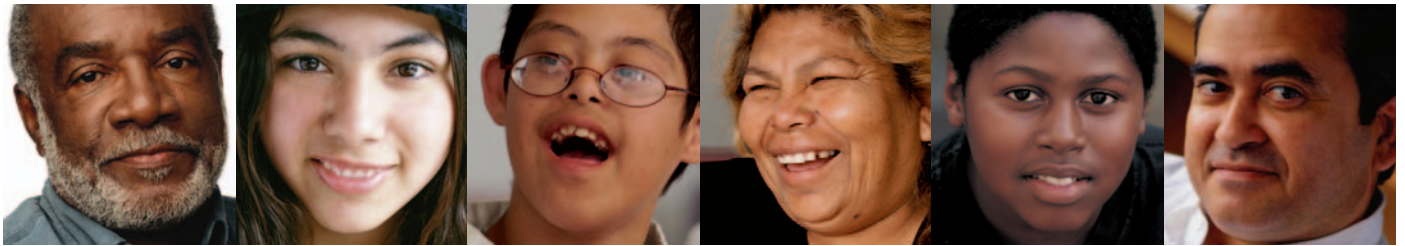


POLICY ISSUES IN DENTAL WORK FORCE DIVERSITY AND COMMUNITY-BASED DENTAL EDUCATION



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TABLE OF CONTENTS

INTRODUCTION.....	1
METHODOLOGY.....	2
PERSPECTIVE	2
I. CONSTITUENCY REVIEW	3
II. GAPS IN KNOWLEDGE	11
III. CONCLUSIONS: STRATEGIES TO ADVANCE COMMUNITY-BASED DENTAL EDUCATION AND RECRUITMENT OF MINORITIES	12
APPENDIX A: NCSL INTERVIEW PROTOCOL.....	A-1
APPENDIX B: ENACTED ORAL HEALTH LEGISLATION BY TOPIC (2002-2004).....	B-1
APPENDIX C: RELEVANT ORAL HEALTH LITERATURE REVIEW.....	C-1

INTRODUCTION

This report is in response to a charge from The California Endowment — a co-sponsor of a major initiative called Pipeline, Profession and Practice: Community-Based Dental Education — to identify policy issues surrounding community-based dental education and diversity of the dental work force. The Endowment requested a policy and constituency review and an analysis of strategies for moving those policies forward.

The publication includes the interview protocol (questions), a review of oral health legislation (2002-2004) as well as a review of the literature related to dental and oral health practice.

METHODOLOGY

The National Conference of State Legislatures (NCSL) gathered data in several ways. Using a national database, we conducted a review of legislation enacted in the last two years across the nation to identify trends in how other states are addressing dental work force shortages, including licensing, scope of practice and supervision for other dental professionals, loan repayment programs and other initiatives. An appendix of legislation by topic is attached.

We conducted an extensive “constituency review” to gauge attitudes and political support for specific policy initiatives. To do so, we developed an interview protocol (attached) that was reviewed by The California Endowment and the Pipeline program directors. The protocol was used to conduct interviews either over the telephone or in person with 20 policymakers (elected officials, legislative staff, state agency officials, officers, board members or top executives of provider and advocacy groups), and 15 officials at state dental schools (deans and officials in charge of admissions and/or diversity or recruitment) between May and late July 2004. While those interviewed are not all equally influential, they are key players and could speak for the groups that move oral health policy forward in the state. Approximately five more interviews were scheduled and rescheduled, but were not successfully completed due to excessive demands on policymakers' time during the legislative session. Interviews lasted between 25 and 60 minutes. Responses were not recorded, but detailed notes were taken via computer during calls, or entered from notes soon afterward. Not all those interviewed answered all questions, either because of time constraints or because they had no opinions on some questions. To ensure comprehensive and candid responses, NCSL promised that the interviews would remain confidential. Therefore, no one is quoted by name or by any other identifying characteristics.

Constituency groups interviewed include: The California Chapter of the American Academy of Pediatrics, the California Chapter of the American Academy of Pediatric Dentistry, the California Area Health Education Centers, the California Dental Association, the California Department of Maternal and Child Health, the California Office of Oral Health, the California Office of Rural Health, the California Office of State Health Planning and Development, the California Primary Care Association, the California Rural Health Association, the Dental Health Foundation, Family Voices, the California State Legislature (legislators and senior legislative staff), State Board of Dentistry (board member and executive staff), Medi-Cal, the U.C.S.F. Center for Health Workforce Studies and multiple officials at each of the state's dental schools.

PERSPECTIVE

NCSL is a bipartisan organization that represents all state legislators around the country. NCSL has no policy on work force diversity or community-based practice in dental education. The views expressed in this report are based on the data gathered and analyzed during the course of the project and do not reflect NCSL policy.

I. CONSTITUENCY REVIEW

THE SUPPLY OF DENTISTS

Despite a palpable sense of unease with poor access to dental care, there is no shared perception of a current shortage of dentists in California. While people acknowledged there are serious access problems, there was no agreement on a shortage of dentists as the cause. Although fully 33 percent of California's dentists are over age 55, and another 31 percent are between the ages of 45 and 54, only one person mentioned an impending shortage. This person, a state official, said, "As the population increases and baby boomers retire, the dentist to population ratio will decline. Now we have access problems for low-income, disabled and elderly populations. Just wait until people in the suburbs can't get a dental appointment. Then things will change."

