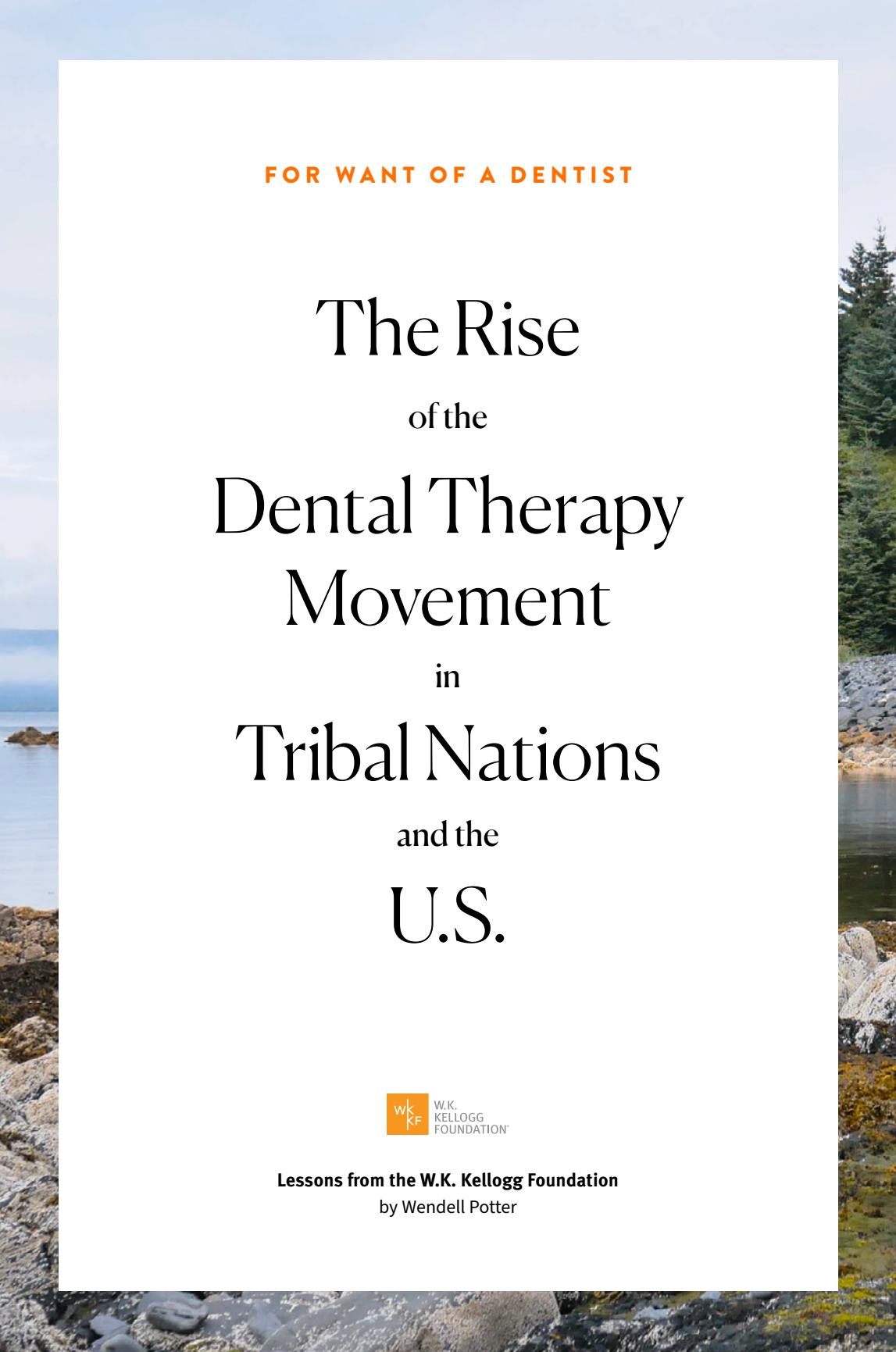

FOR WANT OF A DENTIST

The Rise of the Dental Therapy Movement in Tribal Nations and the U.S.

W.K. KELLOGG FOUNDATION

Lessons from the W.K. Kellogg Foundation

by Wendell Potter

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FOREWORD

by La June Montgomery Tabron

Since the W.K. Kellogg Foundation (WKKF) was established in 1930, children have been at the heart of everything we do. But over the decades we have learned that for children to thrive, their communities need to be equitable places of opportunity. The lessons began with our founder, Will Keith (W.K.) Kellogg. He recognized early on that to improve the lives of children, the adults in their communities—parents, teachers, elected officials, doctors, dentists and others—needed to be actively engaged in a concerted effort to solve problems. When brought together and presented with the chance to thoughtfully address local challenges, he trusted that people would generate insightful, practical and often bold solutions to community challenges. In oral health, as in virtually every other aspect of the foundation's work over the past nine decades, local communities have been the impetus for innovation and the drivers of change.

In 90 years, the W.K. Kellogg Foundation and our partners have covered tremendous ground in oral health. Throughout, we have made a place for communities to craft solutions, given dentists and other providers a leadership role in addressing community needs, built a compendium of online data and resources to support systems change, forged partnerships around education and services and explored alternate models of care.

Despite these advancements, dental workforce shortages persist. Enrollment in dental schools has yet to reflect the growing diversity of the population as a whole. And far too many vulnerable children and families go without regular oral health care. Many of these children live in rural areas. Many more children live in neglected pockets of thriving cities. They are often children of color, from poor families struggling to get the care they need from a safety net that's full of holes.

Mr. Kellogg believed that society could—and should—do better by its children. We continue to affirm and act upon that conviction in partnership with communities. The W.K. Kellogg Foundation's investment in dental therapy is part of that story.

Nearly two decades ago, what started out as a Tribal-led effort to expand dental care to Alaska Native people has grown into a community- and Tribal-led movement to ensure people can get dental care when and where they need it, in their home communities. In that pursuit, Alaska Native leaders confronted the systems that were *not* serving their children. We supported them in that bold effort, and it worked.

This book shares how that change unfolded and continues to grow: How Alaska Native communities paved the way for the contiguous United States to advance change. How the racism and bias within existing systems and policies have constrained options for low-income communities and communities of color. This book shares how, despite these forces, communities that have led with health and racial equity are increasing access to care and providing new job and career pathways for low-income workers. This book is about creating the economic and health solutions many communities so desperately need.

We know dental therapy works. This book is intended as a guide for coalitions, educators and advocates to work locally to improve the oral health of children and families by expanding the dental therapist program and establishing these mid-level dental providers throughout the country.

La June Montgomery Tabron is president and CEO of the W.K. Kellogg Foundation.

A Silent Epidemic

More than 20 years have passed since U.S. Surgeon General David Satcher, M.D., Ph.D., issued a landmark study that was based on a review of the growing body of scientific research into oral health.

In “Oral Health in America,” Satcher decried “a silent epidemic of oral diseases” that largely plagued the nation’s poorer and non-White populations and that had emerged even as fluoridation of public water sources and other advances were making more well-off people healthier and less vulnerable to tooth decay.

“We have tended to separate oral health from the rest of the body,” Satcher told *The New York Times* in 2000. Yet he noted that poor dental care created gateways to serious and sometimes life-threatening diseases, such as cancer of the pharynx, which connects the oral and nasal cavities to the esophagus and larynx. Black men, the report noted, had a much higher rate of this form of cancer than Whites, which dovetailed with findings that Black children were twice as likely as White children to have untreated cavities and that African Americans had higher rates of missing teeth and gum disease. These disparities still existed when the Centers for Disease Control and Prevention (CDC) studied U.S. periodontal disease in 2015.

Satcher’s report noted that scientists had established increasing connections between poor oral health and an array of serious conditions, including diabetes, heart disease, stroke and even low-birthweight babies. “Oral health means much more than healthy teeth,” Satcher wrote, noting issues such as throat cancer, adding that the mouth serves as a “monitor,” providing warnings about other health problems, such as a buildup of yeast that doctors have discovered can serve as a warning sign of HIV.

It’s hard to say that these findings—or the grim numbers on poor people’s lack of access to a dentist—came as a total shock to Satcher. As the former Surgeon General told *The New York Times*, he had been raised by poorly educated farmers in rural Alabama and never saw a dentist until college.

In the two decades since Satcher’s report was released, the situation has not dramatically improved:

- Numbers vary, but some reports suggest that more than one in three people in the United States lack dental insurance, far more than the number without overall health insurance. The expansion of Medicaid in most states after the 2010 passage of the Affordable Care Act only partly filled the large gaps in coverage.

- The United States faces a continuing shortage of dentists. The U.S. Health Resources and Services Administration (HRSA) estimated the shortfall will grow to 15,600 fewer dentists than needed by 2025. And in 2018, according to HRSA, an estimated 60 million people lived in areas that are underserved by dentists. Many of them forego regular care as a result.

- The Centers for Disease Control and Prevention continues to find that oral health lags among Blacks, Hispanics, Native Americans and Alaska Native people compared to White Americans. For example, Blacks and Hispanics who are in the 35–44 age bracket suffer tooth decay at twice the rate of their White contemporaries. Other oral health problems, such as gum disease, also run much higher in communities of color.

Leading philanthropic groups have looked to new models that might repair the broken paradigms for access to dental care in the United States. The Kellogg Foundation has promoted improving oral health since the 1930s when it funded dental care programs in rural areas of Michigan, where dentists were scarce and rarely treated children.

For Want of a Dentist explores the introduction of one of those new models, dental therapy. Dental therapy, initially championed by Tribal leaders, is an effective approach that centers equity, innovation and community-driven solutions: the training and deployment of mid-level care providers in dentistry. It tracks the development of this practice through the perspective of the W.K. Kellogg Foundation, as the nonprofit has played a leading role in funding efforts to expand dental therapy as well as critical research and evaluation.

In this short history, we seek to raise awareness of the enormous potential for dental therapy to bring good oral health to remote villages, low-income neighborhoods and communities of color. We also want to provide insights for advocates seeking to expand dental coverage as part of broader health care reform, spur and bolster organizations that fund such efforts and inform elected officials, academics and journalists.

Here, we trace the evolution of dental therapy in Tribal nations and throughout the United States. *For Want of a Dentist* celebrates local leaders—beginning with many Alaska Native health activists and their allies—who created and championed solutions that work in their communities. This long-term struggle has pitted health

care advocates, grassroots organizers and major U.S. philanthropies against some of the nation's dentists and their powerful lobby, the American Dental Association (ADA). We reveal how determination, scientific evidence and proven results can overcome a well-funded and politically connected opposition.

This heightened push for diversity in dental care, and a nine-decade history of working to improve access to quality oral health care, underscores why Kellogg Foundation leaders were so receptive to an unsolicited request for support in creating better access to dental care when it arrived from Alaska Tribal leaders. Moreover, the fact that dental therapy also centered education and workforce development made it immediately attractive.

The dental therapy activists who have succeeded in winning campaigns that once had seemed all but impossible sold key stakeholders on a bold concept that addressed a range of community and societal issues and problems. The successful community-led campaigns across key states were built around health needs, growing concern about economic and racial inequity in the United States and the economic engine of an expanded dental industry.

To achieve the goal of racial equity in oral health, it will be vitally important for the next round of dental therapy activists to absorb the hard-fought lessons learned by the people who came before them. We believe many of those learned lessons are clear across the pages of this book.

He Thought About the Community

> Use the money as you please, so long as it promotes the health, happiness and well-being of children.
>
> **W.K. Kellogg**

When he established the W.K. Kellogg Foundation in June 1930, Will Keith Kellogg, who also was one of the founders of the Kellogg Company, told the staff to "use the money as you please, so long as it promotes the health, happiness and well-being of children." Yet his interest in oral health is also an element in the foundation's origin story. In one of his letters from the era, Mr. Kellogg recounted his attendance at a 1930 conference on the state of children hosted by then-President Herbert Hoover. At this meeting, Mr. Kellogg took special note of dental health's prominence and importance.

In the Depression-wracked 1930s, poverty and the need for good works were as omnipresent in Michigan as elsewhere in the United States, so it is not surprising that the initial efforts of the Kellogg Foundation were undertaken in the mostly rural communities in the area surrounding Battle Creek, where both the company and foundation are based. Its first venture was called the Michigan Community Health Project. Although its principal endeavors primarily targeted aid to children, the project was noteworthy for actively engaging so many local adults—doctors, librarians, community leaders and parents—in determining where money could best be spent.

WKKF's Historic Commitment to Health Equity and Dental Care

Through the collaborative approach of its first project, the foundation received essential feedback on the health care needs of children in rural Michigan from local physicians and dentists. One of the first things the dentists said was that they needed better professional development and training to bring the newest and best practices for helping kids maintain healthy teeth back to their villages and towns.

As a result, one of the first major initiatives of the foundation was the creation of the W.K. Kellogg Institute of Graduate and Postgraduate Dentistry at the University of Michigan. As the name implies, its primary mission was to offer short, refresher-type courses to licensed dentists to keep them up to date with the latest advances. The training programs increased collaborative ties within the oral health community in Michigan, and many dentists who had worked in isolation returned to their rural hometowns as better-educated, better-connected care providers.

"As a group, providers refined professional practices, developed recommendations for pediatric dental care, piloted techniques for educating children and their parents, and standardized methods of oral health care delivery," according to a history of the foundation's dental health projects entitled "Building a Better Future."

In the 1940s, foundation leaders latched on to a new idea that would revolutionize dentistry in ways that foreshadowed dental therapy's promise decades later. It had become increasingly clear that one way to increase access to oral health care would be to give dentists what advocates of the time called "an extra set of hands"—the dental hygienist. As demand for dental services soared after World War II—with troops returning from overseas and the so-called baby boom taking root—the foundation worked closely with universities and provided support for new programs to train hygienists who could handle the

more routine aspects of patient care while the dentist concentrated on the more complicated procedures.

Even so, the concept of the dental hygienist was initially met with skepticism, especially from dentists. In 1946, when Congress was debating a bill aimed at expanding access to dental care, the American Dental Association opposed it. “Because of the limited number of dentists, it is impossible to carry out any program that promises complete dental care to both children and adults,” ADA representatives testified. The organization was generally not receptive to the idea of training hygienists to even lighten dentists’ loads.

At the Kellogg Foundation, staff realized that in addition to grants for training dental hygienists, research showing that their work was safe and effective needed to be sponsored. The foundation awarded grants to universities, colleges and professional organizations to conduct rigorous research to both evaluate the effectiveness of dental hygienists and to set professional standards. Ultimately, it partnered with highly regarded institutions like the Massachusetts Institute of Technology, Columbia University and the University of Michigan. It also backed a major nationwide survey by the American Council on Education in the late 1950s that played a major role in resolving the controversy. Today, it’s hard to imagine there was a time when adding dental hygienists to a dentist-led team was controversial. The Kellogg Foundation helped change all that.

The foundation also recognized that the best and least controversial way to get oral health care into underserved communities was to train more dentists. Kellogg Foundation grants helped establish new dental schools at institutions like the University of Connecticut and the University of Colorado to help increase the supply of practitioners in the post–World War II years when both population and family incomes were growing. Foundation grants also supported the training of dental hygienists at a rapidly expanding number of community colleges.

Supporting a New Movement

In recent years, a prime focus of the foundation has been the training of more dentists from Black, Hispanic, Native American and immigrant communities to broaden career opportunities and expand care. The foundation provided funding for the American Dental Education Association (ADEA) to make grants to pay for the schooling of underrepresented non-White and low-income students at 11 schools of dentistry that took part in a major Robert Wood Johnson Foundation (RWJF) pipeline program. Eventually, the ADEA established the Center for Equity and Diversity to further these goals—again, with Kellogg Foundation support.

La June Montgomery Tabron, president of the W.K. Kellogg Foundation since 2014, said community-based solutions were central to W.K. Kellogg's vision. "He believed that we should help people help themselves, as he would say," she said. "But more important, what he believed is people have their own answers, and when you allow them the space to take leadership and to be innovative around what it takes to improve their lives, not only do they make the change but it's also more sustainable. Because they own it, and it's their dream that we help actualize. I think our work is to enlighten."

Tabron added that the effort to build public support for better oral health in the U.S. reminded her in some ways of the early days of AIDS eradication efforts, where broad public education about the nature of the problem and what was at stake played a critical role. "I think we need to involve more people on the ground," she said, "because again our value is that people have the capacity to change their own lives."

Lessons from Kellogg Foundation partnerships and grantees have continually illustrated the deep significance of community engagement, collaboration and broad coalitions in promoting positive change on behalf of children and families.

Strategies That Work

Create as broad a coalition as possible.

The type of dramatic social changes needed for a reoriented dental health care system clearly won't happen without grassroots support, which is essential to counteracting the sophisticated efforts of opponents. Arguably the most novel and innovative move from the Kellogg Foundation and Community Catalyst—a nonprofit advocacy organization founded in 1998 by former urban planner Kate Villers to build an influential consumer health advocacy movement that would challenge powerful special interests, which the foundation partnered with to explore the feasibility of dental therapy in the states—was to ensure leadership from experienced, on-the-ground community activists.

The most successful of these efforts built a coalition that included a network of advocates for the disadvantaged, the elderly and rural residents—in other words, those most affected by the dental-access crisis—and expanded to include dentists who work in community clinics, public-health experts and even unlikely allies like the free market–oriented Americans for Prosperity. Such wide support was needed to inform policymakers.

Avoid a "top-down" strategy.

Those involved with successful dental therapy efforts said they cast a wide net for supporters, and once they were on board all voices in the movement were listened to and given equal weight. Specifically, key players in the effort to expand dental therapy in the states adopted a "war room" approach with frequent strategy sessions in which program officers from the Kellogg Foundation, public health experts, state-level advocates and outside communications experts shared ideas.

"It was very much focused on the need," said Linda Loranger, formerly with the communications firm Burness, which was engaged by the foundation to support the dental therapy project. She said community involvement meant it was easier to craft campaigns that tackled the issues that mattered most in each individual state. "It was local, and that way they were able to get down to the grassroots."

The avoidance of a top-down, one-size-fits-all strategy allowed for innovative and often nimble new approaches in the states. Kellogg Foundation's Director of Communications Kathy Reincke credits success to dedicating "time to making sure we were aligned and all working toward the same goal with the same strategies. There were times when some on the team wanted to go a lot faster and add more states, and we knew at the onset it had to be a blended strategy."

Educate the public by telling stories.

Advocates at both the state and national levels believed that a key to winning public support was taking the complicated issues surrounding dental access and talking about them through individual stories that were relatable to community members. They found that while the statistics on the number of families—especially children—who can't see a dentist are alarming, most people relate more when they think of a relative or friend with tooth problems.

"What I learned really quickly is this was never about the data," said Alice Warner-Mehlhorn, Ph.D., who retired as director of policy at the Kellogg Foundation in 2018. "It was never about the information." She said her impressions were shaped as she watched Swinomish Tribal leader Brian Cladoosby tell stories about his people and his appeals for racial fairness to win support in Washington State. "You have to have a very tough mind," she said, "and a very soft heart." Others who worked on the communications effort said stories about real people—both those who needed dental care and the young dental therapists from Alaska—often helped change minds.

Recognize that dental education is a key to change.

Several advocates for mid-level oral health care said one thing that became clear is that support from educators in U.S. dental schools—arguably more concerned

about public health issues than dentists making a living in private practice—can shift the playing field. Early support from a community college dean proposing to train dental therapists was one factor convincing lawmakers in Minnesota to become first in the country to authorize a statewide program.

