

Alaska Dental Health Aide Program Brief

09/14/05

The Department of Health and Human Services' U.S. Public Health Service and its Indian Health Service agency share common goals with the American Dental Association: to assure that our patients receive quality health care from qualified providers and reduce the lack of access to oral health care. This brief was prepared to answer questions raised by the American Dental Association's Council on Government Affairs members and District IV Delegates about the Alaska Dental Health Aide Program. We understand the Association is very interested in this program and extend an invitation to the leadership of the Association to visit the program.

We value the oversight the Association has provided to programs serving American Indians/Alaska Natives and welcome the opportunity to continue to keep the Association apprised of the progress and efficacy of these programs. This brief is organized in four parts: 1) the legal basis for federal obligation to health care for American Indians and Alaska Natives, Indian self-determination and the structure of Alaska Native tribal governments; 2) general background and legislative basis for the Alaska Dental Health Aide Program; 3) highlights of the Dental Health Aide Therapist component of the Alaska Dental Health Aide Program, and 4) summary points to note.

If you have further questions, please do not hesitate to contact RADM Eric Broderick (202 690-6093; Eric.Broderick@hhs.gov), who will serve as the point of contact on behalf of the Indian Health Service and the Alaska Tribal Health System.

I. Legal Basis for Federal Obligation to Health Care

A. What is the legal basis for the federal obligation to provide health care to American Indians and Alaska Natives? 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.

B. What is Indian self-determination? 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.

C. What is the structure of the Alaska Native tribal governments and their relationship to the Indian Health Service? In Alaska 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.

II. Alaska Dental Health Aide Program

A. What is the Alaska Dental Health Aide Program? The Alaska Dental Health Aide Program is a program developed as a specialty area under the Community Health Aide Program (CHAP) and is operated by Alaska tribal health programs. This program, which is described in more detail in II.D, is authorized by federal law only for operation in Alaska. The CHAP Directors, dental program directors and dental consultants of the Alaska Native Tribal Health Consortium developed the Alaska Dental Health Aide Program. The focus of the program is on prevention, pain and infection relief and basic restorative services. ***NOTE: This program was initially called the Community Health Aide Dental Program and had numbered levels of Dental Health Aides (referenced below).*** These previous numbered levels have been reorganized into the following four categories of dental health aides:

- **Primary Dental Health Aides:** will provide dental education, dental assisting, preventive dentistry services (*used to be Dental Health Aide I and II*);
- **Expanded Function Dental Health Aides:** will serve as expanded duty dental assistants in regional dental clinics (*used to be Dental Health Aide III and IV*);
- **Dental Health Aide Hygienists:** will provide dental hygiene services in regional dental clinics and villages (*same*); and
- **Dental Health Aide Therapists:** will provide oral exams, preventive dental services, simple restorations, stainless steel crowns, extractions and take x-rays (*used to be Dental Health Aide V or VI*).

Dental health aides must be employees of the IHS or a tribe or tribal organization.

B. What stimulated this program? In 1999 the Southeast Alaska Regional Health Consortium generated a white paper that described the magnitude of the dental disease crisis experienced by Alaska Natives. This paper documented the extent and severity of oral diseases as exemplified by the data that reveal that Alaska Native children experience caries rates 2 ½ times that of the national rate (1990 and 1999 IHS surveys). In addition, dentist workforce data revealed that Alaska Tribal programs experience a 25% vacancy rate and a 30% average annual turnover rate. Finally, the challenge of the geographic distribution of the population, variation in size of towns and villages and the importance of cultural and linguistic competence was described. Currently there are about 120,000 Alaska Natives, approximately 85,000 Alaska Natives live in the 200 villages that make up rural Alaska and most are not connected to the rest of the State by roads. In most of these villages, the only health care provider available on a routine basis is the community health aide who provides services out of a small clinic many of which lack even running water or piped sewer. In many instances, Alaska Native patients must travel by bush-plane, boat, or snow machine in order to obtain dental services. Alternatively, children, or adults with toothaches, can access care during itinerant visits from dentists working in the Tribal programs, but these visits are very limited and can be sporadic. The Alaska Dental Health Aide Program was developed as one component of a response to this white paper.

C. How was the program developed and how is it funded? The Alaska Native Tribal Health Consortium Dental Consultant, in the role as advisor to the Alaska Tribal programs, prepared a proposal in FY2000, on behalf of the tribes, in response to a call for applications for Dental Clinical Preventive and Support Centers by the IHS. Emphasis for awarding funding was placed upon collaborative efforts between Tribal Programs and IHS-managed programs that were designed to meet the perceived needs of the Areas. The Alaska proposal received a favorable review for technical and scientific merit, by a panel of non-federal experts and Tribal health staff, and was one of the successful grants funded that year. Progress towards stated goals for the funded support centers are reviewed on an annual basis. The Alaska Dental Health Aide Program also receives additional funding from foundations, non-profit organizations, and from commitment of resources by the tribal health programs throughout the state.

D. What is the legislative basis for the program? The Alaska Dental Health Aide Program is part of the Community Health Aide Program. The Community Health Aide concept was developed by IHS in the 1950's in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968, the Community Health Aide Program (CHAP) received formal congressional recognition and federal funding. It was subsequently authorized, exclusively for Alaska, in the Indian Health Care Improvement Act. (Section 121, 25 U.S.C. 1616l.) It has proven to be a cost effective, efficient and essential component in improving the health of the Alaska Native people by decreasing morbidity and mortality. This program is unique in the United States and has become a model for the delivery of primary health care services. Today there are over 550 Community Health Aides in this successful program, providing services in some of the most remote regions in North America. They form the backbone of rural Alaska Native health care and provide for over 350,000 patient visits each year.

