

Indian Country Leads National Movement to Knock Down Barriers to Oral Health Equity

Tribal and other underserved communities are struggling under the weight of devastating oral health disparities. Tribes as sovereign nations are searching for innovative solutions to address their unique barriers to oral health care.

Dental therapists are primary oral health providers who work as part of the dental team to provide a limited scope of services to patients. They were first brought to tribal communities by the Alaska Native Tribal Health Consortium. Despite strong opposition from the American Dental Association aimed at protecting its monopoly on oral health care, dental therapists are sweeping the nation. Evidence shows that they are effective and provide high-quality care, particularly in underserved communities.

A community's ability to develop public health policy solutions tailored to its needs and priorities is essential in eliminating health disparities and achieving health equity. The Swinomish Indian Tribal Community is leading the way to more effective and efficient dental teams and working hard to lay the groundwork for the elimination of oral health disparities. (*Am J Public Health*. 2017;107:S81–S84. doi:10.2105/AJPH.2017.303663)

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It is not an exaggeration to say that the current dental care delivery system in the United States is failing communities of color. Black, Hispanic, Asian, and American Indian/Alaska Native (AI/AN) children are less likely to see a dentist and receive preventative treatments than are White children, and people of color are more likely than are Whites to suffer from untreated tooth decay.

Native communities are struggling under the weight of devastating oral health disparities. The prevalence of tooth decay among AI/AN children aged two to five years is nearly three times the US average.¹ More than 70% of AI/AN children aged two to five years have a history of tooth decay, as compared with 23% of White children.¹ AI/AN adult dental patients suffer disproportionately from untreated decay, with twice the prevalence of untreated caries as the general US population and more than any other racial/ethnic group.² AI/AN adult dental patients are also more likely to have severe periodontal disease, to have missing teeth, and to report poor oral health than are the general US population.²

Unfortunately, these numbers do not surprise anyone who grew up or lives in a tribal community; however, they are staggering nonetheless. There is an oral health crisis in Indian country. The reasons for poor dental health in tribal communities include factors such as geographic isolation that continue to limit

available providers, economic and racial disparities, and the historical trauma of decades of inadequate health care. In response, with the end goal of achieving oral health equity, Native communities are searching for innovative solutions to address the unique barriers that keep oral health care out of reach for many tribal members.

MEETING THE NEED IN INDIAN COUNTRY

There is no single silver bullet for improving oral health in Indian country. However, one key tool to overcome the barriers to dental care in Indian country is the use of dental health aide therapists (hereafter “dental therapists”). Notably, tribes in Alaska have been at the forefront of developing a system of village-based paraprofessionals through the Community Health Aide Program (CHAP) during the past several decades, and in 2005 they added dental therapists to that program. In Alaska, dental therapists are part of a mature system of village-based, midlevel primary care providers available through CHAP.

As part of the dental team, dental therapists advocate for the

needs of patients, extend care to tribal communities, and help dentists see more patients. Under the general (off-site/indirect) supervision of dentists, dental therapists can practice in remote settings where there is need for additional provider capacity. They provide routine services such as nonsurgical fillings and extractions and free up dentists to take on more challenging cases.

Dental therapists are not mini-dentists or dentist replacements; rather, they are part of a high-functioning dental team. As colleagues, dentists, hygienists, and dental therapists can provide support to one another over their entire patient population. In Alaska, dentists provide remote supervision via telephone or through other technology such as teledentistry equipment. The dental team shares x-rays and intraoral photos, allowing them to collaborate on patient care.

The scope of dental therapists' work³ is intentionally limited to procedures that can provide relief from pain, basic treatment of disease, and preventive education and services. Opponents of dental therapy often suggest that dental therapists should not be trained to provide restorative services and that, rather than lack

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of services, lack of education is the real problem. However, the ability of dental therapists to address pain, infection, and damage to teeth (fillings and extractions) is very important for patients who have experienced a lack of access to dental care. Relationships between providers and patients are very important with respect to long-term behavior change. If providers cannot address the immediate needs of patients, they will not be in a strong position to successfully connect with them and build a trusting relationship. Preventive programs must engage patients to effectively support long-term behavior changes. Prevention alone will not address existing treatment needs. Therefore, dental therapists focus on prevention of oral diseases, alleviation of pain, infection relief, and basic restorative services.

