Limited access to dental care is causing pain and disease. What can American Indians do to bring dental care to their communities?

Native Solutions for Oral Health





- The Success Story in Alaska Native Villages
- How Dental Therapists Can Improve Patient Care
- New Research Reveals the Depth of the Crisis
- A Dental Hygienist Goes Home to Pine Ridge
- Thoughts from the First American Indian Dentist

INSIDE: Profiles, opinions, and even a poem

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In Alaska, Better Dental Care

Alaska Natives have found a way to add more dental providers. Can Indian Country be far behind?

Historical evidence suggests that dental disease was rare among American Indians and Alaska Natives (AI/ANs) in the early 20th century. Today, AI/ANs have more untreated tooth decay and gum disease than any other population group, due to socioeconomic status, changes in diet, lack of preventive programs, and simply not enough dental professionals to meet the huge backlog of untreated disease. Indian Country will need even more dental providers beginning in 2014 when thousands of American Indian children will become eligible for Medicaid dental benefits under the Affordable Care Act. Who will provide this care?

In 2006 the Alaska Native Tribal Health Consortium forged the way to introduce dental therapists to dental teams in the United States. In Alaska, Minnesota, and around the world, dental therapists perform routine services like basic evaluations and fillings, allowing clinics to accept more patients and freeing their dentist supervisors to treat complex cases. Thanks to Alaska's thriving Dental Health Aide Therapist (DHAT) Program, about 35,000 people living in remote villages have access to regular dental care, and many of the Alaska DHATs are familiar members of their home communities. The Alaska program can serve as a model for tribal programs in the lower 48 states, but first there are barriers to overcome.

The Alaska Experience

For years, Alaska Native leaders searched for ways to meet the vast need for dental services in rural and remote communities. Then they learned about a successful program in New Zealand, which in the 1920s began training and deploying mid-level dental practitioners known as dental therapists to provide preventive and routine dental care in underserved communities. Dental therapists work as part of a team led by a dentist, in much the same way that nurse practitioners and physician assistants work as part of a medical team to expand access to care.

The Alaska Native Tribal Health Consortium (ANTHC) decided to establish a similar program in Alaska, building on the principles of its successful community health aide program. With funding from the Rasmuson Foundation, the ANTHC sent the first class of dental therapy students to New Zealand for training in 2003. After two years of rigorous training and education, the new dental therapists returned to practice in their villages.

The American Dental Association (ADA) and the Alaska Dental Society tried to block the dental therapists from practicing, filing a lawsuit that challenged the authority of the Indian Health Service to certify the new providers. That lawsuit failed, and Alaska's dental therapists—called Dental Health Aide Therapists or DHATs—were certified under the authority of the Indian Health Care Improvement Act (IHCIA). However, when the IHCIA came up for reauthorization, there was a restriction that dental therapists could not practice in the rest of Indian Country. So Congress prohibited dental therapists except where authorized by state law. In response to these provisions, tribal organizations such the National Congress of American Indians and the National Indian Health Board are taking a stand, encouraging tribal governments to support development of the dental therapist provider modeled by the Alaska Dental Health Aide Therapists for the benefit of their member communities. Several tribes in the exercise of self-determination and self-governance recognize that they have the sovereign right to determine who should care for their children's teeth in their communities and seek to expand their dental workforce now and in the future.

In Alaska, the dental therapist program has blossomed. In 2006, with support from the W.K. Kellogg Foundation, Rasmuson Foundation and Bethel Community Services Foundation, the DENTEX dental therapist training program was created and cosponsored by the ANTHC and the University of Washington. The intensive two-year education program is based in Anchorage and Bethel.

DHAT Bernadette Charles at her clinic near the Bering Sea

Today, things are changing.

Village by village, Alaska is bringing high-quality preventive and routine oral health care to people who previously had little to no access to a dentist. Since 2005, den-

tal therapists have expanded oral health care access to more than 35,000 people. Twenty-four dental therapists are practicing in Alaska today. They work in schools and Head Start programs, where they teach children how to take care of their teeth, and at clinics in tiny, remote communities, where they provide commonly needed services like cleanings, fillings, and uncomplicated extractions. Already, they are making a dent in the cavity rate among children and are practicing less restorative and acute care than when they started.

Dental therapists are also saving the system money. The average dental therapist salary in Alaska is about half that of a dentist—$60,000 per year versus $120,000—so the savings are very real. Medicaid reimbursements are the same for a dentist as they are for a certified dental therapist in Alaska, so the income is viable.

These efficiencies come at no sacrifice to quality. An independent evaluation conducted by the Research Triangle Institute found that dental therapists in Alaska provide safe, appropriate, and quality care.