Proponents of expanding dental therapy say support from academia could and should lead to changes in the way future dentists are trained, so they see the problems of oral disease in the United States through a wider lens. "I think it starts in dental schools," said Terry Batliner, D.D.S., M.B.A., former associate director of Native oral health research at the University of Colorado-Denver School of Public Health and a key advocate. That means professors instill in their students a moral responsibility to see that underprivileged patients have equal access to dental care. "There has to be a commitment," he said, "that as a professional—because you are a professional—you serve everybody, and you have a particular responsibility to serve people who are less fortunate."

Seek allies from the dental community.

> The fight against dental therapy is coming from the leadership of organized dentistry, not from the rank and file. If we can educate dentists about dental therapy, what they can do for patients, what they can do for their practices, we have a better chance.
>
> **Frank Catalanotto, D.M.D.**

One reason advocates are eager for dental schools to encourage more social responsibility is because they've learned that finding dentists willing to step forward and champion dental therapy can help swing support in their states. The hope is that as more states vote to license dental therapists, more dentists will be willing to testify about the skills of trained therapists and how they can help a dental practice financially by freeing up dentists for more complex procedures.

"We have to figure out how to reach the average dentist," said Frank Catalanotto, D.M.D., former dean and current professor at the University of Florida College of Dentistry. Some of his recent work involves surveying and trying to educate dentists about mid-level providers and what they do. "The fight against dental therapy is coming from the leadership of organized dentistry, not from the rank and file. If we can educate dentists about dental therapy, what they can do for

patients, what they can do for their practices, we have a better chance."

Stress what dental therapists mean to a community.

Many of the rural or disadvantaged communities across the country that lack a dentist are also desperate for new, good-paying jobs that will allow residents to stay rather than move away in search of work. As the issue of creating new employment in these forgotten communities draws more attention, advocates are finding the economic development argument often strikes a chord with decision-makers who might otherwise be wary of dental therapy.

Additionally, in many cases, the underserved communities that would train and then benefit from dental therapists are communities of color. Indeed, this kind of multiplier effect—creating jobs and role models in struggling communities—is the economic development argument with a racial equity lens.

Pam Johnson of the Northwest Portland Area Indian Health Board argued that dental therapists can uplift their patients "because they're seeing somebody who probably looks like them, that speaks their language, that understands their concerns, that knows what those barriers to care are in their community and are trained to provide that care—and are recruited from that community so that they have those instincts and that familiarity with the culture."

CHAPTER 1

Building a Twenty-First Century Health Movement

Numerous developments over the last decade have contributed to an era of measured improvement in oral health care for children, perhaps most notably the passage of the Affordable Care Act (ACA) in 2010. The ACA expanded Medicaid dental benefits for children and made coverage outside the workplace more accessible and affordable. As a result, 90% of children now have some form of dental coverage, and millions more adults also now have dental benefits. Still, a bright future is not promised. Having benefits is no guarantee of finding a dentist taking new Medicaid patients. And Congress came within one vote of repealing the ACA in 2017.

Another problem advocates face is the fact that many Americans have grown accustomed to the premise that taking care of one's dental health is an individual responsibility. Former *Washington Post* reporter Mary Otto explored this belief in her 2017 book, *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America*. As the writer Sarah Jaffe noted in a review of the book in *The New York Times*, "all of the problems with healthcare in America exist in the dental system, but exponentially more so."

Additionally, activists and public health advocates most eager to bring better oral health to isolated and resource-deprived communities have, for the most part, lacked key allies in this battle: dentists. Dentists now earn more on average than most physicians, with much of their income coming from expensive teeth whitening and other high-end cosmetic services that only their most affluent patients can afford. When practitioners can successfully offer dental services that cater to wealthy markets, isolated, lower-income communities become even less attractive to those who might relocate.

Given the scale and urgency of this crisis, major philanthropies like the Kellogg Foundation and the Pew Charitable Trusts have funded several new approaches to

expand dental care.

Answers from "The Last Frontier"

Some of the most promising interventions have been not top-down but bottom-up—solutions conceived by activists on the ground that powerfully incorporate racial equity, community involvement and economic empowerment. As public-health advocates absorbed the new data and call to action in Satcher's 2000 report, a drastically different kind of experiment—with the potential to radically alter the debate over dental access—was beginning at the farthest possible corner of the United States.

In many ways, Alaska's sprawling Tribal lands provided an ideal setting for new approaches to oral health care. It is often said, after all, that necessity is the mother of invention. No one could dispute the need for new ways to deliver health care to Alaska's more than 120,000 Native American people, members of more than 200 Tribes, most of whom live in remote villages.

In some of the most isolated places, accessible only by small plane or boat or only during a few months, a dentist might visit once a year for a few days or a week, if at all. This meant that the dentist did not have nearly enough time to see every potential patient, and most oral health emergencies went unaddressed during the rest of the year. The dentists who reached these villages were largely doing what one expert called "damage control," not preventive care.

Given these stark realities, oral health statistics in these communities were bleak. Studies have shown the rate of tooth decay among Alaska Native children runs two or more times the national average, and those disparities continue into adulthood. Anecdotally, most Alaskans raised on Tribal lands recall how common it has become to see adults with missing teeth or wearing dentures at young ages.

Bad teeth were considered just a grim fact of life in these remote villages—until Tribal leaders decided to look for answers. The cruel irony is that Alaska Native people—much like their Native American counterparts in other states—have been shown to have had very good dental health before colonization, perhaps because of their natural diet. That changed after the arrival of processed food and sugary beverages.

Other unique circumstances in Alaska set the stage for a daring experiment in dental-care reform. Most important, the daunting challenges of delivering health care in such isolated places persuaded more than 200 Alaska Tribes to put aside differences and rivalries and cooperate in a unique organization established in

1997 called the Alaska Native Tribal Health Consortium (ANTHC). Deeply rooted traditions of Alaska Native autonomy, not to mention the state's off-the-beaten-track location, allowed ANTHC greater freedom to deliver medical services in new ways. And the consortium's early success with community health aides led its leaders to ponder if a similar approach could work for dental care.

That innovative thinking drew them to a means of broadening access to dental health that had proven successful, not only in the United States, but in dozens of other countries. For nearly a century, dental therapists—mid-level providers, offering basic services but not requiring training as time-consuming or as expensive as a traditional dentist—have improved oral health in previously underserved communities. They can extract failing teeth or fill cavities, while counseling community residents on healthy eating or quitting smoking.

> We know dental therapy works. We know dental therapists provide services that are more cost-effective than those same services when provided by dentists. And we also know that they in fact can aid the dental office in productivity. What we haven't figured out—although we are making real progress—is how to get more dentists on board.
>
> **Maxine Janis, Ed.D.**

Maxine Janis, Ed.D., associate professor at Heritage University in Toppenish, Washington, and the president's liason on Native American Affairs said the expansion of dental therapy in the United States would aid non-White patients while providing new careers for Native Americans and all people of color. "We know dental therapy works," she said. "We know dental therapists provide services that are more cost-effective than those same services when provided by dentists. And we also know that they in fact can aid the dental office in productivity. What we haven't figured out—although we are making real progress—is how to get more dentists on board."

To quickly launch a dental therapy program in Alaska's Tribal villages, ANTHC would need to form an unlikely partnership with educators on the far side of the globe—in New Zealand—and overcome fierce opposition from Alaska's dentists.

Hope (and Resistance) Springs in Alaska

As a 2017 *Indian Country Today* article asserts, the Alaska Native story is "one of endurance: developing ways to survive and thrive in a challenging environment; overcoming enslavement and disease during the Russian and U.S. trade era; adapting to statehood; and fighting to restore rights and reestablish sovereignty."

And Indigenous Alaska is composed of many distinct cultures. William Hensley, Ph.D., former Alaska state legislator, longtime educator and advocate for Alaska Native rights told *Indian Country Today* that at "the time of contact in 1741, the various Indigenous nations of Alaska controlled all of Alaska's 586,400 square miles—the Inupiat in the Northeast and the Arctic, the Dene (Athabascan) in the vast Interior, the Yup'ik in the Yukon-Kuskokwim Delta, the Unangan (Aleut) in the Aleutian Islands, the Sugpiaq in Kodiak and the Gulf of Alaska, the Tlingit and Haida in Southeast Alaska." Yet by 1800, Hensley said, "the population of the Aleutian region and Kodiak had been reduced by about 80% due to Russian atrocities, war, disease, starvation and enslavement."

Today, Alaska's Indigenous Peoples comprise roughly 24% of the state's population. Many live in the 229 federally recognized Alaska Native villages, and close to 5% of Alaska Native people still speak one of the 20 Alaska Native tongues the state recognized as official languages in 2014. Nevertheless, numerous health indices for the Alaska Native communities reflect the cumulative and ongoing impacts of colonization, trauma, displacement and disinvestment.

For instance, in the 1990s, the infant mortality rate for Alaska Native people was three times higher than that of Whites, while the suicide rate was about double. Today the infant mortality rate among Native Americans is double that of Whites; the suicide rate among young Native Americans is 2.5 times that of Whites.

> When I was little, we were lucky if we got to see a dentist once a year when he came through town. Sometimes every other year, but typically once a year. When you see somebody once a year, you don't develop a relationship with them.
>
> **Valerie Nurr'araaluk Davidson, J.D.**

By the 1990s life expectancy for Native Americans, then 67 years, still lagged

considerably behind Whites, then 75 years. It still does, although the gap had narrowed somewhat by 2017, according to the U.S. Census Bureau, when life expectancy for Native Americans had risen to 76.2 years compared to 80.0 for Whites.

Valerie Nurr'araaluk Davidson, J.D., president of the Alaska Native Tribal Health Consortium, earlier served as its senior director of legal and intergovernmental affairs. She was born near the remote village of Bethel, near the Bering Sea, as a member of the Yup'ik Tribe, one of the largest among the Alaska Native population. The Bethel community has long been an epicenter of efforts to bring health care to Alaska's isolated villages. It's where the first nurse in the territory arrived in 1893, three years before the first physician. In the early 1900s, traveling nurses who stitched up wounds and delivered rudimentary medicines went from village to village, sometimes on foot or on dog sleds.

Yet Davidson recalled that "when I was little, we were lucky if we got to see a dentist once a year when he came through town. Sometimes every other year, but typically once a year. When you see somebody once a year, you don't develop a relationship with them."

Until recently, Alaska Native people who grew up and made their homes in the remote Tribal lands were accustomed to life without good dental care: nagging pain from untreated tooth or gum disease or seeing adults with missing teeth. The idea that you might get to see a visiting dentist once a year—if you were one of the lucky ones—was just something Alaska Native people took for granted, a part of life on the frontier.

Devastating Indicators of Poor and Precarious Health

The powerful traditions of Native autonomy meant local leaders weren't intimidated by the factors that had made the idea of dental therapy a non-starter in other U.S. communities—primarily, political pressure and opposition from dentists and their powerful lobby.

Not surprisingly, an issue that came up repeatedly in the early years of ANTHC was the lack of access to dental care and the impact it had on overall health. When ANTHC was established in the late 1990s, the consortium initially opened a small office with just two dentists—not nearly enough personnel to cover the expansive oral health needs of the many Tribes in Alaska. To the group's leaders, there was no obvious answer. A potential model existed, however, in the way that Tribal

health leaders had addressed similar gaps in medical care: by employing the growing network of mid-level providers such as nurses, physician assistants and community health aides.

The Community Health Aide Program in Alaska was launched in the early 1970s around the time that the broader crusade for Native rights was flourishing. The program had been authorized by Congress as exclusive to Alaska, with the community health aides provided either through the federal Indian Health Service or the individual Tribes. Eventually there were five training centers and a unique federal certification board for the Alaska program. The willingness of Tribal leaders to try unconventional solutions would create a powerful test case to show whether dental therapy could meet similar needs in many other underserved communities.

By the early 2000s, about 500 community health aides were providing care in 180 villages across the most remote areas of the state. The aides had the ability to respond to emergencies, administer vaccines and provide other medical care with the consultation of a physician. But no such network existed for providing dental care.

More than Learning to Brush

Davidson, who left ANTHC for a few years to serve as Alaska's health and social services commissioner and later as lieutenant governor, recalled that the most obvious solution—recruiting dentists to make visits to remote Tribal villages—proved to be inadequate. "The truth is when those volunteers come, they don't necessarily want to go to the places that we need them," she said. "When they do come, they really want to come to also be able to go fishing and be able to do other fun things in Alaska, like everybody naturally would want to do. The other is they want to come in the summer. They don't want to come in the winter which is when we really need them. They don't speak the language and they're not invested in that community."

Ron Nagel, D.D.S., M.P.H., who received his dental degree from Emory University in 1987, headed Northwest after his graduation to work with the U.S. Public Health Service. In 2004, he told a newspaper that typically some Alaska villages would get a dentist for a week or two, once or twice a year. "Some have been skipped because there aren't even dentists to do the visit," he said. Through the federal health service, Nagel had worked in other states with dental nurses to bring oral health care to rural areas, and he began meeting with the consortium to urge a similar concept of mid-level care in Alaska.

Mary Williard, D.D.S., a dentist originally from Ohio who became the director of

the department of oral health promotion for ANTHC in 2007, was involved in some of the earliest efforts to bring oral health care to areas such as the remote village of Bethel—where residents struggled to be seen by the tiny numbers of available dentists—beginning with the launch of ANTHC in 1998.

Her initial work involved bringing in prevention specialists such as dental educators and patient navigators, but Williard quickly saw that Bethel residents needed more than just prevention.

"That's where we tried to start the program and we failed in Bethel with that program at the start, because the people had disease that needed more than just learning how to brush their teeth to deal with it," Williard said. "They had big holes and they had teeth that needed to be extracted and the navigators had no more providers to send them to… It really was sort of an ineffective type of provider to send out into the communities…that had so little access for so long."

Increasingly, those community members were speaking up and demanding a more aggressive approach to dental health. Williard said she discovered that "we need to listen to the communities and meet them where they're at."

Dr. Gail Christopher, former senior advisor and vice president at the W.K. Kellogg Foundation, said the dental reform in Alaska "came about because the elders, the female elders of the Tribe had had enough. And they said we have got to do something to help our children… That's who did it. If you talk to the folks in Alaska they'll tell you that. What was important was, you can't beat a made-up mind."

CHAPTER 2

Making a Transpacific Connection

It's hard to imagine a more innovative solution to Alaska's oral health crisis than recruiting Alaska Native people from remote snowbound villages near the Arctic Circle and flying them to the other side of the globe to learn the practice of dental therapy at a New Zealand college.

The seeds of this far-flung collaboration were planted in the fallout from former U.S. Surgeon General David Satcher's influential 2000 report on oral health in America. In November 2000 public health experts convened at the Oral Health America conference in Boca Raton, Florida, and discussed the implications.

Two experts, Dominick DePaola, D.D.S., Ph.D., then-president of the Forsyth Institute in Boston, and Wendy Mouradian, M.D., then a professor of pediatrics and pediatric medicine at the University of Washington, presented a model that offered a possible solution to the problems identified in the Satcher report. In New Zealand, they reported, mid-level aides, called dental therapists or school dental nurses, had been trained to perform basic procedures such as a tooth extraction. This role allowed for greatly expanded access to oral health care, with some notable exclusions, for more than three quarters of a century.

Their presentation sparked interest in an energized public health community focused on providing dental care to the underserved. Just a few months later, a larger group of experts convened at the Forsyth Institute in Boston to talk more about the dental therapy concept—how it might work and how funding could be obtained for a pilot project in the United States.

The dental therapist role is similar to that of a physician assistant (PA). PAs are mid-level health care providers who work under the supervision of doctors to dispense advice, consult on but not make final diagnoses and perform certain procedures. Yet even though the push for physician assistants is relatively recent, beginning in the 1960s, mid-level medical care gained acceptance in the U.S. much more quickly.

The dream of expanding access through mid-level dental care has faced a tougher and more uphill battle, as dentists and their lobby have resisted change more aggressively than physicians did. The fight has exasperated dental-care advocates who view using highly trained mid-level aides to expand care as a commonsense intervention.

Alaska Native people were identified in that early conversation as the best possible community for such an effort. One of the reasons was the serious dental health problems faced by Alaska Native people. But another factor was Tribal autonomy, which has proved helpful in overcoming efforts by a dental lobby that has long resisted mid-level dental-care alternatives.

Davidson recalled that other Alaska dentists also became proponents of the dental therapy concept, including Tom Bornstein, D.D.S., who would later head the dental program at the Southeast Alaska Regional Health Consortium (SEARHC). It was Bornstein, she said, who first brought up the idea of dental therapy to the Tribal health directors and Tribal leaders. What he described was very consistent with ANTHC's community health aide program and behavioral health aide program in which the organization hires and trains people from Tribal communities to provide both medical and behavioral health services.

Over the next two years, ANTHC held discussions with the University of Otago in New Zealand, the only university in the world at that time with a program in dental therapy, to begin training Alaska Native people. A big issue, of course, was how to pay for the dental therapy training, including the costly travel involved. "We basically agreed to nurture the idea of the dental therapist," recalled Paul Sherry, former health system strategist and later chief executive officer at ANTHC who first came to Alaska in the 1970s under the auspices of the federal VISTA volunteer program. "But we had no money."

The plan's proponents at ANTHC turned to the largest Alaska-based philanthropy, the Rasmuson Foundation, started in 1955 by Jenny Olson Rasmuson to honor her late husband, Edward Anton Rasmuson. When he died in 1949, Edward, who led the Bank of Alaska, left the bank to his son, Elmer, who would also become mayor of Anchorage. When Elmer died in late 2000, he bequeathed $400 million to his family's foundation, which pledged $1 million to get ANTHC's dental therapy program off the ground. At that time, it was the foundation's largest grant ever.

A Serendipitous Clinic Trip Yields an Early Recruit

Pursuing a career as a dental therapist would not have ever occurred to Aurora Johnson. She was a young woman raising a family in Unalakleet, a hardscrabble fishing village of fewer than 700 people on the Bering Sea, in the remote Western frontier of Alaska. Indeed, the moment that changed the direction of Johnson's life might never have happened if her infant hadn't gotten sick.

"I brought my baby to the clinic—he wasn't feeling well—and when I saw the posting at the clinic, I went home and told my husband, 'Hey, there's a position open, and it would require us to move to New Zealand for a couple of years,'" Johnson recalled more than a decade later. "He said, 'Let's just think about it and pray about it for a while.' We did that. I turned in an application and got hired."

Johnson was a member of the first cohort of Alaska Native people to go to the University of Otago for the two-year training program under an agreement between the university and ANTHC. That cohort's expenses were underwritten by the grant from the Rasmuson Foundation.

Alaska Native people like Johnson—who had dreamed of a career in health care, only to find herself raising a family right out of high school—saw a remarkable opportunity.

"We have three kids. For them, it was sad because they were leaving their friends, and two years to them felt like an eternity," Johnson recalled. "Even for us…having to move to another country with three kids in school, being immigrants [was difficult]. But I wouldn't trade it for anything."

In early 2006, Johnson was back in Alaska, trained and certified to do many of the oral health procedures that her neighbors had once waited months or years for. With her new training, Johnson could drill and fill cavities and extract diseased teeth. Over the ensuing decade she has become a fixture for patients not just in Unalakleet but the smaller nearby villages of St. Michael, Stebbins, Shaktoolik and Koyuk. Her work—and that of scores of dental therapists in Alaska and eventually elsewhere in the United States—is a reminder of what sometimes gets lost amid the lawsuits and the legislative debates: the simple promise of oral health care.