Fully 33 percent of California's dentists are over age 55, and another 31 percent are between the ages of 45 and 54. (Source: American Dental Association, 2000.)

There is, however, a strong consensus that there is a maldistribution of dentists, and a shortage of those who take care of low-income and rural residents, people with special health care needs, and children. Pediatric dentists were mentioned as being in particularly short supply. Several respondents commented they had not seen any data or information, objective or otherwise, from government, provider groups or research centers, to inform their decision on the question of a shortage. While a number of people interviewed were in positions where they would normally be expected to have seen information on supply, distribution and recommended ratios for dentists to population, none had. The question seems not to have been raised in broader policy discussions of access difficulties, or, if it has been, attention has been diverted elsewhere. These answers were consistent across the spectrum of political views and positions; officials in dental schools, the legislature and advocacy and provider groups were likely to voice similar opinions.

According to the Center for California Health Workforce Studies, in 2000, there were approximately 23,000 clinically active dentists practicing in California. The ratio of dentists-to-population in California is 65 per 100,000, which is higher than the national average of 58. However, there are 68 federally designated dental health professional shortage areas in California, and 16 rural counties that are underserved by Denti-Cal. There are 3 million California residents who are underserved for dental care, and up to 9 million who have untreated dental disease. (Source: Mertz, et al, "Evaluation of Strategies to Recruit Oral Health Providers to Underserved Areas of California," January, 2004.)

STATE ROLE IN DIVERSIFYING THE WORK FORCE

Although there is broad general support for a state role in diversifying the dental work force, there are a few firm dissenting views from powerful, visible policymakers and little consensus among supporters about what the state should do to achieve it. Many people feel that the state should support initiatives that expand the pool of qualified minorities who are interested

in and qualified to become dentists, such as: career development for minorities; bridge programs that prepare them for professional education programs; and promotion of dentistry as a career. One person observed that, “regardless of whether or not state involvement is justified, without it the dental work force will never become diversified.” Even if there were a consensus, the methods to use to achieve diversity goals are not clear. Proposition 209 was mentioned by a number of educators as a barrier which severely limits what public dental schools can do to promote attendance by under-represented minorities.

In the post-Proposition 209 world, the University of California (UC) system now uses a multipronged approach that defines diversity in a broad sense and attempts to expand the number of students eligible for college. It employs a "comprehensive review" process, reading all applicants' essays and looking at their achievements in the context of their opportunities and experiences, including socioeconomic status and family education. Although the U.S. Supreme Court, in reviewing the system used by the University of Michigan Law School, said that a state can choose to use race in the admissions process, California has chosen not to. To broaden admissions and sweep in eligible minorities, UC undergraduate programs automatically admit the top 4 percent of students at each high school.

How dental schools have adapted is less clear and systematic. Dental educators described the following factors in considering students' applications: a student's status as the first in his or her family to go to college; community service or Peace Corps experience; strong commitment to care for underserved groups; economic hardship; and community or culture of origin. Although none of these factors are proxies for race or ethnic background, they are intended to help identify and give a higher weight to applications from disadvantaged students, whether or not they are from a racial or ethnic minority. More than one educator considered diversity in dental education an institutional issue and not a policy issue, while at the same time pointing out that availability of financial aid for low-income students from the government, coupled with diversity goals, was needed to achieve even modest diversity goals.

There was some cynicism in answers that involved a possible state role in diversifying the dental student body, since state funding has been steadily diminishing as an overall percentage of school resources. With greater state support for financial aid, high student debt, which presents a daunting barrier for low-income students, could be lowered. A few educators commented that in the post-Proposition 209 world, the demographic make-up of dental school classes has become more heavily skewed towards Asians, with the same persistent problem of too few African Americans and Hispanics. One person noted, “Out of 34 million people, we have no majority population group. Hispanics will be a majority by 2010. We need cultural competency and more providers.”

Two of those interviewed, who said the state has no role in diversifying the dental work force, feel it is sufficiently diverse already, even if the demographics do not mirror the population. One policymaker said, “I don't see the problem. Look at the names of the students in school and they reflect everything. I get calls (from dental students) and I can't even understand people. It's already pretty diverse.” One influential policymaker felt strongly that the state's interest is best served if dental schools admit the best possible dental students, no matter what their racial, ethnic, geographic or economic background, and that “going for diversity

leads to divisiveness.” Another policymaker who supported the state's role in promoting diversity felt the goal was to admit students who wish to practice in underserved areas and treat people with special needs, not more students of a particular race or ethnicity.

Of those who feel the state should have a role in diversifying the dental work force, the main reason is the substantial public investment in dental schools and the obligation that arises from it to achieve public goals. Several others vented frustration in that dental and other professional schools have tried for years to attract more qualified minorities, without great results. One educator said, “They can't go out and drag dentists in. It's the educational system we need to change to develop a more diverse work force.

