



NATIONAL CONGRESS OF AMERICAN INDIANS

December 1, 2014

Submitted via email to: tookss@ada.org

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NCAI HEADQUARTERS
1516 P Street, N.W.
Washington, DC 20005
202.466.7767
202.466.7797 fax
www.ncai.org

Dr. Sherin Tooks, EdD, MS
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

Re: Comments on the Standards for Dental Therapy Education Programs

Dear Dr. Tooks and members of the Commission on Dental Accreditation:

On behalf of the National Congress of American Indians, I would like to sincerely thank you for the opportunity to comment on the Commission on Dental Accreditation's (CODA) Accreditation Standards for Dental Therapy Education Programs. Given that the cost and availability of oral health care providers in American Indian and Alaska Native communities are major barriers to care and that dental therapists have increased access to care in underserved communities, we appreciate the Commission's work to develop minimum standards for a dental therapy training program.

The National Congress of American Indians (NCAI) is the nation's largest, oldest, and most representative American Indian/Alaska Native organization. Founded in 1944, the NCAI serves the broad interests of tribal governments and communities by advocating the advancement of policies and programs that improve the quality of life for Native peoples. NCAI, as a representative congress of American Indian and Alaska Native tribes, unites in advocating for the advancement of tribal health services and access to high-quality health care for American Indians and Alaska Natives (AI/AN). NCAI and our partner organizations continually strive to find ways to address the need for better access to health care in our communities. AI/ANs face significant disparities in oral health when compared to the rest of the U.S. population. AI/ANs lack access to dentists, consistent dental treatment, and prevention services. As a result, NCAI, with its partners, are working to increase access to care by advocating for the addition of an evidence-based new provider, a dental therapist, to the dental care team.

The need for access to dental care in AI/AN communities is significant. Tooth decay is five times higher among American Indian children ages 2-4 years than the U.S. average and 72 percent of AI/AN children 6-8 years have untreated caries, more than twice the rate of the general population. Older data indicate that 25 percent of AI/AN adults 35-44 years have fewer than 20 natural teeth and 75 percent of AI/AN elders (55 years and older) have fewer than 20 natural teeth. Fifty-nine percent of AI/AN adults have periodontal (gum) disease and 78 percent of AI/AN adults 35-44 years and 98

percent of elders (55 or older) have at least one tooth removed because of decay, trauma, or gum disease.¹

In addition, American Indian communities are often located in poor and rural areas and face difficulty in recruiting and retaining a sufficient amount of dentists to meet their populations' needs. In our communities, the dentist-to-population ratio is 1:2800, nearly twice the national average. The Indian Health Service (IHS) consistently has a 20% vacancy rate in dental provider positions and states with large AI/AN populations face similar shortages. For example, in the state of California, home to 109 federally recognized tribes, there are a total of 341 dental health professional shortage areas.

NCAI has heard repeatedly from tribal leaders and tribal citizens about the oral health disparities and the need for more oral health care providers in their communities. NCAI along with several tribes, consortiums of tribes, and AI/AN organizations have passed resolutions in support of dental therapists, including, the Prairie Band of Potawatomi, the Oglala Sioux Tribe, the Affiliated Tribes of Northwest Indians, Eight Northern Indian Pueblo Council, All Indian Pueblo Council, Inter-tribal Council of Arizona, Northwest Portland Area Indian Health Board, the Albuquerque Area Indian Health Board and the National Indian Health Board.

We know that dental therapists would provide a continuity of routine care for AI/AN communities and fill the need for a more robust network of culturally competent health professionals. Alaska Natives have access to dental therapists and have had significant improvements in their oral health due to the culturally-centered and continuity of care provided by dental therapists in their communities who are from the communities they serve which further ensures this continuity of care.

Unfortunately, this continuity of care does not exist in the lower 48 and many stories tell of the need in AI/AN communities. Laverne is a 45-year old American Indian woman in New Mexico who has lost several of her teeth, including her two front teeth, due to caries and lack of access to routine oral health care. Not only does Laverne have difficulty eating but she is self-conscious about the loss of her two front teeth and tries hard to conceal her mouth when she smiles. People like Laverne can be helped before they lose their teeth by increased access to oral health care provided through dental therapists.

Successful implementation of dental therapists in AI/AN communities would also have great economic benefit for these communities as most AI/AN communities have high rates of unemployment and poverty. Dental therapists would create new, livable-wage jobs not just for dental therapists, but also for clinic staff such as secretaries and dental assistants. It would also ensure that AI/ANs would be able to

¹ See Indian Health Service, Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences, and National Comparisons, 1999; U.S. Department of Health and Human Services (HHS). Oral Health in America: A Report of the Surgeon General. Rockville, MD: HHS, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000; W.K. Kellogg Foundation, Native Solutions for Oral Health, 2013

receive care locally rather than have to drive hundreds of miles to the nearest metropolitan area for care.