Tribal communities have long struggled to retain providers, most of whom are not native. Only 0.1% of dentists are American Indian/Alaska Native in origin.⁴ People should not consider it a privilege to see a provider who looks like them and understands their language, culture, history, and community; this should be the norm. In Alaska, 78% of dental therapists practice in their village or region of origin,⁵ and 87% are American Indian/Alaska Native in origin.⁶ The retention rate for dental therapists in Alaska is 81% over 11 years.⁵ Currently, approximately 35 dental therapists serve roughly 45 000 people in 81 tribal communities in rural Alaska. In addition to expanding preventive care options among the populations most in need, dental therapists are very cost-effective.⁷

Long-term improvement requires more than simply tweaking the existing broken system. Improving care and

access is not only about bringing more providers to Indian country or other underserved communities; rather, it includes fixing the current training system for health professionals, as the Alaska Native Tribal Health Consortium (ANTHC) has been doing through the CHAP program. We can and should “grow our own” providers and create an education system that breaks down barriers to training health professionals from tribal and other under-represented communities.

Dental therapists in Alaska build community health care delivery capacities and create jobs by training community members to become dental therapists. ANTHC, in partnership with Ilisagvik College, administers the two-year training program for dental health aide therapists. Tribal members are selected by their communities, usually through the dental program or some other competitive process, to receive training. Students spend their first year in Anchorage completing the didactic portion of their education. Students are in class for 40 weeks each year from 8 AM to 5 PM. The second year is the clinical year and takes place in Bethel. Students spend part of their day in class and the rest of their day seeing patients under the supervision of teaching dentists. At the end of the training program, they receive an associate of applied science degree in dental therapy.

Dental therapists have a proven record of success in Alaska Native communities.⁸ Communities that once had high school graduates with full sets of dentures now have cavity-free clubs in their schools.⁹ Elders who were afraid of the dentist now have a familiar and trusted face in the dental office to help them conquer that fear.

At the request of legislators, the Washington Department of Health conducted a health impact review of statewide dental therapy legislation.¹⁰ Such reviews can inform and enhance equitable, health-aware decision-making, and they are used to evaluate a policy and its potential impact on the health of a population and help identify the health and equity effects of proposed legislation. According to the review’s results, passing legislation to authorize dental therapists statewide has the “potential to improve oral health and overall health outcomes, particularly for low-income and communities of color as well as individuals with medical disabilities or chronic conditions. These communities are disproportionately impacted by negative oral and other health impacts; therefore improving health outcomes for these populations would likely decrease health disparities.”¹⁰

Dental therapists are also working to improve access to care among underserved communities in Minnesota. Given their success rate, dental therapists should be available throughout the United States to address the oral health needs of their communities. As primary oral health care providers, they can be successful in any population, not only tribal communities. However, a significant legal barrier has prevented their expansion, specifically amendments of legislation intended to expand and improve access to health care for Native communities and all persons in the United States. The Indian Health Care Improvement Act (IHCIA; Pub L No. 94-437) was passed in 1976 to address the health status of the AI/AN population in the United States. In 2010, the IHCIA was permanently reauthorized as part of the Affordable Care Act

(Pub L No.111-148). During that permanent reauthorization, the American Dental Association (ADA) successfully lobbied for the addition of language to the IHCIA intended to slow the expansion of dental therapists in tribal communities.

LEGAL BARRIERS TO EXPANDED DENTAL TEAMS

The ADA is effectively protective of its market. Similar to the American Medical Association, it has unparalleled control over its own professional licensure, structure, and regulation in the delivery of health care. Unlike medicine, however, in which a variety of midlevel and allied health professionals work with physicians, there is only a small cadre of providers of oral health services. The ADA has used this control over licensure and regulation to stifle competition in the industry.¹¹

In 2005, the first dental therapists in Alaska were certified by the CHAP board. In February of that year, the Alaska Board of Dental Examiners asked the Alaska Department of Law to take action against dental therapists practicing dentistry without a license.

Tribes as sovereign nations have a government-to-government relationship with the United States, and states do not have jurisdiction over tribes except as delegated by Congress or determined by federal courts.¹² In September 2005, the Alaska assistant attorney general wrote an opinion in favor of dental therapists citing federal preemption¹³; according to the opinion, “the Alaska state dental licensure laws stand as an obstacle to Congress’ objective to provide

dental treatment to Alaska Natives by using non-dentist, non-hygienist paraprofessionals.”¹⁴

Nonetheless, in January 2006, the Alaska Dental Society and the ADA filed a lawsuit against ANTHC, the state of Alaska, and eight dental therapists.¹⁵ Organized dentistry lacks an understanding of barriers to dental care. While the lawsuit was pending, the president of the Alaska Dental Society stated on a listserv for dentists that Alaska Native oral health disparities were attributable to a lack of personal responsibility and that “[a]ny culture that allows such disease will soon disappear and rightfully so.”¹⁶ Unfortunately, racist and uninformed viewpoints can often enter policy discussions and create and perpetuate barriers to access.