What Lies Ahead?

State or federal actions are necessary before dental therapists can be deployed to care for more American Indians. These actions could take the form of changes to state dental practice laws or, at the federal level, amendments to the IHCIA (now part of the Affordable Care Act).

Currently, more than 20 states are exploring mid-levels such as dental therapists as a way to address the oral health needs of their communities.

The experience of the Alaska Native Tribal Health Consortium shows how success can happen when communities commit to solving their most pressing health problems. ■

A Promise to Our Children: Better Oral Health

BY VALERIE DAVIDSON

When I was a young girl growing up in a small Yup'ik Eskimo village in southwest Alaska, children enjoyed a strong sense of community thanks to special promises made on our behalf by every parent to every other parent in the community:

As your children walk outside your door,
I promise to look after them,
to make sure they are safe,
they have what they need.
I promise to carry them in my heart.
I trust that you too will look after mine.

In this way, our children will know they are loved.
They will know they are important.
They will know their place in our world.
They will know they too are responsible for younger children.
They will know we are all connected.

What affects one child affects every child.
What affects one family affects every family.
What affects one community affects every community.

In Alaska, we have been working to restore the smiles of Alaska Native children by improving access to oral health care in new ways.

For me this work is deeply personal. As a child I remember when the dentist came to our village once a year. As we waited in line to be seen, we could hear the screams behind the door as teeth were pulled from children ahead of us. The door would open and we'd see our crying brother, sister, cousin or friend holding a bloody gauze bandage to their mouth. We always asked how many teeth were pulled.

For the youngest kids, this was especially traumatic because they had not experienced it before.

When we began to develop our Dental Health Aide Therapist (DHAT) program, we were told there was too much opposition. We were told that we were out-resourced and we were politically out numbered. We were told it was simply going to be too hard.

While we knew that was probably all true, we also knew that some of our children were graduating from high school with full sets of dentures. Many other children covered their mouths when they smiled and laughed because they had "ugly teeth" or missing teeth. These things happen when you only have access to oral health care once every year or two, if you are lucky.


Valerie Davidson

Today, 24 certified DHATs practice in rural Alaska. Our children receive oral health care from people who look like them, who speak our languages and understand our cultural norms. Our children look up to our DHATs. They are people that we know and trust.

Because of these close relationships, we are already changing the smiles of Alaska Native children. We are beginning to see cavity-free kids. We are raising the oral health IQ of our children, our families and our communities. What began as our local solution to our local problem is being looked at by other states as people realize that this model can work anywhere.

We have learned a number of valuable lessons. The most important may be this: that people will do the most amazing things when given the right reasons. And children are always the right reasons.

The result of our efforts will be to ensure that our children grow up healthy and strong and equipped to make their own promise to the children of the future. Just as I made that promise to my daughters. ■

Valerie Davidson is the senior director of intergovernmental and legal affairs for the Alaska Native Tribal Health Consortium. She helped lead the fight to bring dental therapists to remote Alaska areas. This essay was excerpted from the 2012 Annual Report of the W.K. Kellogg Foundation. Visit www.wkkf.org to read the full text.

Oral Health Disease Takes a Heavy Toll on Children, Adults

New studies at Pine Ridge, Santo Domingo Pueblo, reveal startling rates of tooth decay

It is clear that oral disease exacts a far heavier toll on children in Indian Country than on children in other parts of the United States. Tooth decay is five times higher among Native American children ages 2 to 4 than the U.S. average. Seventy-two percent of American Indian and Alaska Native children ages 6 to 8 have untreated cavities—more than twice the rate of the general population.

What is also becoming clear, however, is that while Native American children suffer a disproportionate share of tooth decay, Native American adults may be the worst-off of all.

In 2011, Terry Batliner, D.D.S., of the Colorado School of Public Health and the Cherokee Nation of Oklahoma, conducted an oral health survey of the Pine Ridge Indian Reservation in South Dakota. Forty percent of children and nearly 60 percent of adults had moderate to urgent dental needs. Batliner and his research team also discovered that 84 percent of children in the study and 97 percent of adults had ongoing decay, which can lead to loss of permanent teeth. The Pine Ridge study also found high rates of precancerous conditions, chronic pain and missing teeth.

Terry Batliner

Just a few months ago, Batliner conducted a similar assessment of the Santo Domingo Pueblo (also known as the Kewa Pueblo) in New Mexico. Nearly 70 percent of adults ages 20 to 64 had untreated cavities, and nearly half of adults ages 45 to 64 suffered from moderate or significant gum disease.

"In certain locations we have very high rates of tooth decay, as bad as anywhere in the world," he said. Despite efforts to address the problem, there is "not enough manpower, and not enough dentists, to provide the preventive care that could make a difference," he added.

