Extending the W.K. Kellogg Foundation's Legacy in Oral Health Care: The Pediatric Oral Health Therapist as an Innovation

Presentation at W.K. Kellogg Foundation's Oral Health Conference
Legacy and Innovation: Improving Oral Health for ALL Children

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Borrowing from the title of this conference I will entitle my comments *"Extending the W.K. Kellogg Foundation's Legacy in Oral Health Care: The Pediatric Oral Health Therapist as an Innovation."* A philosopher friend of mine once said to me: *"David, concepts are intimately related to words."* How true. I will attempt to explicate the words of my title and assign them conceptual meaning as I proceed.

The W.K. Kellogg Foundation is a philanthropic organization. *Philanthropic*-- a word that does not easily roll off the lips. However, it is an important word. The Greek roots of the word are "philos" meaning "love," and "anthros," meaning "humanity." Mr. W.K. Kellogg established the Foundation in 1930 because of his "love for human kind;" particularly for children. Since that time, the Kellogg Foundation has established itself as one of our nation's great philanthropic organizations. It has a remarkable legacy of good works benefitting humanity. Nowhere is that more evident than in the Foundation's support for improving the oral health America's children.

The charter of the Kellogg Foundation states unequivocally: *"The purpose of the Foundation is the promotion of the health, education, and welfare of mankind, but principally of children and youth, directly and indirectly."* Additionally, the original Articles of Association stated the Foundation would be dedicated to *"improving the health, happiness, and well-being of children and youth, without discrimination as to race, creed or geographic distribution."* The capitalized ALL in referencing children in the title of this conference—"Improving oral health for ALL Children"—is an important dimension of the Foundation's legacy—support for ALL children.

The first major project undertaken by the Foundation was the Michigan Community Health Project, a comprehensive program designed to improve all aspects of the lives of children living in seven counties in Michigan—dentistry was an integral dimension of the program. All children in the seven counties received an annual dental examinations and care—in their schools. We will return to the topic of oral health and schools later.

From the outset an expressed major interest of the Foundation was in dentistry; specifically the lack of attention by dentists to the oral needs of children, and somewhat ironically, to the problem of an inadequate oral health care workforce. The 1943-44 Annual Report said: *"The shortage of dentist manpower is acute... and, because adult dentistry is more lucrative than dentistry for children, the children are the ones to suffer most."* Interestingly, Dr. Emory Morris, a dentist, was President and Chairman of the Kellogg Board of Directors during this period.

The Kellogg Foundation began to focus significantly on the issue of expanding the potential of dentists to provide more care to more individuals in the late 1940s by supporting dental hygiene programs at several universities. In the 1970s, they provided a grant to my College of Dentistry at the University of Kentucky for over $800,000 to study Expanded Duty/Expanded Function Dental Auxiliaries. The research from that project, along with a companion project at the University of Washington, also funded by Kellogg, provided the major impetus for states to expanding their practice acts to include expanded functions for both dental assistants and dental hygienists. In publicizing the results of these efforts, the Foundation emphasized that it was not

necessarily required to expand the number of dentists, but rather to multiple and extend the dentist's *hands*. Extending the *hands* of the dentist to care for children is still at the heart of Kellogg's current support for adding therapists to the oral health care team. In a very direct and substantive manner, the expanded utilization of dental assistants and dental hygienists can be attributed to funding from the Kellogg Foundation.

In early 1976, the Foundation convened an Ad Hoc Advisory Committee on Dentistry to assist in setting future priorities for its oral health agenda. One of the first grant awards emanating from that Committee's advice was to the Institute of Medicine, in cooperation with the Pan American Health Organization, to convene a panel of experts to examine world-wide approaches to dental care delivery. A colloquium was conducted on May 5 and 6, 1977, in Washington, D.C., at which over 90 prominent leaders in dentistry from the United States and around the world participated —some of whom are participating in this conference. The proceedings of the Colloquium were published as a book *International Dental Care Delivery Systems: Issues in Oral Health Policy.* Of note, were presentations by representatives from a number of countries whose dental care delivery system for children utilized school-based dental nurses. Dr. Harold Hillenbrand, the highly-respected Executive Director of the American Dental Association, spoke at the conclusion, summarizing the colloquium. Relevant to our issue of the moment, he said, and I quote: *"When the dental history of our time is eventually written, I believe the New Zealand Dental Nurse Program will be considered one of the landmark developments in the practice of dentistry and dental public health."* He went on to say: [New Zealand has] *"pioneered in a very effective method for delivering dental health services to children."* Finally he concluded, *"the New Zealand experience proves that we can develop an auxiliary program—and a very advanced one—that is acceptable to, and approved by the profession of the country involved."* Amazing statements! These are comments by one of the most revered leaders in the history of the American Dental Association; would that we had such leadership today.

