

The Alaska Dental Health Aide Program

The Alaska Dental Health Aide Program, a component of the congressionally authorized Alaska Community Health Aide Program (CHAP), is on the national agenda due to concerns expressed by the American Dental Association (ADA). Their concerns are specifically related to the planned provision of basic irreversible surgical procedures (simple restorations and extractions) by these individuals. This brief is designed to provide you with essential factual background on the genesis and status of the program, the relationship between the Indian Health Service and tribal governments and the related issues. A more thorough background will be posted on our bulletin board for your reference. The issue is complex and the facts need to be clear. For that reason this message is longer than usual and includes a description of the relationship between the Alaska Native tribal governments (and other tribal governments) and the Indian Health Service. Specific questions about the Indian Health Service issues should be directed to CAPT Chris Halliday. Questions regarding the ADA should be directed to me.

Issue: This year an ADA Alaska Native Oral Health Access Task Force studied the program and submitted a report and recommendations to the Board of Trustees that in turn was submitted to the ADA House of Delegates (Board Report 13). Thirteen resolutions are specified and predominately focus on ways to enhance dental care for Alaska Natives. One of these resolutions states that the ADA is opposed to non-dentists performing irreversible procedures.

At this time CHAP is confined to Alaska. The Indian Health Care Improvement Act Amendments of 2003 (H.R. 2440) proposes expanding the CHAP program to the rest of the nation. Last week the American Dental Association activated its constituents to inform their legislators about recommended changes to the H.R. 2440. The ADA is concerned with Section 121 of H.R. 2440 that will extend the CHAP program that in turn would imply that a dental health aide component that permits non-dentists to perform irreversible “surgical” procedures can be a part of this program. The ADA amendment supports a dental health aide program within CHAP, but one that would not provide irreversible dental procedures.

Background:

What is the program? The Alaska Dental Health Aide Program is part of the Community Health Aide Program (CHAP), a congressionally authorized program operated by Alaska Tribal leaders and the Alaska Native Health Consortium. It is focused on prevention, pain and infection relief and basic restorative services. There are three categories of dental health aides: Primary Dental Health Aides (dental education, dental assisting, preventive dentistry); Expanded Function Dental Health Aides (expanded duty dental assistants in regional dental clinics); and Dental Health Aide Therapists (oral exams, preventive dentistry, restorations, stainless steel crowns, extractions and x-rays). The latter category of the program that has garnered the most attention.

Why was this program developed? The program was developed in response to the Southeast Alaska Regional Health Consortium white paper that highlighted the major

crisis in dental disease and care experienced by Alaska Natives (dental caries 2 ½ times national rate; early childhood caries up to 10 times higher than the national rate; 25% vacancy rate; 30% average annual turnover rate of dentists; major geographic isolation, and cultural competency and rural challenges) at the direction of Tribal leaders and the Alaska Native Health Consortium by the CHAP Directors, Native health corporation dental program directors and dental consultants of the Alaska Native Tribal Health Consortium.

What is the status of the Dental Health Aide Therapists part of this Program? This part of the program is designed as a five year pilot to train and place therapists in villages selected by tribal leaders and the Consortium. It will be evaluated and continued if successful. To date no therapists have been assigned to villages. Candidates for this program (high school graduates) are recruited by individual Alaskan tribes and the initial six students have completed the 18 month training program this year at Otago University School of Dentistry, New Zealand. Six new students have started their first year in February 2004 and current recruitment is underway for another class to start in 2005. The partnership with Otago University was established given their 85 years of experience with this practice model, namely the New Zealand dental nurse program. The New Zealand dental nurse program is the oldest and best known of the auxiliary-based programs that provide dental care in public settings. Many other countries have adopted similar programs, and tailored them to suit the local environment and community needs. They include Canada, Great Britain, Australia and Thailand, among others.

How will the quality of care provided by the Dental Health Aide Therapist be maintained? Ensuring the quality of care provided by these therapists is a critical part of the program. Before their assignment to a specific village, new graduates will practice under the direct supervision of a dentist for a minimum of 400 hours or three months. Based on their performance an individualized scope of practice will be developed for them based on their competency. A 12-member board that includes a dentist administers the certification program. Upon completion of their certification they will be sent to provide select services under general supervision of a dentist who is responsible for writing the standing orders and being the point of contact for the therapist. This dentist is located in the hub hospital that serves the respective village and will conduct periodic reviews that include both chart review and patient examination. In addition the therapist is required to complete a specified number of CE credits and recertification is planned to be completed once every two years.