A dental screening at Santo Domingo Pueblo

The Indian Health Service, which is responsible for providing oral health care to American Indians and Alaska Natives, in recent years has prioritized care for children. This has helped improve access for American Indian children somewhat, but adults are still gravely underserved because of severe dental care shortages in Indian Country.

"There are good dentists doing everything they can to help," Batliner said. "But there are not enough of them, and the level of disease is overwhelming. Things like abscesses that would be considered a dental emergency anywhere else are not considered emergencies here but conditions that people must endure."

Dental therapists hold great promise for Indian Country.

"I have seen dental therapists at work providing excellent care. And they are invested in the people and the community," says Batliner. "We cannot let children and adults on reservations suffer to the point where an easily treatable dental problem becomes life-threatening. I have seen it too many times. We can and must do better." ■

A Lakota Sioux Dental Hygienist Goes Home

BY MAXINE BRINGS HIM BACK-JANIS

To get to Pine Ridge Indian Reservation, you leave Rapid City, South Dakota, and drive south for 80 miles. There you go through the Badlands, the moonscape topography that is now part of our reservation lands, the land of the Lakota people.

Imagine yourself with me on this drive in July 2010. My tribal homeland is barren for mile after mile—and remote—yet we experience the beauty and the silence of that place. It brings harmony and balance.

My Ancestral Lands

I am Lakota, I am a registered dental hygienist, and I am part of a study team documenting oral health conditions on Pine Ridge Reservation. Our lands, largely overlooked by mainstream society, are an immense area of South Dakota. We are preparing to travel through the vastness of my childhood and ancestral homeland. There I will find that inadequate dental services, flawed systems delivering dental care, and punishing poverty all contribute to the reservation's crisis in oral health.

The Way Things Are

On Pine Ridge Indian Reservation—an area as large as the state of Connecticut—there are three Indian Health Service dental clinics. These three clinics share two dental hygienists among them for the approximately 40,000 reservation residents. Compare that to a typical private dental practice clinic, where usually there is one dental hygienist for 2,000 people.

On my reservation, there is an inadequate number of all oral health care providers—dentists, registered hygienists, and dental therapists—and their low numbers are an old,

enduring problem. Preventive dental hygiene services for children and adults are almost never available. Dental rehabilitative procedures, such as crowns, root canals, bridges, and dentures, are common elsewhere but rare here.

Again and again on this journey I will hear the voices of people I meet saying, "I need services, but I don't have any money," "I can't get an appointment," and "I can't make it to the clinic."

Assessing Oral Health

We set up our portable dental chairs—patio lounge chairs from Walmart—in living rooms, front yards, backyards, community centers, and clinics. In one location, on the edge of the Badlands, our lawn chair is under a makeshift canopy of tattered tarps where a woman sells beadwork to the tourists who pass through that part of the reservation. We find rocks to hold down our materials, and while the hot dusty winds of the Badlands whip and swirl in front of us, we screen the woman and her grandchildren.

Maxine Janis

Pine Ridge Indian Reservation is the poorest reservation in the United States—and one of the poorest parts of the country, with a per capita annual income of about $7,000, compared to overall estimated U.S. annual per capita income of $47,200. This explains in part why the study participants are so pleased to receive the only tangible items we are able to offer: toothbrushes, toothpaste, floss, and bottled water (an alternative to a sweetened drink). Some start to brush their teeth immediately, while still standing in front of us. In the world of the "haves," it is nothing to buy a toothbrush. Among some of my people, it is quite different matter.

Throughout the checkup study, we ask people to share their experiences about dental care on the reservation. What they tell us bears witness to a people who are doing what they can despite poverty, lack of services, distance, and bureaucracy. They are extraordinary, these individual stories shared by a proud people.

Thoughts after the Journey

In the Lakota language, our children are called wakanyeja, meaning sacred children. On this journey I am seeing wakanyeja with decaying teeth or diseased gums and, sometimes, ones who appear hungry. Ending their hunger, I am sure, is more important to them than their oral health. I understand; I experienced hunger as a child.

One day, after I get back in my car, I begin to weep for the wakanyeja, for my people, the Lakota. We have the same faces, they and I, and they, too, appear to be weeping. They seem voiceless, but I hear them. Through their tears they are saying, "I have these problems. Somebody hear my voice."

At the conclusion of the study, I drive to an old cemetery where many of my family members are buried. As I read the old names on the grave markers—Sharpfish, Crow, New Holy, Mountain Sheep—I wonder about the people buried beneath my feet. I know how some died, others not. Yet I believe it true that the ancestors were healthy and lived in a manner that was honorable and sacred. But now my Lakota people have serious oral health issues, as well as diabetes and end-stage renal failure. Amid the existing disparities and social injustices that surround these health issues, I worry whether we Lakota will ever see health and wellness.