Another Pair of Hands

> In a relatively short time period, dental therapists have made a difference.
>
> **Donald Chi, D.D.S., Ph.D.**

"It's another pair of hands for the dentist," said Alice Warner-Mehlhorn, retired director of policy for the Kellogg Foundation. "It's not about replacing the dentist. It's not about the dentist going away. It's about another pair of hands."

The long history of dental therapists practicing outside the United States is instructive, and inspiring, for advocates working to bring about change today. Dozens of other nations—including Australia, Canada, the Netherlands and the United Kingdom—have experienced the same shortages of care providers, especially in marginalized or remote communities. And advocates have encountered similar opposition from established communities of dentists. Yet dental therapy has become much better established outside the United States.

Boosters of dental therapy cite more than a century of evidence—now developed in every corner of the globe—that the practice does exactly what it promises to do: expand dental care to patients whose oral health care problems otherwise would have been ignored, with little proof to support the argument from organized dentistry that these patients are receiving "second-class care." In 2017, the most comprehensive report on the subject, by Donald Chi, D.D.S., Ph.D., of the University of Washington School of Dentistry, found that "in a relatively short time period, dental therapists have made a difference." Alaska Native children and adults served by a therapist had fewer tooth extractions and received more preventive care.

"Just in the [first] 10 years…that the program has been in existence we now have cavity-free kids in our communities," said Davidson in 2018. "We haven't had cavity-free kids in our communities in these large numbers since before contact [with non-Natives] and before sugar was introduced into our communities."

Davidson also noted other meaningful benefits of the spread of dental therapy in the state. "We have people, we have dental health aide therapists who are out there, part of the community. They are from those communities. They are like superheroes of those communities," she said. "They give kids someone to look up to. They're their friends' parents. They have children of their own. And they're encouraging other young people after them to go into health careers. Maybe not even dental therapy, but maybe a dentist, or maybe a doctor or maybe fill-in-the-

blanks."

Dental Therapy's Growing Global Presence

What started in New Zealand a century ago has expanded around the world. Over the decades, a general pattern was established. Support for dental therapy typically hinged on a government's commitment to expanding social services as well as the level of need among either low-income or geographically remote populations. Opposition would develop from dentists who were wary of allowing practitioners without an advanced degree to handle essential procedures like extractions. In the case of Great Britain, mid-level practitioners—now known there as "dental auxiliaries"—did not win approval until 1957 and, even then, their scope was limited to the country's public health service. Their level of care was also more restrictive than in New Zealand.

Nevertheless, by the late 1990s, the New Zealand model of dental therapy had spread to at least 28 countries in Asia, Europe and North and South America. In Canada's Yukon territory, where the issues with accessing dental care in remote areas are like those in Alaska, especially in First Nation communities, the territory's medical director turned to Great Britain in the early 1970s to provide services to the remote villages beyond White Horse. The success of that initiative encouraged Canadian officials to launch a more comprehensive dental therapy program of their own, including the establishment of a school of dental therapy at Fort Smith in the Northwest Territories.

Today, according to some researchers, dental therapy has expanded to about 70 nations. But the United States, with the world's largest economy but also with barriers to care created by income and geography, has been a late adopter. It hasn't been for a lack of trying. Efforts to bring some form of mid-level dental care to the U.S. began and ultimately faltered in the 1940s when a Massachusetts law that would have allowed dental hygienists to fill cavities was quickly repealed under pressure from the dental lobby. It stalled out again in the 1970s when a Massachusetts-based project called "the Forsyth Experiment," in which hygienists were successfully drilling cavities, was abruptly shut down by state regulators.

There's clearly a sharp contrast between the U.S. experience and that of New Zealand, where nearly a century of progress allowed the practice of dental therapy to flourish alongside other modern practices in oral health. Today, New Zealand's dental therapists are permitted to perform several procedures on children under the age of 18—cleaning, filling cavities, applying sealants and extracting primary, or baby, teeth—without the presence of a dentist, greatly expanding the number of young patients who can be treated. Many practitioners now study in a three-year

program that combines dentistry and hygiene. This allows them to register with the Dental Council of New Zealand as either therapists or hygienists, or both.

By most measures, the New Zealand initiative has been a remarkable success, aided by the government's willingness to publicly fund the program for all children up to 18. In 2018, the island nation listed approximately 1,000 licensed dental therapists, with the vast majority working in school-based clinics. In recent years, New Zealand has also established more mobile dental clinics with the goal of reaching children who were falling through the cracks, including Indigenous children.

One recent study found that 72% of low-income New Zealand school-aged children had received a dental visit over the course of one year, while the comparable number for the United States was only 39%. And the gap was even larger for preschool children. The overall dental health of New Zealanders is generally considered comparable to people in the United States, although in one critical measure—the number of teeth requiring extraction because of permanent damage—New Zealand fares better.

So, it's hardly surprising that when Tribal health leaders in Alaska looked to launch their program, they looked to the country that remains the world leader in training dental therapists and promoting their use. The agreement ANTHC reached with the University of Otago in 2003 may have seemed odd to those unfamiliar with the history of dental therapy, but the reality was that the best place to train this first group of Alaska Native people was thousands of miles from home.

The Busy Life of a Dental Therapist in Rural Alaska

> I know all my patients, pretty much. It's like a family reunion when I go to a community and see everybody, watching all the kids grow. I feel that I am part of it all.
>
> **Aurora Johnson**

For Aurora Johnson, her difficult decision to spend two years in New Zealand with her husband and three young children led to her returning to Alaska in 2005 with her degree in dental therapy and both the skills and the determination to

work with her fellow Alaska Native people. She had grown up in the tiny village of Noorvik north of the Arctic Circle, where a healthy diet of fruits and vegetables was hard to come by and where she saw some of her high school classmates already wearing a full set of dentures. After her education, in January 2006 Johnson began working in the extreme northern community of Nome, where she teamed up with a supervising dentist and then spent three months traveling to remote villages as part of her training.

The oral health of the first patients she treated was often quite poor. “In the beginning, we did a lot of extractions,” Johnson said. “That’s probably pretty much what we did most of the time [in the early years]—extracting teeth.”

Johnson’s personal story is instructive for understanding what dental therapists do and the value of their role in underserved communities. Although much of the controversy over dental therapists centers on whether they should perform the more advanced procedures such as extracting teeth and drilling cavities, a lot of their work also involves teaching basic hygiene and prevention, especially after Johnson’s first year, which was dominated by more urgent care that required extractions.

“Our region has 15 school sites,” Johnson said. “We started a school toothbrushing program. We send out toothbrushes, toothpaste, floss and in some sites, we do fluoride rinses. Only one of the 15 communities has fluoridation. So how are we going to get fluoride to them? We do a fluoride rinse program in which you rinse for a minute once a week. We started that.”

In March 2008, *The New York Times* followed Johnson on one of her sojourns to Unalakleet, a predominantly Alaska Native community of about 750 people that was only accessible by snowmobile or small plane. Outside, an icy wind was blowing off the Bering Sea and the mercury was barely above zero, but inside, *The New York Times* reported, patients received treatment in a comfortable setting that looked much like any mainland dental clinic, with spanking clean floors and a waiting area with magazines stacked high.

The journalist watched as Johnson drilled and then filled three cavities for a giggly 10-year-old patient who had not received any dental care in the four years before Johnson’s visit to the village. “This is not the time to laugh, bud,” Johnson quipped to the child as she reached for her drill.

Over the dozen years Johnson has worked as a dental therapist in the Tribal regions of Alaska, she has developed something of a routine:

> *Let me just tell you my schedule. When I go to a community, I’m there, depending on which community it is, I’m there either four weeks, two*

weeks or three weeks. It just depends. We go, we do all exams from third grade on up, because a [pediatric] dentist comes and does all the younger kids. So third grade on up to seniors, 12th grade, we do exams on everybody, and then we do all sealants, all the [operations] as we need.

It's hard work. In a typical village visit, Johnson works a five-day week of 12-hour shifts, seeing adults beginning at 8 a.m., then a steady stream of school kids throughout the day and then more adults until about 7 p.m. Her ambitious goal is to treat the entire community during those long weeks.

But frequently the real value is in ongoing education about the importance of good oral health, which means that kids—and their parents—will practice prevention during the 11-plus months of the year that the dental therapist is not there. Today, Johnson speaks with great pride of the results in one of the villages where she works, Shaktoolik.

"There is a teacher aide that puts it upon herself to do a toothbrushing program or help with a toothbrushing program. She went into every classroom for that whole school year, and then she also did the fluoride rinse," Johnson said, noting you must do it consistently. "We usually saw five kids with no cavities, [but] the next year [after the rinse program], we saw 34 kids with no cavities."

One of the reasons this all works so well is that the Alaska dental therapists like Johnson are an integral part of the communities they serve. "We *are* the culture," Johnson said. "I've been raised in a community. I've been in the community for years on end." She said she's seen the outside dentists who come into villages and "just lay their patients down and start working" with little or no communication. For Johnson, it's not like that at all. "I know all my patients, pretty much. It's like a family reunion when I go to a community and see everybody, watching all the kids grow. I feel that I am part of it all. I am enjoying my job. I can't imagine doing anything else."

CHAPTER 3

A Transformative Partnership Between Community and Philanthropy

After decades of supporting programs that aimed to train more dentists and encourage them to practice in remote or resource-denied locations, the push for mid-level dental care in Alaska, barely off the ground and in need of outside support, aligned perfectly with WKKF's goals.

"It made sense," said Albert Yee, M.D., a former foundation program director. "We thought it seemed like a good investment, and there were local, state and regional partners already on board, so it wasn't the Kellogg Foundation coming in and doing something that those who knew the community most closely—our peer funders who are in the community—weren't willing to do."

The foundation's leaders, including members of the board of trustees, say their work to promote the growth of dental therapy as a practice in the United States, which would soon begin to gain force and momentum, is a natural outgrowth of the way the Kellogg Foundation and other philanthropies view public health problems and the best ways to solve them.

"This work is so important and so consistent with Mr. Kellogg's legacy and what he wanted for children and their families," said Celeste Clark, Ph.D., a nutritionist and expert in food and health policy who became chair of the Kellogg Foundation's board of trustees in 2020.

By 2006, Alaska's first dental health aide therapists, like Aurora Johnson, had successfully finished their training in New Zealand. They were heading home to treat their fellow Alaska Native people in the remote villages where the oral health needs were most urgent.

The Pivotal Role of Philanthropy

The early enthusiastic backing of Alaska's Rasmuson Foundation was critical.

"ANTHC was a new organization, they acted together and they united to look for solutions to a major health problem in rural Alaska," Cathryn Rasmuson, vice chair of the foundation, told graduating dental therapists in a 2013 speech. "They didn't know that the first answer out of agencies' mouths is, 'Nope. Can't do it. It's impossible!' They didn't know that a fierce tiger of outside pressures would soon be unleashed upon them. They did know that tooth decay was a major problem in Alaska. They did know there was an almost total lack of access to dental care in the rural villages."

Rasmuson described her philanthropy's support for the dental therapy program as a perfect fit. The mission of the Rasmuson Foundation was for its endowment "to be spent in Alaska on Alaskans." And the idea that ANTHC had presented to Rasmuson was, in her words, "audacious" and "wonderful." The support from WKKF and Rasmuson was essential to getting the program off the ground, but it also helped compel leading national philanthropic groups to support the endeavor.

ANTHC received a grant in 2004 from the Robert Wood Johnson Foundation—through its Local Initiative Funding Partners program—to help train one of its other categories of practitioners, dental health aides. They received two weeks of training and were able to offer a limited range of valuable services, such as patient education and fluoride rinses. The Princeton, New Jersey–based foundation also provided a small amount of funding to fly members of the ADA to Alaska to witness both the dental health aides and the New Zealand–trained dental therapists in action.

Other foundations also played a role in getting the Alaska program established. Among them was the Paul G. Allen Family Foundation, which joined the Kellogg Foundation in helping MEDEX Northwest at the University of Washington School of Medicine in Seattle develop an academic curriculum. But the call for help that connected the ANTHC with the Kellogg Foundation was especially promising for the future of dental therapy in the U.S. and for WKKF.

Dark clouds hovered over Alaska's unique, first-in-the-country experiment in dental therapy, most notably in the form of legal action from the Alaska Dental Association—supported by the large and politically well-connected ADA—seeking to shut the program down before it became well-established. The aura of uncertainty, coupled with the huge sacrifice for potential new dental therapists in moving halfway around the world to New Zealand, sometimes with family

members in tow, threatened to discourage new trainees.

New Obstacles to Training Closer to Home

Officials with ANTHC hoped to cement their early years of progress by establishing a training program closer to home. The idea of an advanced two-year certification program that would be like the one at New Zealand's University of Otago, but on U.S. soil, offered big advantages but faced major hurdles. Those obstacles included not just the considerable start-up costs of opening new classrooms and recruiting instructors, but also likely resistance from the established community of dentists wherever they decided to set up shop. It was a project that was clearly beyond the means of ANTHC; they would not be able to push it through without significant outside help.

In the case of the Dental Health Aide Therapist (DHAT) program in Alaska, it took a practically perfect storm of events—the newfound autonomy of the Alaska Native health system at the end of the 1990s, the 2000 report by U.S. Surgeon General David Satcher that brought sudden attention to the lack of dental health access and a strong response from the public health community, as well as an initial slow response from the oppositional dental lobby—to get the first true dental therapy program off the ground in the United States. But even with all those positive winds at their back, dental therapy would not have gained the toehold that it has in the United States had it not been for strong support from the philanthropic sector.

It would be difficult for underprivileged, isolated communities to overcome inertia, the country's dental lobby and a political establishment highly susceptible to pressure from well-heeled special interest groups without an equally powerful advocate in their corner. In many ways, the history of improving access to dental care in the United States is intertwined with the story of one foundation's history and mission.

It's not just that the project—establishing a program to train dental therapists on U.S. soil that would end the disruptive need for two years of schooling in New Zealand—was a deserving one. But perhaps more important, the unwavering support of a major national philanthropy, at a time when the dental lobby was waging a ferocious battle to prevent the Alaska program from taking root, was a major source of sustenance when the effort could easily have been crushed.

Davidson said that after the first couple of cohorts of dental therapists had returned from New Zealand, there was growing talk of how to train future practitioners on U.S. soil.

"As we were visiting with our congressional delegation and keeping them in the loop," Davidson recalled, "Congressman Don Young [an Alaska Republican], kept saying, 'Why are we sending people to a foreign country? We need our own training program in the United States. We shouldn't be sending them to the other countries.' We said, 'Okay.' He said it more than once and each time more vociferously. We said, 'Okay. Well, we probably should have a training program in the United States somewhere.'"

Nagel, the Anchorage-based dentist who was critical in launching the program, prepared a grant application and reached out to the Kellogg Foundation. Given the mounting resistance from the dental lobby to the dental therapy experiment in Alaska, it was eventually decided to work with MEDEX Northwest at the University of Washington School of Medicine—not with the dental school, where officials were highly skeptical. The MEDEX program was already training mid-level medical professionals for Alaska Native people.

"It was all about the training," Sherry recalled. "That's where the Kellogg Foundation came in and said, 'We'll commit to making this training possible for a while to allow this program to prove out.' I think the Kellogg Foundation helped us with this whole evaluation and media effort, essentially, the public education effort about it."

Gaining Momentum

At the Kellogg Foundation's Battle Creek offices, officials recalled they were enthusiastic about the proposal from the start. Their interest didn't diminish when they found out the Alaska Dental Association, with support from the national lobby, was suing to halt dental therapy in the state.

Carla Thompson Payton, a vice president for program strategy at WKKF, said, "It's really risky to put your name out there, to put your reputation out there, to make a bet on something you think is going to work." But staff at the foundation also had a sense from the very beginning that the Kellogg Foundation legacy and reputation as a trailblazer in the field of oral health were needed as a counterbalance to the power of the ADA.

In many ways, getting involved in Alaska, despite resistance from the ADA, offered the foundation opportunities to exercise the lesson learned over the course of its history: seek solutions that create conditions for the most disadvantaged families to thrive, engage and develop community leaders, and center racial equity in programming and grantmaking. Going forward, the Alaska effort helped make dental therapy a priority because it supported all the foundation's priorities of

thriving children, working families and equitable communities.

Indeed, by the time the Kellogg Foundation got involved, Tribal leaders and their allies had already shown remarkable resourcefulness and steadfast gumption in standing up to their better-financed opponents. As the future of dental therapy in the United States hung in the balance, the foundation's support clearly could be a tipping point.

"The start of this was interesting timing, because in 2007, our board mandated that the Kellogg Foundation would become the most effective anti-racism organization," Reincke recalled. She also remembered what Gail Christopher, who'd just recently joined the foundation, had said, suggesting "not standing as a foundation for what you're against, but standing for what you're for."

Looking back on the push for dental therapy, Christopher said that "the degree of racially based inequity and disparity is so overt and so profound. It creates one of the imperatives for taking action. When you look at the level of dental care in our young people…it's unacceptable."

CHAPTER 4

David vs. Goliath

As the momentum for dental therapy grew in Alaska, there were some dark clouds on the horizon. In hindsight, supporters of the dental therapy initiative were initially surprised at how little scrutiny the Alaska effort was getting from the dental lobby.

Sherry recalled that a decision had been made to certify these newly trained dental therapists through the same federal panel that signed off on the Alaskan community health aides. The first class of a half-dozen volunteer students was sent off to New Zealand, as Sherry and others recall, followed by another group. Only then did the ADA begin to take notice.

By the middle of the 2000s, Alaska was on the radar screen of the dental lobby. The ADA team visited in March 2004. ADA officials described it as a special task force to study ways to improve oral health among Alaska Native people as well as Native Americans in the contiguous United States—a sign of how Alaska's dental therapy plans had suddenly raised the stakes within the profession. The 10-member delegation was headed by a dentist from Washington, D.C., Bernard McDermott, D.D.S., and it visited Bethel, Fairbanks and Anchorage.

The visit was covered by the *Anchorage Daily News*, which reported that the ADA's visiting team was happy with the initial idea for mid-level dental health aide therapists who shared the same cultural background as the Tribal patients and could offer useful advice on preventive dental care. But the training of the dental therapists to perform more complex procedures alarmed the dentists' task force. Members complained in dire tones, in the words of the newspaper, that these newly minted therapists "will perform irreversible procedures such as fillings and extractions with just a high school diploma and two years of training."

What the ADA team was really doing, Sherry said he came to understand, was gathering data for the purpose of fighting Alaska's dental therapy program before it could take root. "And they pretty much told us right then that they were going to fight us doing this," he said. "Extractions, doing minor fillings. They could not handle it. It was pure market encroachment risk."

McDermott told the newspaper: "It's that part of them treating patients, acting

like a dentist, that has us concerned." Their argument was that settling for dental therapy essentially discriminated against Alaska Native people by providing them with inferior care. However, the reality was that the choice thousands of Alaskans had was to see a dental therapist or see no one.

At the time of the visit, Nagel told Anchorage reporters that he hoped to sell the ADA task force on how much training the dental therapists would receive, working with a licensed dentist for 400 hours or more. Also, only licensed dentists would determine which procedures, such as extracting teeth or filling cavities, an individual dental therapist could perform. Yet despite the training that was already underway in New Zealand and the $1 million Rasmuson grant, McDermott's ADA delegation was sticking to completely different solutions. "We have retired dentists who have no clue there is an access problem in Alaska, and we'd like to publicize that," he said.