Probably (we have to) go out to minority districts to advertise dentistry as a career. But with what money?” A number of people mentioned the successful post-baccalaureate program model at UCSF which provides training for underrepresented minorities, who afterwards enjoy close to a 100 percent admittance rate to dental schools.

The possible reasons the state should work towards a diverse dental work force were not delineated by anyone interviewed, which either means there is a consensus or that people make a variety of assumptions. Affirmative action has long been seen as a way to remedy past discrimination in all walks of life: education, housing, employment and health care. Those arguments have been refuted in voter-driven initiatives, such as Proposition 209, and complicated by court decisions overturning the use of quotas in education.

However, there is concrete evidence in the research literature about the effect of a diverse dental work force on the patient population. Put more clearly, minority dentists are more likely than white dentists to see minority patients. Given the evidence, it is safe to say that a more diverse dental work force would ease access barriers for minority and underserved patients.

When asked to outline their organization's policy agenda, not one person included increasing the diversity of the dental work force. Each person was then specifically asked if their organization was working on this policy issue, and only one said yes, but indirectly, through the work of the Oral Health Access Council (OHAC). The OHAC work on this issue is spearheaded by one person, and the project in question hinges on funding for a

According to the Center for California Health Workforce Studies, fewer than 7 percent of active dentists and 15 percent of dental hygienists are Hispanic or African American, compared to 40 percent of the population. (Source: FN, Mertz, *op.cit.*)

One study showed that 76.6 percent of the patients seen by white dentists are also white, compared to 27 percent of patients for black dentists and 43.6 percent for Hispanic dentists. The patient load for black dentists is 73 percent minorities, and for Hispanic dentists is 69.4 percent minorities. Asian dentists, who are the largest minority group in dental schools in California, see 52.3 percent minority patients. (Source: FN, Brown, L.J. et al, *JADA*, Vol. 131, Dec. 2000, p.172.)

survey. There are many related policy issues that rank higher on many organizations' policy agendas, such as continued funding for adult dental benefits in MediCal, access to services in rural areas, and a number of scope of practice and licensing issues. Dental educators, by and large, did not describe policy agendas in the same terms as other people interviewed. Employees of state colleges or universities may work with elected officials but do not lobby, and therefore may have underplayed policy activities. While every educator interviewed discussed activities to diversify their student body, they couched them in institutional rather than policy terms.

CURRENT LICENSING RULES

Many people interviewed had strong opinions about California's licensing process for dentists, although not all along the same lines. There are both educators and policymakers who feel that state dental boards operate purposefully to restrict movement of dentists between states, particularly from bad weather to good weather states, rather than to guarantee quality of care and patient safety as they claim. Many respondents feel dental school graduates should be able to take the Western Regional Exam, or any regional exam, because the California exam has been designed to be overly difficult in order to limit the supply and keep competition to a minimum. There were several people who felt that using live patients in licensing exams is unethical, and more than one who felt that clinical licensing exams should not be given at all because successful graduation from an accredited four-year dental school is a much clearer indication of competency than a single clinical exam.

There was cautious support expressed by some people for having the State Dental Board certify more foreign dental schools so their graduates can sit for the California exam. Concerns voiced were about the slow pace of certification and the length of time it takes for foreign schools to make up any deficits. A number of people felt that allowing foreign dentists to sit for the exam is not a promising way to go because of the great variety in quality and content of foreign schools, setting aside concern about graduates' English fluency. Dental schools that offer two-year remediation programs derive a significant amount of income from foreign students, which may alter educators' perception of the value of these programs and their role in increasing supply and diversity of the dental work force. One educator called these programs a "cash cow for universities," and another said the programs are "inflexible and do not reflect the differing needs of foreign students," many of whom do not need, but are required to take two years more schooling. One person said foreign students have a low pass rate even after attending remediation programs, while an educator observed that most return to their home countries anyway; both argued that this is an unpromising mechanism to achieve diversity in the state's dental work force.

According to the State Board of Dentistry, 860 licenses have been granted to out-of-state dentists since licensure by credential was enacted in California in 2003. A report to the Legislature on their practice choices is due in December 2004. A questionnaire sent to them shows that of the 628 who responded to a questionnaire, only 91 are practicing in California. Of those 91, 15 are practicing in dental professional shortage areas, and two more are in frontier areas that may also be shortage areas. Many of these obtained a license by contracting with an agency that treats underserved people. (Source: FN, *Conversation with State Board, October 2004.*)

Aside from certifying foreign schools, there was no support for changing rules to license “unqualified” dentists from other countries as a way to achieve diversity, nor for the demonstration program that would have allowed dentists from Mexico to practice for a limited time in public health settings and heavily Hispanic areas in Southern California. Concerns over this approach were strongly worded, voiced by both educators and policymakers, and centered around establishing a lower standard of care for minority and low-income patients and creating a perception in those communities that they are getting second-class care.