In June 2007 the Alaska Superior Court ruled, in a comprehensive and strongly worded 21-page opinion, that the Alaska Dental Practice Act conflicted with federal law and obstructed the execution of the federally implemented CHAP. In addition, according to the opinion, “[C]ongress expressed purpose to create an independent statutory framework as a way to provide health care to Alaska Natives that would be wholly defeated if the court were to allow a system, which has failed to serve the dental health care needs of Alaska natives, to oversee and regulate the dental health aide therapists.”¹⁵ There was no appeal.

When the IHCIA was being permanently reauthorized as part of the Affordable Care Act, the ADA lobbied to incorporate language into the legislation that would exclude dental therapists from the nationalization of CHAP. Because, as a result of federal preemption, the ADA had been unsuccessful in shutting down the dental therapy program

in Alaska through its court actions, it wanted new language in federal laws that would preclude the spread of dental therapy in tribal health programs to states outside Alaska. As part of the permanent reauthorization, the IHCIA was amended to allow for the nationalization of the CHAP program subject to certain limitations. Two such limitations are the exclusion of dental therapists without state authorization and the exclusion of certain procedures from the scope of practice of dental therapists.¹⁷

That language seemingly left tribes at the whim of state legislatures. Until this year, no tribe had successfully moved state legislation that would authorize the use of dental therapists in tribal health programs. But tribes are resilient. As governments, we have the responsibility to provide for the health and welfare of our citizens, so the Swinomish Tribe began seeking other ways to expand dental teams.

A TURNING POINT

As Chairman of the Swinomish Indian Tribal Community, I was frustrated that the language in the IHCIA represented a clear and inappropriate disruption of the federal-tribal government-to-government relationship. This specific and unprecedented language injected the state into the federal relationship, which is inconsistent with fundamental federal Indian laws that have long recognized the federal trust responsibility and the government-to-government relationship.

Nonetheless, for six years, tribal leaders in Washington State worked with a coalition of advocates in an attempt to pass a state law that would authorize dental therapists statewide. This is

not only a tribal issue in Washington State or in the United States; it is a matter of providing equitable oral health care to rural and underserved communities. After many failed attempts to pass state legislation authorizing the use of dental therapists either statewide or in Indian country, in 2015, the Swinomish Tribe could no longer wait for permission to provide much-needed dental care for its members. Tribal leaders have a responsibility and the inherent authority to take a stand for tribal members, especially children and elders, who are suffering unnecessarily and face a health crisis. Their health and well-being could not be put on hold because of the strength of the Washington State Dental Association’s lobbying machine.

MODERN DENTAL TEAMS IN INDIAN COUNTRY

Without a state licensing structure, the Swinomish Tribe, with the full support of the tribal council and the entire community, exercised its sovereign authority and created the Swinomish Licensing Department and a dental health provider licensing board. This board licenses all Swinomish dental providers. The Swinomish Tribe adapted the federal CHAP code as a basis for scope of practice, supervision, certification requirements, and disciplinary actions for practicing dental therapists.

This is an exercise of the tribe’s inherent sovereignty and responsibility to care for the health of its members. It may be a first in Indian country, but it will not be the last. Other tribes will similarly exercise their own sovereignty to

license professionals in a manner consistent with their needs and values. The Swinomish Tribal Code requires that dental providers demonstrate cultural competence through interviews with community members and through formal educational, training, or personal or professional experiences that would be reasonably expected to result in cultural competency, something that is absolutely essential for successful oral health services in Native communities.

At present, services provided by dental therapists in Alaska to Medicaid-eligible individuals are reimbursed by Medicaid. Tribes continue to work on setting up a framework that would allow Medicaid reimbursement for services provided by dental therapists outside Alaska. This is necessary for economic sustainability, as without Medicaid reimbursement, tribal communities with the most needs will not have access to dental therapists.

NEXT STEPS AND NATIONAL MOMENTUM

The need for dental therapists is great across the country. There is a positive movement in some states that will have a significant impact on the ability of communities to expand access to care by bringing dental therapists to rural, underserved, and tribal communities.

Four states—Maine, Vermont, Minnesota, and now Washington—have authorized the use of dental therapists. In 2017, we successfully passed tribal-specific DHAT legislation in Washington on the foundation of the work of the last six years and the strong collaboration and support from all

29 tribes in Washington. An additional 12 states are actively exploring dental therapy legislation, and Oregon has authorized a tribal dental therapy pilot project. Students from two Oregon tribes are enrolled in the dental health aide therapist training program in Alaska and will return to their communities to join dental teams.

Governments, the ADA, educators, and communities all share a responsibility to eliminate health disparities in tribal and other underserved communities. It will take a united effort to achieve oral health equity in our communities. The Swinomish Tribe will continue this fight on all fronts—legislative, administrative, and in the clinic—to provide oral health services to our communities, which is a basic need of all youths, adults, and elders. This generation will be the last to suffer needlessly and the first to usher in a new era of oral health care. **AJPH**

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