

# Dental Public Health Activity Descriptive Summary

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## Dental Health Aide Program

In November 2000, work began in developing a Dental Health Aide (DHA) Program. The DHA Program created new dental provider types as a specialty area under the Community Health Aide/Practitioner (CHA/P) Program operated by Alaska Tribal health programs. 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. The DHA Program was developed with assistance from dental consultants of the Alaska Native Tribal Health Consortium, Alaska Tribal Health Organization dental programs, and the CHA/P Directors. There are four categories of dental health aides reflecting different levels of training:

- (1) Primary Dental Health Aide (PDHA): The PDHAs provide dental education, nutritional counseling, and the application of topical fluorides. The PDHA II provides a greater range of services depending on their training track. These services include dental assisting, taking radiographs, placing sealants, supporting clinical periodontic services, and placement of interim therapeutic restorations (ITR).
- (2) Expanded Function Dental Health Aides (EFDHA). EFDHA levels I and II will serve as expanded duty dental assistants in regional dental clinics.
- (3) Dental Health Aide Hygienist (DHAH): DHAH are licensed dental hygienists that with appropriate training can administer local anesthetic under general supervision.
- (4) Dental Health Aide Therapist (DHAT): The DHAT level requires two years of full-time training and a preceptorship. DHATs perform oral exams, cleanings, fluoride treatments, sealants, radiographs, restorations including stainless steel crowns, extractions and community prevention programs.

At this time there are over 57 Certified Dental Health Aides working throughout the state at 12 of Alaska's Tribal Health Organizations. As of January 2012, there were 25 Certified DHATs. Dental Health Aide education occurs throughout Alaska and is overseen by the Community Health Aide Certification Board. In 2007, the Alaska Native Tribal Health Consortium began educating DHATs (previously educated in New Zealand). The two-year program has training locations in both Anchorage and Bethel, Alaska.

### Lessons Learned:

There have been examples of emotion and fear surrounding new dental providers, especially when the provider is licensed or certified to provide services which have only been in the scope of practice of dentists previously. There is a cost of time and money trying to negotiate through the political issues arising from organized dentistry's concerns.

40,000 people now live in a community served by a DHAT. The communities are very satisfied with the care they receive and are especially pleased to be able to see so many Alaska Native dental care providers. The DHA Program was developed with flexibility in mind. As the program has matured, there have been many different configurations of providers in the various regions of the state. Some DHATs work remotely from their supervisor, while others are part of a team of dentists, hygienist, assistants, and primary dental health aides working in larger regional hub clinics. Some areas have their DHAs working outside of dental clinics to expand their reach and to bring care to where the patients are. Non-dental work settings for DHAs include; WIC offices, Operating Rooms where ECC full

mouth rehabilitation takes place, elders homes, elder community centers, Early Head Start and Head Start Centers, Schools, parenting group meetings, and individual community members' homes. The flexibility of working remotely from your supervising dental provider under general supervision has allowed programs to get very creative about how these new providers are engaging individuals and communities. The result is further outreach, better access to the most vulnerable populations, and interprofessional collaboration.

The sustainability of the programs have been borne out over the last 17 years. All types of DHAs are able to bill out services to Alaska Medicaid and the reimbursement has been quite favorable- PDHAs more than pay for their salaries, benefits and other costs of delivering their scope of practice, often providing additional income for the dental programs to support other initiatives beyond the DHAs. For DHATs we are seeing the same good revenue outcomes with DHAT generating collections that average \$125,000-\$245,000 more than the cost to employ them and their assistants. Another added benefit is that on average, having a DHAT in a remote community will save Medicaid \$40,000 in avoided travel costs because patients can be treated at home.

Retention rates of DHATs over the past 10 years is about 73%, a remarkably high retention rate for the HPSA areas where they work.

The Research Triangle International, Inc. evaluation of the implementation of dental health aide therapist demonstrated positive outcomes. However, there were no benchmarks with which to compare the findings to private practice dentistry. It is important for dentistry to start evaluating care delivered in all settings and work towards improvements. While the data set was small, only 5 DHAT evaluated, the findings are consistent with those from studies of dental therapists around the world. Follow up studies are being conducted which show some very promising preliminary data, such as much improved access, improved oral health status, and decreases in invasive and traumatic dental services when DHAT are utilized.

In 2017 Alaska is starting to see the benefits of a well-established program. As DHAT the number of certified DHAT reached 37, the ability to successfully implement the PDHA and EFDHA models has improved. PDHAs once had trouble getting patients to see them for their preventive services because these patients were suffering from dental disease that needed higher level care than the PDHA could provide. Now that DHAT and Dentists are able to cover remote communities more effectively, the role of the PDHA as the "prevention coach" is expanding. Patients are ready to learn more about prevention since they have had the chance to get their acute needs met. The typical scenario in a region where a DHAT has been newly employed is that they spend the first 6 months to a year addressing longstanding oral health issues such as extractions and large restorations. Once the DHAT has been able to stabilize the community, then we start seeing an increase in prevention services and an increase in oral health literacy in the community. This is exactly what the people who developed this program had hoped for. Another trend that we are seeing is that having DHATs and PDHAs working on a dental team allows the dentist to increase the number of high level services they can provide, including crown and bridge, endodontics, implants, and dentures. This leads to a higher level of care for the patients and dentists feeling more satisfied with their practice. All this means improved care and satisfaction for the patients.

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