What is the relationship between the Alaska Native tribal governments (and other tribal governments) and the Indian Health Service? The United States Constitution, treaties between the US government and Indian tribes, and Supreme Court cases form the legal basis of the relationship between tribes, states, and the federal government. Tribal governments enjoy sovereign status. As a result a government-to-government relationship exists between the United States and Federally-recognized Indian tribes. American Indians and Alaska Natives, as citizens of the United States, are eligible for all programs available to the general population. In addition, federal law and treaties

between the United States and tribes also impose a duty on the United States to provide health care to American Indian people.

The Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976 “provide specific legislative authority for Congress to appropriate funds specifically for the health care of Indian people.” (Public Law 94-437, 25 U.S.C 1601 et seq.) These and other laws, court cases and Executive Orders form the foundation for treating Indians differently than other groups. The duty for fulfilling the obligation of the United States to provide health care to American Indian and Alaska Native people has been vested in the Department of Health and Human Services (DHHS). The Indian Health Service, as a Public Health Service agency of DHHS, has the primary responsibility to meet tribal health care needs; however, all Divisions within DHHS share this responsibility within the construct of their respective missions.

The Indian Self-Determination and Education Assistance Act of 1975 recognized the primacy of the government-to-government relationship between the United States and sovereign tribal nations. (Public Law 93-638, 25 U.S.C. 450 et seq.) The Act provides tribes with the right to assume some or all of the programs, services, functions and activities carried out by the IHS on their behalf and to receive the funding that IHS would have spent had it remained directly responsible for providing care. Even when tribes have assumed full responsibility for the programs previously carried out by IHS, IHS retains certain residual responsibilities, including the duty to reassume operation of the program should the tribe choose to give up operation or fail to meet the standards for operation imposed under the Self-Determination Act. After more than a decade of successful tribal activity under the Self-Determination Act, it was further amended to give tribes additional flexibility, first through a self-governance demonstration project and later in August 2000 through adoption of Public Law 106-260, which made permanent the right to carry out IHS programs under self-governance agreements.

In Alaska, as well as many other geographic areas in the country, there has been a long history of tribes and tribal organizations carrying out the programs of the IHS on their own behalf. Due to the great number of tribes and their relatively small size and extraordinary remoteness, most tribes in Alaska chose to exercise their right to join with other tribes to create a regional tribal organization to carry out health programs on their behalf. This led to very efficient regional health systems. When the opportunity to take part in the self-governance demonstration project became available, all of the tribes and tribal organizations in the State came together to propose to the IHS that they enter into a single agreement with the IHS, called the Alaska Tribal Health Compact, under which they would all negotiate together with the IHS to carry out programs. Under the Compact, each tribe or tribal organization then negotiates its own funding agreement through which it identifies the specific programs, services, functions, and activities it carries out. This varies widely from one to another with some carrying out comprehensive health services and others carrying out only a few preventive health programs, while relying on IHS (and later another tribal organization) for the balance of services. In 1994 this self-governance activity culminated in the formation of the Alaska Native Tribal Health Consortium (ANTHC), which with the Southcentral Foundation, the tribal organization for

Anchorage and surrounding areas, assumed responsibility for the operation of the Alaska Native Medical Center, the tertiary care IHS hospital in Anchorage. In addition, ANTHC assumed responsibility for all non-residual statewide IHS functions. Thus, a tribe or tribal organization now carries out all direct services of the IHS in Alaska. These tribes and tribal organizations function in close collaboration with each other, operating as the Alaska Tribal Health System.

We should be reminded that the major message of the Surgeon General's report on oral health highlighted that while major improvements have been made in the oral health of Americans, "not all Americans are achieving the same degree of oral health"...and "many among us still experience needless pain and suffering, complications that can devastate overall health and well-being, and financial and social costs that diminish the quality of life..." As members of the US Public Health Service, I know that you are well informed about the magnitude of needs facing these populations, among them oral health needs. The needs of American Indian/Alaska Native communities are particularly significant given the magnitude and severity of their oral health needs, and the extremely challenging local conditions including in many cases severe geographic isolation. Addressing the needs of all our communities, including our Indian communities, will require approaches that are creative, targeted, culturally-sensitive and tailored to their unique needs and desires.

I also want to bring to your attention that there are other reports before the ADA House of Delegates that provide important insight and recommendations for addressing access to dental care. I urge you to review these and work collaboratively with your local and constituent societies. Addressing the needs of all populations is a challenge that will require close collaborations with the private sector. For dentistry, public health needs must be addressed through public-private partnerships. As pilot programs such as the Dental Health Aide Therapist program are undertaken we must encourage the documentation and publication of health outcomes, utilization, and community acceptance so others can benefit. I thank you for your efforts to address these needs through clinical, epidemiologic, regulatory, research, administrative and other essential services you provide.

RADM Dushanka V. Kleinman
Chief Dental Officer, US PHS