elements of the program take shape.

The volunteer effort is making some progress. The ADA has hired a full-time employee whose sole assignment is to help place volunteer dentists in Alaska. Just recently, we reached agreements with two tribal corporations to place eight volunteers in March and April 2006. We would like to work with the other tribal corporations in a similar manner. But the administrative barriers, including credentialing requirements, criminal background checks, malpractice liability protection and other issues, continue to impede bringing dentists to the villages.

***Dentistry is health care that works—when provided by the entire dental team*.** The American oral health care system is unparalleled in its ability to prevent disease and treat it cost-effectively. The system owes many of its strengths to the team care approach, in which dentists provide care and coordinate care provided by support personnel such as dental assistants and dental hygienists.

DHAT proponents often cite the success of the Community Health Aides and Practitioners (CHAP) program as evidence that a similar model will work in dentistry. CHAPs perform limited medical procedures (and a very few dental preventive services), including patient education, physical exams, collecting samples and interpreting certain lab tests, injections, suturing wounds and administering IVs.

Unfortunately, comprehensive dental services were added to CHAP without sufficient consideration of the unique dental delivery model. DHATs' scope of practice is dramatically broader than that of CHAPs, including restorations (drilling and filling teeth), extracting teeth and pulpotomies (root canals on the teeth of children in which the decay is so rampant as to preclude saving the tooth). **It is critical to understand that these are *surgical* procedures, well beyond the degree of complexity and risk of the services that CHAPs provide.**

Patient safety at risk

Placing patients under the sole care of dental health aide therapists, or DHATs, whose training the ADA believes is insufficient to enable them to perform invasive, irreversible procedures, is putting patients at undue risk. DHAT proponents refer to these procedures as "simple." This is inaccurate and misleading. While some procedures are easier than others, any of those cited above can lead to complications that can threaten not only the patients' oral health, but also their general health. In extreme cases, infections and other complications from dental procedures can be life-threatening.

These dental procedures generally require pain control, which increases their complexity and the risk of complications. Also, many adult patients have other diseases, such as diabetes and heart problems, which add to the complexity and make treatment more dependent on comprehensive training.

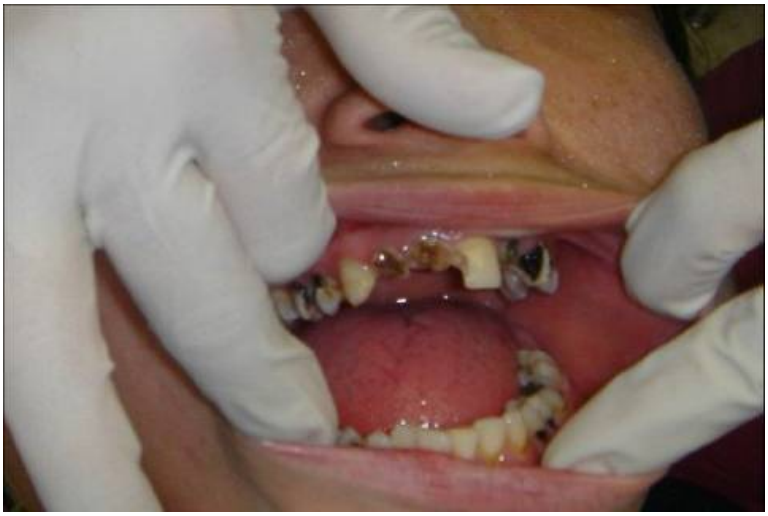
High-quality dental care is much more than performing procedures. Disease prevention and proper treatment planning call for diagnostic skills beyond the scope of non-dentists' training.

Dental disease among American Indians and Alaska Natives is widespread and severe.

Increased severity of dental disease increases the risk of complications from procedures. American Indians and Alaska Natives (AI/AN) have significantly greater incidence and severity of dental disease than the general U.S. population.