The Community Health Aide Program, and its dental component, do not fall within the parameters of the Alaska State Medical or Dental Practice Acts and are not intended to do so. Instead, they are certified by a Board appointed by the IHS according to *Standards* adopted by the Alaska Area Director of the IHS. All community health aides and dental health aides must be employees of the IHS or a tribe or tribal organization operating programs of the IHS under the Indian Self-Determination and Education Assistance Act.

III. Dental Health Aide Therapists (used to be Dental Health Aide V)

A. How are the Dental Health Aide Therapist candidates selected? The Dental Health Aide Therapists is the highest level of dental health aide. Candidates for the Dental Health Aide Therapist program, like those for other portions of the overall program, are recruited by the individual Alaskan tribes mostly from tribal members who live, work and serve in their community. After completing their two-year program, all students will return to their home communities to provide services.

B. How are the Dental Health Aide Therapists trained and how many are there? To ensure high quality training, the Dental Health Aides Therapists are being trained through

the partnership with Otago University in New Zealand, an internationally recognized school of dentistry that has over 85 years of experience with this practice model. Dental Therapy programs in New Zealand and Canada have maintained an excellent patient safety record. Studies conducted in Canada suggest that the quality of services provided by dental therapists is in keeping with those of dentists. Currently there are eight students, all from Alaskan tribes, enrolled in the Dental Health Aide training program.

C. How will the quality of care for the Dental Health Aide Therapists be maintained? As part of the Community Health Aide Program, the oversight of the Dental Health Aide Therapists will be managed in the following manner: Each provider in the Community Health Aide Program must meet the qualifications as outlined in the Federal Community Health Aide Program Standards and Procedures. A 12-member board that includes a dentist, required by Congress and appointed by IHS, administers the certification program. Each provider in the program must be an employee of IHS or of a tribal health program and, in addition to meeting training requirements, must undergo a protracted preceptorship and each of their skills is evaluated by direct observation. This skill evaluation is completed every two years and, in addition to continuing education, is required for recertification. Every health aide provider in the program is assigned to and is under the supervision of either a physician (in the case of Community Health Aides), or a dentist (for the Dental Health Aides). Each has a well-defined individualized scope of practice. Thus the program has developed rigorous administrative controls, gleaned from 36 years of experience, to ensure quality of care.

Each Dental Health Aide Therapist will be assigned to a dentist who will be responsible for writing the standing orders and being the point of contact for the therapist. This dentist will be located in the hub hospital that serves the respective village and will be connected to the Dental Health Aide Therapist via the established telemedicine/telehealth network. The oversight and recertification of the Dental Health Aide Therapist will be done by the dentist who writes the standing orders. These reviews will include both chart review and patient examination.

D. Update on the Current Practicing Alaska Dental Health Aide Therapists

The first cohort of four Dental Health Aide Therapists graduated in December 2004 from New Zealand's National School of Dentistry in Otago. One more member of this first cohort completed the course requirements and joined the others during the summer of 2005. In January 2005, the initial four graduated DHATs began the process of completing their preceptorship providing direct patient services. The regional dental programs located in Bethel and Kotzebue each have two certified DHATs and Kotzebue has an additional DHAT who started the preceptorship in August 2005.

The two Dental Health Aide Therapists in Bethel have completed 375 exams, 519 preventive services, 242 restorations, 13 SSC and 16 pulpotomies, and 171 extractions. The two certified therapists in Kotzebue have seen 857 patients and completed 390 exams, 745 preventive services, 576 restorations, and 89 extractions as of August 31, 2005. In addition to this clinical work the Dental Health Aide Therapists are studying

telemedicine and developing community prevention strategies for their villages. Continuing education is being planned for the Dental Health Aide Therapists; their annual continuing education requirements are equivalent to that required of a dentist with an AK license.

The dentists working directly with the Dental Health Aide Therapists have been impressed by their patient management skills and the quality of their work. In addition there have been many positive comments from patients who have received care from the Dental Health Aide Therapists.

The DHATs in villages in the Kotzebue region are communicating with their dentist supervisors on a regular basis, usually 3-6 times per day. They send x-rays and photos by e-mail and discuss cases over the phone with their dentist supervisor and refer appropriate cases to Kotzebue or Anchorage. In addition to providing clinical care, the DHAT living in one of the villages goes to the school each day to provide preventive services such as setting up tooth brushing and fluoride supplement programs and providing oral health education.

IV. Summary Points

Alaska Dental Health Aide Program:

1. The Program was developed in response to the Southeast Alaska Regional Health Consortium white paper highlighting a major crisis in dental care experienced by Alaska Natives (dental caries 2 ½ times the national rate; 25% vacancy rate and 30% average annual turnover rate of dentists; major geographic isolation, rural health and cultural competency challenges).
2. The Program is part of the Community Health Aide Program, a congressionally authorized program exclusively for Alaska in the Indian Health Care Improvement Act.
3. The Community Health Aide Program does not fall within the parameters of the Alaska State Medical or Dental Practice Acts.

Dental Health Aide Therapist:

1. Candidates are recruited by the individual Alaska tribes and once training is complete, will return to their home communities to provide services.
2. Six students are currently in training, and another eight have been selected.
3. A 12-member board, required by Congress and appointed by IHS, that includes a dentist administers the certification program. Oversight and recertification will be done by the dentist who writes the standing orders. The dentist will be located in the hub hospital that serves the respective village.
4. Therapists are under the general supervision of a dentist who is responsible for writing the standing orders and being the point of contact for the therapist.
5. The supervising dentist will conduct periodic reviews of the therapist that include both chart review and patient examination.