



Dental Public Health Activities & Practices

Practice Number: 02002
Submitted By: Alaska Department of Health & Social Services, Division of Public Health
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SECTION I: PRACTICE OVERVIEW		
Name of the Practice: Dental Health Aide Program		
Public Health Functions: Policy Development – Collaboration/Partnership for Planning and Integration Assurance – Building Linkages and Partnerships for Interventions Assurance – Building Community Capacity for Interventions Assurance – Access to Care and Health System Interventions		
HP 2010 Objectives: 21-1 Reduce dental caries experience in children. 21-2 Reduce untreated dental decay in children. 21-8 Increase sealants in 8 year-olds' first molars & 14 year-olds' first and second molars. 21-10 Increase utilization of the oral health system. 21-12 Increase preventive dental services for low-income children.		
State: Alaska	Region: Northwest Region X	Key Words: Workforce, dental provider, dental health aide, workforce development, provider training
Abstract: The Dental Health Aide (DHA) program would create a new dental provider type as a specialty area under the Community Health Aide/Practitioner program operated by Alaska Tribal health programs. The DHA program is being developed with assistance from dental consultants of the Alaska Native Tribal Health Consortium, Native health corporation dental programs and the CHA/P Director's. The Primary Dental Health Aide I (PDHA) provides dental education and the application of topical fluorides. The PDHA II would provide a greater range of services depending on their training track. These services may include dental assisting during itinerant dental visits in the villages, sealants, radiology, and clinical periodontics and atraumatic restorative technique (ART). The Expanded Function Dental Health Aides (EFDHA) levels I and II serve as expanded duty dental assistants in regional dental clinics. The Dental Health Aide Therapist level would require 2-years of full time training at a dental school and at this level would perform oral exams, cleanings/scaling, fluoride treatments, sealants, x-rays, restorations, stainless steel crowns and extractions. Initial funding for this training comes from an Indian Health Service grant and funding for program sustainability comes from reimbursement from the Medicaid program.		
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SECTION II: PRACTICE DESCRIPTION

History of the Practice:

The Community Health Aide Program was developed to meet the health care needs of Alaska Natives in remote villages. The program emerged as a result of the tuberculosis epidemic and the use of village workers to distribute antibiotics in the 1950's. The program evolved into a formal, federally funded program in 1968. Today over 500 Community Health Aides/Community Health Practitioners (CHA/P) provide emergency and primary health care services in 178 rural communities.

Over the past four years CHA/P have been able to direct bill the Medicaid program for services provided to clients enrolled in Medicaid including well-child exams. This has been done through federal certification of the program.

The Indian Health Service has used expanded duty dental assistants in the past in Alaska and the model is attractive at this time to maximize efficiency at the regional dental clinics. Maximizing dental provider time has also become more of an issue with dental staff vacancies and recruitment issues.

The DHA program would add dental education and preventive services in the rural communities served by the CHA/P program. The program also would provide additional assistance to itinerant dentists visiting these communities.

Justification of the Practice:

Traditional Native diets were rich in proteins and fats with an almost absence of fermentable carbohydrates resulting in very low caries activity. Diets of the Native people of Alaska have largely switched to diets rich in processed foods, refined sugar, soda pop and other beverages with high-sugar contents (e.g., Tang). These nutritional changes along with limited access to fluorides and dental services have contributed to rampant decay, including high rates of early childhood caries, in many rural area of the state. Itinerant dental visits have long had to focus on acute treatment needs with few opportunities for dental education. Furthermore, even when dental education is provided there are limited opportunities for reinforcement/support activities for these messages along with the preventive dental services to supplement these issues (e.g., topical fluorides).

In regional hub communities, where children are often taken for dental services, wait lists for preventive dental services may exceed four months. Problems of access for dental visits in both regional hub communities and for itinerant dental visits in the villages are compounded by staff turnover, vacancy rates and recruitment issues.

Further, at this point at least three generations of Native people have suffered from high caries rates and the resulting loss of permanent teeth. There is a need in many areas to change adult attitudes/perceptions about teeth and home care for both themselves and as caregivers for their children.