The W. K. Kellogg Foundation has, through the years, awarded 417 grants, totaling $55 million dollars, to entities in dentistry to promote oral health; including grants to 135 colleges and universities.

Gathered in this room are leaders from both the public and the profession, leaders who will be critical in the success of the effort to bring the *hands* of therapists to the *mouths* of our children in order that they may be the beneficiaries of good oral health. I encourage you to promote three basic principles that have enabled therapists to be successful internationally.

1) The training of therapists is a two year post-secondary education process. We must be vigilant to ensure that we do not make the training of a therapist more than it is or should be. Professional political pressures have already begun to create an expectation that the training period for therapists should be a longer curriculum than two academic years. I was pleased that Kellogg funded the American Public Health Dentistry Association to develop competencies and curriculum guidelines for a two academic year program.

   Kellogg has supported dental hygiene education for many years. Dental hygienists should also have the opportunity to gain the restorative skills of a therapist in caring for children. As has been demonstrated in the 1970s by the Forsyth Institute, the University of Kentucky, and the University of Iowa, this can be accomplished in a relatively brief period of time—one academic year is probably even more than is necessary. The research

at Iowa was funded by the Kellogg Foundation.

I have advanced the proposal that dental hygiene programs should develop flexible curricula of three years. In such a curriculum, the first year would be jointly studied by both hygienist and therapist students. After a second year in one discipline or the other, the individual could graduate as a hygienist or a therapist. If a person wanted to possess skills in both scopes of practice they could continue one additional year completing the second year curriculum, which they had not pursued previously. Practicing hygienists who want to gain therapists' skills could return to school to retrain in that one year of the therapist-specific curriculum. I also believe that on-line and distributed approaches could readily be developed for practicing hygienists that would enable them to gain therapists' skills with little time away from their practices—now there is an innovative funding opportunity for our colleagues at Kellogg! There is no need for a baccalaureate or master's degree program to become a therapist. As you might be able to gather at this juncture, I am not partial to the educational approaches that have evolved in Minnesota as a result of a politicized process.

2) I am strongly persuaded that therapists should focus their care on children, not adults. I have attempted, since writing my first article in 2003 advocating adding therapists to the oral health work force, to refer to therapists as "pediatric oral health therapists." I have used the term "oral health," as oral health is the goal of their practice. It is my attempt to emphasize ends over means; dental is a means, not an end. Ends assist us in keeping our focus on the vision of oral health. I use the adjective "pediatric," as I think therapists should care for children, not adults. In an article published in the *Journal of Public Health Dentistry* I have justified seven reasons therapists should focus their care on children—not adults. I only have time to briefly enumerate them her—not justify them:

- Ethical considerations support therapists focusing their care on children. Ethics requires that when resources are inadequate to address the needs of all, then what resources exist should be distributed most favorably to children. John Kennedy, in his first inaugural address, said it well: *"Children may be the victim of fate—they must never be the victims of neglect."* Kellogg's motto summarizes it: *"Our Children, Our Mission, Our Future."*
- Prevention of oral disease supports therapists focusing their efforts on children. *"He who is wise, begins with the child,"* so said Goethe. If a lifetime of oral health is to be achieved, it must be initiated in childhood.
- Safety considerations support therapists focusing their care on children. Students graduating from our dental schools today are inadequately trained to care for the myriad of chronic diseases affecting the U.S. population; clearly therapists are not.
- Complexity of care supports therapists focusing on children. Adult dental care is complex in ways in which care for children is not. In safety net settings, where many advocate that therapists practice, patients will likely present with mutilated dentitions and significant periodontal disease. Therapists should not be asked to address such complex conditions with their circumscribed training.

