

**STATEMENT OF THE**

**AMERICAN DENTAL ASSOCIATION**

**TO THE**

**COMMITTEE ON INDIAN AFFAIRS**

**UNITED STATES SENATE**

**ON**

**“EXPANDING DENTAL HEALTH CARE IN INDIAN COUNTRY”**

**SUBMITTED BY**

**DR. RONALD L. TANKERSLEY, D.D.S.**

**PRESIDENT**

**DECEMBER 3, 2009**

Mr. Chairman and Members of the Committee:

I am Dr. Ron Tankersley, president of the American Dental Association (ADA), which represents 157,000 dentists around the country. I am a practicing oral and maxillofacial surgeon from Newport News, Virginia.

Let me begin by thanking you for your efforts to reauthorize the Indian Health Care Improvement Act. Enactment of this legislation, which contains so many important provisions to improve the health of American Indians and Alaska Natives, is long, long overdue.

I have been asked to appear before you to discuss our position on whether to expand the new dental health aide therapist position currently being tested in frontier Alaska into other areas of the country. You know from previous ADA committee testimony that the ADA does not support delegating surgical dental procedures to those without the comprehensive education of dentists. So, we are opposed to Congress expanding the Alaska therapist model.

To us, it's not a matter of whether similar providers exist in other countries. The United States has higher educational requirements than many other countries. Currently in this country, surgical services are not delegated to any healthcare providers with just two years of post-high-school training. Even nurse practitioners, with six years of education and training, are not given surgical privileges.

The real question is whether establishing such a position, with the attending challenges of recruiting, educating, training, supervising, and regulating such providers, is the best solution for improving access to oral health care in tribal areas.

Furthermore, we believe that recent events make expanding that model even less necessary than in the past. Specifically, the drastic shortage of dentists in the Indian Health Service (IHS) is finally being addressed—this year alone there will be 70 additional dentists providing care in tribal areas. With one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated. No other action could have a more significant impact upon increasing access to surgical oral healthcare in tribal areas with profound need.

The ADA has played a critical role in this success, working with the IHS to create and fund a dental summer extern program and lobbying to increase student loan repayments for dentists hired by the Service or tribes. Last year, over 300 dental students applied for 150 openings in the extern program. This year, ADA successfully advocated for increased funding to double the number of summer dental externs in 2010. We believe that this will lead to more young dentists choosing to work in tribal areas, reducing even further the need to look for other models to provide surgical dental care.<sup>1</sup>

We agree with many that innovations in the dental team could help increase access to dental services in underserved areas, including tribal lands. For example, the expanded function dental assistant model that has been used with great success by the U.S. military. We also strongly support the creation of new innovative dental workforce models that parallel that of medical community health aides. The ADA is currently funding and pilot testing one such model, the Community Dental Health Coordinator (CDHC).

Our initial classes of CDHCs will work in rural, urban, and tribal areas. These allied dental personnel come from the underserved communities in which they will work and who will provide community-focused oral health promotion, prevention, and coordination of dental care. And importantly, for this discussion, the CDHC program will be independently evaluated during the pilot phase before the program is replicated in other areas.

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<sup>1</sup> See attachment for additional ADA activities on behalf of IHS/tribal oral health.

To qualify for a CDHC credential, an individual will have to be a high school graduate and complete a 12 month series of classes, with 3-6 months of on-site practice depending on the student's prior experience. The individual will have to be trained at a Commission on Dental Accreditation (CODA) approved training site. Working under a dentist's supervision in health and community settings (such as schools, churches, senior citizen centers, and Head Start programs) and with people who have similar ethnic and cultural backgrounds, CDHCs will:

- Provide individual preventive services, such as screenings, fluoride treatments, placement of sealants, and simple teeth cleanings.
- Place temporary fillings in preparation for restorative care by a dentist.
- Help patients and/or their caregivers navigate through the maze of health and dental systems to assure timely access to care and to help prevent reoccurrence of the Deamonte Driver tragedy.
- Collect information to assist the dentist in the triage of patients, which will enhance delivery system effectiveness and efficiency.
- Overcome the barriers to seeking care by working with community leaders to promote oral health literacy and nutritional literacy and to address additional social and environmental barriers, such as assistance with transportation issues and enrollment in publicly funded programs.

We all agree that American Indians and Native Alaskans deserve access to the same oral health care as the rest of the population. Accordingly, the ADA asks Congress to focus on eliminating dentist shortages and supporting workforce innovations that increase efficiency and focus on prevention while still ensuring that people who need surgical care still receive that care from fully trained dentists.

Thank you.

## **American Dental Association's American Indian/Alaska Native Activities**

The ADA is the founding member of the "Friends of Indian Health", which works to ensure adequate funding for the Indian Health Service and tribal health programs, including oral health care services. And each year the ADA aggressively lobbies the United States Congress to ensure the dental health programs funded by the Indian Health Service (IHS) receive adequate appropriations dollars. In addition:

### American Indian/Alaska Native (AI/AN) Dental Placement Program

In 2005, the ADA hired a full time staffer to develop a volunteer dentist program for Indian Country. To date, volunteer dentists have served at 13 sites in eight states, including North Dakota.<sup>2</sup> In Minnesota we have sent 17 dentists on 19 trips. In November 2009, the ADA sponsored a team of eight prosthodontists, who travelled to Taos-Picuris Health Center (NM) for one week to provide full and partial dentures to local patients. The ADA continues to recruit, assign and coordinate volunteer dentists and dental students to serve at Indian Service (IHS) and/or tribal clinics.