Moving Into Oral Health

I believe that the paltry resources allocated year after year to the Indian Health Service are shameful. This must be remedied, and remedied quickly.

But I also believe that money alone is not the answer. We must create education opportunities that train and nurture many more tribal members to deliver oral health care services to the people of their home communities. Growing our own health professionals must be a mandate.

I believe that the growing existence in the United States of mid-level dental providers is a positive development and will help the residents of Indian Country. Traditionally in the United States, oral health has never had the equivalent of a nurse practitioner or a physician assistant—but that is starting to change.

Illustration by Brett Ryder

Ending Divisions

The past has drawn divides among the various dental professional organizations. Today we can no longer remain divided. Finding solutions to shortages of adequate oral health care that harm populations means that we need to collaborate. My specific call is that we explore creative solutions to put oral health services within the reach of the Lakota people. ■

Maxine Brings Him Back-Janis is on the faculty of the dental hygiene department of Northern Arizona University, in Flagstaff, Arizona, and is in a doctoral program in higher education. Before becoming a registered dental hygienist, she spent 24 years as a dental assistant with the Indian Health Service. The dental checkup study in the essay was funded by the W.K. Kellogg Foundation. The study results, "An Assessment of Oral Health on the Pine Ridge Indian Reservation," were presented to tribal leaders on the reservation in spring 2011.

Adapted with permission from Health Affairs. Copyrighted and published by Project HOPE/Health Affairs as Brings Him Back-Janis, Maxine. A Dental Hygienist Who's A Lakota Sioux Calls For New Mid-Level Dental Providers. Health Aff (Millwood). 2011; 30(10): 2013-2016. The published article is archived and available online at www.healthaffairs.org.

Trying a New Approach in South Dakota

Not-for-profit dental insurance provider Delta Dental of South Dakota is responding to the critical need for better access to dental services by adding 24 registered dental hygienists and community health representatives to treat, educate, and coordinate dental care for American Indian mothers, young children, and diabetics. The approach is being supported with a $3.4 million innovation award from the Centers for Medicare & Medicaid Services.

Currently, Delta Dental covers more than 30,000 isolated, low-income and underserved Medicaid beneficiaries and other American Indians on reservations throughout the state.

Many adults end up going to emergency rooms and dental surgical centers because they aren't treated early enough. By avoiding emergency visits, Delta Dental estimates that health spending could be reduced by $6.2 million over three years. ■

The Minnesota Story

Minnesota authorized dental therapists in 2009, but with more schooling and stricter oversight than other programs

Christy Jo Fogarty, the newly minted advanced dental therapist (ADT) at Children's Dental Services in Minnesota, has been busy. Since December 2011, Fogarty has seen nearly 1,000 children who came to her for a dental checkup, cleaning, or fillings for their cavities.

They're still coming.

Fogarty is not alone. She is one of 16 mid-level oral healthcare providers licensed in Minnesota since 2009, when the legislature voted to add mid-level dental providers to the dental workforce. Without Fogarty, many of her young patients likely would have had to wait many months for care.

At Children's Dental Services, Fogarty quickly emerged as a top performer, saving the safety net clinic $1,200 a week while bringing in many more patients. In fact, the clinic has hired two additional ADTs and is picking up the full $35,000 tuition for two of its current hygienists to complete their ADT education.

Minnesota created a two-track licensing system for dental therapists (DTs), who must obtain bachelor's or master's degrees, and ADTs like Fogarty, who have already graduated from a registered dental hygienist program and must complete an additional accredited master's degree. Tribal advocates note that Minnesota requires more schooling and stricter oversight than the established international model for dental therapists, differences that could diminish effectiveness and reduce career opportunities for tribal members. ■

What is it like to be a dental therapist, or to work with one? A dentist, dental hygienist, and dental therapist discuss the expanded dental teams now working in Alaska Native villages.

Voices from the Field

Aurora Johnson, DHAT

Dental Health Aide Therapist based in Unalakleet, AK

Aurora Johnson

Living in a village where dental care only came once a year and dental products were not a priority in many homes, I was very fortunate that at a very young age I had someone in my life to encourage me to take care of my teeth. Now as a dental provider myself I make it a priority to make dental products available for kids at all school sites. It has been nearly seven years and when I first started the kids were half my size and now they are taller than me. Each year as I provide care to the kids in the communities I am building a

DHAT Aurora Johnson teaches children about oral health

relationship of trust with the continuity of care. As a DHAT I believe our preventive care has helped to fight the enormous decay rate we have in our region. Working together with other entities in our communities, such as the schools, can only better our program toward improved oral health.

