Testimony: Dana Marie Obey

Vice President, American Dental Therapy Association
Tribal Oral Health Sovereignty Act — H.R. 10751
House Natural Resources Committee, Subcommittee on Indian & Insular Affairs
November 19, 2026

Good morning, Chairman Hurd, Ranking Member Leger-Fernandez, and distinguished Members of the Subcommittee.

My name is Dana Marie Obey. I am an enrolled Tribal citizen of the Sault Ste. Marie Tribe of Chippewa Indians, a practicing dental therapist serving the Bay Mills Indian Community on the Upper Peninsula of Michigan, and Vice President of the American Dental Therapy Association.

I am honored to testify on behalf of ADTA in support of H.R. 10751, the Tribal Oral Health Sovereignty Act.

Today, I want to speak about three interconnected issues: the oral health crisis facing American Indian and Alaska Native communities, the proven contributions of dental health aide therapists, and the importance of respecting Tribal sovereignty and the federal government's trust and treaty responsibilities.

Oral Health Disparities and Workforce Shortages

Across Indian Country, American Indian and Alaska Native communities continue to experience disproportionately high rates of untreated dental disease, tooth loss, and barriers to essential oral healthcare.

Indian Health Service has documented that more than 80% of five-year-old American Indian and Alaska Native children receiving care through IHS and Tribal dental clinics have experienced tooth decay, which is much higher than the national average.

These disparities reflect longstanding shortages of oral healthcare professionals, geographic isolation, inadequate resources, and barriers to accessing timely preventive and restorative treatment.

Workforce shortages also place significant pressure on existing Tribal dental teams.

When clinics cannot recruit and retain enough providers, dentists, hygienists, assistants, and other oral healthcare professionals must manage growing treatment backlogs, urgent dental needs, and increasingly complex cases.

These conditions contribute to stress and burnout and make workforce retention even more challenging.

For patients, the consequences can be devastating.

A cavity that could have been treated early may progress into an infection, an extraction, or an emergency department visit.

Emergency departments often cannot provide definitive dental treatment, leaving patients with temporary relief but without resolution of the underlying disease.

For Tribal health systems and the federal government, this represents an opportunity to improve health outcomes and make better use of limited healthcare resources by investing in prevention and timely treatment.

The Indigenous Origins of Dental Therapy in the United States

The history of dental therapy in the United States is inseparable from the history of Alaska Native healthcare and Tribal self-determination.

The Community Health Aide Program was established in Alaska in 1968 to address severe healthcare access challenges in rural Alaska Native communities.

CHAP created a community-based workforce model in which trained health aides could provide essential services close to home, supported by education, certification, clinical supervision, and quality assurance.

In the early 2000s, Alaska Native Tribal health leaders built upon this model to address critical oral healthcare shortages.

The first Alaska Native dental health aide therapists completed their education in New Zealand in 2004 and returned to serve their communities.

A domestic dental therapy education pathway was subsequently established in Alaska.

This history matters.

Dental therapy in the United States was not developed because traditional healthcare systems had successfully met the needs of Tribal communities.

It was developed because Alaska Native communities needed another way to deliver care.

Tribal leaders recognized the need, invested in their own workforce, and developed a system designed around the realities of their communities.

The model was grounded in community needs, culturally responsive care, and the principle that Tribal nations should be able to participate meaningfully in determining how healthcare is delivered to their people.

A Qualified Workforce Supported by Research

Dental health aide therapists are educated and clinically trained to provide a defined range of preventive and restorative dental services.

We practice within established certification, supervision, and scope-of-practice requirements.

Our scope is limited by law and regulation, but those limitations should not be mistaken for evidence that dental therapists lack the education or clinical competence to perform the procedures for which we are trained.

Research conducted in Alaska Native communities has demonstrated the contributions of dental health aide therapists.

A ten-year study of communities in Alaska's Yukon-Kuskokwim Delta found that greater DHAT service availability was associated with increased preventive dental care and fewer extractions among children and adults.

Additional research found that greater DHAT availability was associated with fewer emergency dental consultations.

Clinical evaluations have also supported the ability of appropriately trained dental health aide therapists to provide competent care within their defined scope.

These findings are important because they come from Tribal health systems serving Alaska Native communities.

They demonstrate how community-based workforce models can improve access to care and help address oral disease before it becomes an emergency.

Dental therapists are not a replacement for dentists.

We strengthen the oral healthcare team, expand clinical capacity, and help dentists and other providers focus their time and expertise where they are most needed.