Several policymakers and educators asserted that the State Board of Dentistry is underfunded and understaffed, which has caused significant delays in administering and grading exams and doing other business in a timely manner. Several educators were worried that the new law allowing licensure by credential and certifying foreign dental schools would create a two-tier system of care in California. According to a policymaker, one impetus behind this policy change was the hope that many will locate in rural and underserved areas of the state. Dentists licensed this way are not required to locate anywhere, but must report their practice site to the State Dental Board. One person said “licensure by credential allows dentists and hygienists to come to California more easily from other states, but they have their own shortages.”

ARE OTHER SERVICE MODELS NEEDED?

Almost everyone interviewed agreed that the dental safety net is inadequate and there needs to be alternative approaches to delivering dental care to underserved populations. One person commented that if dental care were properly financed, no alternatives would be needed. Another said that community health centers were the alternative model and no new ones needed to be considered. About one-third of those interviewed agreed that if there were enough federally qualified health centers with dental components, and they were properly funded, the discussion would be over. Other than that, everyone had ideas about what approaches should be considered in the mix, and in what proportion. Several people said that financial incentives, such as loan forgiveness programs, are needed. Three educators said that “PGY-I,” a requirement for one post-graduate year of work in a community-based setting, was the alternative service model that would go the farthest to solve problems.

The idea that got the broadest support by far, from fully half of those interviewed, both educators and policymakers, was using dental auxiliaries to remedy access shortfalls. Most people thought the state should expand the scope of practice—even to include simple restorative procedures—and loosen supervision requirements for dental hygienists. Others sought more autonomy and expanded functions for dental assistants, and several wanted to explore the use of new dental mid-level practitioners. Several people also supported using medical professionals such as pediatricians and nurses to deliver preventive services, such as fluoride varnishes and education. One person said that parents should be given more education about preventing dental disease among their children. Another person commented that new service delivery models were not needed: “We are already doing them; the hard thing is making alternatives profitable when Medicaid doesn't pay.”

Of those interviewed, non-dentists and state officials were the most likely to support expanding access to care for underserved groups by broadening scope of practice and loosening

supervision rules for hygienists and assistants. With respect to a new type of mid-level dental provider, one mentioned as a promising model the community health aides that will soon be used in Alaska tribal areas after a two-year training program in New Zealand that mirrors the last two years of dental school. (These are not to be confused with community/lay health workers or promotoras who do case management or education and outreach.)

The American Dental Hygiene Association (ADHA) passed a resolution this summer supporting the creation of an advanced dental hygiene practitioner who would provide diagnostic, preventive, restorative and therapeutic services directly to the public. It is unclear exactly how closely this new type of professional resembles the New Zealand model. The American Dental Association (ADA) has mobilized at the federal level to fight the use of community health aides in the Indian Health Service across the country and, if history is any guide, is likely to oppose ADHA's initiative at the federal and state levels. At the House of Delegates meeting on October 1, 2004, the ADA considered a resolution opposing the ADHA proposal, then voted to establish a task force to study the issue at the request of the new president, Dr. Richard Haught, an access advocate. While the ADA-elected leaders and executive staff are currently very interested in working to increase access to care, they have traditionally opposed any non-dental professional performing diagnosis of dental diseases, irreversible procedures or restorations.

Colorado, which gave hygienists the authority to establish independent practices in 1987, has seen relatively few pursue it. The ADA and ADHA both estimate that about 25 hygienists are currently in independent practice in Colorado. *(Conversation with Tim Lynch, ADHA, October 2004.)*

In supporting expansions for non-dental professionals, caveats emerged. One person noted that in Saskatchewan, new auxiliaries with expanded functions caused the few dental practices still left in rural areas to close because there was no longer enough business to support them. Another said that because of concerns about quality and comprehensiveness of care, the best use of dental auxiliaries in underserved areas is as dental “extenders” for dental practices, not as independent practitioners. Yet another said, “independent practice for dental hygienists won't help anything because very few of them are interested in this type of practice.”

Most ideas discussed were for rural rather than urban underserved areas. There was significant support for expanding school-based services, and for using mobile vans and units that can be used in nursing homes, group homes and other settings to serve elderly and disabled patients. State oral health directors cite many pros and cons involved with mobile vans, but they are useful in sparsely populated rural areas that cannot support a dental practice full time. They are expensive to purchase and outfit, and incur significant costs for energy hook-ups and waste disposal. They are also challenging to staff consistently, and patients do not necessarily have continuity of care or a dental home.

One person discussed the unique, hard-to-meet needs of mentally disabled or emotionally disturbed patients, many of whom need to be sedated in hospitals to receive care. Even insured families have difficulty accessing care for these people because of the scarcity of

dentists who have training or experience to care for them and a common insurance rule that is peculiarly unsuited to special needs people. Prior authorization requirements for both Medi-Cal and private insurance generally necessitate a diagnosis before use of general anesthesia and hospital care. However, for many special needs patients, anesthesia is needed in order to even be able to examine a patient and make a diagnosis.

