



July 26, 2017

Dear Dr. Taylor:

We are writing in response to your editorial “We Have a Work Force Model in Place” in the June issue of the Oregon Dental Association membership newsletter. We were disappointed when we read this editorial. The Oregon Dental Association has spent the last few months making an effort to reach out to Tribes under the guise of wanting to partner with us to improve the oral health of tribal communities. But what this editorial makes clear is that the Oregon Dental Association does not respect the sovereignty of Tribal nations nor the responsibility and dedication of Tribal leaders or Tribal health providers to their communities. Also, the editorial is contrary to the many years of commitment and work between the Tribes and the State of Oregon around self-determination and Government to Government relationships. It would be impossible to build a fruitful and lasting partnership without a basic level of respect and understanding.

The current oral health work force model in place has failed Tribes. Not just in rural areas or in village settings such as in Alaska, but also American Indian/Alaska Native people that live in urban settings. For decades, Tribal communities have been forced to accept substandard, itinerant, and emergent dental care. For decades, Tribal communities have been denied the routine, sustainable, and culturally competent care that so many people take for granted. Our Tribal leaders and Tribal health providers are committed to turning the tide of the oral health crisis facing Tribal nations. To insinuate that Tribal leaders would advocate for and accept substandard care is insulting.

In collaboration with the Oregon Health Authority, Tribal leaders in Oregon have been working to implement an evidence-based provider into our oral health system. Tribal leaders are looking for a long term sustainable solution that builds up our communities. The Alaska Native Tribal Health Consortium pioneered the use of Dental Health Aide Therapists (DHATs) in their communities and all of the research on those providers has shown that they provide high quality, culturally competent, primary oral health care. For the Oregon Dental Association to reach out for partnership while actively spreading misinformation about our project and disrespecting the efforts of Tribal leaders in this state is disingenuous to the notion of partnership. The Oregon Dental Association will not be able to partner with Tribal communities and Tribal leaders until the association can respect the will and the expertise of the community.

The editorial was full of misinformation about the project in which we participate. First and foremost, you have chosen to ignore the facts as related to the actual oversight, evaluation, and monitoring of our project. The pilot program requires extensive oversight, evaluation and monitoring of every approved project, including ours. The ODA knows this because it and the Board of Dentistry are participating fully in that oversight. You spent considerable time wondering aloud about standard of care, safety and quality, however, if you had bothered to read the extensive approved application to the state (available to the public online) or our evaluation and monitoring plan (also available on line), called us, talked to one of your colleagues on the Advisory Committee, or called the Oregon Health Authority you would have learned that the standard of care, safety, and quality is equivalent (if not higher) to that required of dentists in Oregon. Instead you chose to muse and insinuate and offer false information to the members of the ODA.

You assert that *“the term “adverse outcomes” is frequently mentioned as an objective measure of the success of DHAT-based care facilities”*. We would ask you to please provide documentation where *“adverse outcomes”* are a measure of success for DHAT based care facilities. In fact, all DHAT programs in Alaska, WA and now in OR, are some of the most highly scrutinized and monitored programs in the country. Unlike dentists, who are only judged on safety and quality if they are brought before the Board of Dentistry, our DHATs in Oregon are monitored by their own supervising dentist, an external dentist, and OHA and its Advisory Committee. Direct oversight, chart reviews, site visits, patient satisfaction surveys, tracking of every single procedure performed and explicit definitions of success of each procedures are all part of a multi-layered, intense monitoring program that ODA has reviewed and offered insights. An ongoing evaluation of the data we are collecting about access, wait times, changes in types of procedures a clinic can do, costs and patient care is on top of the safety and quality monitoring.

You also state that *“Proponents often casually remark that this will allow dentists to provide ‘more complex services’.*” It is a fact that if a mid-level provider is able to provide routine services a dentist was previously doing, that dentist can take on patients and procedures that were previously referred out to other clinics or simply not offered. Your tone suggests that freeing up dentists to provide more complex procedures and therefore allowing our patients to achieve higher level of functionality is not a desirable outcome for our clinics. One of the greatest successes of the dental therapy model in safety net clinics is the ability for every provider to work at the top of their scope and provide the appropriate care at the appropriate time in an efficient and effective way.