For communities experiencing chronic workforce shortages, that additional capacity can make a meaningful difference.

Tribal Sovereignty and the Federal Statutory Barrier

Despite the demonstrated contributions of dental health aide therapists, federal law continues to restrict their implementation through the national Community Health Aide Program.

When Congress authorized national CHAP expansion through the 2010 reauthorization of the Indian Health Care Improvement Act, it retained a provision generally requiring state permission for dental health aide therapist services outside Alaska.

This means Tribal nations seeking to use this component of a federally authorized healthcare program face an additional state-law barrier.

This is not a restriction arising from a demonstrated failure of DHAT clinical safety or competence.

It is a statutory restriction that affects the ability of Tribal governments to determine how to meet the healthcare needs of their communities.

Tribal sovereignty is inherent. It predates the establishment of the United States and is recognized through federal Indian law and the government-to-government relationship between Tribal nations and the federal government.

The United States also has longstanding trust and treaty responsibilities to Tribal nations.

Although individual treaty provisions vary, these responsibilities provide important context for understanding why Tribal self-determination in healthcare matters.

Requiring state legislative authorization for DHAT services within a federally established Tribal health program raises fundamental concerns about the extent to which Tribal nations can exercise meaningful authority over their own healthcare systems.

Tribal governments should be able to develop and implement healthcare workforce solutions that reflect their communities' needs while maintaining rigorous standards for patient safety and clinical oversight.

CHAP Expansion and the Need to Address the Restriction

CHAP has an established history in Alaska, and Tribal organizations in the Pacific Northwest have developed regional certification and education infrastructure.

Other Tribal health organizations are now advancing CHAP implementation.

In September 2026, the Indian Health Service announced $2.3 million over three years in awards to four Tribes and Tribal organizations to support national CHAP expansion.

These investments reflect the continued importance of community-based healthcare workforce development in Indian Country.

Yet the federal DHAT restriction remains.

The federal government is supporting CHAP expansion while maintaining a statutory condition that limits Tribal nations' ability to implement dental health aide therapy through that program.

The Tribal Oral Health Sovereignty Act would address this restriction while preserving requirements for certification, training, supervision, scope of practice, and continuing education.

It would recognize the ability of appropriately certified dental therapists to provide services within qualifying Indian health programs under the standards specified in the legislation.

My Experience as a Tribal Citizen and Dental Therapist

For me, this issue is deeply personal.

By the time I was 18, I had visited a dentist only three times. I had a cavity in every one of my adult teeth.

Once I gained access to oral health education, basic hygiene supplies, and the knowledge to care for my teeth, my oral health changed.

I have not developed another cavity since.

That experience shaped my understanding of the importance of prevention, education, and access to timely care.

Today, I practice on the Bay Mills Indian Reservation, where my patients are my neighbors, family members, and friends.

I understand many of the barriers they face because I have experienced those barriers myself.

My work is about more than treating dental disease.

It is about helping children avoid preventable pain, supporting families in preserving their natural teeth, and building relationships that encourage people to seek care before an emergency develops.

It is also about demonstrating to Native youth that they can pursue careers in healthcare and return to serve their own communities.

When Tribal nations invest in educating and training their own people, they create opportunities to strengthen their healthcare systems and develop a workforce connected to the communities it serves.

Closing

The American Dental Therapy Association was founded by pioneering dental therapists whose work was rooted in the early Tribal dental therapy movement.

Today, our association supports dental therapists across Tribal, federal, and state-authorized healthcare systems.

We recognize that the history of this profession began with Indigenous communities identifying their own healthcare needs and developing solutions to address them.

That history should not be forgotten as the profession continues to grow.

We have a qualified workforce. We have research from Alaska Native communities demonstrating improved access to preventive care and better oral health outcomes. We have Tribal nations seeking solutions to longstanding workforce shortages.

For American Indian and Alaska Native communities, this is more than a workforce issue. It is about whether Tribal nations have meaningful authority to determine how healthcare is delivered to their own people.

It is about preventing avoidable disease, supporting an overburdened workforce, and using limited federal and Tribal healthcare resources responsibly.

And it is about honoring the principles of Tribal sovereignty and self-determination that are fundamental to the relationship between Tribal nations and the United States.

On behalf of the American Dental Therapy Association, I urge the Subcommittee to support the Tribal Oral Health Sovereignty Act, HR 10751.

Thank you for your consideration and for the opportunity to testify. I am happy to answer any questions.