Robert J. Allen, DDS

Dentist and DHAT instructor based in Bethel, AK

Robert Allen

We're in contact with DHATs out in the villages on a daily basis, particularly if there are difficult cases, via telemedicine equipment and a shared electronic charting system. So if they take a photo or x-ray we can look at it here in Bethel. They can tell us what they have observed, and we can help them decide whether it's something they can handle or not. They are very good about that. They are trained to know the limits of their scope of service.

Through the years, we tried all kinds of programs to prevent cavities. Really, the dental therapists are the best hope for the caries epidemic. One of the reasons is that the dentists come and go, but the therapists are usually from rural Alaska. So in many ways they almost become a foundation for the dental program, because they're the stable part.

I would say to other dentists that therapists offer an extra set of hands to see more patients and do more work. Trying to get a dental appointment is difficult no matter where you are in Indian Country, so by having more providers, we will be able to care for more people.

Monica Pasquale Rueben, RDH

Dental hygienist based in Fairbanks, Alaska

Monica Pasquale Rueben

I am from the Pueblo of Acoma. I belong to the Big Sun/Little Bear clan. I graduated from the dental hygiene program at the University of New Mexico in Albuquerque. I initially went to Alaska in 1999 with the U.S. Public Health Service for a tour that I thought would last two years, but have stayed for nearly 14, so I guess I'm here for good! I first met DHATs when they came through the training program in Fairbanks, and now I work with them during my village trips to 10 of the 26 rural communities we serve in the Interior of Alaska. I support the DHAT program. It allows our patients to receive dental treatment in their home village which helps them save on travel, time and money. The DHATs are a big asset in the rural communities. With DHATs on board as part of the dental team, we can provide access to care for more patients.

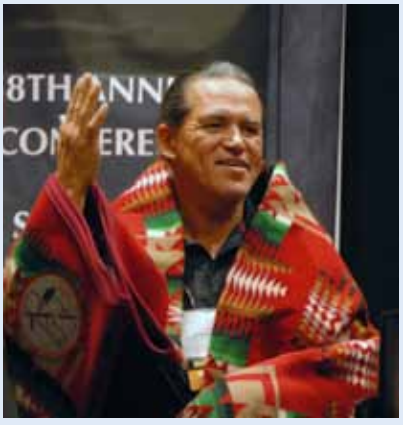
Alaska's New Dental Teams

Americans are familiar with dental teams consisting of dentists, hygienists and assistants, who work under the leadership of the dentist to care for patients. Alaska's Dental Health Aide Therapists (DHATs) bring additional skills and strengths to the team. The DHATs maintain close communication with the supervising dentist and other team members through phone calls, email, advanced teledentistry equipment and shared charting software.

Alaska Dental Health Aide Therapist
Educates patients
Conducts evaluations
Routine care
Sealants
Cleanings
Fillings
Simple extractions

Dentist
Manages clinical work
Authorizes therapist procedures
Continually evaluates therapist competency
Stays available for real time consultation
Performs complex or advanced procedures
Makes required observations for recertification

DHAT Training
Intensive 2-year program with 3,000 hours of training
More clinical training on routine procedures than dental students
4 to 6-month preceptorship with supervising dentist



Swinomish Chairman Brian Cladoosby at the end of his term as president of the Affiliated Tribes of Northwest Indians

A Tribal Leader Speaks Out about Dental Therapy

Swinomish Tribal Indian Community Chairman Brian Cladoosby, formerly chair of the Affiliated Tribes of Northwest Indians, champions dental therapy in his state. He urges other tribal leaders to do the same.

Why have you taken a leadership role in educating others about dental therapists?

Health care, especially dental care, in Indian Country is abysmal. The hard cold fact is that dental therapists are needed here in Washington state and elsewhere. All you have to do is just look around the country, around the world, to where this program has been implemented, and you see results immediately.

We have this saying in Indian Country that it takes two generations to break the cycle. And so when our community in the last two, three, four, generations has not had adequate dental care, and when parents do not have the best dental care, and their children don't have the best dental care, we need to start breaking that cycle.

The Swinomish have a great dental facility. Why are you, of all tribes, so involved?

Our population is still underserved. We do not have enough chairs and dentists to service the people who come into our clinic. We reviewed our charts and found that about half of our work could easily be done by dental therapists, and it would take a huge burden off the dentists.

How would a dental therapist program help the young people of your community?

We have a very unskilled workforce right now just because our grandparents were placed in the boarding schools. And with that boarding school mentality, education was not top priority. So if we can get some of these kids trained in this dental therapist program and put them to work, it will be a benefit for them and also for the future generations to see what is possible.

