Current Use of Dental Health Aide Therapists in Indian Country and Beyond

The Alaska Native Tribal Health Consortium (ANTHC) has operated the Alaska Dental Health Aide Program as a specialty area under the Community Health Aide Program (CHAP) since early 2000. The focus of the Alaska Dental Health Aide Program is on prevention of oral disease, alleviation of pain, infection relief, and basic restorative services to improve primary health care in rural Alaska. The Program continues to be successful in providing critical oral health care in areas of Alaska where it has not been previously possible to provide continuity of care.

A unique aspect of the Alaska Dental Health Aide Program is the Dental Health Aide Therapist (DHAT) program, which has been serving Tribal patients since 2006. The site employs the following categories of Dental health aide providers:

- **Primary Dental Health Aides**: provide dental education, dental assisting, and preventive dentistry services.
- **Expanded Function Dental Health Aides**: serve as expanded duty dental assistants in regional dental clinics.
- **Dental Health Aide Hygienists**: provide dental hygiene services in regional dental clinics and villages.
- **Dental Health Aide Therapists**: provide oral exams, preventive dental services, simple restorations, stainless steel crowns, extractions and take x-rays.

Currently, 25 DHATs serve approximately 35,000 citizens in 81 of Alaska's remote rural communities. An additional 15 DHAT students are in training. A summary of the Alaska Dental Health Aide Therapist Initiative is available at http://www.anthc.org/chs/chap/dhs/index.cfm.

The IHS is currently funding six objectives under review at the Alaska Dental Clinical and Preventive Support Center (DCPSC): Basic Screening Survey (BSS); Continuing Dental Education (CDE); Health Promotion/Disease Prevention (HP/DP); Dental Sealants; Access to Care; and the Alaska Dental Web site. Among the HP/DP objectives are prevention efforts focused on increasing the number of dental health aides in the State. Approximately 20 percent of the annual $250,000 funding to the Alaska DCPSC is used to supplement the DHAT educational program.

Published research on the use of DHATs includes an October 2010 study by RTI International of Research Triangle Park, North Carolina, which found that DHATs practicing in Alaska provide safe, competent, and appropriate dental care. The study confirms what numerous prior studies of dental therapists practicing in other countries have already shown: that DHATs provide safe care for underserved populations. (See http://www.wkkf.org/knowledge-center/resources/2010/10/alaska-dental-therapist-program-rti-evaluation-report.aspx).

A May 2013 economic study conducted for Community Catalyst by Frances M. Kim, D.D.S., DrPH, provides an assessment of the economic viability of services provided by mid-level dental providers who practice in the United States. Study findings indicate that besides expanding preventive care options to people who need it most, mid-level dental providers currently practicing in Alaska and Minnesota are very cost-effective. Relative costs to employers for this category of providers when compared to the revenue they generate is 27 percent in Alaska and 29 percent in Minnesota. Additional information on the report is available on their Web site at (http://www.communitycatalyst.org/doc_store/publications/economic-viability-dental-therapists.pdf).

The Indian Health Care Improvement Act (IHCIA) as enacted by the Patient Protection and Affordable Care Act authorizes DHAT services or midlevel dental health provider services if such services are permitted under State law. This currently applies to Tribes and Tribal Organizations that reside in Alaska, and, since 2009, Minnesota has passed legislation specifically authorizing the use of dental therapists. The State created two new dental provider categories (a dental therapist with a bachelors' degree and a masters-level advanced dental therapist), along with a framework that establishes scope of services and oversight by dentists.

With growing interest at the State-level in addressing these and related issues, the American Dental Hygienists' Association notes that States as varied as Kansas, New Mexico, Vermont, Washington State, Iowa, North Dakota, Nebraska, Hawaii, and Tennessee are considering legislation or other action that combines changes to dental educational standards, practice oversight, and/or licensure requirements to create new types of providers that can deliver needed dental services to underserved populations. (See archives, *Stateline,* March 2013, at https://www.adha.org/access-magazine.)

Expansion of the DHAT program into other IHS Areas would require authorization by the State, additional resources and Tribal consultation. Based on the success of the Alaska DHAT program, some Tribes have expressed interest in exploring the use of DHAT in their communities.

If you have an interest in this topic and would like additional information, please contact Timothy L. Lozon, D.D.S., Director, Division of Oral Health, IHS. He can be reached via e-mail at timothy.lozon@ihs.gov, or by telephone at (301) 443-0029.