The entire tone of the editorial demonstrated how completely out of touch the ODA is with communities that struggle with lack of access to care and in particular, Tribal communities. You claim that *“Oregon does not have a Native American population in areas that have the same type of isolation as they do in Alaska”*. But the reality is if you can't get into a dental clinic when you need care, it doesn't matter if you live next door, 3 hours away by car, or 5 hours away by plane from the nearest clinic. The outcome is the same. The CTCLUSI dental clinic is the only tribal clinic for IHS eligible members in a 7 county service area of SW Oregon. NARA serves an urban Indian population in Portland of approximately 15,000 AI/AN people that live in Portland plus has relationships with some of the Oregon Tribes to provide care to their members. NARA is also a safety net clinic. Finally, Tribal communities face more barriers to oral health care than just geography and deserve to be served in a place where they feel comfortable and know that their culture and history is respected.

You also go so far as to say that *“even for the population in the rural areas, this is not where the pilot location sites are in Oregon. One of the pilot sites is located in the rural community of Coquille, yet five of the sites are located in the Portland metropolitan area”*. This is simply wrong. There are two dental clinics included in the pilot project and the first DHAT to offer services is working at the CTCLUSI dental clinic in rural Oregon. There are 3 approved pilot sites, 2 of which are Tribes that serve the most rural counties in Oregon including: Coos, Curry, Josephine, Lane, Lincoln, Douglas, and Jackson. The third site is NARA. NARA as a site is significant because we wholeheartedly agree with your conjecture that there is significant evidence that eliminating the transportation issue is a step in the right direction for increasing access to care. That is why we want to explore, at all of our sites, how to integrate services that can meet people where they are. Whether this be at school, at a residential drug treatment facility, medical clinic, community center, or in a mobile unit in their community.

This is not a new concept, and it is one that increasingly represents the best thinking about achieving the triple aim. That is why when NARA was approved as our 3rd site, we listed their facilities in which they work or partner as potential practice settings. We know that with the addition a DHAT, education and preventive services can be increased, and delivering these services outside of the 4 walls of the clinic offers enormous possibilities. These are all facilities where ODA, private dentists, and other providers have chosen not to work.

You go on to express concern that only one of our sites is located at a school and point out erroneously that it is not a public school. Clarendon is the first Regional Early Learning Academy in Portland Public Schools. The Early Learning Academy was opened in the fall of 2014 with the mission of providing services to children from 15 months to 5 years of age and their families. It features partnerships between Portland Public Schools, Albina Early Head Start, Oregon Community Foundation, Indian Education, Neighborhood House, Teen Parent Program, and Early Learning Multnomah.

Tribes and Tribal organizations have dedicated, diligent, and well educated and informed leadership and have demonstrated over and over that their solutions are more effective than those that might be imposed on them based on the perceived benevolence of the federal government, established organizations like dentistry, as well as other disciplines. This is why it's important to listen to the needs and solutions of Tribal communities on how to best address their oral health needs. It is as you say a *“simple truth is that Native Americans deserve the same level of care that every other member of our society deserves”*, but it is not the Oregon Dental Association that will deliver that to our communities. In fact, the ODA has failed in that area for decades. Every Tribal Leader and Tribal health provider in Oregon works hard to ensure that the best possible care is available to Tribal members. Tribal leaders and Tribal health providers in Oregon are exploring DHATs because the current system is failing our communities and changes need to be made to the oral health delivery system.


Alaska Natives created an oral health delivery model using DHATs that has resulted in over 45,000 more Alaska Natives getting care. You claim that *“DHATs are not going to practice in rural areas, and there is no compelling reason why children will be more likely to be treated by a DHAT if they aren't being treated by a dentist now”*. However the reality of what is happening in Alaska, the data, and the real life experience of communities that have DHATs providing services in their villages all tell a different story. Having DHATs as part of the dental team has resulted in far fewer children going to the operating room for full mouth rehabilitation services. It has lowered costs for patients and clinics alike. It has increased access


to preventative care and decreased the number of extractions in children and adults. And it has started to rebuild trust in dentistry, which historically equated to itinerant dentists visiting a village once a year to pull teeth. Recruiting providers from the community they come from results in providers that stay, providers that are connected by language and history, and providers that are trained to deliver care in a culturally relevant setting.

So it is not surprising that Tribal communities and organizations in Oregon are piloting this model in response to similar barriers, and as an option to improve access, lower costs, and increase patient satisfaction—all of the goals laid out in the Dental Pilot Project Program, authorized by the state legislature in 2011.

It should go without saying that a paramount duty of our Tribal leaders and Tribal health providers is the health, safety, and wellbeing of our Tribal citizens. It is clear that is not a paramount concern of the Oregon Dental Association.

Sincerely,


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Brenda Meade
Chairperson
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Jackie Mercer
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Cc:

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