After the team of dentists visited Alaska, the ADA began to lobby Alaska's delegation in Congress, urging them to harness the power of the federal government to rein in Alaska Native health advocates and the dental therapy program. At the ADA's annual convention in the fall of 2004, the group adopted a resolution on Alaska Native and Native American oral health that supported the work of dental therapists as long as they didn't perform tooth extractions, cavity filling or pulpotomies (the removal of infected pulp from under a tooth's crown) on baby teeth. The resolution, which passed on a voice vote, added: "The ADA is opposed to non-dentists making diagnoses or performing irreversible procedures."

Their focus quickly turned to the Indian Health Care Improvement Act that was before Congress at that time; the then-House member from Alaska, Representative Don Young, had inserted language that would allow dental therapists to perform the disputed procedures, but the ADA's lobbyists were fighting hard to strike it. Indeed, they succeeded during the final markup of the proposed legislation in getting language that was similar to the ADA resolution, only to see the Indian health care bill fail to come up for a vote in the waning days of the Congressional session.

In opposing the plan, both the ADA and the Alaska Dental Society (ADS) focused on the notion that dental therapists with less training than a licensed dentist should not be allowed to do the procedures that are "irreversible"—removing a tooth or drilling into one.

With the ANTHC program now well underway in the spring of 2005, the ADA and the ADS stepped up their opposition. The dental lobby had considerable money at its disposal to spend on public relations efforts, and it turned up the volume to convince Alaska residents that "forcing" Alaska Native people to see dental therapists instead of dentists was a form of discrimination. In May, the ADS ran a

full-page ad in the *Juneau Empire*, published in the state capital. According to an Associated Press report, "it showed the tooth maw of a brown bear" and called dental therapy "2nd-class dental care for Alaska Native people."

"They spent millions in marketing," Davidson recalled. "We had almost no marketing budget and certainly none for this." She cited another ad that ran around the same time that she found particularly offensive. "While they were [in Bethel], they took a picture of an elder and said, 'Oh can we use your picture,' and I think they paid her like, I don't remember what it was, like $500," she said. "This is a person who has no income, didn't speak English as a first language, and they asked if they could use her photo. She of course said yes… They used her photo to do an ad that basically said, 'Don't experiment on our grandchildren.' It was shameful. It was so incredibly shameful. She had no idea."

Community Members and Policymakers Voice Strong Support for Dental Therapy

At the same time, the dental groups strived to convince Alaska officials that the program violated state dental law. Furthermore, they argued that ANTHC's claims to Alaska Native sovereignty, which allowed certification of the dental therapists by a federal board rather than the state, were superseded by state law. An open letter in 2005 from the Alaskan Dental Society to then-Governor Frank Murkowski urged him to shut down the young program, asking that he "stand firmly for states' rights and equal-quality care for all Alaskans."

But the arguments seemed to be falling on deaf ears. Again, most rural residents didn't see the choices as seeing a dentist versus seeing a less-trained provider, but rather as seeing a provider who could alleviate their tooth pain versus doing nothing at all.

In spring 2005, Senator Lisa Murkowski, who had been appointed three years earlier by her father, Frank, to replace him in the Senate when he ran successfully for governor of Alaska, said she'd listened to the testimony from the ADA and from public health advocates back home and that she strongly supported the dental therapy program. "We have a dentist shortage and a dental health crisis throughout rural Alaska," Murkowski said. "We also have the greatest state on Earth and when we can't get the professionals into the villages, we need to be creative and do what we can to solve this problem." She also disputed the ADA's advertisements.

But the ADA saw this as just another battle in its decades-long war against dental

therapy's establishment in the U.S. As the ANTHC program began to establish roots in isolated communities like Bethel, the dental lobby did not back down; Alaska was now perceived as the test case for whether dental therapy could work in the rest of the country. With state leaders and bureaucrats seemingly siding with Alaska Native leaders and federal legislation to restrict dental therapy seemingly on hold, the ADA and ADS could only appeal to the courts to shut down the program.

Opposition from the dental lobby began to jell right around the time the first cohort of Alaska Native students, including Aurora Johnson, were wrapping up their studies at the University of Otago in New Zealand. Johnson said she received a call in New Zealand in 2005 informing her that the Alaska Dental Society had gone to court to prevent the ANTHC initiative, and that she had been personally named in the lawsuit.

"To me, I was… 'Did I do this for nothing?'" Johnson recalled. "'What am I going home to?' Because we were still in New Zealand." Her husband and the program director at Otago assured her there was nothing to worry about, but she was not totally convinced. "During the whole ordeal, it was uncomfortable knowing that I was personally sued…for something that can only help a community, can only help our rural communities."

The Dental Lobby Counters and Blocks

The lobby had been caught off guard by the launch of the program and the decision to train the initial cohort of therapists in New Zealand, and its political clout was falling short in the 49th state, where Alaska Native people held considerable sway. When the Alaska attorney general ruled in favor of ANTHC in 2005 and upheld the legality of the work that dental therapists were performing, the ADA's last remaining recourse was taking the case to court.

In the dead of an Alaska winter, the American Dental Association and the Alaska Dental Society leased a big room in the Hotel Captain Cook in downtown Anchorage and flew in the then–national president of the ADA, Minnesota oral surgeon Robert Brandjord, D.D.S., to announce the legal action. "We believe that Alaska Native people are being placed at risk, unfairly and unnecessarily, by non-dentists doing irreversible dental surgical procedures," Brandjord told the news conference, as reported the next morning by the *Anchorage Daily News*. Their lawsuit claimed that contrary to the opinion of the attorney general, allowing dental therapists to extract teeth and fill cavities violated the state's licensing laws for practicing dentistry.

The lawsuit was similar to the approach the ADA had successfully deployed in beating back plans for mid-level oral health providers over several decades. But as Davidson arrived with Sherry at the Hotel Captain Cook, she felt the legal avenue would never work—not in Alaska. "We got there and [there was] lots of very grandiose kind of grandstanding, sort of 'United States of America,'" Davidson said, referring to the way things are done in the contiguous United States. "That litigation strategy just really doesn't play well here in Alaska."

Then, Davidson, as ANTHC's attorney, gave a briefing to Sherry, assuming that he would give the Alaska Native response. But Sherry insisted that Davidson do the talking to the media, and then he walked away so that she would have no choice in the matter. "He said, 'No, you're going to be the one to do the interview,'" Davidson recalled. "'You're the right person to do it.'"

The next day, the *Anchorage Daily News* quoted Davidson as saying that the dental lobby was only concerned with preserving its monopoly, not with the worsening oral health of Alaska Native people, and that dental therapy was "a creative solution to a local problem."

Years later, Davidson said she realized that Sherry was right to understand that the rebuttal to the ADA should come from an Alaska Native. She called herself "this short little Yup'ik girl" doing battle against powerhouse attorneys from Washington, D.C., but she still remembers what Sherry told her that day: "'This is a local issue. This is a Tribal issue and it seemed more appropriate to have a Tribal member speaking about this issue.'"

A Pivotal Win

The outcome of the case would essentially determine whether dental therapy—now successful in more than 70 other countries around the globe—could even gain a toehold in the United States. On paper, it looked like a true David vs. Goliath battle. The ADA, as Davidson and others involved in the fight recalled, had a multi-million-dollar litigation fund and seemingly millions more to spend on public relations and advertising to sway public opinion. Davidson recalled that, in contrast, ANTHC's budget for outside legal counsel was just around $200,000.

Beating back the lawsuit and creating a more permanent home for dental therapy in Alaska would prove critical for two reasons. First, if ANTHC were to win Alaska Native people would show that the ADA was not invincible. Second, and more important, the focus could shift to establishing a permanent U.S.-based training program and collecting the data that would prove to other states that dental therapy is safe and effective.

At the height of the battle, as Sherry recalled, the ADA kept floating different ideas, such as increasing the number of dental assistants with less clinical training and responsibilities to bring better dental care to Alaska Native people without allowing the dental therapy concept to get a foot in the door. But the volunteer dentists never materialized. The ANTHC's dental therapy program was up and running, and it was working.

The dental lobby's tactics, when applied against Alaska Native people, were turning into a significant public relations problem for the American Dental Association. ADA president Brandjord, who'd been adamant about taking legal action against the dental therapists just weeks earlier, made a surprising offer that in hindsight may have been the turning point in the long battle for expanding access to oral health care. He invited Sherry and Davidson to come to the ADA's annual convention in Las Vegas that fall and make their case for change to their thousands of member dentists.

Sherry said he remembers first pitching the idea to Brandjord. "And to his credit, he said, 'We make provision in our conferences for alternative points of view.' And so he said, 'Come down.'" But as ANTHC's lawyer, Davidson thought it was a terrible idea to speak to the dentists who were suing them, and she tried to talk him out of it. Two weeks later, as Davidson recalled, Sherry said, "'Val, I've decided that I'm going to do it. This is an opportunity to tell our side of the story and I'm going to do it.'" And two weeks later, he convinced his lawyer to come along.

It proved to be a momentous trip in more ways than one. In addition to fighting the lawsuit, ANTHC leaders were also still working to win approval for a training program in Alaska that would replace the costly and geographically inconvenient New Zealand program. They met in Las Vegas with the dean of the University of Washington Dental School—who they hoped could run the classes at a facility in Anchorage—but Davidson recalled the dean was clearly facing political pressure not to support the initiative.

That summer, a professor of dental public health sciences at the University of Washington wrote in a newspaper op-ed that the dental school, in the face of pressure from the Washington State Dental Association, a state chapter of the ADA, was backing off from a preliminary commitment to support the training program for Alaska's dental therapists. The professor, Peter Milgrom, D.D.S., added that the state organization had "intimidated university officials by threatening to block donations by their members."

A Command Performance

It looked like a dire situation but, as Davidson recalled, it was right after that meeting with the dean in Las Vegas that she received an email that the Kellogg Foundation had finalized a major grant to support a training program on U.S. soil, possibly in conjunction with the University of Washington School of Medicine if the university's School of Dentistry continued to balk.

"Our training program is on," Davidson said. "It was the same day, literally the morning that we met with [the ADA's] board." The news that one of the country's most prestigious philanthropies had committed to backing the dental therapy program proved to be a big morale boost as the Alaskans promoted the program to the dentists in Las Vegas.

Next, Sherry recalled making a pitch with Davidson to the ADA's executive committee of roughly 30 dentists and finding a mix of strong opposition and a minority willing to tolerate an experiment with dental therapy.

Davidson recalled she was nearly done with her presentation when she said, "'Well, we have one more piece of information and news to share. You should know that we just received word from the Kellogg Foundation that they have provided funding to start a training program in the United States…' You could have heard a pin drop, and then there was this gasp and then one of the folks there says, 'How dare you come to this meeting and share this information? How dare you?'"

There was very little time for Davidson and Sherry to ponder the abrupt end to the meeting before Sherry was slated to give his talk to hundreds of rank-and-file dentists. Sherry told the convention delegates, according to his prepared remarks, that "we cannot ignore the magnitude of the problem of active dental disease going untreated among Alaska Native people. Watching more generations of Alaska Native people lose their teeth because they could not get access to dental care is something that we must urgently address. I know we agree on this point, and that you are trying to help. We simply have a disagreement about how to take care of dental disease in these remote areas."

In addition to its lawsuit, the ADA had hoped to kill the ANTHC program through its political clout in Washington, but Alaska's delegation in Congress was not going to be turned against a program that was important to its Alaska Native constituency. Eventually, the ADA was forced to make a deal on Capitol Hill, and when they did it was largely on terms that were favorable to the new dental therapists.

Representatitve Don Young amended his original bill in the House Resources Committee that initially would have prevented dental therapists from performing any type of irreversible procedure. His new version, agreed to by both sides, now

said that dental therapists could perform pulpal therapy—a type of root canal—and extractions, but only if a consulting dentist agrees there is a medical emergency that other pain relief can't resolve. Such consultation was required only for adult teeth.

"We still believe that patients are best served by a licensed dentist," William Prentice, a lobbyist for the ADA in Washington, D.C., was reported as saying. "But we're trying to do everything we can to try to respond to the Tribes' concerns on getting dental care in frontier Alaska." The deal in Washington helped put the program on solid ground.

In June 2007, an Alaska Superior Court judge in Anchorage ruled in favor of ANTHC in the lawsuit. Rather than pursue a costly and time-consuming appeal, the ADA worked to initiate settlement talks. The task of the association's new leader, Sherry said, was to convince the Alaska Dental Society that the fight was over. He said she told them, "'If you guys want to keep fighting it, you can do it on your nickel, but we're not going to subsidize it.'" Under the settlement, the ADA made a $537,000 donation to the ANTHC foundation but with the stipulation that the money support other health care projects and not the dental therapy program. In addition, the dentists' lobbying group paid $75,000 to the state of Alaska.

Crucial Steps Toward Stability

With the ongoing cloud of ADA opposition finally removed, the Alaska program became a laboratory for proving that dental therapy could succeed in the United States. ANTHC's support from the Kellogg Foundation was critical in both improving training and in evaluating the program's impact on oral health.

Now the other issue for WKKF was to aid ANTHC in overcoming resistance at the University of Washington to running the proposed training for the dental therapists that would take place in Alaska—the principal purpose of the $2.8 million grant announced in September 2006.

Rigid resistance from the University of Washington School of Dentistry was not a surprise, given the unyielding position of most practicing dentists in the state. But the university's School of Medicine, which already had a close relationship with ANTHC through a training program for community health aides, was much more open to the idea.

In the end, a rapid confluence of events—a change in leadership at the ADA, the dental lobby's public relations missteps, favorable legal ruling, and the resolute backing from the Kellogg Foundation—took the Alaska Native dental therapy

program from shaky ground to solid, more permanent footing in a span of roughly 12 months.

Indeed, on Jan. 15, 2007, less than one year after the ADA had filed its lawsuit to stop the program, the University of Washington in Anchorage opened its doors for what the *Anchorage Daily News* described as "the first U.S. school to defy national and state dental societies by training dental therapists to fill cavities." The new program became known as DENTEX because of its affiliation with the university's MEDEX program, which had been training health care aides for Alaska since 1969.

The academic curriculum was overseen by Louis Fiset, D.D.S., a professor of dentistry, from the university's main campus in Seattle, about 1,400 miles away. It was Fiset's difficult task to quickly develop a curriculum, evaluate the students' performance in Anchorage and coordinate some 23 different dental professors from around the country who flew to Alaska to instruct the students in one- or two-week modules. Fiset and the other university officials who launched the program understood the highly sensitive nature of the project, according to a project history commissioned for a Robert Wood Johnson Foundation anthology. They decided early on that the names of these professors would not be released to protect them from harassment.

"It was just not safe," Ruth Ballweg, who was director of the MEDEX program, told the RWJF chroniclers, reporting that, as she feared would happen, a member of the Washington State Dental Association contacted her and demanded that she turn over the professors' names. "I told her I would not do that," she recalled. "And she said she would ruin my career. Of course, she could not do that. I am not a dentist."

Tackling Unique Recruitment and Training Challenges

Nevertheless, the ANTHC program continued to contend with obstacles after the ADA lawsuit was settled and the DENTEX program became established in Anchorage and Bethel. According to the RWJF history, in the early years of the 2010s the biggest hurdle was recruitment. It was difficult to find candidates from remote Alaskan villages who could leave their family for the two-year training program.

Ironically, the biggest problem was that Alaska Native people who expressed interest in the program were too wedded to their lives in their hometowns to leave for the two years of training. Edwin Allgair, D.D.S., a Bethel-based public health dentist, told RWJF about the reasons he heard for not signing up or, in some cases,

for dropping out: “My family’s cutting fish right now, I have to go home. It’s time for berry-picking, my family needs me.”

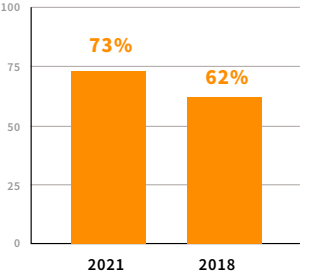
Despite those difficulties, the early trainees who stuck with the ANTHC program served as ambassadors for dental therapy, and important resources for others who wished to expand access to dental care in other parts of the United States.

The timing was critical. The Alaska program had taken root by the late 2000s, just as more people became aware of Deamonte Driver, a 12-year-old Maryland boy who died in 2007 because of an infection from his untreated dental disease. Also, the push to expand health care access to the uninsured and low-income families that eventually resulted in the Affordable Care Act had begun. In other words, right at the moment when the body politic was questioning why millions weren’t able to be seen by a dentist, a possible solution had emerged in the unlikely setting of Alaska’s most remote villages.

Research was beginning to prove the success of dental therapy in Alaska. For example, two independent evaluations found that Alaska’s dental therapists were providing high-quality, appropriate care that was within their scope of practice. But much of the most compelling evidence was anecdotal. “Every year, as I provide care to the kids in the communities, I am building a relationship of trust,” said Johnson. “It used to be that nearly every child I saw had cavities, but now we are seeing more and more who strive to be cavity-free.”

Graduation Rates

As of May 2021, of the 109 students who had enrolled in the Dental Health Aide Therapist program, 80 had graduated, which is a 73% graduation rate. By comparison, as of 2018, 62% of students at four-year institutions had completed a bachelor’s degree at the same institution where they started.



CHAPTER 5

How Native Sovereignty Supports Dental Health

Brian Cladoosby can still remember vividly growing up in the 1960s and ’70s as part of the Swinomish Indian Tribal Community in northwestern Washington state. Once a year, usually as school was winding down for the summer break, a dentist would show up in a small portable trailer for an annual visit to their small island.

“That dentist’s job was one of three things,” Cladoosby recalled of his childhood decades ago. “Drill, fill or extract. There was never any kind of long-term program in place.” For many of the Swinomish kids, the arrival of the dentist to deal, often forcefully, with teeth that had become disease-ridden over the previous 12 months was an unpleasant experience they’ve never been able to fully forget.

“Right now, a generation of Tribal members is so traumatized that they’d rather go with missing teeth or suffer from terrible toothaches” than see a dentist, said Cladoosby, who served as chair of the roughly 900-member Swinomish Indian Tribal Community from 1997 to 2020. During his tenure, Cladoosby worked hard to create jobs for Tribal members—many of them in the community’s casino along the highly traveled corridor between Seattle and Vancouver—and won plaudits for innovations like a fully accredited police force, an advanced drug-treatment program, and support of environmental protections for its coastal community.

But Cladoosby never forgot about the oral health problems in the community. When he emerged as a national leader on Native American issues—eventually serving two terms as president of the National Congress of American Indians (2013–2017)—he also began to learn the story of how Alaska Native people had successfully fought for a dental therapy program and how effective dental therapists are even in the most remote villages.

The Swinomish leader also learned about the complicated politics surrounding dental health care. During the lengthy political fight that eventually resulted in the passage of the Affordable Care Act in 2010, at the last minute the dental lobby won a provision in the related Indian Health Care Improvement Act allowing for expansion of dental therapy to Tribes in the contiguous United States, but only

with the approval of respective state legislatures.

As a longtime advocate for Tribal sovereignty on a wide range of issues, such as fishing rights and environmental protection, the provision troubled Cladoosby and other Native American leaders. Nevertheless, he also had many friends and political allies in the Washington legislature, so he assumed that passage of a bill to give the Swinomish and the state's other Tribes permission to train and hire their own dental therapists would pass easily.