What's next?

What I love about this dental therapy program is that it is a win-win situation. We need to sit down, craft a plan, and get these dental therapists in places in Indian Country and other rural communities and public health settings where they can have a positive impact. And I will bet you my bottom dollar that when we analyze this in five or 10 years down the road there will be nothing but positive reviews and positive results.

Resolutions of Support

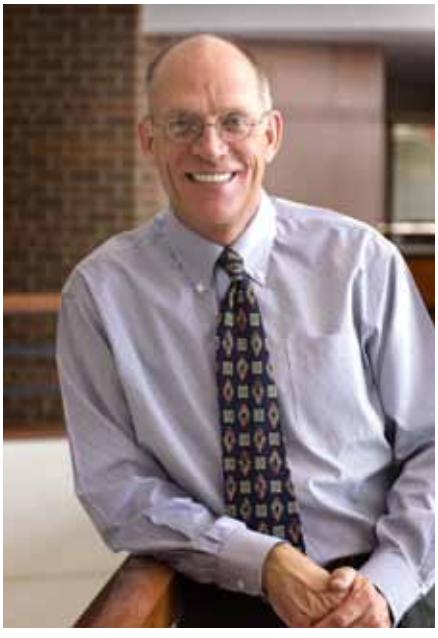
The following organizations and tribes support dental therapy:

- National Congress of American Indians
- National Indian Health Board
- Affiliated Tribes of Northwest Indians
- Albuquerque Area Indian Health Board
- Northwest Portland Area Indian Health Board
- Oglala Sioux Tribe

'It just made so much sense'

W.K. Kellogg Foundation President and CEO Sterling K. Speirn speaks out about the lessons we can learn from Alaska's Dental Health Aide Therapists

BY MARK TRAHANT



Sterling K. Speirn

The president and CEO of the W.K. Kellogg Foundation says there's a missing narrative in the health care conversation. "We just don't talk enough about oral health," said Sterling Speirn. "The whole way we approach early childhood and early care; we just don't talk enough about oral health. And dental disease is entirely preventable."

Yet in Indian Country, what should be preventable dental disease occurs at much higher rates than in the general population. That is why the Alaska Native community came up with its own solution: mid-level dental providers, or Dental Health Aide Therapists, that deliver high quality care to communities.

"I don't think that the tribes are alone" when it comes to the challenge of im-

proving oral health," Speirn said. "I know that oral health may be more severe, or the lack of it in Indian Country, but Deamonte Driver, who died from a tooth infection, was living in urban Maryland."

The Kellogg Foundation , one of the world's largest philanthropic organizations, has been working to improve oral health since the foundation opened its doors in 1930. But this mission is accelerating now for a variety of reasons, including the links between better oral health and overall health, better information about healthy living, improving the diet, and even health care reform.

"Most people, when they think of chronic early childhood diseases, think of asthma or something like that. They are very surprised to hear that dental disease is the most prevalent disease among our young children ... now we're looking at more innovations to get oral health care to people," Speirn said. "The mouth is the gateway to nutrition, gateway to health. There are so many diseases that can be caused by bad oral health."

Treating chronic diseases is important because that's what costs the most, consuming about three-out-of-four of all health care dollars. But it's not just about money, it's about healthy living by preventing diseases before they take root. "That's also an idea whose time has come," Speirn said. "We can prevent disease and we can promote wellness at the same time."

The Dental Health Aide Therapist program is a good example of how the elements of improving health can be fused. The practitioners don't just fix teeth. They also visit with their neighbors, their patients. They listen. They teach. It's one pathway leading to healthy living.

"In every decade since 1930, when we were founded, we have been very active in oral health care ... we helped fund the innovation that was called dental hygienist. Our friends the dentists remind us they were very skeptical to that idea when someone suggested there could be someone in the dentists' office who could clean your teeth. Now we just take those for granted," he said. "The idea of a dental therapist, or a licensed practitioner ... seemed to be a natural given our history in dental health care. It was something that was innovated, researched, and developed in a rural community led by the Alaska Native Tribal Health Consortium."

The Alaska Native Tribal Health Consortium sent a proposal to the Kellogg Foundation after they had already begun their program. "It just made so much sense. Here we are in a time when 50 million Americans really don't have access to oral health care on a regular basis," he said. Mid-level dental practitioners have the potential to expand access working under the general supervision of existing dentists. It's "an affordable way to get more oral health care out to more and more people, and it's a great workforce development. It's jobs for people in communities. And, again, I credit the Alaska Native Tribal Health Consortium for saying, we'll recruit people from these communities, we'll train them, and they'll go back into their communities."

