American Dental Association
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ADA Position on the Dental Health Aide Program in Alaska

The American Dental Association (ADA) has lobbied vigorously for increased funding for dental programs and construction or improvement of Indian Health Service dental facilities for more than 35 years. We have visited IHS dental programs throughout Indian country and met with tribal leaders and dental personnel to observe conditions and strengthen our ability to lobby Congress in support of IHS' mission.

The ADA strongly supports passage of the Indian Health Care Improvement Act, S. 1057, with one important caveat: that the bill is amended to ensure that the Community Health Aide Program does not allow Dental Health Aide Therapists to perform certain irreversible dental procedures.

Contrary to some misconceptions, the ADA, Alaska Native tribes and the IHS agree on most issues affecting the delivery of oral health care in Alaska—including expanding the Community Health Aide Program (CHAP) to include Dental Health Aides to address the needs of Native Alaskans in rural villages.

The only concept that the dental community opposes is allowing one category of dental health aide, Dental Health Aide Therapists (DHATs), to perform such irreversible surgical procedures as extracting teeth, drilling cavities and performing pulpotomies (which are similar to root canals). These procedures involve the use of high-speed drills in the mouth and require the skills of a licensed dentist to ensure patient safety and health. All 50 states limit these procedures to licensed dentists, who routinely have eight or more years of post-high school education and training (as compared to the 18 to 24 months of post-high school foreign training of DHATs).

Many adult patients have medical conditions—diabetes, heart problems, etc.—that add to the complexity of dental treatment and are more dependent on comprehensive training. And, unfortunately, it is not possible to predict the more routine, simple extractions from the more complicated procedures before treatment begins.

The dental community's fundamental concern is that DHAT training is not adequate to help them recognize complex cases—cases in which patients could be at great risk. While the ADA acknowledges that in any given procedure things can go wrong for either a dentist or a therapist, the difference is that a dentist can draw upon an extensive set of knowledge, skills and abilities, whereas a DHAT cannot.

Washington Office
1111 14th Street, NW, Suite 1100, Washington, DC 20005
p 202-898-2400 f 202-898-2437

The ADA established a task force to explore options for delivering high quality oral health care services to Alaska Natives in October 2003, and has worked ever since to find solutions that would be acceptable to all stakeholders. At a November 15, 2004 meeting with tribal leaders, the ADA and Alaska Dental Society (ADS) extended an invitation for all to work together to address the current backlog of dental need in the villages. This was followed-up with a letter from the ADA and ADS presidents to all tribal health directors.

Unfortunately, the initial positive response to our backlog initiative, one element of which would have sent volunteer dentists from around the country to Alaska villages for short stints, has since been met with apathy on the part of tribal leaders. One of the reasons given has been the difficulty in credentialing dentists to come to Alaska. In response, the ADA has approached the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to seek a solution to the credentialing paperwork burden. The ADA also established a new full time position within the Association for an employee who would help coordinate the placement of dentists in Indian Health Service (IHS) and tribal programs.

It is a false choice to suggest that Alaska Natives must either receive no care or care provided by DHATs. Instead, the ADA has suggested that a dental health aide be placed in every village to provide oral health prevention and education, that a coordinator work with the tribes to bring more dentists to the villages to provide comprehensive dental care, and that credentialing paperwork redundancy be reduced to make it easier for dentists from around the country to help provide care.

Toward these ends, four dental experts, including the current dental director of the Alaska Native Medical Center in Anchorage, recommend that the best way to address the access problems facing Alaska Natives is to make the current dental delivery system more efficient, which can be accomplished with more dental assistants and more dental chairs per dentist. In addition, they call for the creation and use of Community-based Oral Health Providers (COHPs) as an Alaska-based solution, with training in Alaska specifically designed for Alaska Natives. COHPs, like DHATs, would be mid-level providers, but they would have an expanded management role (in addition to an expanded clinical role) which would enhance the efficiency of the current delivery system. The ADA believes that this promising model—many aspects of which have already proven to be successful in the Alaska Southcentral Foundation program—should be tried by other Alaska tribal programs.

Finally, the ADA supported language in the House Resource Committee's version of last session's Indian Health Care Improvement Act (H.R. 2440) that prohibited non-dentists from performing irreversible procedures on patients. We strongly recommend that the new senate version of the Indian Health Care Improvement Act, S. 1057, be amended to include that restriction.