He was wrong. Initial efforts to pass a dental therapy bill in Olympia, even a limited one that only applied to Native American reservations within Washington, faltered for three years. Some of Cladoosby's closest allies retreated due to opposition to the bill by the state's powerful dental lobby. And so, in early 2016, Cladoosby and the Swinomish Tribe made a fateful decision and applied their longstanding belief in Tribal sovereignty to the complicated arena of dental health. In defiance of the provision in the 2010 federal law and fully expecting a forceful response, including legal action from the Washington State Dental Association, the Swinomish Tribe announced it was certifying and hiring a dental therapist who'd been trained in Alaska.

"The American Dental Association," Cladoosby said at the time to the *New York Times*, "is no friend to American Indian Tribes." The Swinomish and their allies had tried and failed for five years in a row to get the dental therapy legislation passed in Olympia. "We had to take matters into our own hands," he said.

He and other advocates learned that building support around the significant needs, as well as pride, of Native Americans could be powerful tools to lobby for expanding the dental team. His bold maneuvering proved to be a turning point for the movement.

An Emerging Hub

What played out in the mid-2010s in Washington and neighboring Oregon has proven to be a double-edged sword for the dental therapy movement as it has advanced toward the long-term goal of expanding into other parts of the United States. While Cladoosby and other key advocates ultimately won a strategic victory in convincing the dental lobby to back away from opposing dental therapy on Native American reservations, it was only the result of a deal that also confined the approval of new dental therapists to Tribal lands.

That meant that Native Americans living in major cities and towns—the majority of Native Americans—would see no improvements in their access to dental care. And

that meant that more work needed to be done.

Cladoosby wrote in 2017 in the *American Journal of Public Health* that he "was frustrated that the language in the Indian Health Care Improvement Act 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, the Swinomish, along with other Tribes in Washington state and the Northwest Portland Area Indian Health Board, did go to Olympia in the early 2010s and began lobbying for the enabling legislation required by the new federal law. The bill's backers hoped that longtime alliances with key lawmakers would overcome any opposition from the powerful Washington State Dental Association, the same group that had earlier pressured the University of Washington School of Dentistry not to train Tribal dental therapists for Alaska.

Dr. Warner-Mehlhorn views the story of the expansion of dental access in the Northwest's Indian Country as an expression of pride: During generations of various forms of oppression White people were basically saying, "'You're never first-class.' And here, they care about their kids. Those kids and those folks, they stepped out and they lived their courage, they lifted their leadership. And that's an amazing story."

Another Broken Promise

To Cladoosby, it's a story with roots that go back to 1855, the year that his ancestors, along with the leaders of other Tribes in the Puget Sound region, signed on to the Treaty of Point Elliott, the landmark agreement that paved the way for White settlement of the then–Washington Territory. Chief Seattle of the Suquamish and Duwamish people, along with leaders of seven other Tribes, agreed to live on reservations in return for some key promises such as fishing rights. But Cladoosby notes that the treaty included one other promise largely forgotten both by history and by the Americans who signed it: access to health care.

"In 1855, we ceded a million acres," Cladoosby says today. "Some promises were made and one of those promises was health care for our Tribe… That was a promise broken." By the time Cladoosby was born in 1959, the U.S. Indian Health Service provided only sporadic medical service of any kind to a small Swinomish reservation that, as Cladoosby described, had virtually no jobs and high rates of alcoholism and substance abuse.

The green shoots of positive change began to emerge around the start of the 1970s, as the nationwide Native American movement pushed for greater recognition of the problems that communities like the Swinomish Tribe were experiencing. That effort led to the Indian Health Service contracting with more Tribes to develop and provide health care for specific communities. In the Pacific Northwest, the Northwest Portland Area Indian Health Board was established in 1972 to promote better health solutions among some 43 Tribes: 29 in Washington state, nine in Oregon and five in Idaho.

Yet for a long time, the push for expanded health care often took a back seat to economic development. On the Swinomish Reservation north of Seattle, Cladoosby and other leaders went from roughly 40 jobs in the 1970s to close to 1,000 today. Many of those are in the Swinomish Casino and Lodge, which started as a small bingo operation in 1985 and grew to offer not only full-service gaming but a 98-room luxury resort with sweeping views of blue water and the nearby Cascade Mountains.

Cladoosby said he came to believe that additional help would not only expand access to dental care on the Swinomish Reservation but would also be a critical step toward making Tribal members more comfortable with the idea of regular oral health care. “The problem was not having somebody here that the community could relate to full time,” Cladoosby said. “A lot of the kids fell through the cracks”—especially as other issues like curbing alcoholism took precedence.

The Affordable Care Act and Next Steps in Washington State

A turning point came in 2010 when the 1976 Indian Health Care Improvement Act was permanently renewed by Congress through language tucked into the much more expansive passage of the Affordable Care Act.

Then-President Barack Obama had announced early in 2009 that enacting sweeping health care reform was his top priority, and the final, narrow approval of the ACA roughly a year later came after extensive lobbying on Capitol Hill by reform advocates and industry trade associations and other special interests. Among them was the ADA, which worked to minimize changes that would affect the dental profession, including dental therapy.

Toward the end of the debate on the ACA in 2010, lobbyists for the ADA were able to insert language in the section of the Affordable Care Act renewing the Indian Health Care Improvement Act that prevented Native Americans’ community-health

programs from licensing dental therapists without approval from the respective state legislature and placed restrictions on procedures that dental therapists could perform. With the Alaska Native dental therapy program well-established and winning early praise, the dental lobby wanted to ensure that a similar scenario—Native Americans using their own licensing authority to bypass state regulation, through the existing framework that also certified community health aides—didn't play out on Tribal lands elsewhere.

The 2010 federal law became an instant source of frustration to Cladoosby and other Tribal leaders who had been fighting for enhanced sovereignty for years. Cladoosby noted that the Swinomish Tribe had been dealing not with Olympia but directly with the federal government since the 1800s. There wasn't a historical precedent, in other words, for state lawmakers to exert this kind of authority over Tribal decisions.

Initially, a bill that would have allowed the Washington State Tribes to deploy certified dental therapists failed to even make it out of committee. Over the years, the alliance supporting dental therapy grew. The legislation was endorsed by the National Dental Association, which for more than a century has represented dentists of color, and the American Association of Public Health Dentistry. Labor unions and social-justice organizations also joined in a coalition that eventually became known as the Washington Dental Access Campaign.

Then–Washington state Senator John McCoy, who was the only Native American serving in Olympia's upper chamber and a member of the Tulalip Tribe, was personally quite familiar with the difficulty in getting to see a dentist on a Native American territory in the Pacific Northwest. "On some reservations…it's pretty bleak out there," McCoy said. "There are some Third World countries that are better off."

Initially the network of coalition members was no match for the power of the Washington State Dental Association, a familiar story to those who'd been fighting for dental therapy for decades. In January 2016, as the measure remained stalled in Olympia, a detailed report by *The Seattle Times* showed that lobbying activity by the dental association had increased five-fold during the 2010s, to more than $1 million.

Inherent Sovereignty

Eventually, Cladoosby had seen enough. After attending a convening hosted by the Kellogg Foundation, he went back to his community and conducted a clinical analysis to determine which procedures could be done by dental therapists so they

could ultimately serve more patients. “In 2015, we got sick and tired of going down to Olympia—I instructed my team to just do it,” he recalled. “I said, ‘I don’t care what they do to me.’” He had decided to hire an Alaska-trained therapist for the Swinomish dental clinic without the approval of the state or federal government. “We were lawyered up,” he added, and waiting for the dental lobby to file suit, as had happened in Alaska.

Cladoosby’s move was a bold exercise of what he called at the time the “inherent sovereignty” of the Swinomish Tribe. They even created their own licensing board to grant approval for the very first dental therapist—Daniel Kennedy, a Tlingit Alaska Native who had already been trained through the program in Anchorage a few years earlier—to begin working from the Swinomish’s modern clinic on the main highway near the town of La Conner.

At the time of the Swinomish decision, Cladoosby had moved into his role as a leader and spokesman for Native Americans at the National Congress of American Indians. That same year, 2015, he’d been invited to Washington, D.C., by the Congressional Black Caucus to speak specifically on a topic of shared interest: lack of access to good dental care. The alliance was a natural one. Both groups had been searching for ways to improve oral health in their communities when the 2007 death of Deamonte Driver energized African American lawmakers who knew from studies that Black children had twice the rate of tooth decay as White children. The rate for Native Americans and Alaska Native people was *four* times higher.

The Swinomish move also would not have happened without a $2.5 million grant from the Kellogg Foundation to the Northwest Portland Area Indian Health Board in 2015 that supported the initiative. The money for exploring alternative workforce models was critical because it was an exercise of the Tribe’s inherent sovereignty and responsibility to care for the health of its citizens.

Rank-and-file Swinomish members were grateful for Cladoosby’s assertiveness and for the outside help from the Kellogg Foundation. In May 2016, a reporter from *The New York Times* visited La Conner and the Tribal clinic, where he met 40-year-old William Bailey, who said he was there for treatment of an inflamed molar and was happy to be looking up from the dental chair at another Native American. “He knows what we’ve gone through,” he said of Kennedy. Another patient, 70-year-old Verne McLeod, shared similar memories to those of Cladoosby of the days of the portable trailer visits and sporadic dental care. “They just strapped us down and drilled,” he said.

“The problem was not having somebody here that the community could relate to full-time,” Cladoosby would say later in a defense of why a dental therapist could be vital even in a community that already had a permanent dentist. As the

Swinomish Tribe started to get positive publicity for its dental therapy program, the push for expanded access gained traction elsewhere.

Facing Down Obstacles in Oregon

In Oregon, advocates who were pursuing expanded dental therapy also experienced years of frustration. In 2011, lawmakers voted to authorize pilot projects to study mid-level oral health care, but no pilot projects were launched, at least initially. Two years later, legislators in Salem voted to give $100,000 for the Oregon Health Authority to create a staff position to oversee pilot programs, but there was still no effort to start one, nor was there any support for dental therapy from the state's lone dental school at Oregon Health & Science University.

That caused the one nonprofit group interested in a pilot, the Northwest Health Foundation, to back out of its initial efforts. "All the reasons are there why we should have gone for it, but the stars weren't aligned," said Democratic Oregon state Representative Laurie Monnes Anderson, the legislature's leading dental therapy proponent.

"It was very difficult," Anderson recalled. She noted that as early as 2009 she'd called in a facilitator to work out a compromise between Oregon's dental lobby and its Tribal leaders, only to see the Oregon Dental Association turn around and lobby against what she thought was their tentative agreement. She said that forward progress on dental therapy—the 2011 bill and the addition of state funding—had largely been the result of persistence by supporters, including herself.

But in 2016, a combination of the high-profile push in neighboring Washington by the Swinomish, the Kellogg Foundation grant to explore dental therapy in the region and growing awareness of the need to improve oral health care among Native Tribes led to a breakthrough in Oregon. The Oregon Health Authority finally began taking applications for pilot programs, and the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians and the Coquille Indian Tribe signed up with the Kellogg Foundation's grantee in the region, the Northwest Portland Area Indian Health Board, to bring in Oregon's first dental therapists. Even then, both Tribes needed to wait for trainees to work their way through the two-year program in Alaska.

The Kellogg Foundation–backed initiative had other positive impacts as well. In Washington State, the Swinomish geared up for a harsh response and a lawsuit from the state and national dental lobbies. They were shocked when no one tried to shut down their operation. The early success and upbeat reports coming from the clinic in La Conner provided ammunition for lawmakers hoping to pass the

long-stalled enabling legislation, which would allow for federal Indian Health Service funding of the efforts and make it easier for other Tribes to participate.

“We had to learn and shift strategies in terms of the legal moves,” said Dr. Warner-Mehlhorn in recalling how the strategy played out among the Pacific Northwest Tribes.

McCoy, a long-time sponsor of the legislation, noted that Republicans still held a majority in the Washington state Senate and were hesitant as 2017 began to move on the bill. He recalled that the GOP chair of the key committee holding up the legislation “kept telling me she was worried about the safety” of dental therapy. “I said, ‘Why don’t you come out to the reservation and see for yourself how safe it is,’” recalled McCoy. He said that her legislative visit to La Conner in early 2017 helped calm whatever lingering fears existed about the program.

Other Tribal leaders came forward to tell lawmakers about the desperate need for greater access to oral health care. At a hearing in January 2017, Mel Tonasket, the vice chairman of the Colville Tribal Council, pleaded with legislators to approve dental therapy because dentists would not work in their remote location. “When we got word on the dental therapist program and started looking into it, we said ‘that would fit us,’ so we can get into some preventative care,” said Tonasket, noting that just one dentist was seeing 6,000 patients at that time.

The Power of a Determined Advocate

At the Kellogg Foundation, officials gave a lot of the credit for the bill’s final passage to the determination of the Swinomish and their chairman, Cladoosby, in not letting go of the issue. “When Brian ran that Tribal bill through, essentially, after many times,” said Dr. Warner-Mehlhorn, “he got in their face and he said, ‘You don’t care about my people. You’ve never cared about my people, and we’re going to do this.’ I’ve seen and heard that conversation described a number of times, and at the same time what I know about that is that the tipper to getting that Tribal bill through was there was no way [opponents] could not be seen as racist… Openly to do that, in a state with a large number of Tribes, sitting legislators and everything else, and basically they said, ‘We’ll try to get along better.’”

Caroline Brunton, the Kellogg Foundation program officer who manages the dental therapy portfolio, said the foundation provided critical support to the Washington State initiative on dental therapy. She said a key takeaway for advocates was the importance of determining their best points of leverage—the areas where they could most easily wear down or break down opposition.

Promoting dental therapy as an instrument of Native American sovereignty and racial equity, advocates were "finding those opportunities" that will eventually show the viability of dental therapy for other populations, said Brunton.

Pam Johnson of the Northwest Portland Area Indian Health Board noted that Northwestern Tribes had gained political clout in recent years to rival that of the dental lobby—in part the result of the economic power of Native American gaming—and that exposure in *The Seattle Times* of the efforts to stymie the legislation also helped. In addition, Johnson said she believed that limiting mid-level oral health care providers to reservations where only about 30% of Washington State's Natives live was a political fallback strategy of "let's keep dental therapy in a box."

Once the Washington State Dental Association dropped its ardent opposition to the bill, approval was relatively easy. It passed by a unanimous vote in the state Senate and 80-18 in the House. Bracken Killpack, the dental association's executive director, told *The News Tribune* in Tacoma that the association was trying to "turn a leaf and engage with Tribal communities" better. Nevertheless, the dental lobby continued to oppose the expansion of dental therapy both to non–Native Americans and to locations not on a reservation.

Cladoosby recalled that "by 2016 the American Dental Association was seeing that this thing was only going to keep growing, so they decided they were going to neither support nor oppose it." Still, he said, the dental lobby worked to change the bill so that therapists could only serve Tribal members and only at reservation-based clinics. The problem with that, he and other advocates noted, is that most Native Americans wouldn't be well-served by that compromise. Government statistics show that some 78% of Native Americans do not live on reservations. Most live in Seattle, Portland, Spokane and other urban areas.

With the legislation in Washington State passed and the pilot programs finally underway in Oregon, Tribal leaders could turn their attention to either finally training new dental therapists or hiring others who had been educated and trained in Alaska. After one year, the Swinomish were reporting that wait times for an appointment at the Tribal dental clinic had dropped from three months to roughly three to four weeks.

Brunton said that having a dental therapist on the Swinomish Reservation has "really helped with the fear that the kids have had—seeing him in their school, teaching them how to brush their teeth." What's more, she said, the presence of Native Americans working as dental therapists would inspire young people to follow the same or similar career paths.

> We heard dental therapists in Alaska say, "I never thought I could even go to college. Now I think I could be a dentist."
>
> **Caroline Brunton**

"It's providing jobs particularly for people of color coming from the communities that have the most need going back to them," Brunton said. "Good-paying jobs help boost the economics in that community. And it gives them a career path as well. We heard dental therapists in Alaska say, 'I never thought I could even go to college. Now I think I could be a dentist.'"

Cladoosby continues to serve as an evangelist for expanded access to oral health care while working on ways to improve the program. While the Tribe was training two more therapists in Alaska in 2018, the Swinomish were also working with a nearby institution, Skagit Valley College, with the goal of finally training new therapists within the contiguous United States.

"The Swinomish will license these students," Cladoosby said. "They will take a test and they will get a license and be able to go into any Indian community in the nation." He still sees himself as waging a long-term conflict with the American Dental Association, adding: "We're on the right side of history."

The Work is Not Done

Less than a year after their victory in Olympia, the Swinomish and other Tribes in Washington state found themselves in a conflict with the federal Centers for Medicare and Medicaid Services (CMS) during the Trump administration over Medicaid reimbursement for patients treated by a dental therapist. The stated reason was something of a catch-22. While the state legislation had required that the new therapists only treat Tribal members, CMS invoked the so-called "freedom of choice provision." If the Tribal dental clinics don't treat all Medicaid patients, including non-Tribal members, the federal agency ruled, the work isn't eligible for reimbursement.

"Our argument is that a Medicaid patient can go anywhere in the state," said Cladoosby of the challenge to the federal rule. "Their argument doesn't hold water" because the Tribal dental therapists are providing a new level of service that didn't previously exist. But the long-term viability of the program would be threatened without the flow of money from Medicaid. The bizarre nature of the controversy is proof to advocates that while allowing dental therapy on Native

American lands is a step forward, the concept is still subject to contradictions and issues that would not exist if mid-level dental care were universal.

Johnson said that the Northwest Portland Area Indian Health Board recently moved into Idaho and is pushing to bring dental therapy to Tribes there, drawing on the lessons learned in nearly a decade of the organization's advocacy in Washington and Oregon.

The Northwest Portland Area Indian Health Board also received funding for a two-year study of the health impacts of dental therapy in the region, which she expected to show modest gains, noting that significant improvement often takes as long as a decade. Yet time is of the essence, she and other advocates noted, in the goal of moving away from the significant seed money from the Kellogg Foundation and other philanthropies such as the Pew Charitable Trusts and toward reliance on public health funding such as Medicaid.

In Oregon, advocates and Tribal leaders are also hailing the arrival of that state's first dental therapists and expanded access while struggling with some growing pains to get their pilot projects off the ground. In July 2017, the Confederated Tribes of Coos, Lower Umpqua and Siuslaw on Oregon's South Coast employed the first dental health aide therapist in Oregon, employing a Tribal member who had been trained in Alaska.

CHAPTER 6

Exploring Expansion

In 2010, the positive results in Alaska and success in getting Minnesota's statewide program off the ground led the Kellogg Foundation to announce an effort led by Community Catalyst. The initiative would support community-led projects to build grassroots efforts, centered in racial equity, to advocate for expansion of dental therapy across the country. The project aimed to invest $16 million in five years in five states that showed a promise for expanded access to oral health care in low-income or remote communities.

The timing was no accident: Then-President Barack Obama had just signed the ACA, which called for the establishment of pilot programs to expand dental access. In announcing the Dental Therapist Project, the Kellogg Foundation and Community Catalyst cited research that the U.S. needed 10,000 additional dental practitioners, yet the number of licensed dentists had been steadily declining, not growing.