POST GRADUATE YEAR I

During interviews, people were asked to discuss the pros and cons of requiring dental school graduates to complete one year of post-graduate training in lieu of taking the clinical exam. This idea is clearly still controversial: Not quite half of the people who gave an opinion support the concept of PGY-I. 15 of 29 answers were largely supportive of the proposal, six were unsupportive and eight saw both pros and cons. The primary reason for supporting the idea seems to be that an additional year of supervised practice would make a better dentist with increased clinical competency. Only one person specifically mentioned this would be an attractive option to get more dentists into underserved communities. (However, two more people mentioned PGY-I as an alternative model of practice in response to an earlier question.) The main concerns that led people to oppose PGY-I were that it would delay new dentists' entry into the dental work force, thus exacerbating shortages, and present an added barrier for low-income students who need a higher income stream more quickly to repay loans.

One person asserted that PGY-I might allow more care to be provided in underserved areas in the short term, but would persuade more people not to locate in those areas long term because the delay in entering private practice would increase pressure to make a high salary to pay debts. Several of those who oppose the idea said that, while another year of supervised practice would be likely to increase the quality of care those dentists could provide, *quantity* of dentists, not *quality*, is the problem. One person dismissed the idea as merely a financial boon to dental schools. Quite a few questioned whether a year of post-graduate training without an exam is sufficient to guarantee quality of care and weed out incompetent dentists, particularly with the variety of practice sites and supervision that students would have during their year. Other implementation barriers mentioned, primarily by educators who were more likely to have considered them, include limited funding for graduate dental education, too few slots for the number of graduates, and a shortage of qualified clinical preceptors. Four people thought it would be a good idea, but only on a voluntary or pilot basis to avoid saddling indebted students with another year of low earnings and forcing them into a type of practice they might not otherwise choose.

REQUIRING COMMUNITY-BASED PRACTICE BEFORE LICENSING

Those interviewed were also asked to discuss the pros and cons of requiring dental school graduates to complete one year of practice in a community-based setting before they could sit for their licensing exams. This is the option taken in Delaware, which requires one year of post-graduate residency (or three years in practice in another state) before a dentist can sit for the state clinical exam. While no other states have this exact requirement, one year of post-graduate residency can be substituted for passing the state clinical exam in Minnesota.

Among California policymakers, there was less support, more confusion and there were more conflicting viewpoints between dental educators and other policymakers regarding this option than PGY-I. 13 people out of 30 who answered the questions supported the idea, while six opposed it, some strongly, and 11 had mixed feelings about it. Two people assumed this was not a different option, but simply another way of describing PGY-I, and did not understand that completing a PGY-I means students do not have to sit for a clinical exam. The same basic pros and cons were mentioned for this as for PGY-I: participating dentists would strengthen their skills, more care would be delivered to underserved areas, but the extra year would make the pipeline longer and delay dentists' entry into the work force at a time when graduating students have increasing debt burdens. One person involved in safety net health care delivery was concerned that patients would perceive students completing their year in a community-based setting as less qualified than licensed dentists. An influential policymaker who supports piloting PGY-I absolutely rejected the idea, calling it "slave labor."

Among people who presented mixed views on the matter, several said it would be an acceptable policy if sufficient funding were available for salaries and loan repayment, as well as an adequate number of accredited slots and qualified supervisors. Another said a good selling point is that "service in communities would help change the culture of the profession." Two people said it would be unfair to take away dental graduates' freedom of choice, and that they anticipated huge opposition to the idea from dentists. One questioned whether there really would be a positive impact on the community in the quantity of dental care delivered. Two educators said there would be no way to implement this proposal without a way to make up revenues that would be lost to dental schools as a result.

SHOULD DENTAL SCHOOLS RECRUIT MORE QUALIFIED MINORITIES?

While there was general support for the idea that dental schools should do more to recruit qualified minority and non-traditional students, there were many concerns and a few solidly opposed to the idea. One person thought the question (about altering admission policies to admit more qualified minorities) implied that dental schools would have to lower their admission criteria, which she found insulting. Two others reiterated their feeling that current dental students are sufficiently diverse already, and a number of educators said they are already doing all they can within the limits imposed by tight budgets, too few qualified minorities and Proposition 209.

Educators and policymakers alike supported the need for outreach and career promotion to get more minorities interested in dentistry as a career, although there was not much optimism about sources of funding to support these activities. Three policymakers opposed the idea because dental schools should recruit the best possible students, or those who will make the best dentists, regardless of color, ethnicity or background. Two went as far as to say changes in dental school admission standards to admit more minorities would be unacceptable because they would deprive someone else of a slot. One policymaker bemoaned the loss of a sound strategy to replace affirmative action, saying, "Legislators with diverse backgrounds are afraid to tie an initiative to poor background or socioeconomic factors. They are still stuck on trying to achieve affirmative action."

SHOULD DENTAL SCHOOLS RECRUIT MORE RURAL STUDENTS?

While most people supported the idea that dental schools should make an effort to recruit students from rural areas, many asserted that there is no evidence it makes a difference in where graduates locate their practices. One person commented “The real issue isn't where they're from but where they go.” An educator said, “Students don't usually go back to rural areas. I have some big city kids going to semi-rural areas. Gradually, the dental population is filtering out through the laws of supply and demand. It just takes having enough dentists to do that.” Two people opposed the concept, and one explained, “Dental schools should set a standard that is equally applied to all individuals, and where they are from should have nothing to do with it. I want to know when I walk into the dental office that the students were the best they could get.”