### Indian Health Service Externship Program Support

Since 2008, the ADA has financially sponsored 18 dental students who provided practical support for upper classmen who are participating in the IHS externship program. This provided the chance for more dental students to participate in the IHS dental extern program, a key recruitment activity. The current vacancy rate for IHS dentists has dropped from 140 last year to 67 today. We believe that some of that success is due to the IHS summer extern program. Last year over 300 dental students applied for 150 openings. The IHS has reported that their positive summer experience makes them great ambassadors to their dental school colleagues. As a result of this program the ADA successfully advocated for additional funding in FY 2010 to double the number of summer dental externs.

### Summit on American Indian/Alaska Native Oral Health Access

In 2007, the ADA hosted the Summit, which included more than 100 participants, public and private interests, from tribal organizations, local communities, state dental societies, dental educators, specialty organizations, the U.S. Public Health Service, philanthropy and the Association.<sup>3</sup> The Summit focused around the question, "What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaskan Native people?"

At the conclusion of the Summit, all participants agreed to work on activities related to the following seven AI/AN oral health focus areas:

1. Creating a new paradigm for improving the dental workforce;
2. developing collaborative strategies for lobbying, funding, policy making, etc.;

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<sup>2</sup> Alaska (Bristol Bay Area Health Corporation/Togiak), Arizona (Hopi Health Care Center/Pollaca), Maine (Presque Isle), Minnesota (Cass Lake, Red Lake and White Earth Health Centers), New Mexico (Taos-Picuris Health Center), North Dakota (Belcourt and Fort Yates), South Dakota (Pine Ridge, Rosebud and Wagner) and Wisconsin (Menominee Tribal Clinic/Keshena)

<sup>3</sup> Stakeholder Groups: 1) Indian Health Service Area Dental Officers and Headquarters Personnel, 2) State Dental Societies, 3) Local Tribal Health Programs, 4) American Dental Association, 5) Indian Health Service Dental/Clinical/Preventive Support Programs and Other Local Programs, 6) Specialty and Special Interest Oral Health and General Health Care Organizations, 7) Regional Health Boards and Philanthropic Organizations, 8) Dental Education

3. designing research and implementing “best practices” for the prevention of oral disease, including early childhood caries;
4. fostering broader community involvement to identify oral health issues and their solutions;
5. advocating for a fully funded IHS/Tribal/Urban (ITU) dental program;
6. building trust among the partners/communities of interest; and
7. encouraging meaningful tribal empowerment in oral health policy making.

#### American Indian/Alaska Native Strategic Workgroup

The AI/AN Strategic Workgroup is comprised of leaders for the action team areas identified during the 2007 Summit. The Workgroup continues to meet two times per year to foster and maintain collaborations for effective advocacy, research, policies and programs at the local, regional and national levels, resulting in: 1) increased access to oral health care, 2) reduced oral health disparities, and 3) improved prevention of oral disease. One outcome of this continued effort was a FY 2009 joint appropriations request seeking \$1 million for research into the unique causes and needed new treatments for tooth decay among AI/AN children. The Strategic Workgroup also identified a long term funding plan for the IHS dental program. The ADA conveyed that message in an April 2009 letter to President Obama. Tribal members of the AI/AN Strategic Workshop planned to work with their organizations to send similar letters to the Administration.

#### Symposium on Early Childhood Caries in American Indian and Alaska Native Children

In October 2009, the ADA co-hosted, with the IHS, the Symposium on Early Childhood Caries (ECC) in American Indian and Alaska Native (AI/AN) Children. The Symposium was attended by national and international ECC experts; Indian Health Service dental, pediatric and child development personnel; and local tribal representatives. There was a consensus among Symposium participants that early childhood caries among AI/AN children represents a different disease from that experienced by other populations of children: it starts earlier, follows a more aggressive course, results in a much higher burden of disease for the children and their families, and has been refractory to many years of determined efforts to control it using intervention strategies found effective in other populations. Control of ECC among AI/AN children thus requires new approaches which are likely to be multimodal in nature with an enhanced emphasis on the infectious etiology of the disease. It will also require development of new metrics with which we can better characterize the disease and measure the effectiveness of new prevention approaches. Symposium participants intend to present a research agenda to the National Institute of Dental and Craniofacial Research and similar entities.

#### Pathways Into Health

In 2008 and 2009, the ADA co-sponsored the Pathways Into Health (PIH) annual conference. PIH is a grassroots collaboration of more than 150 individuals and organizations dedicated to improving the health, health care and health care education of American Indians and Alaska Natives. PIH recognizes that an important factor to improving the number of health care providers serving in Indian country is to “grow your own” and has developed distance education and mentoring programs to ensure that AI/AN students succeed in becoming health care providers. ADA personnel serve on the PIH advisory committee.

#### Society of American Indian Dentists (SAID)

Dr. Lindsey Robinson, ADA CAPIR Council chair represented the ADA at the Society of American Indian Dentists’ annual meeting, April 30-May 3, 2009 at University of California, Los Angeles. Dr. Robinson gave a presentation about ADA access to care activities, highlighting advocacy and programs for AI/AN populations.

ADA Institute for Diversity in Leadership

Two Summit participants; Dr. Alyssa York, dental director, Inter Tribal Council of Arizona and Ruth Bol, secretary/treasurer, SAID; were accepted to participate in the ADA's Institute for Diversity in Leadership, a three-part personal leadership training program designed to enhance the leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been traditionally underrepresented in leadership roles in the profession.