David Jordan, former Community Catalyst dental therapy project director, said he only learned of the idea of mid-level providers as an oral health care solution after Minnesota became the first state to allow dental therapists to practice as part of dental teams statewide. "We wanted to try to explore whether or not we [could] follow Minnesota's lead and change corporate practice to add dental therapists to the dental team," Jordan said.

As in Alaska, advocates in Minnesota faced formidable opposition from the dental lobby. The Minnesota Dental Association spent heavily on both lobbying and an aggressive statewide advertising campaign to try to kill legislation, championed by state Senator Ann Lynch, that would allow dental therapists to practice in the state. But advocates—with support from the Kellogg Foundation and the Pew Charitable Trusts—built what would prove to be an effective broad-based coalition made up of public health dentists, hospitals, health care providers, oral health educators and nonprofit groups. Although Lynch's first bill failed in 2008, state lawmakers authorized the creation of a 13-member work group to study new dental workforce models and make recommendations for legislation to be introduced the following year.

The result was a compromise bill that created two types of licensed oral-health professionals: a dental therapist who would work on-site under the direct supervision of a dentist, and an advanced dental therapist who would work under a collaborative practice agreement with an off-site dentist. Soon after that bill was passed in 2009, the University of Minnesota's dental school and a Metropolitan State University–Normandale Community College partnership developed curricula to train the dental therapists. The first students graduated in 2011.

What needed to be learned from Minnesota was how to mount a statewide campaign for dental therapy: How to identify the key constituencies most affected by a lack of access to dental care and how to best marshal the new incoming data about the effectiveness of dental therapy in Alaska and elsewhere, and—perhaps most important–how to overcome the industry objections.

Staff with both the Kellogg Foundation and Community Catalyst viewed Minnesota's experience as helpful in determining whether dental therapy was a viable solution to expand access to dental care in other states, and not just in unusual, hard-to-replicate situations like the Alaska Tribes, where issues like sovereignty, the unique Native American health care law and geography came into play.

"I think it's persistence," said Michael Scandrett, with the Minnesota Safety Net Coalition, the driving force behind the Minnesota dental therapy effort. "I think the ingredients are: Know your state, the politics, the current way your health care institutions are structured and make sure [the plan] fits for you. Know where the need is and try to go with the need. You need to find strong champions who will fight for it and who will believe in it, and you have to have a strong coalition of supporters. You also have to have good evidence of what's happening to people, their health and kids. And then I would say you need to have some really experienced advocates who know how to do strategy and use the procedures—because we had to jump around in the process."

Making a Dental Therapy Movement

The 2009 enactment of the Minnesota law accelerated conversations within Community Catalyst about how the nonprofit group might receive support from the Kellogg Foundation to fund an effort to identify other states with strong enough community-led support to advance dental therapy. Jordan was also looking at the initial studies of the quality of care in Alaska—which showed success rates similar to licensed dentists performing the same procedures—as well as the data collected from other nations that had employed dental therapists for decades.

Jordan noted that in other efforts, it had been standard procedure to approach educational institutions about coming on board fairly late in the process, during the implementation phase. But with the dental therapy campaigns, Jordan and Community Catalyst learned it helped to raise awareness among key educators and bring them on board early in the process alongside community-led mobilization. The same is true, he said, of creating a regulatory framework for dental therapy where none existed because of how new the concept was in the United States. Such efforts, Jordan said, are also essential to creating a climate for success beyond changes in scope of practice.

"The movement to build awareness for dental therapy and then engage stakeholders who are key to delivering those services like dentists, like FQHCs [Federally Qualified Health Centers], or training, like educational institutions or regulatory boards that deal with education—we had to engage them along the way to get them ready to participate in the advocacy process," Jordan said.

At the same time, he said, it was understood that it was important to change some of the fundamental perceptions around dental care. For one thing, average citizens not only didn't know what a dental therapist was, but they also lacked awareness of the pervasiveness of the lack of dental access, how that affected public health and how it would negatively impact people's lives—not just whether they feel healthier or if they're in too much pain to go to work or go to school, but also their employability.

State Exploration

Jordan said another goal was to identify states where the need was great and where there was strong community support for identifying alternative ways to increase access to care. These factors came into play in 2010 as the organization—working with financial support and coordination from WKKF—looked to identify which handful of states to explore. For advocates of dental therapy, it was a kind of calculus: Which states had high rates of low-income or isolated patients not able to visit a dentist, which states had current or looming shortages of licensed dentists and which states had an existing advocacy climate that was community-led and receptive to initiating an exploration? The answer wasn't always simple.

"You look at Vermont, which at first glance might not seem like an appropriate target state because 56% of the kids on Medicaid are seeing a dentist," Jordan said. But drilling deeper into the data revealed problems in the largely rural state. "A third of their dentists are slated to retire in the next 10 years. You're still looking at over 4 in 10 kids and over 4 in 10 adults who aren't getting care. That is a significant need, especially when you compare it to the medical side of things."

In the end, Vermont—with its recent traditions of activism, a political establishment in both parties broadly in favor of expanding health care and its demonstrable shortage of dentists in isolated rural areas—was selected by the Kellogg Foundation as one of the five states for exploring the possibilities of dental therapy to improve access to dental care. The others were New Mexico, Ohio, Kansas and Washington, where there was already significant movement among the Tribes. In Washington, the goal was to expand dental therapy beyond Tribal communities. The list offered geographic diversity, yet the states also shared an advocacy base that—at least when the $16 million effort was launched in late 2010—offered hope.

A cornerstone of the work was to partner with communities and grassroots organizations interested in exploring alternative models to address gaps in access to care. That process blunted the potential criticism that wealthy philanthropies or outsider nonprofits were mounting some type of attack on homegrown dentists. More urgently, these local coalitions understood the lay of the land. Jordan said he was pleased to learn that much of the local support he was looking for was already in place, practically waiting to be activated.

Lessons from Vermont

> Lack of dental access is a national problem, but those who are most impacted are people who are low income, racial or ethnic minorities, pregnant women, older adults, those with special needs and those who live in rural communities. Simply put, the groups that need care the most are the least likely to get it.
>
> **Senator Bernie Sanders**

It could be easy to look at Vermont, a small New England state, and assume that dental therapy would be taken up in a matter of months, not years. Just as the Vermont dental-access project was getting off the ground in 2011, state lawmakers approved a statewide universal “single-payer” health care system that would have been the first of its kind. Its ultimate failure to be implemented has been attributed

to logistical and political issues, not a lack of public support for expanding access to care.

What's more, Vermont's most visible public leader—U.S. Senator Bernie Sanders, who was a leading contender for president in 2016 and 2020—had made expanded access to dental care one of his signature issues. In a 2012 op-ed that appeared in *The Plain Dealer* in Cleveland and other publications, Senator Sanders wrote that he had begun thinking about lack of dental care in the early 1970s when he lived in Vermont's remote Northeast Kingdom section and met a young man whose teeth were already heavily rotted out. The largely rural character of Vermont and its pockets of mountainous isolation contributed to the state's large dental deserts with little or no oral health practitioners.

"Lack of dental access is a national problem, but those who are most impacted are people who are low income, racial or ethnic minorities, pregnant women, older adults, those with special needs and those who live in rural communities," he wrote. "Simply put, the groups that need care the most are the least likely to get it."

Senator Sanders, an Independent who caucuses with Senate Democrats, had been pushing for dental clinics inside nearly 1,400 FQHCs in the United States and vowed, in 2012, to fight in Congress for dental therapists and expanded dental coverage under Medicaid. When the op-ed appeared, local activists were already pushing for similar action in the state capital of Montpelier.

Yet even under all these favorable conditions, winning approval for dental therapy in Vermont was not easy, despite the Community Catalyst initiative to support the advocacy campaign. The difficulties would certainly sound familiar to anyone who has studied the history of dental therapy in the United States. The Vermont State Dental Society voiced the usual concerns about lack of training for dental therapists and urged their standard solutions of recruiting more dentists to come to the Green Mountain State, in tandem with more slots in dental schools.

Fortunately, there was a strong and aggressive advocate on the other side of the issue. The lynchpin of the new coalition fighting for dental therapy in Montpelier was Voices for Vermont's Children, an independent nonprofit group that works on a variety of issues related to the health and well-being of kids.

> We did a lot of grassroots organizing through our partners. We collected stories from families, in particular, because we have a child focus. We heard from families that had to drive an hour and a half each way to bring their child to one of the handful of pediatric dentists in the state.
>
> **Michelle Fay**

Michelle Fay, the executive director of Voices for Vermont's Children and a former state representative, said the Vermont coalition was able to counteract the influence of the dental lobby by making sure lawmakers heard the stories of their constituents and their struggles with oral health care.

"We did a lot of grassroots organizing through our partners," she said. "We collected stories from families, in particular, because we have a child focus. We heard from families that had to drive an hour and a half each way to bring their child to one of the handful of pediatric dentists in the state." They were aided in that effort by the Vermont Public Interest Research Group (VPIRG), which had developed a simple online tool that allowed citizens to not only sign petitions but tell their stories and follow up with advocates.

Voices for Vermont's Children also strived to broaden its coalition. It worked closely with the American Association of Retired People (AARP) to bring older Vermonters into the campaign, as well as groups that worked mostly in lower-income communities. "Voices for Vermont's Children is very collaborative and coalition-based, so we're the advocacy arm and the research arm, but we really relied on our partners and communities to connect us with the real stories," Fay said.

Those stories helped legislators understand that the solutions being proposed by the Vermont State Dental Society were not going to solve the state's problems, that there needed to be a lower-cost alternative for dental care. In 2015, the Vermont Senate passed the dental therapy bill, but the House would not act until the following year. It wasn't until the spring of 2016 that the measure passed both chambers. It was signed into law on June 20 that year by then-Governor Peter Shumlin, who hailed the measure as one that "will make it easier for Vermonters to get the care they need, closer to home and no matter what type of insurance they have."

Just as in Minnesota, there were compromises to get the bill passed without

aggressive opposition from the dental lobby. Similar to what happened in Minnesota, a dental therapist was defined as a cross between a licensed dental hygienist and a dentist, so that trainees would already be certified hygienists. That meant that mid-level oral health providers in Vermont would require more training than the two-year Alaska/New Zealand model.

Still, it was an important victory and advocates hoped the approval of statewide dental therapy in another state would provide much-needed traction elsewhere. Tera Bianchi, who succeeded Jordan as dental therapy project director at Community Catalyst, said on the day that Shumlin signed the legislation that “we see this as a tipping point.”

CHAPTER 7

The Playing Field Expands

"When we first began the project, I would talk to legislators who had no concept about the connection between oral health and overall health," recalled David Maywhoor, who led the Ohio-based advocacy group Dental Access Now. "When you talked to lawmakers about access to dental care, you could almost see them going back into the community and thinking about an uncle or a brother or a sister or their own wife who have had trouble getting dental care. We spent an awful long time educating legislators about the issue in Ohio, making sure that it was front and center on their plate."

And yet, even as Maywhoor and his fellow advocates built a broad coalition and appeared frequently in news articles informing readers about the dental-care shortage in Ohio, it took nearly five years for a dental therapy bill to even come up for debate in the state legislature. And as of this writing, Ohio has yet to join the roster of states that license dental therapists.

Playing the Long Game

The Ohio experience was not designed to bring results overnight, or even in a year or two. Although a few dentists agreed with the need for more mid-level providers, such allies were rare initially. Generally, opposition from the main dental lobbies to any bill that created a substantial role for dental therapists remained strong. Nevertheless, the campaign was designed to create a sense of momentum, so that success in one state—and the expected positive outcomes from dental therapists then seeing more low-income patients—could convince lawmakers in other jurisdictions to come around. The goal was to reach a tipping point where mid-level dental care is viewed as being just as routine as the mid-level medical care provided by physician assistants. But the most important attribute, as the battle for Ohio has shown, remains patience.

> The key to movement building—and that's what this turned out to be—is to follow community-led momentum.
>
> **Carla Thompson Payton**

Perhaps as a result of the momentum-building promoted by WKKF and Community Catalyst, progress has been made in other states. Some of this was spurred on by the work of other philanthropic efforts, most notably the Pew Charitable Trusts. Still, the power and opposition of the dental lobby remained formidable.

What happened in Maine was instructive. Lawmakers there, which like Minnesota has a large rural population, approved a statewide dental therapy program in 2014. But the Maine Dental Association succeeded in amending the final bill. Unlike the Tribal dental therapists in Alaska, the Maine law required dental therapists to work with and be directly supervised by a dentist at all times, limiting their ability to visit schools or nursing homes. Other restrictions on licensure and accreditation meant that some four years after the bill passed, there were still no dental therapists working in Maine.

In Arizona, a large Native American population and support from Tribal leaders was critical in the enactment of that state's dental therapy law in 2018. Later in the year, Michigan became the eighth state to approve the training and licensure of dental therapists. A push for more treatment for Medicaid patients, and statistics showing a shortage of dentists in 78 of Michigan's 83 counties, overcame opposition from that state's dental lobby. In many ways, the Michigan law, which allows for the licensure of dental therapists after 500 hours of dentist-supervised practice and whose caseload is made up of at least 50% Medicaid beneficiaries, is seen by many advocates as a model bill. Notably, the bill followed the 2015 standards established for dental therapy education programs by the Commission on Dental Accreditation (CODA). It also allowed communities to define their own needs.

When the Michigan bill was signed into law by then-Governor Rick Snyder at the end of 2018, a dozen other states were considering dental therapy bills.

Except for Vermont and Maine, the states that were either supported by the Community Catalyst effort or that successfully enacted legislation tended to have significant or rapidly growing populations of Blacks, Hispanics or Native Americans. That was not an accident. The Kellogg Foundation has been making investments to advance racial equity for at least 80 years of its nine-decade history.

The idea of centering the campaign for dental therapy on racial and economic justice made what the Kellogg Foundation and Community Catalyst were doing

substantively different from previous attempts at mid-level health care, which were built around a more simplistic public health argument. And the racial equity goals expand the push for dental access to include a wide coalition of grassroots organizations.

WKKF's Brunton said seeking racial equity "means to break down some of those barriers around implicit bias and institutional racism." She said that meant, for example, elevating Native Americans on the vanguard of the movement and expanding that approach to work with other historically underrepresented groups—and especially supporting local communities in shaping and spearheading advocacy efforts.

How to Grow Support in the Heartland

Kansas is a Midwestern state where modern conservatism has occasionally clashed with a unique brand of prairie populism. The Jayhawk State still had a Democratic governor when it was selected for the Dental Therapist Project in 2010, only to take a sharp right turn during the decade. However, activists coalesced around a broad network of support for establishing mid-level dental care, including Kansas Action for Children (KAC), the Kansas Association for the Medically Underserved (KAMU) and the Kansas Health Consumer Coalition (KHCC).

Although the problems faced by Kansans were largely rural in nature, the issues came with a numbing familiarity for anyone familiar with the debate over expanding access: an aging pool of dentists that was shrinking instead of expanding to meet growing demand, a large number of less populated counties either underserved or with no provider at all and only a quarter of all dentists accepting Medicaid (compared to 9 out of 10 medical doctors).

"Dental care is out of reach for far too many Kansans," Anna Lambertson, former executive director of KHCC, said in 2010. "We're talking about farmers, small business owners, families that have lost their jobs in this economy being unable to find a dentist. We know that the unavailability of dental care affects our children in school. It affects adults in our workforce. And it affects overall health and health care costs for all of us."

Unfortunately, things would get worse in Kansas before they got better. In the early 2010s, then-Governor Sam Brownback's signature achievement was a steep cut in taxes that was supposed to spark an economic boom in Kansas but instead created a deep fiscal crisis for the state. By 2016, the lack of tax revenues forced a 4% cut in Medicaid reimbursement that was the last straw for some of the few dentists who took government insurance.

In 2018, *The Topeka Capital-Journal* ran a lengthy exposé on the growing number of Kansans who lacked access to a dentist, including the thousands who lined up—sometimes at 4 a.m.—to get oral health care from a series of free clinics. The article noted that the coalition supporting the establishment of dental therapy in Kansas was broad and included—as in Ohio—the conservative Americans for Prosperity chapter as well as community advocates, the board president of the Kansas Association for the Medically Underserved, the Kansas Association of Counties and the state chapter of AARP. Notably, the coalition would also soon include the Kansas Dental Hygienists' Association.

The group that showed up at a February 2018 hearing to oppose dental therapy legislation was much smaller—representatives from the Kansas Dental Association and the Kansas Dental Board. The Dental Board's executive director urged lawmakers to instead find money to open a dental school—Kansas has never had one—that could churn out more homegrown dentists. In 2021, more than seven years after the campaign to bring dental therapists was announced, the bill once again failed to get voted out of committee. Advocates noted, however, that the bill was still alive as of this writing and could advance during the second year of the 2021–2022 legislative session.

Seeking Equity in New Mexico

In New Mexico, the state's large non-White, heavily rural population—with large numbers of both Native Americans and Hispanics—helped advocates make a powerful case for mid-level dental care. In 2010, Community Catalyst turned to advocates like Barbara Webber, the executive director of Health Action New Mexico, to help lead a coalition that included the Con Alma Health Foundation, New Mexico Health Resources and New Mexico Voices for Children.

Webber spent the earliest months of the campaign simply traveling around the state listening to the stories of everyday citizens and their difficulties in seeing a dentist. "The stories we heard were so dramatic that it made it clear to me that this was an issue that really engaged people in New Mexico." She was alarmed to learn how many New Mexico residents were traveling to neighboring states, and even into Mexico, with help from organized tours.

Webber heard, for example, of a staff radiologist at a small hospital in rural Clayton, New Mexico who would take his kids to Amarillo, Texas—more than three hours away—to see a dentist. Sometimes, if follow-up care was needed, he'd be gone for two or three days, forcing the hospital to temporarily close his department. And he wasn't the only professional who struggled with seeing a dentist. Webber recalled that the state's head of Indian Affairs, a cabinet secretary, was told

through his Indian Health Service coverage that he'd have to wait six months to see a dentist for his infected tooth. When he finally did, the official was informed the office didn't have provisions for root canals, so the tooth would simply have to be removed.

"They're powerful stories," Webber said. "One time when I was speaking at a community forum a gentleman from one of the Pueblos told me about serving as a parent assister at a school relay race. He said he couldn't help but notice that many of the children running past him had rotting teeth."

Webber and her fellow advocates uncovered disturbing statistics about how the dental access crisis played out in New Mexico. For one thing, nearly 7 out of every 10 dentists in the state were clustered in and around the largest city, Albuquerque, leaving many rural counties with no practitioner at all. Even in Albuquerque, Webber noted, patients typically waited two or three months to see the dentist at one of the city's FQHCs.

Sharing States' Best Practices

Kellogg Foundation staff encouraged local activists to develop strategies that reflected the unique aspects of their state. WKKF's Reincke recalled that advocates were encouraged to expand their community base by finding unlikely allies, which often included engaging Tribal leadership to join in coalition.

In New Mexico, for example, Webber and other advocates pressed for training to be coordinated with the state's network of community colleges, with the idea that it would help recruit dental therapy students from smaller localities—and keep them there.

New Mexico advocates supported establishing a three-year training program that would be run through the community college system. Critically, it would also allow dental therapists to practice alone, off-site, using telehealth technology to collaborate with a dentist.

"We don't have a lot of dentists," said state Representative Gail Armstrong of Magdalena. "We are close to the Navajo Reservation. We have three dentists in Socorro, one who is there once a week. Dental therapists are highly needed in areas like mine."