II. GAPS IN KNOWLEDGE

Many gaps in knowledge and needs for data were identified, although several people said the real problem was not lack of information, but lack of political will to address oral health disparities. Some mentioned gaps in information that others said were available, such as needs assessments and caries rates. One person complained that the State Dental Board has been unwilling to allow their licensing database to be used to gather information about the work force. One policymaker said “From a data perspective, the biggest roadblock is in politics. What information is out there points to serious problems. Most fixes require money and it isn't available, and there are only so many times you can go to the private sector and foundations when many people believe those are the state's responsibility. Most legislators do not care if the information is 2 or 5 or 10 years old because it continues to show the same problems. Legislators aren't willing to raise or divert money. Oral health isn't catchy. People do not die from dental problems. It does not have the immediacy or crisis mentality you encounter in other health areas.” Another policymaker said, “We've made the fiscal arguments, the disproportionate impact arguments. It's hard to know what will work at this point. There is a strong philosophical feeling among Republicans that government ought not to be doing these things.” The following is a consolidated list of ideas mentioned.

NEEDS ASSESSMENTS

1. A needs assessment should be done for children and adults every five years. The needs assessment should include treatment, prevention and early intervention services.
2. Data is needed on the incidence of caries, particularly among children, the underserved and low-income groups.
3. There is a lack of county and local, rather than state, data on needs (particularly among adults).
4. Data is needed on the actual and perceived barriers to dental care among underserved people, plus their actual use of services.
5. The Health Plan Employer Data and Information Set (HEDIS®) should be collected on dental outcomes to measure quality of care delivered.

WORK FORCE

1. There were many requests for information about dentists in California, including their demographic profile, practice locations and areas served, geographic distribution, sites of multiple offices, specialties, education source, participation in Denti-Cal, population served (particularly underserved groups), hours and days worked and number of allied personnel employed.

2. Data is needed on the supply of dentists, dental specialists, hygienists and assistants. Future projections are also needed.

SAFETY NET

1. The number, quality and content of dental encounters in dental clinics should be examined.
2. Data is needed on the capacity of the safety net to absorb placement of PGY-I residents, the patient population students would be handling, funding streams to support such training, and the willingness and ability of local providers to serve as preceptors.

PROGRAM EVALUATIONS

1. Studies are needed that show the cost-effectiveness of solutions, the savings gained from investing in prevention and program evaluations that demonstrate whether solutions to problems really work.
2. Data is needed that shows that if Denti-Cal fees increased, services would increase and access would improve.
3. Objective information is needed on fraud and abuse in Medi-Cal and Denti-Cal.

DENTAL EDUCATION

1. Data should be gathered on which underrepresented minorities aren't enrolling in dental school because of tuition hikes.
2. A study is needed that compares state subsidies by dental school with what service to the underserved each school provides.
3. Research is needed that shows whether dental students recruited from rural areas return there to establish practices.
4. Data is needed on the perceptions of dentistry as a career among disadvantaged youth.

III. CONCLUSIONS: STRATEGIES TO ADVANCE COMMUNITY-BASED DENTAL EDUCATION AND RECRUITMENT OF MINORITIES

It is clear from this constituency review that the Pipeline Program is out ahead of the oral health policy community. While there is broad general support for increasing the diversity of the dental work force, there is no consensus on the specifics of how to achieve it or if the state should take the lead. Some of the approaches to increasing dental work force diversity licensing foreign dentists, the Pilot Program that would have brought Mexican dentists into Southern California, and admissions policies that smack of affirmative action are controversial and elicit a few strong opposing views. Ongoing budget problems in California will present a huge challenge in garnering new resources for programs such as career development, bridge programs and outreach in minority communities. Scholarships for disadvantaged students might be an easier sell in Sacramento. Dental educators have already adapted their admissions policies in the post-Proposition 209 world to do the best job they can to admit a diverse pool of dental students without running afoul of legal limits. Evidence that minority dentists see more minority patients than their white counterparts is not widely known and might build support for diversity efforts. However, it might not matter to policymakers who oppose affirmative action in education on principle.

PGY-I is not as controversial as work force diversity, and is largely viewed as an education and service delivery mechanism rather than a way to change the work force. Support for the concept is not yet widespread, probably because the idea is still new to many. The major reason

people mentioned they support the concept is that it would increase the skill level of dentists, not that it would get more services to groups with poor access. Opposition to PGY-I is not strong and is centered around supply and implementation concerns that could be addressed more easily than serious philosophical differences. PGY-I has not yet been embraced by advocates for health centers and rural residents as a promising strategy to ease access problems for underserved groups. These advocates are pushing other mechanisms to remedy access problems for the underserved, and are an untapped source of support. One year of community service as a requirement before dental graduates can sit for licensing exams is not an idea that has gained much support, and a few powerful policymakers strongly oppose it.