NCAI would like to first recognize the strides that CODA has made in the work surrounding dental therapists, and thank you for including the following policies in the most recent draft standards:

- Including dental therapists as members of the oral healthcare team (P. 22, Lines 2-4)
- Removal of the onerous and restrictive supervision requirements (P. 25, Line 5-8), which would have limited dental therapists' ability to expand access to care to underserved populations.
- Removing the restrictive requirement in Standard 2-1 which requires that all dental therapy programs result in a baccalaureate degree. By removing the requirement that programs result in baccalaureate degrees, colleges and universities will have the flexibility to develop evidence-based programs aimed at producing culturally competent, community-based providers.
- Updating Standard 3-2 to recognize that the program director of dental therapy programs could be health and dental professionals other than a licensed dentist (DDS/DMD). By removing the requirement that only dentists can serve as program directors, colleges and universities have proper flexibility to hire qualified program directors to meet the unique needs of their program, their students and the communities they serve. The removal of this requirement also lessens the burden on the administration to find a dental administrator, which are harder to hire at some institutions than others.
- Including recognition of advanced standing for dental professionals who enter dental therapy programs. By recognizing advanced standing, dental professionals will have the opportunity to build on their existing dental education and expertise, which will create a pathway to opportunities for dental professionals and help produce more providers to meet the needs of our, among other, underserved populations (P. 15, Line 37-43).

These policies are important for meeting the needs of our communities and move us one step closer towards reaching our ultimate goal of increasing access to dental care for all those in need. . We urge you to keep these policies in the final draft of the standards.

There are, however, several areas of concern for us that remain as to the draft standards. Our three main areas of concern are:

1. The current draft standards require dental therapy programs to be three years in length.
2. An incomplete scope of practice for dental therapists that excludes diagnosis, treatment planning, limited extraction of primary teeth and exclusion of any extraction of permanent teeth.
3. The lack of national education standards for dental therapists.

We will address each of these areas of concern in turn.

1. Length of Dental Therapy Programs: Standard 2-1

CODA's current recommendations on length of training could negatively impact the ability of training programs to recruit and train culturally competent providers. The length of training has a direct impact on the type of student who enters an education program and the likelihood of graduates to practice in underserved communities. In reviewing the Commission on Dental Accreditation's draft standards, we are concerned that length of training is prohibitive. Our goal is to ensure that dental therapy education will be accessible to students from underserved communities and will prepare dental therapists to practice in their home communities or other underserved areas. An unnecessarily long training period will diminish the accessibility of the training program to individuals from underserved communities.

Evidence shows that dental therapy programs can produce competent providers in two years. Over 1,100 articles have been written about dental therapy practice and education in the nearly 100 years of dental therapy practice internationally. There are over 50 countries that utilize dental therapists and most have done so with dental therapists educated in two-year programs. The evidence overwhelmingly shows that dental therapists educated in a two-year program without prerequisites provide safe, competent and appropriate care. I respectfully ask the CODA to review the evidence from the Alaska DHAT Educational Program and other well-established international models of dental therapy education, and accept our proposed amendment to Standard 2-1 that states "The curriculum must include at least two academic years."

The American Association of Public Health Dentistry (AAPHD) convened a panel of dental educators that reviewed the Alaska DHAT program and other international models. The panel outlined the principle competencies and curriculum to educate dental therapists. The panel consisted of dental educators who engaged in a thorough 14-month program that reviewed the Alaska model as well as international models. The panel's findings were published in a special edition of the Journal of Public Health Dentistry and detail the framework for a two-year dental therapy curriculum that culminates with an Associate's degree.

As follow-up to the AAPHD panel, the national consumer advocacy organization Community Catalyst convened a panel of academic and program experts comprising representatives from all three of the existing U.S. educational programs for dental therapists, as well as experts in dental therapy practice in the U.S. and Canada and educational standards experts. The panel researched accreditation models, standards and competencies for existing health professions to address critical issues such as curricula, faculty credentials, basic program length, and the level of financial support and type of setting needed to offer quality education programs. The panel recommended:

- Dental therapists should be trained to practice under the supervision of a dentist and to work collaboratively as part of a dental care team.
- Dental therapy curricula must include at least two calendar years of full-time instruction or its equivalent at the post-secondary level, and graduates must receive an Associate's degree. If a student is to be jointly trained in dental therapy and dental hygiene, the curriculum must include at least three years of full-time instruction or its equivalent.
- Graduates from dental therapy programs must be able to competently provide care within a scope of practice that includes assessing patients' oral health needs, providing preventive care and treatment for basic oral health problems and recognizing and managing complications, while adhering to all recognized community and professional standards.
- Dental therapy education program leaders must be qualified to administer the program, but do not need to be dentists. However, if a program is not dentist-led it must employ a dental director—a licensed dentist who is continually involved in the program.