- Economic considerations support therapists focusing on children. As a result of the expansion of the Children's Health Insurance Program, the majority of America's children will soon have public dental insurance through Medicaid and CHIP—40 million of our 78.6 million children. Health care reform offers no adult dental benefit.
- International experience and research supports therapists focusing their care on children. The overwhelming preponderance of experience of dental therapists internationally has been on children, not adults. With distinguished colleagues from around the world, I am in the middle of a review of all of the international literature on dental therapists—a project supported by Kellogg. Our research team has gathered over 600 documents thus far from around the world related to the practice of therapists. The result of our literature research will only serve to confirm that internationally--therapists treat kids.
- Lastly, Professional barriers support therapists focusing their care on children. Many dentists do not want to treat kids. As the old expression goes, *"there are more dentists afraid of children than children afraid of dentists."* As the Kellogg report I cited earlier stated, it is more lucrative to treat adults, I believe that organized dentistry will be less threatened, and thus more readily accept a paraprofessional on the dental team whose focus of care is not adults, but rather children.

3) My final guiding principle in advancing the therapist movement is not new. The leaders of the Kellogg Foundation understood it when they launched the Michigan Community Health Project in 1930. Oral health care for children must be provided in their schools. It is interesting to speculate the impact on the oral health of our children if elementary schools in America had a dental clinic, as in New Zealand, staffed by a dental therapist and dental assistant. While inadequate numbers of dentists willing to care for children with public insurance is a barrier to children receiving optimal dental care, parents are also a barrier. If children are to receive care we must remove the obstacles created by parents; for many of whom education and (understandable) life circumstances are such that the oral health of their children falls to a lower priority than desirable. As Dr. James Dunning, the dean of American public health dentistry, and at one time dean of the Harvard Dental School, said over 40 years ago *"any large-scale incremental care plan for children, if it is to succeed, must be brought to them in their schools."*

   Today, school-based health programs are emerging as an important dimension of the nation's health care delivery system. The establishment of school-based health centers is a significant dimension of the Affordable Care Act. The National Assembly on School-Based Health Care is the nation's leading advocacy body for overcoming the structural barriers to children receiving health care by placing health care in schools. In comparing the costs of school-based health care in New Zealand provided by therapists, with private practice office-based models staffed by dentists in the United States, evidence suggests a public supported school-based program staffed by therapists could result in dramatic financial savings, while also providing care for the overwhelming percentage of America's school-children, as well as a significant number of preschool children.

   Increasingly, leaders in health policy understand that the only way to ensure a healthy start to adulthood for our disadvantaged children—recall that the majority of our nation's

children now qualify for public insurance based on economic need—is to reach them in their neighborhood schools. Would it not be desirable if every school in the country had a health clinic—a "health home," that includes a dental clinic staffed by a therapist and an assistant that serves as a "dental home." Schools are a second home for our children—education and health go hand in hand. In my home state, the number one health problem encountered by elementary teachers is toothaches. For over 90 years school-based care has enabled 97% of New Zealand school children to receive regular dental care such that at the end of a given school year essentially no decay remains in their dentitions. It is an idea that enables 56% of New Zealand's preschool children to receive care at their neighborhood school.

It has been my good fortune to have been involved in this movement from the beginning; from the time I, along with Wendy Mouradian and Dom DePaola, approached the Indian Health Service about training therapists to care for our underserved American Indian/Alaska Native population—through to the development of the Dental Health Aide Therapist program in Alaska—and up until today. I remember, with some emotion, hosting our first six Alaska Native therapist's students for dinner in Dunedin, New Zealand, and listening to them express their sheer delight at the opportunity being afforded them. I told them that night that they would be remembered in the history of dentistry as true "pioneers." They were--and will be so remembered. While the ultimate goal of my involvement was to see therapists caring for children throughout the United States, I must confess I held little hope of that happening—at least not until the W. K. Kellogg Foundation became involved. There was a sense of extraordinary optimism developed in me when I read President Sterling Speirn's comments in committing $16 million dollars to the cause—and it is a cause—with the words: *"Training and placing dental therapists, under the general supervision of a dentist in underserved areas could help ensure that more families, particularly those who are most vulnerable, can access quality, affordable dental care. Oral health is essential to overall health, yet too many Americans go without needed dental care. The dental therapy model, which has been successful internationally and here at home in Alaska can help us address this glaring gap and increase racial equity in dental care."*

The W. K. Kellogg Foundation, in making the commitment it has made to the supporting the innovation of pediatric oral health therapist's caring for America's children, has extended its legacy of concern for the oral health of our kids. This conference is a time for us to recognize the courage and generosity of the W. K. Foundation as well as to applaud the legacy of innovation that is its hallmark. It is a time for us to draw strength for the challenge that lies before us as we work with Kellogg to realize the dream that exists for all of us in addressing the unmet oral health care needs of America's children.