Dental therapists are an economically sustainable model in remote Alaska villages, rural communities, and in urban areas where dentists don't practice.

They talk about the relationship with their patients, knowing they can't drill and fill their way to better oral health. "That is just the opportunity to sit with families and patients and talk about oral health care. They really feel their mission as health educators, and as health promoters, as much as it is practitioners fixing the problems in the mouth today," Speirn said. "Getting health messages from someone who understands you is so powerful. That's what we would love to try and replicate in the lower 48 states and Hawaii. That is the power of the model that Alaska taught us." ■

The practitioners don't just fix teeth. They also visit with their neighbors, their patients. They listen. They teach. It's one pathway leading to healthy living.

Why 'Growing Our Own' Professionals is So Important

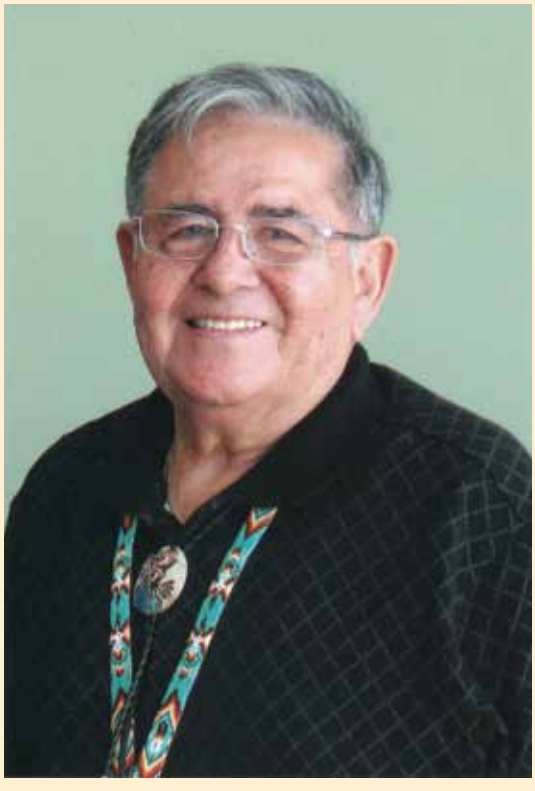
The first American Indian to become a dentist discusses oral health in Indian Country

George Blue Spruce, D.D.S., M.P.H., is a member of the Laguna and Ohkay-Owinge Pueblos. He became the first American Indian dentist in the United States upon graduation from Creighton University School of Dentistry in 1956. Nineteen years later he recruited the second, and he hasn't stopped recruiting since. Today there are about 190 American Indian dentists—still a tiny fraction of the total number of U.S. dentists—and the nation's 58 dental schools add only about 30 American Indian students per year. Dr. Blue Spruce is committed to building the dental profession and improving oral health in Indian Country. His message to young people: You can do this, and you are needed.

Why does Indian Country need more Native dentists?
We need to "grow" our own. The massive turnover of dentists in the Indian community is a problem and results in many vacant dental positions. Many non-Indian dentists on the reservations are there for only two years, as part of paying back their student loans, before leaving to enter private practice. Many Indian people, like other people, are apprehensive about going to a dentist. When they find one that they are finally comfortable with, it's a sad day when that dentist announces that he or she is leaving. The key to delivering dental care to American Indian communities is recruiting dental students from those communities.

Second, when you visit health facilities in Indian Country you find very few American Indians in meaningful leadership positions. We'll never realize the intent of the Indian Self-Determination Act until we can manage and control our own health programs, and to do that we need many more dentists, physicians, pharmacists, and other doctoral-level health professionals.

Why are there so few Native dentists?
Our students don't see American Indian dentists growing up. They do not have a parent or grandparent who is a dentist. So many of them don't even have support from parents, the extended family, or tribe. High school counseling is better than it used to be but even today counselors in our Indian communities too often talk to students about a marketable skill right out of high school and not enough about going to college. Oftentimes their high school courses do not include those subjects that will prepare them for college. And of course, there are the financial issues. Our students need help to overcome each issue. But one serious barrier is the dental schools themselves. Very few dental schools have made a genuine commitment to enrolling American Indian students. One exception is my school, the Arizona School of Dentistry & Oral Health.



George Blue Spruce

What will it take to increase the number of Native dentists?
"Pathways" from childhood through completion of dental school need to be established. It is said that a child commits to a profession as early as eight years old. A genuine and permanent involvement of parents, extended family, and organizations such as the Society of American Indian Dentists is needed to offer role models and encouragement. School administrators, teachers, counselors, colleges, universities, and organizations offering scholarship opportunities must all play responsible roles in ensuring the success of talented Native students.