The population size of these rural, remote communities and geographic isolation of the communities speak to the need to have a local provider to provide dental education and preventive dental services, yet the small population sizes make it financially unfeasible for dentists or dental hygienists to establish practices and/or routine visits to these areas. These same dynamics led to development of the CHA/P program originally to augment services provided by physicians, mid-level practitioners and Public Health Nurses. It is felt the DHA program can serve a similar role for addressing oral health issues in these areas.

Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:

The program has a full time Director who oversees activities such as the development of certification standards, curriculum, and the training of the Dental Health Aides.

At this time 18 EFDHA I have been trained and are in the process of consolidating their skills at regional hub dental clinics in preparation for certification. Certification standards for the various provider levels within the program have been developed and are pending approval. Curriculum development for the balance of the program levels is ongoing.

The Director works closely with the Alaska Native Tribal Health Consortium's consultant, Tribal Health Directors, Tribal dental programs, and CHA/P Directors in program development. The State Dental Director and other state officials also provide input into program development.

Budget Estimates and Formulas of the Practice:

The IHS grant currently funding this program is for \$265,000 each year for five years. Additional funding is being sought.

Lessons Learned and/or Plans for Improvement:

Early discussions and development of curriculum have made it clear the Dental Health Aide Program needs to be integrally associated with the CHA/P program and not as a specialty group under the program. DHAs will be oriented to the CHA/P program and complete training appropriate to the duties they will perform.

It is necessary to train and orient dentists to work effectively with the Expanded Function Dental Health Aides in the clinic and to work with Primary Dental Health Aides in the villages. To maximize efficiency of these auxiliaries will require some changes in the dentists' practice patterns.

Available Resources - Models, Tools and Guidelines Relevant to the practice:

- Canada: Canadian Dental Therapist training program
- New Zealand: New Zealand Dental Therapist training program
- Indian Health Service / Haskell Indian Nation University: Expanded Function Dental Auxiliary training programs

SECTION III: PRACTICE EVALUATION INFORMATION

Impact/Effectiveness

Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?

It is felt that the Dental Health Aides can serve a similar role as the current 500 Community Health Aides/Community Health Practitioners (CHA/P), who provide emergency and primary health care services in 178 rural, remote communities. Dental Health Aides (DHAs) would add dental education and preventive services in the rural communities served by the CHA/P Program. DHAs also would provide additional assistance to itinerant dentists visiting these communities. Eighteen EFDHA (level I) have been trained. Baseline data collection is underway for this new program to allow monitoring of its impact and effectiveness.

Efficiency

Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?

Rural, remote communities in Alaska need to have a local provider to deliver dental education and preventive dental services. Yet, the small population sizes make it financially unfeasible for dentists or dental hygienists to establish practices and/or routine visits to these areas. These similar dynamics led to development of the Community Health Aid Program, originally to augment services provided by physicians, mid-level practitioners and Public Health Nurses. Dental Health Aides would provide dental education and preventive services to the rural communities, serving in a similar role as the Community Health Aides and integrating their services in the same communities served by the CHA/P program. Baseline data collection is underway for this new program to allow further evaluation.

Demonstrated Sustainability

Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?

The program promises to be sustainable through an agreement with Medicaid allowing Dental Health Aides to bill for services.

Collaboration / Integration

Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?

This program is an example of collaboration between the Indian Health Service, Alaska Native Tribal Health Corporations, Alaska Tribal Dental Programs, and the Alaska Community Health Aide Program.

Objectives / Rationale

Does the practice address HP 2010 objectives, the Surgeon General's Report on Oral Health, and/or build basic infrastructure and capacity?

It is expected that the program will help to address the following HP 2010 objectives:

- 21-1: Reduce dental caries experience in children
- 21-2: Reduce untreated dental decay in children
- 21-8: Increase sealants in 8 year old first molars & 14 year old first and second molars
- 21-10: Increase utilization of the oral health system
- 21-12: Increase preventive dental services for low-income children

Extent of Use Among States

Is the practice or aspects of the practice used in other states?

Not at the present.