STRATEGIES THAT ARE SUGGESTED BY ANALYSIS OF THE CONSTITUENCY REVIEW:

1. *Pursue a pilot project to test PGY-I in California.* There is sufficient support for it from all sectors of the oral health policy community, including legislators, to work with legislators and the State Dental Board to establish a pilot. Given the lack of evidence from other states about how similar programs are working, a pilot may be more feasible than a permanent change. Data requested on the capacity of the safety net to absorb PGY-I residents and other implementation issues would help spur development of a pilot.
2. *Replicate post-baccalaureate programs that have increased acceptance rates for minority students.* U.C.S.F.'s program was mentioned as a successful and cost-effective model for increasing the pool of qualified minority candidates. More such programs in California and other states would be an effective strategy to diversify the dental work force. Data on which underrepresented minorities aren't enrolling in dental schools because of tuition hikes, and perceptions of dentistry as a career among disadvantaged youth, could be used to support targeted program expansions.
3. *Study financing for community-based education to remove a potential barrier to PGY-I.* A task force or study group of dental educators, provider group representatives and clinic representatives could be convened to ensure that schools do not lose critical revenue in a pilot program and that training sites can be financially viable. Groups that may stand to gain or lose from PGY-I should be involved to build support and allay opposition based on financial concerns. Information on the funding streams available to support PGY-I residencies would help smooth the transition and forestall opposition from schools sensitive to diversions in revenue.
4. *Build awareness of and support for PGY-I among legislators and the oral health community.* There are many potential advocates in the oral health community who would support a pilot program for PGY-I, but who do not work on diversity or community-based education issues. Legislators and staff are mostly unaware but receptive to the idea. Education efforts are needed. Program evaluations about how similar programs have worked in other states would be useful in the effort.
5. *Work with organized dentistry at the state and local level on work force diversity.* Dentists have no ownership of this problem, and some do not see it at all. If enlisted, local dental societies might be the best recruiters of promising minority and disadvantaged students in nearby high schools and colleges, perhaps with activities during children's oral health month. Data on the perceived barriers to care among underserved people, plus data on the patient population of California dentists by race or ethnicity, would help build support among organized dentistry for diversity efforts.
6. *Focus on equal opportunity for disadvantaged students, rather than minority recruitment,* in seeking more state support for dental education, scholarships, post-baccalaureate programs or outreach to younger students. While parts of the policy community have not yet moved beyond affirmative action, state support for programs that increase minority participation is extremely unlikely. Data on the number of qualified minorities who are not enrolling in dental school because of the cost would help inform the debate over appropriate state support.

NCSL INTERVIEW PROTOCOL

EXPLAIN GROUND RULES ABOUT CONFIDENTIALITY OF RESPONSES AND TIME NEEDED FOR THE INTERVIEW.

1. What oral health policy issues is your organization working on?
2. What is your organization doing on dental education and diversity of the dental work force?
3. What are California's challenges in providing access to care for the underserved?
4. Is the dental safety net adequate? If not, please describe what you see as strengths and weaknesses.

What is your opinion?
 - a. Is there an overall shortage or maldistribution of dentists in California?
 - b. Should the state have a role in diversifying the dental work force in California? If so, what ?
 - c. Do current state licensing rules help or hinder the existence of an adequate supply of dentists in California? If so, how?
 - d. What should dental schools do to recruit underrepresented minorities?
 - e. What should dental schools do to recruit students from rural areas?
 - f. Does California need more alternative approaches to delivering dental care (other than traditional private practice) to underserved populations? If so, what approaches?
From your perspective, what are the pros and cons of the following policies and programs?
 - a. Altering dental school admission policies to favor admitting more (qualified) under represented minorities.
 - b. Requiring a dentist to have one year of post-graduate education in lieu of taking the state licensing examination.
 - c. Requiring a dentist to do one year of post-graduate training in a community-based setting in order to be licensed in the state.
 - d. The current demonstration project in California of using dentists from Mexico to deliver care in designated underserved communities.
5. How will California's current budget problems and the new administration influence dental education and access to care for the underserved?
6. What kinds of data are needed in California to support policy efforts to increase community-based dental education, improve the diversity of the dental health work force, and increase access to oral health care for underserved communities?
7. What other organizations in California are working on dental education, diversity of the dental work force, and access to care for the underserved issues?
8. Which California legislators work on oral health issues? What are their particular interests and concerns regarding oral health?

NCSL INTERVIEW PROTOCOL (CONTINUED)

ADDITIONAL QUESTIONS FOR DENTAL SCHOOL OFFICIALS

1. What are your recruitment goals for dental students?
2. Please describe the criteria you use for awarding financial aid.
3. Do you have a program to interest more youth from disadvantaged populations in dental careers?
If so, how does it work?
4. Do you have a program to recruit underrepresented minorities and low-income students?
If so, how does it work?
5. Do you have a program to recruit more students from rural areas of California?
If so, describe how it works?
6. Do you have a program to train more students in community-based and medically underserved settings?
If so, how does it work?
7. Do you have a program to provide postgraduate training opportunities in community-based settings in areas of high need?
If so, how does it work?
8. Do you have a program to encourage or assist graduates to find practice opportunities in settings that care for the underserved?
If so, how does it work?
9. What are the biggest barriers for your school in implementing these policies or programs?