- By third grade, 91 percent of AI/AN children have experienced tooth decay and 72 percent have unfilled cavities.
- Alaska Native children and adolescents experience approximately 2½ times the amount of dental caries than that seen in the general US population
- Astonishingly, 60 percent of Alaska Native children have severe Early Childhood Caries (ECC), defined as any child age five or younger with dental decay in the maxillary anterior teeth, or six or more teeth with decay
- Approximately one third of Alaska Native adults have severe periodontal (gum) disease, compared to 12 percent of adults in the general population.

Considering the prevalence and severity of dental disease and the conditions in which dental care must be provided, bringing Alaska Natives to an acceptable level of oral health will require considerable effort by highly skilled and experienced dentists working with an effective team of dental auxiliary personnel.



Alaska patient treated by ADA volunteer dentist.

The need for adequate training and supervision

Meeting the unique oral health needs of Alaska Natives will require major efforts to arrest the rampant progress of untreated dental disease and prevent future outbreaks by dramatically increasing both the delivery of screening and preventive services and the population's oral health knowledge. Auxiliary personnel—dental assistants, hygienists and aides—are critical to the dental team model that provides most Americans with the best care in the world. But this model only holds when a dentist coordinates each patient's care, supervising auxiliary personnel and performing those procedures that only a dentist is properly trained to do.

What follows is a *partial* listing of the comprehensive range of biomedical and behavioral science education, ethics and professionalism, and clinical sciences that dental schools must teach in order to be accredited. According to the Commission on Dental Accreditation (CODA), dental school graduates are expected to demonstrate:

- Knowledge of biomedical, behavioral and clinical science of sufficient depth, scope, timeliness, quality and emphasis to ensure achievement of the curriculum's defined competencies;
- An in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems, in which the mouth and face are a critical anatomical area existing in a complex biological interrelationship with the entire body;
- A high level of understanding of the development, spread, diagnosis, treatment and prognosis of oral and oral-related disease; and
- Biomedical science knowledge of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.

CODA clinical science requirements are equally rigorous, with required competencies caring for pediatric, adult and geriatric patients including, but not limited to:

- Patient assessment and diagnosis;
- Comprehensive treatment planning;
- Health promotion and disease prevention;
- Informed consent;
- Anesthesia, and pain and anxiety control;
- Fillings, using the full range of safe and effective materials;
- Replacement of teeth;
- Periodontal (gum disease) therapy;
- Pulpal (root canal) therapy;
- Hard and soft tissue surgery;
- Dental emergencies, such as those resulting from blows to the face or other traumatic injury;
- Malformed bite; and
- Evaluation of the outcomes of treatment.

In addition to this broad range of scientific knowledge and clinical skills, "Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental practice."

U.S. dental students are required to master all of the knowledge and skills above before graduation. The training received by DHATs simply does not prepare them adequately to perform surgery safely.

Licensure: The public's watchdog

Licensure is the state's way to protect the public from practitioners without adequate education, training or clinical skills. All states require graduation from a dental school accredited by the Commission on Dental Accreditation, successful completion of a written national board examination and a state or regional clinical examination in order to be eligible for a dental license.

In addition, most state boards require dentists and dental auxiliaries to meet continuing education requirement in order to keep their licenses. CE requirements are another way that state boards ensure that everyone involved in delivering dental care not only meets standards of competency, but also maintains them. **There is no licensure process for DHATs.**

The ADA supports the dental health aide program.

The ADA supports nearly every aspect of the dental health aide program.
That means we support education, prevention, oral health literacy programs, water fluoridation, sealant programs, nutrition programs, literally anything and everything that helps prevent dental disease.

Dental health aides can play critical roles in improving the oral health of Alaska Natives—especially those living in remote villages—when working under a scope of practice focused on education and prevention, ***but not surgery***.

The dental community is prepared to do its part in resolving the severe access needs of Alaska Natives. We can do this as soon as all of the stakeholders begin working together for a better future.

#