The New Mexico House first passed the bill in 2015, but it didn't get through the Senate that year. Four years later, though, efforts paid off when both chambers approved the dental therapy bill. Governor Michelle Lujan Grisham signed it into law on March 28, 2019.

For those who'd been crusading for expanded dental therapy since the start of the decade, victories like those in New Mexico and Michigan were exactly what they were looking for.

The growth of dental therapy in the states fits within a broader strategy at the Kellogg Foundation, Brunton said. "With dental therapy, we've done the model development, we've tested it, it works. Now we're looking at leveraging other funding, scaling it up." At the same time, she said, the often risk-averse philanthropic sector was receiving a lesson—thanks to the opposition from the dental lobby—in tackling a complicated terrain. "I think this affords some opportunity to step into spaces that are uncomfortable," Brunton said. And successfully navigating them "could be a potential learning opportunity."

In other words, a critical mass of states to help make dental therapy a nationwide phenomenon was growing—albeit slowly. Still, with the movement poised for a breakout, activists could now look back on nearly two decades of fighting to gain a toehold for dental therapy and point to many valuable lessons that have been learned along the way.

CHAPTER 8

The Push for Nationwide Standards

Two months before the Michigan legislature passed the dental therapy bill in 2018, a key House committee convened a hearing that was different from other legislative hearings that had been held around the country over the years, in which advocates' testimony would often be drowned out by the powerful dental lobby.

Indeed, the director of the Michigan Dental Association (MDA) was at that October hearing to insist that the state had more than enough dentists and that the real problems were low Medicaid reimbursement rates and apathy from potential patients. But on this day, the MDA lobbyist's testimony was more than counterbalanced by witnesses who collectively made a compelling case for mid-level providers. Unexpectedly, some of the most persuasive advocates for the bill were dentists.

As the push to expand dental therapy reached a more mature phase at the end of the last decade, dentists who advocated for laws allowing dental therapists to practice fell into two broad camps. Most common were practitioners from community clinics serving underprivileged communities who saw the need for an extra set of hands that would allow overworked dentists to see more patients at a lower cost, which would enable them to treat more Medicaid patients.

Kevin Steely, dental director of Grace Health, an FQHC in Battle Creek, told lawmakers that he was already using non-licensed dental students to perform irreversible procedures under a dentist's supervision because of a shortage of practitioners. "If we get a doc who's going to come into the public health arena, they usually migrate out within two to three years, and they move to private practice. I'm perpetually recruiting," he said.

But by 2018, the push for mid-level care was also getting support from a new type of advocate: dentists in Alaska and Minnesota who had seen over several years how dental therapists were valuable additions to the dental team. They were willing to testify that not only was the practice of dental therapy safe but that an increasing

number of patients in underserved areas were getting treatment.

“Anyone who claims dental therapy is an experiment or unproven is sorely mistaken,” David Gesko, D.D.S., who was senior vice president and dental director of HealthPartners in Minnesota, told the Michigan hearing. “In fact,” he added, “nearly every dentist in Minnesota who has hired a dental therapist continues to work with them, and many dentists now are hiring their second, third and fourth dental therapist to expand their practices and treat more underserved patients.” He said there had been no safety issues in the state and went on to say that dental therapists had freed up licensed dentists to do more high-level and complex procedures.

The endorsements from dentists who understood how dental therapists practiced and how they were expanding access to care in the communities they served clearly had an impact in Michigan and was making a difference in other states. It represented a trend that boded well for the future of dental therapy.

Creating Anchors for Dental Therapy

While most of the efforts to establish dental therapy in the United States were taking place in state capitols, there was a parallel national movement of dentists, dental-school leaders and other health professionals that has proven to be critically important for creating a climate of wider support.

First, the dental and medical groups that supported mid-level oral health care providers gave policymakers a different perspective than that offered by the American Dental Association. They made a compelling argument for expanding access. In addition, groups like the American Association of Public Health Dentistry (AAPHD), which developed and promulgated curriculum standards for dental therapists in 2011, and CODA, which implemented national training standards four years later, created the national infrastructure for mid-level care that had not previously existed in the United States.

The ADA and its most vocal members framed their arguments against dental therapy as ultimately a case study in economics. They argued for expanding the number of dentists or increasing Medicaid reimbursement rates to provide a greater financial incentive for dentists to treat poor patients. But on the other side, news about the deaths of low-income patients, including the story about the death of Deamonte Driver, as well as publicity over the rising number of dental deserts in the United States, gave the community a sense of urgency to push for a quicker, less-expensive way to increase access. Dental therapy was becoming more and more understood and embraced as a way to do that.

Making Sure Voices Are Heard

> The people who were working on the ground who actually knew communities, understood communities, understood what the challenges were in communities, nobody was talking to them.
>
> **Larry Hill, D.D.S., M.P.H.**

One prominent industry organization that has taken a supportive stance toward dental therapy is the American Association for Community Dental Programs (AACDP), which represents oral health programs at the city and county level across the country. The association has made expanding access to underserved communities, especially the poor, its top priority.

Larry Hill, D.D.S., M.P.H., the Cincinnati-based executive director of the AACDP, said the group was established in the early 1980s by dentists who were working in local communities—particularly lower-income areas—and felt their voices were not being heard in policy debates. The organization now has more than 350 members. "The people who were working on the ground who actually knew communities, understood communities, understood what the challenges were in communities, nobody was talking to them," Hill said.

Unlike many private-practice dentists, Hill and other AACDP members began to advocate for allowing dental therapists beyond Alaska Native communities. They viewed dental therapists not as a threat but as a potential way to reduce the long lines of patients that community clinics were seeing outside their offices.

Hill said that he's optimistic about the future for dental therapists, noting that the states that have passed enabling legislation have created momentum for other states to follow. He said he believes it is important for advocates to stress that the ability to hire a dental therapist and see more patients will make it easier for dentists of color to return to their neighborhoods to practice.

What's troubling, Hill said, is "an expectation by some that we're just going to increase the number of African American students in dental schools and then we're going to expect them to graduate with $300,000 in debt and go work in a low-income neighborhood where they can't make any money. Now if that isn't racial discrimination, I don't know what is." To the contrary, he argues, employing

dental therapists would allow a practice to increase its caseload and see more Medicaid patients, benefiting the community while also creating more revenue for the practice.

Educating His Fellow Dentists

Despite continuing opposition from dental schools and their leaders, some individual academics have fought against the grain, especially those whose focus falls more on public health or community dentistry. University of Florida's Dr. Frank Catalanotto, D.M.D., is one of those leaders. During his career, he also served as vice chair of the board of directors of Oral Health America, a platform to lobby for expanded care.

Catalanotto said that early in his career at the dental school he wasn't particularly concerned about the problem of expanding dental access in less privileged areas, but then he had two life-changing experiences. The first was a two-week project working and living in a community on the Rio Grande River in Texas, where he saw "poverty that I really didn't know existed in this country, and the resulting health care problems." The second was a research project on pediatric AIDS that sent him into homes in some of the poorest areas of Newark. "From that point on," he said, "my career took a very different focus."

Catalanotto said he learned about the effort to allow dental therapists to serve the Tribal regions of Alaska—and the pushback from organized dentistry—fairly early in that battle. At that time, he recalled, he didn't know a lot about mid-level dental care, but he was determined to learn. As part of regular educational tours, which were critical to building the movement, he went to Alaska to find out more about the project and to read as much as he could find about dental therapists. Over the ensuing years he became one of dental therapy's most vocal champions.

While he's been to both Alaska and Minnesota numerous times to observe the practice of dental therapy, he said his best tool in educating other dentists has been a review paper, published by a scientific advisory council, about the main obstacle to dental therapy expansion in the United States: the American Dental Association. The paper concluded that the quality of care provided by dental therapists is identical to that of a dentist. He noted that his own research, including surveys he has taken of dentists, has found as many as half do not have a good understanding of what dental therapists do. Much of his work centers on trying to change misperceptions.

"The fight against dental therapy is coming from the leadership of organized dentistry, it's not coming from the rank and file," Catalanotto said, "so I think if we

can educate dentists about dental therapy—what they can do for patients, what they can do for their practices—I think we have a better chance. We've just got to figure out ways to reach them."

The biggest problem, Catalanotto said, is fear, especially among younger dentists who've taken on large debt and are afraid that working in an underserved community will harm their ability to repay their loans.

"They see what's happening to the future of dental care in this country, they know that patient visits by adults are decreasing because of the costs of dental care, they know that corporate practices are growing larger and larger, and they're very afraid that corporations are going to hire dental therapists," Catalanotto said. "What we've got to do is try to show them that dental therapists can be part of *their* practice and part of helping them address our societal problems of health care disparities, in particular racial or ethnic health care disparities."

It's a Green Light

A major milestone in the years-long effort to have dental therapists seen as an important and valuable member of the dental team came on August 7, 2015, when, as noted earlier, the Commission on Dental Accreditation voted to implement national standards for dental therapy training programs. The commission said its findings were influenced by the growing demand to train dental therapists in the United States as well as the growing body of research papers from Alaska and elsewhere that showed the efficacy of mid-level oral health care.

David Jordan, former Community Catalyst dental therapy project director, called CODA's support "critical recognition of the strong evidence that dental therapy training programs prepare dental therapists to provide high-quality oral health care." He wrote at the time that CODA's national accrediting standards amounted to "the overwhelming support for dental therapy from the public and within the dental industry to increase access to dental care for the 181 million Americans who go without a visit to a dentist each year."

The CODA decision on accreditation came after three years of evaluation and was driven by community and professional voices coming together to highlight the need for dental therapists. "Tribal leaders stood alongside non-Tribal and community members impacted," Jordan recalls. "Dentists and dental educators were engaged. With the foundation's backing, we all provided support through technical letters and testimony, relying heavily on WKKF-funded research of the scientific evidence in support of dental therapy."

“What the accreditation standards really did was legitimize them,” Catalanotto told Dental Products Report when the standards were announced. “The data on how well they perform and what they’re doing in Alaska and Minnesota is one form of legitimacy. But when you have accreditation standards, that’s saying an official body that accredits all dental educational programs is agreeing that this is a very important program, and it should be held to what we call accreditation standards, so the quality of the education is high.”

He added that the CODA standards also offered “uniformity across the country” and would make it easier for dental therapists to move and work among the states that licensed them. It also created the potential for students to receive federal financial aid more easily by attending accredited programs.

> [The CODA accreditation] provided needed guidance to policymakers across the country considering dental therapy as a way to address substantial unmet oral health needs in their communities.
>
> **David Jordan**

Advocates saw the CODA standards as a key selling point in convincing states that dental therapists were here to stay. “The implementation of standards will provide needed guidance to policymakers across the country considering dental therapy as a way to address substantial unmet oral health needs in their communities.” Jordan said.

As predicted, the pace of state approvals began to accelerate after the CODA standards were announced. With Alaska and Minnesota establishing a solid track record for mid-level oral health care and newer states starting to build an educational pipeline for new providers, the future for dental therapists had reached a new level of acceptance. Nearly a decade had passed since Tribal leaders in Alaska began their fight to bring dental therapy to the United States. For advocates, both the early successes and early failures had provided many lessons to help them reach the goal of widely accepted mid-level care and expanded access in underserved communities.

CHAPTER 9

Crafting a New Narrative

There was a time during the mid-2010s when motorists driving into downtown Albuquerque from each of the four main arteries into the city—from the north, south, east and west—were confronted by a striking billboard. It depicted two Native American children, smiling broadly with healthy, gleaming teeth. It was a way for advocates to thank New Mexicans who supported a bill to allow dental therapists to practice in the state.

"People really saw them and commented on them," recalled Linda Loranger, a former principal at Burness, one of the firms the Kellogg Foundation engaged to develop a communications strategy to win public support for dental therapy. In fact, the billboards were seen an estimated 3.5 million times. Loranger said the broader public relations campaign in pushing for mid-level oral health care in New Mexico was centered on a theme of pride, one that celebrated the state's strong Native American heritage.

WKKF engaged Burness and Kauffman & Associates, a Spokane, Washington–based and Native American–woman owned firm, soon after the foundation made a commitment to help expand dental therapy beyond Alaska. Kauffman's work included efforts to help expand dental therapy throughout Indian Country.

Loranger and her colleagues at Burness worked closely with Kellogg Foundation staff, and later with Community Catalyst, to develop a national narrative and support communications plans with foundation grantees in the five targeted states: Kansas, Ohio, New Mexico, Vermont and Washington. Because the states differed in so many ways, messaging varied from state to state. In Washington, for example, grassroots organizers thought the best way to win support was to stress what dental therapy and a stronger system of dental care would do for the economy.

That's just one example of what emerged as a key weapon in turning the tide over the course of the debate on dental therapy. That the list of states permitting some

form of dental therapy has surged to a dozen as of this writing is, in many ways, the result of the realization that advocates needed a bold communication strategy to educate multiple audiences both about the millions lacking access to proper dental care and about the role mid-level care could play in solving that problem.

The work took place in stages. When it began, participants said, research on what type of information people needed showed there was a need for basic education. "We created a common language," Loranger said. "When we first started, no one knew what a dental therapist was."

> We also took the time to build a community of practice around racial equity.
>
> **Kathy Reincke**

"We also took the time to build a community of practice around racial equity," said WKKF's Reincke. In its decades-long commitment to advancing racial equity, the Kellogg Foundation has learned that communities must acknowledge the role that race has played in oral health disparities, heal those wounds and move forward to implement strategies that can allow dental therapists to provide much-needed care to families and children.

"We would host annual, peer-to-peer state coalition meetings as a time to share best practices among community leaders, grassroots organizations and state advocacy groups," Reincke recalled. "At those meetings, we made space for advocates to lean into racial equity practices, including participation in healing circles as a way to understand implicit bias and the unique racial traumas within the communities and the dental field. We also conducted site visits to learn more about our country's significant and complex racial history. For example, we spent time at the *Brown v. Board of Education* National Historic Site in Topeka, Kansas, to learn from the landmark decision and it's far-reaching impacts on education today."

As the foundation took its effort into more states after successfully supporting the Alaska Native effort, it became clear that one reason dental therapy efforts had faltered in the United States, even as they found success in more than 50 other countries, is that the powerful dental lobby had largely set the terms of the debate. With the ADA and many rank-and-file dentists united in opposition and using aggressive lobbying, campaign contributions and radio and newspaper ads to get people to believe that mid-level oral health care is somehow substandard, dental therapy advocates stood little chance—until a more sophisticated and better-funded communications effort was launched.

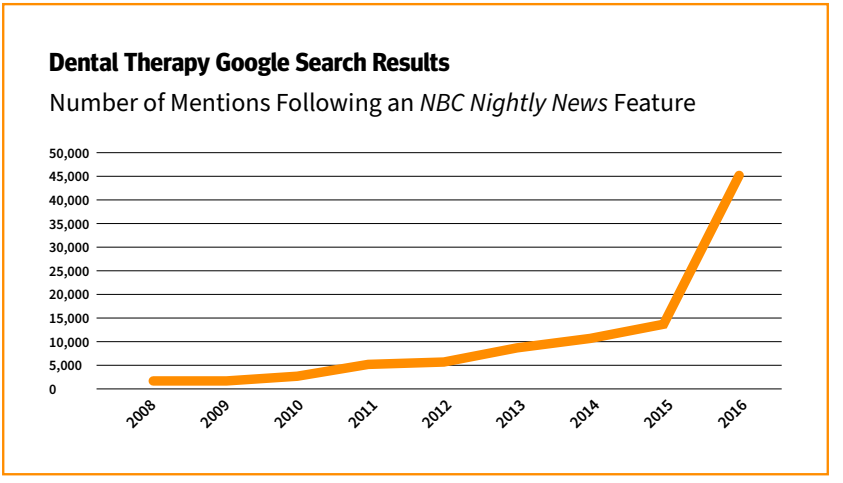
Getting Help from the Outside

When program officers at the Kellogg Foundation turned to outside communications efforts, including Burness and Kauffman & Associates and later Wendell Potter Consulting and The Ingram Group, it was with the understanding that changing the playing field would take time and require a more cohesive strategy.

Over the course of the decade, the communications team established what it called a "war room"—essentially constant contact among messaging experts, grassroots organizers, top researchers and others both to share what worked and to put out the occasional public relations fire.

When WKKF assembled the team, the communications specialists convened a series of focus groups that were not only held in several geographic areas of the country but also targeted key demographic groups, such as Native Americans, or dental professionals, such as hygienists. Those sessions convinced the campaign organizers there was much work to be done, beginning with the question of how exactly to brand this new member of the dental team.

Given where the campaign started, metrics the communications team used to assess its impact are impressive. For example, Google searches about dental therapy increased by 1,452% from 2008 to 2018. And there was a lot more to look up. In 2019, Google search results totaled 75,400, including 27,481 mentions in digital media.



Impact

National Visibility for Dental Therapy

1,690%	11,300	15	45,600
Percent increase in media mentions of dental therapy from 2008 to 2016	Number of media mentions of "dental therapists" from 2008 to 2016	Number of states interested in the dental therapist model, up from five states in 2008	Number of Google search results for "dental therapists"

Lack of awareness wasn't the only issue. Prior to the launch of the campaign, advocates for mid-level oral health care didn't have sufficient hard data to counter the ADA's oft-repeated argument that dental therapists couldn't perform key procedures up to U.S. standards. That changed in 2010 with the publication of a Kellogg Foundation–funded evaluation of Alaska's dental therapy program by Research Triangle Associates (RTI), which showed not only a high level of patient satisfaction but also that dental therapists provided competent and appropriate care as well as, if not better than, dentists. And because the profession was new, the team spent much time and investment researching and sharing findings related to the economic modeling of the profession, plans for community-based evaluation of programs, informed knowledge on implementation like working with community colleges or FQHCs and evidence to support the workforce expansion to include dental therapy.

The communications team also understood that a lot of the early work would involve educating the public and policymakers about the seriousness of dental access. Focus groups and other information made it clear that many people did not realize how many families—especially children—rarely or never saw a dentist or knew much, if anything, about the shortage of care in rural or low-income communities.

The spirit of the Dental Therapist Project—which looked to build diverse, locally oriented grassroots coalitions that could counteract the lobbying and PR clout of the ADA—required both a core national message and a targeted focus on the specific issues in each state, which ranged from job creation to spotlighting disadvantaged or isolated populations.

Pitching Tribal Leaders in the Contiguous United States

Jo Ann Kauffman, the founder of Kauffman & Associates, grew up on the Nez Perce Reservation in Washington state. Both her background and expertise would help develop new strategies to bring dental therapy to the Native Americans of the Pacific Northwest.

Kauffman said her team looked closely at how mid-level medical providers such as nurse practitioners and physician assistants had won public acceptance, and it carefully studied the state of play in Washington, D.C.—where the debate on the Affordable Care Act continued—and where both future supporters and opponents of dental therapy might come from. "We looked at potential opposition from dental hygienists, and that has proved accurate in a number of states," she said. "I think we were pretty accurate across the board."

That initial work convinced the Kellogg Foundation to broaden Kauffman & Associates' work to include the development of literature and a strategy to build a network of support among Native Americans. Kauffman brought on board Yvette Joseph, the former executive director of the National Indian Health Board, who was able to network with top Tribal leaders. The Kauffman team became a frequent presence at major Native American conferences. For groups like the National Congress of American Indians, Kauffman & Associates arranged workshops, dropped brochures and strategized with key decision-makers on how to extend Alaska's success to other Tribes.