We respectfully ask the CODA to review the evidence from the Alaska DHAT Educational Program, other well-established international models of dental therapy education, the findings of the AAPHD panel, and the results of the Community Catalyst panel that explored dental therapy education standards, before adopting a requirement of three years of training. These established programs and the evidence-based work of the AAPHD panel demonstrate that a dental therapy program should consist of two academic years of training and therefore, we urge CODA to amend Standard 2-1 to read, "The curriculum must include at least two academic years."

2. Scope of Practice for Dental Therapists: Standard 2-20

It is disappointing that the CODA draft standards included an incomplete scope of practice for dental therapists. While the scope of dental therapy enumerated in section (2-20) is appropriate, it is incomplete. The list excludes diagnosis, treatment planning, and complete scope as it relates to extractions within the dental therapy scope of practice.

Diagnosis and treatment planning are both critical pieces to ensuring that dental therapists can practice in areas or settings that are remote from a dentist so that they can diagnose problems within their scope of practice and work on treatment planning. Diagnosis and treatment planning are established parts of a scope of practice for dental therapists and key to helping improve access to underserved populations. By excluding diagnosis and treatment planning in the scope of practice the Commission is ignoring the evidence-based practice of dental therapy, which includes diagnosis and treatment planning. Dental therapists' scope has included diagnosis and treatment planning and enables them to work under the general supervision of dentists. This precedent has met the needs of the underserved and should continue to be the model for standards.

Dental therapists are limited in the primary teeth they can extract and unable under current standards to extract any permanent teeth. This limitation is problematic to providing routine care that dental therapists are well established and well trained to provide.

We respectfully request that the Commission add diagnosis, treatment planning, primary extractions, and extractions of permanent teeth that are not impacted and that do not need sectioning or an incision for removal to the list of areas of competency required for oral health care provision in the scope of dental therapy in Standard 2-20.

3. Adoption of Dental Therapy Standards

Lastly, we request that CODA adopt dental therapy education standards that accurately reflect the evidence. Adoption of standards will help streamline education programs, avoid multiple dental boards from wading into accrediting education programs in their state, and help establish a dental therapy program based on national standards.

Dental therapists are making a profound difference in expanding access to care. The need for dental therapists is only growing as more Americans go without dental care. Yet, there is no national accrediting process for the profession. With over 15 states exploring emerging workforce models, we urge you to adopt standards and implement a national accrediting process for dental therapy education programs.

Due to the success of dental therapists in Alaska, many tribal organizations that we partner with are ready to establish tribal programs. Tribal organizations throughout the country are interested in developing training programs for dental therapists as well as employing dental therapists. There is a significant demand for the routine, preventive and culturally competent care provided by dental therapists in our communities.

In addition to filling an immediate health demand, dental therapists and dental therapy training programs would also provide good paying jobs for our communities as well as make a significant economic impact. An Alaska Native Tribal Health Consortium study in 2012 showed that 19 dental therapists created 76 jobs and had \$9.3 million economic impact on rural, tribal communities. These jobs and the corresponding economic impact would be a significant benefit to our communities.

From a health and economic standpoint, we hope you work to establish national standards because there is significant demand and many positive impacts that could affect tribal communities as a result.

Additionally, it is important to note that there are three dental therapy programs training dental therapists in the United States: two in Minnesota, and one in Alaska. With passage of legislation in Maine there will be additional training programs launched within the next two years. Each of the programs is graduating competent

providers. In Minnesota the two programs have produced 42 graduates and it is anticipated that by 2016 there will be 71 graduates. In Alaska, 25 dental therapists are practicing and have increased access to care for over 40,000 Alaska Natives.

Until CODA adopts standards, individual state dental boards will continue to be forced to oversee dental therapy training programs on a state by state basis, which perpetuates a confusing and complicated system for dental therapy programs, their graduates and all interested parties. Thus, we hope you adopt evidence-based standards.

Again, thank you for your work in developing draft standards and for the opportunity to provide feedback to the Commission on Dental Accreditation on this important matter. We look forward to working with you to further develop standards for this emerging profession's graduates who will be an integral part of the dental team and will play a critical role in extending care to currently underserved communities throughout the country.

Sincerely,

A handwritten signature in cursive script that reads "Brian Cladoosby".

Brian Cladoosby
President
National Congress of American Indians