Would adding more auxiliary providers strengthen the dental team?
Many Native individuals will not have the opportunity to become dentists. However, they can enroll and train in an auxiliary program, such as those for hygienists, assistants, and therapists, where they can be part of a dental team striving to extend and improve oral health at the various levels of treatment. They will help to improve and develop a comprehensive dental care delivery system for Native people, especially those people in remote and rural areas. A dentist's supervision will always be needed in those situations where treatment is more complicated and beyond the parameters of treatment by auxiliaries. ■

Dr. Blue Spruce founded the Society of American Indian Dentists in 1990 after retiring as director of the Phoenix Area IHS with the rank of assistant surgeon general. He is assistant professor and assistant dean for American Indian affairs at A.T. Still University's Arizona School of Dentistry & Oral Health. He has played tennis since high school and is at present the only male tennis player in the American Indian Athletic Hall of Fame.

Dental Insurance, but No Dentists

BY LOUIS W. SULLIVAN

The author, a physician, was the secretary of the Department of Health and Human Services from 1989 to 1993. This article appeared in the New York Times on April 8, 2012. Used by permission.

WE know that too many Americans can't afford primary care and end up in the emergency room with asthma or heart failure. But in the debate over health care coverage, less attention has been paid to the fact that too many Americans also end up in the emergency room with severe tooth abscesses that keep them from eating or infections that can travel from decayed teeth to the brain and, if untreated, kill.

Former HHS Secretary Louis W. Sullivan

More than 830,000 visits to emergency rooms nationwide in 2009 were for preventable dental problems. In my state of Georgia, visits to the E.R. for oral health problems cost more than $23 million in 2007. According to more recent data from Florida, the bill exceeded $88 million. And dental disease is the No. 1 chronic childhood disease, sending more children in search of medical treatment than asthma. In a nation obsessed with high-tech medicine, people are not getting preventive care for something as simple as tooth decay.

It's easy to understand why. Close to 50 million Americans live in rural or poor areas where dentists do not practice. Most dentists do not accept Medicaid patients. And the shortage of dentists is going to get only worse: by 2014, under the Affordable Care Act, 5.3 million more children will be entitled to dental benefits from Medicaid and the Children's Health Insurance Program. Little is being done — by the dental profession or by the federal or state governments — to prepare for it.

During the physician shortage of the middle of the last century, the federal government began creating about 50 new medical schools, doubling the number of graduating doctors. Today our government can and should train more dentists to address the long-term problem. But there is no guarantee that the new recruits would practice in underserved areas, and we need practitioners now.

A more immediate solution is to train dental therapists who can provide preventive care and routine procedures like sealants, fillings and simple extractions outside the confines of a traditional dentist's office. Dental therapists are common worldwide, and yet in the United States they practice only in Alaska and Minnesota, where state law allows it. Legislation is pending in five more states.

The dental profession has resisted efforts to allow mid-level providers to deliver this kind of care, and the government has so far failed to push for the change. It must do so now. The federal government could encourage states to pass laws allowing these providers to practice by calling for demonstration projects proving their worth.

The best model for how this system can work is found in remote Alaska Native villages, many accessible only by plane, snowmobile or dogsled, where high school seniors once graduated with full sets of dentures. Unable to recruit dentists to these areas, Alaska has been training its own dental therapists.

When Alaska began the project in 2003, there were no training programs in the country, so the state first sent students to New Zealand, which had a rigorous training program for dental therapists. These therapists now travel to small clinics and schools, often carrying their equipment with them. They consult with a supervising dentist from the region but do most procedures themselves. Many were raised in the communities in which they now work, so they understand the culture, children trust them and they have quickly become local health care leaders. Thanks to the program, around 35,000 people now live in communities where there is regular access to dental care.

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. 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. ■

Imagine Your Community with Better Dental Care

- **Native providers who return home to practice**
- **New jobs and career pathways**
- **Education, prevention, treatment**

Imagine a new workforce of highly trained Native dental providers who can ease suffering and improve oral health in your community. The dream is a reality in Alaska Native villages, where 35,000 people now have access to dental therapists. They are professionals, mostly Alaska Natives, who teach about oral health and perform basic services like exams, sealants, and fillings. Dental therapists are part of the dental team in 50 countries worldwide. ***Indian Country needs dental therapists.***

Find Out More

W.K. Kellogg Foundation: www.wkkf.org/dentaltherapy

Alaska Native Tribal Health Consortium:
www.anthc.org/chs/chap/dhs/

Dentex Training Program:
http://depts.washington.edu/dentexak/

Request a tribal toolkit: DentalTherapy@kauffmaninc.com

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