One of the biggest challenges, Kauffman said, was "how to bring oral health to the top when there were so many other problems in Indian Country. We had to figure out how to get people's attention focused on oral health." She said she found that personal stories from the Alaska experience, both of everyday people's oral health problems and how individual dental therapists had helped, played a key role in generating interest.

Social media provided early platforms to tell these stories. In 2015, the campaign produced a video on a day in the life of Bonnie Johnson, one of the Alaska dental therapists. Her story was so compelling it was viewed more than 12,000 times on YouTube and received 1,200 Facebook engagements.

There was another factor, Kauffman noted, and that was that Tribal leaders were angered—and motivated—by the way the American Dental Association had fought the dental therapy efforts of Alaska Native people. "[Native American leaders] were working hard to improve the health of their communities. To know a large political body is out there opposed to what they were trying to undertake" was infuriating

to some, she said. To date, approximately 24 Tribal communities have passed resolutions in support of dental therapy.

In the end, Kauffman said, the professionalism of the campaigns by the Kellogg Foundation, Community Catalyst and others who worked with them was critical to gaining acceptance. It showed that "this is not a fly-by-night idea, that this is a movement that is real and is going to keep happening."

Finding New Champions

Another key leg of the communications strategy was developing what came to be known as "a champions network" of dentists, academics and other influencers within the oral health community who were willing to break free from the ADA and voice public support for dental therapy. It was a frustrating effort at first. When the Kellogg Foundation first became involved in the Alaska effort in 2006, there was one such "champion"—and still only 30 in 2009 as the push expanded. A decade later, the pool had expanded to 120 and was continuing to grow. These champions were typically available for media interviews to make keynote addresses or otherwise advance the cause.

One of the key components to successfully building the champion network was the Kellogg Foundation–supported educational tours to Alaska. Dentists, community leaders, oral health stakeholders and journalists spent three days in Alaska. They learned about the history and rationale for the ANTHC dental health aide therapist program: how it evolved, and the challenges and opportunities associated with the program; key aspects of the training program and curriculum; the relationship between dental health aide therapists and supervising dentists; and the benefits of the program to the local community and residents. Tour participants heard directly from the students about why they wanted to be dental therapists and what it meant to their communities, while observing live patient demonstrations in remote Alaska Native communities.

> Patients are highly satisfied. The change from seeing a dentist once a year to having full-time access to dental care has been profound.
>
> **Louis Sullivan, M.D.**

Louis Sullivan, M.D., a physician who had served as U.S. Secretary of Health and

Human Services during the George H.W. Bush administration, noted after a 2012 Alaska tour that, "Patients are highly satisfied. The change from seeing a dentist once a year to having full-time access to dental care has been profound."

The long-term goal of adding new members to the champion network is what caused members of the communications team to aggressively work the corridors at meetings of the American Association of Public Health Dentists, which ultimately came to support mid-level oral health care, as well as other groups of providers such as dental hygienists.

"We would organize dinners and invite dentists who we thought might be open to dental therapy" as one way to increase the champion network, said Loranger. The idea was that independent voices who had no affiliation with known advocacy groups would advance the cause.

An example of what having champions and other allies could do came on April 9, 2012, when *The New York Times* published an op-ed by Sullivan. He wrote about the consequences of the growing lack of access to dental care in the United States and explicitly called for the expansion of dental therapy. The op-ed aligned with the communications team's goals of both raising awareness of the problem and proposing a remedy.

"We have two years to prepare before millions of children will be entitled to access to dental care, and Alaska shows us the way forward," Sullivan wrote when sections of the ACA that would expand dental benefits to more children under the Medicaid program were yet to be implemented. "Access means more than having an insurance card; it means having professionals available to provide care. Public officials should foster the creation of these mid-level providers—and dentists should embrace the opportunity to broaden the profession so they can expand services to those in need."

The Sullivan op-ed was an important media placement, but there were many others, including a discussion of dental therapy on Diane Rehm's popular syndicated show on National Public Radio. A pitch to the highly rated "PBS NewsHour" convinced producers there that there was enough human interest in the topic of lack of access to dental care that it aired a report that stretched across an entire week of broadcasts. Other news coverage included "NBC Nightly News," *The Washington Post*, additional coverage in *The New York Times* (including a mention of dental therapy as one of the top 60 social-change ideas), "60 Minutes," "Marketplace" and an influential investigative story by reporter William Drabold in *The Seattle Times*.

But much of the communications work involved wooing journalists and getting favorable coverage in smaller and mid-sized local newspapers in Ohio, New

Mexico, and other states where the Kellogg Foundation was supporting grassroots campaigns. Many of these articles appeared in the same communities where there was a shortage of dental care. The communication strategists working for the Kellogg Foundation and Community Catalyst also set up booths at events such as the National Association of Black Journalists, the National Association of Hispanic Journalists and the Association of Health Care Journalists. Communications team members and advocates who attended those events emphasized the benefits of expanding access to dental care in non-White communities.

The positive news coverage helped raise both public awareness and support. WKKF supported focus groups and polling that tracked the level of approval for mid-level oral health care. The results were then used to counteract the ADA's argument that the public viewed care provided by dental therapists as inferior. By 2011, a nationwide survey conducted by Lake Research Partners and funded by the Kellogg Foundation showed that 15% of Americans lacked access to a dentist where they lived and that 80% would support allowing dental therapists to practice in their state.

Taking It to the Opposition

One of the most unique aspects of the campaign for dental therapists—the fact that the idea had such a determined and well-resourced opponent in the ADA—was seen by communication specialists not so much as an obstacle but a challenge.

> When the project started, it was very much defensive. The ADA was attacking, and we had to refute every point that was made. Advocates responded with letters to the editor across the country, for example. We didn't let anything go.
>
> **Linda Loranger**

The communications team also took changes in the political landscape into consideration. The battle for establishing mid-level oral health care was being waged primarily in the states, and over the course of the first years of the campaign, Republicans had also gained hundreds of state legislative seats and some key governorships.

Two of the states that had been funded by the foundation and supported by Community Catalyst in the campaign—Ohio and Kansas—had seen control of the governor's office switch from Democratic to Republican soon after the campaign was launched, and dental therapy legislation was stalled in both states. The political change wasn't viewed as an insurmountable obstacle, but advocates for expanding dental care understood that talking to conservative lawmakers required a different kind of pitch.

The Conservative Argument Takes Root

In Kansas, support from Americans for Prosperity, a conservative free-market organization, provided the Dental Therapist Project with something of a road map for what a pro-business, job-creation pitch looked like. Eventually joining in this effort were conservative activist Grover Norquist and his Americans for Tax Reform as well as state organizations like the Mackinac Center for Public Policy and the Texas Public Policy Foundation.

In 2017, The Ingram Group, with offices in Nashville and Washington, D.C., joined the team to assist with strategic communications. The firm would later work directly with Community Catalyst. Tom Ingram, the firm's founder, had been a top aide to GOP Senator Lamar Alexander, and the principal staffer working on the dental therapy effort, Rachel Albright, had been a press aide to then–Senate Majority Leader Mitch McConnell of Kentucky.

"From a workforce perspective, you're creating an entirely new profession," Albright said. "Dental therapy creates well-paying jobs that are coming back to the community."

There was also growing evidence that adding mid-level practitioners to the dental team frees up dentists to perform more procedures and operate their offices more efficiently. Key evidence was a Pew study showing that practices that hired a dental therapist reported seeing 27% more patients while posting an overall gain of 38% in new patients after one year. "It impacts the bottom line," Albright said, "and the ability of the dentist to expand the practice and perform more complex procedures."

The campaign also promoted the study of how among Tribal communities of Alaska alone, dental therapy had generated 76 full-time jobs on an annual basis with a net economic impact of $9.6 million. Other studies showed that dental therapists made dental teams more productive while reducing wait times.

Still, Albright acknowledged that nearly a decade since the push to take dental

therapy beyond Alaska began, there are ongoing discussions about how to best educate the public about a job that many people still know nothing about. She and her colleagues have found that comparing dental therapists to mid-level medical providers such as physician assistants can be helpful.

The communications specialists promoting dental therapy believe the growing number of practicing dentists and dental-school leaders who have now endorsed the use of mid-levels in dental care—often after seeing how the program works in places like Alaska or Minnesota—are ready to further bolster the "champions network."

To amplify the voices of those champions, the National Partnership for Dental Therapy, co-chaired by Community Catalyst and the National Indian Health Board, was formed in 2019. The third co-chair, National Coalition of Dentists for Health Equity, provides information and recent news reports about dental therapy. By highlighting practitioners who support dental therapy, Albright said, the group hopes to build on the idea that people trust dentists for information on access to care.

The launch of the organization represented a major advance in advocates' decade-long struggle to educate the public, thought leaders and decision-makers. The time had come to deemphasize communications efforts on responding to attacks from the ADA (although that would have to continue) and start framing the campaign more around a positive message about dental therapy.

The Dental Therapy Project's victories over the years were hard-fought. The communications team and advocates had to educate people about what dental therapists do, convince them that it was a cause worth fighting for, get attention for an issue that received comparatively little media attention and do so while fighting a well-entrenched and well-funded dental lobby. The successful outcomes went well beyond a traditional communications effort. The result was the building of a true movement.

CHAPTER 10

Building on Momentum

Create as broad a coalition as possible.
Avoid a 'top-down' strategy.
Educate the public by telling stories.
Recognize that dental education is a key to change.
Seek allies from the dental community.
Stress what dental therapists mean to a community.

In 2019, for the second time in barely a generation, the oral health community was jolted by a major report on the state of dental care. The first was Satcher's report, "Oral Health in America," which brought attention to the "silent epidemic of oral diseases" and the disparities between different racial and ethnic groups.

Less than two decades later, a team of top oral health experts took on a massive project for the prestigious medical journal *The Lancet* with a much wider focus: to assess the state of dental care throughout the world. In many ways, their two-part report, entitled "Oral Health: A Global Public Health Challenge," was an even louder clarion call for action than the earlier Satcher report had been.

In studying dental care around the world, *The Lancet* team landed on two significant findings. The first was that changing dietary habits were leading more people in the developing world, especially children, to increase the amount of sugar in their diet, which was causing a large spike in tooth decay. That result closely tracked conditions of Alaska Native people, where the move away from a healthy traditional rural diet and the rise of sugary drinks and snacks led to a rise in oral disease. Now, according to *The Lancet* study, the oral health issues that developed in Alaska were now occurring in the Philippines, India, Tanzania and elsewhere.

But a second major finding was even more relevant to ongoing efforts to make the position of dental therapist an accepted part of the oral health care practice team in the United States. *The Lancet* researchers wrote that the broader system of dentistry is falling short because the focus of the profession has been so heavy on treatment and so light on prevention. The authors found that more oral-hygiene

efforts need to focus on teaching children the necessity of toothbrushing and other good habits. Yet in the United States, most dentists have placed an emphasis on money-making procedures and located their practices in wealthier urban and suburban areas.

The Lancet project specifically called for an overhaul of dental practice with more of a focus on public health than on profit, aided by a push to place more routine procedures in the hands of mid-level providers. It suggests the use of "a wider professional team," noting: "Mid-level care providers are also instrumental in increasing access to dental care in underserved and remote population groups. Indeed, in many settings, and particularly in LMICs [low- and middle-income countries], training a more community-oriented oral health workforce rather than dentists is a realistic solution to address the acute workforce shortages and access challenges." It singled out dental therapists as one of those mid-level providers.

The Foundation is Set

The arrival of the 2020s marked roughly two decades since the Satcher report and the first stirrings toward the dental therapist breakthrough in Tribal Alaska, and about a decade since the Kellogg Foundation announced the Dental Therapy Project, enlisted Community Catalyst and helped plant the seeds for grassroots campaigns in selected states.

On one hand, the progress on every front—winning legislative approval in a growing number of states and establishing a foothold in education and training for U.S.-based dental therapists, as well as the necessary professional standards—has been truly remarkable, especially when considered against the deep pockets of the opposition and its past success in blocking positive change.

On the other hand, even the most optimistic and dedicated activists recognize that there is much that needs to be done for dental therapists to be permitted in every state and to be as widely recognized as nurse practitioners and physician assistants are in the medical world. In addition to the ADA's opposition, advocates say concerns raised by some in the dental hygienist community, who view dental therapists as potential competitors for jobs, need to be addressed. Moreover, educational opportunities need to be further expanded, and the free-market arguments—that dental therapists can meet a great need with minimal government involvement or resources—must be strengthened to appeal to a broader coalition of lawmakers and policymakers.

A milestone on the slow but steady path of progress for dental therapy occurred in 2016, when Iḷisaġvik College in Barrow, Alaska—the state's only Tribal college—

was approved to offer dental therapy as a fully CODA-accredited two-year degree program by the Northwest Commission on Colleges and Universities. Classes had been offered at locations in Anchorage and Bethel, following the curriculum established since the 2000s, but CODA accreditation and university recognition allowed students to apply for financial aid and other college benefits and offered the power of a diploma. The program trains future practitioners not only for Alaska's 81 Tribal communities served by the program but also for Native American communities elsewhere in the Pacific Northwest.

It was another small but important step toward making the dental therapist an established profession in oral health care.

At the same time, these developments spurred advocates in the contiguous United States to begin working on creating many more academic slots needed to train enough dental therapists to truly close the access gap—a gap that is only growing wider.

By the end of 2020 the number of dental deserts, where few if any dentists practice, had increased to more than 6,500. The many gaps and barriers to dental coverage in the United States—the millions who lack private insurance, the failure of Medicare to cover even routine dental visits, the deficiencies in Medicaid coverage and the number of dentists who accept it—persist.

The potential for a new army of mid-level dental providers to become a critical part of what breaks this logjam remains enormous. A major challenge for the growing network of advocates—from public health experts to community organizers to those dentists willing to break ranks with the ADA—will be the way to keep the forward progress going toward the day when dental therapy is universally recognized from coast to coast.

Advocates also contend that progress in the coming decade will require understanding the changing nature of the playing field. While the initial thrust was, understandably, winning the conflict with the dental lobby, legislative debates are often being influenced by the objections of dental hygienists.

Increasingly, the debate at the state level has been less about whether there should be dental therapists than whether the therapist position should be established as an advanced-level dental hygienist with a six-year academic model that would make it much harder for people from disadvantaged communities to become dental therapists.

Going forward, advocates say they want better and more unified strategies not because of past failures in some places but because they want to accelerate the momentum that has created a track record of increasing success.

“We just have to continue to maintain this momentum,” said Dr. Larry Hill of the American Association for Community Dental Programs. Pointing not just to success in a dozen states but the growing number of others such as California and North and South Dakota where legislation has been introduced, he added: “The cat’s out of the bag on this one.”

The lessons that have been learned over the last 20 years are largely a legacy to both celebrate and imitate—a template for how grassroots energy, clever strategy and a steady focus on fighting inequity can gain traction in the face of big money and politically connected opposition. But the statistics showing that these efforts are only just beginning to reach the millions of children who lack the ability to see a dentist, whether because of geography or poverty, are a constant reminder of how much more work is ahead. The dental therapist in the United States is here to stay, but deploying enough of them to make a real difference in our country’s oral health crisis is, in many ways, the new challenge for advocates.

Acknowledgments

The idea for this book began to take shape during a meeting I had with Kathy Reincke, the Kellogg Foundation's director of communications, five years ago in Battle Creek. The Dental Therapy Project was well underway by that time and advocates had scored some important victories, but success was far from certain. We agreed it was important to chronicle the events and milestones and, more important, share the variety of experiences from the leaders and communities engaged in this effort that would be useful for future advocates, academicians, policymakers and other funders in their efforts to achieve a more equitable health care system.

Five years before that conversation, I had never even heard the term "dental therapists," nor had I paid much attention to what 15 years earlier former U.S. Surgeon General David Satcher had appropriately called a silent epidemic. During the debate on what became the Affordable Care Act in 2009 and 2010, a debate that I participated in, there was very little discussion or media coverage about the lack of access to dental care.

The year after that bill was signed into law, I was invited to speak at the annual meeting of Grantmakers in Health in Los Angeles. After my talk, Dr. Gail C. Christopher, D.N., N.D., who at the time was a vice president of the W.K. Kellogg Foundation, handed me her card and said the foundation had recently launched a project she thought I might find of interest.

When I learned more about it—and that the project's biggest barrier to success was an entrenched and powerful organization that was spending millions to protect a status quo that left millions without access to often life-saving oral health care—I was all in.

A few months later, I was on a plane to Alaska where I would join a small group of other folks, including former U.S. Secretary of Health and Human Services Louis Sullivan, to see first-hand how dental therapists were being trained and how they already were making a big difference in the lives of Alaska Native people spread out over more than 80 communities.

Over the next few years, I would make several other trips to Alaska as well as to Tribal communities in the "Lower 48" and to several dental therapy convenings hosted by the Kellogg Foundation and Community Catalyst. One of the most memorable of those many trips was to the small communities of Savoonga and

Gamble on St. Lawrence Island in the Bering Sea where Alaskan Yup'ik and Siberian Yupik people have lived for hundreds of years. It will come as no surprise that very few dentists had ever stepped foot on the island, which is closer to Russia than the U.S. mainland.

It was well worth a harrowing flight in a bush plane from Nome just to see Elsie Pelowook, who had graduated a few days earlier from the two-year Dental Health Aide Therapist training program in Anchorage and Bethel, return to her native home and begin her career. I'm happy to report that DHAT Pelowook is still providing dental care to the people of Savoonga and Gamble, under the general supervision of a dentist 163 miles away in Nome.

Both Gail Christopher and Elsie Pelowook came to mind as I thought about how to begin this final part of *For Want of a Dentist*. Thank you, Dr. Christopher, for the role you played in getting the Dental Therapy Project off the ground, and thank you, DHAT Pelowook, for the work you and now hundreds of other dental therapists (I wish I could name them all) are doing to bring previously unavailable yet essential dental health care to people in communities large and small across the United States.

The progress those communities and advocates have made—and will continue to make in the years ahead—would not have been possible without the generous support of the Kellogg Foundation and the commitment of its president and CEO, La June Montgomery Tabron, and her predecessor, Sterling Speirn. Both knew from the day an unsolicited grant request arrived from Alaska Native people that this was not going to be a cakewalk, that supporting this work would be viewed by some as controversial and a risk to the foundation's reputation. Despite that, they and the WKKF board never backed down.

It wasn't just the money the foundation has provided that has enabled dental therapy to take hold in the United States. Just as important if not more so has been the hands-on work of foundation staff, current and former, to help communities and advocates advance the ball, Tribal community by Tribal community, state by state.

I'm grateful to them not only for their determination to make dental therapists as common in the United States as nurse practitioners and physician assistants but also for providing their insights for this book in often lengthy interviews. They include Alice Melhorn-Warner, Caroline Brunton, Dana Linnane, Kathy Reincke, Lynn Wilson, Carla Thompson Payton, Jill Petty, Brett Eisner and Al Yee. And at Community Catalyst, the foundation's lead partner in promoting dental therapy in state capitals, they include David Jordan, Tera Bianchi, Susan Sherry and Donna Keefe. Advocates who led the work in those states include Michelle Fay in Vermont, Anna Lambertson in Kansas, Pam Johnson in Washington state and the Pacific

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Public health policy leaders whose support proved essential and whose comments appear in this book include former Surgeon General David Satcher and former Health and Human Services Secretary Louis Sullivan.

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Wendell Potter
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