APPENDIX B
ENACTED ORAL HEALTH LEGISLATION BY TOPIC (2002-2004)

2004

LICENSURE

CA AB 1467; AUTHOR: MCLEOD

Allows foreign-trained dentists to be eligible for licensure examination if they meet education and training requirements.

CA SB 928; AUTHOR: AANESTAD

Establishes licensure by credentials for dentists.

GA H 1141; AUTHOR: CHILDERS

Establishes licensure by credentials for dentists and hygienists.

MN H 2175; AUTHOR: ABELER

Establishes licensure by credentials for dentists.

DENTAL PROVIDERS' SCOPE OF PRACTICE AND/OR SUPERVISION REQUIREMENTS

CO H 1102; AUTHOR: CLAPP

Allows general supervision by dentists for dental hygienists and assistants.

IL H 4157; AUTHOR: SAVIANO

Allows general supervision for hygienists.

KS S 425; AUTHOR: SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Allows dentists to utilize unlicensed assistants for some services if trained in CPR.

RI H 7975 & S 2541; AUTHOR: SLATER & ALVES

Allows dentists to delegate approved dental procedures to hygienists.

ORAL HEALTH ACCESS/SERVING UNDERSERVED POPULATIONS

CT H 5636; AUTHOR: JOINT COMMITTEE ON PUBLIC HEALTH

Establishes a committee to investigate access to and quality of oral health care, including the consideration of a PGY-I in lieu of an examination for dental licensure.

HI S 2586; AUTHOR: BAKER

Provides informal community licenses for out-of-state oral health providers to serve in approved public health agencies.

ID S 1289; AUTHOR: SENATE HEALTH AND WELFARE COMMITTEE

Establishes dentist volunteer licenses.

KY H 321; AUTHOR: GRAHAM

Categorizes dentists as “charitable health care providers.”

UT S 1; AUTHOR: BLACKHAM

Increases Medicaid reimbursement rates.

VA H 1049; AUTHOR: HAMILTON

Provides temporary licenses to advanced dental students to provide services in public health settings.

2003

LICENSURE

AL H 43; AUTHOR: BEASLEY

Establishes licensure by credentials for dentists.

AR S 258; AUTHOR: BISBEE

Establishes licensure of foreign dentists by credentials.

ID S 1068; AUTHOR: SENATE HEALTH AND WELFARE COMMITTEE

Establishes licensing by credentials and endorsement.

IN S 340; AUTHOR: MILLER

Establishes licensing by credentials.

MD H 334; AUTHOR: DONOGHUE

Establishes licensing by credentials.

MN S 13A; AUTHOR: LOUREY

Waives clinical licensure examination for graduates who complete a one-year residency in accredited postdoctoral program.

MS H 1055; AUTHOR: MOODY

Establishes licensure by credentials for dentists and foreign-trained dentists.

NH H 617; AUTHOR: LANGLEY

Establishes licensure by endorsement for dentists and hygienists.

TX S 263; AUTHOR: NELSON

Establishes licensure and certification requirements for dentist, hygienists and assistants.

DENTAL PROVIDERS' SCOPE OF PRACTICE AND/OR SUPERVISION REQUIREMENTS

MD S 225; AUTHOR: HOLLINGER

Allows hygienists to practice under general supervision of dentist.

MI H 4356; AUTHOR: VANDER VEEN

Expands scope of practice for hygienists; expands assistants' scope of practice under direct supervision of dentist.

MN S 135; AUTHOR: LOUREY

Expands authority for hygienists who complete a board-approved course to perform certain procedures; provides collaborative agreement between dentists and hygienists with standard practice protocols.

NM S 453; AUTHOR: CAMPOS

Provides certification of a collaborative dental hygiene practice; creates a dental assistant license; provides requirements for licensure of dentists and hygienists.

NV A 489; AUTHOR: ASSEMBLY COMMERCE AND LABOR COMMITTEE

Authorizes a temporary license for hygienists licensed in another state who has practiced for five years without requiring an examination. After two years, they can apply for permanent licensure.

VA S 1090; AUTHOR: BOLLING

Allows certain dental services to be performed by a hygienist under a dentist's general supervision.

WA S 5966; SPONSOR: DECCIO

Allows dentists with valid out-of-state licenses to be granted an in-state license without an examination.

ORAL HEALTH ACCESS/SERVING UNDERSERVED POPULATIONS

CA AB 116; AUTHOR: NAKANO

Expands the Telemedicine Development Act of 1996 to apply to dentistry making it possible for dentists to deliver services using interactive audio, video or data communication.

CA AB 1627; AUTHOR: FROMMER

Improves access to care in underserved areas.

NM S 247; AUTHOR: JENNINGS

Creates program with Baylor University to train dentists to work in the state.

OK H 1445; AUTHOR: STANLEY

Allows hygienists to operate in public health settings under the general supervision of dentist.

OR H 3157; AUTHOR: KRUSE

Authorizes hygienists and assistants to perform oral health screenings under state board protocols.

SC H 4007; AUTHOR: BINGHAM

Prohibits dentists from delegating certain functions to hygienists; expands general supervision to dental hygienists in private dental practice; lists services that can be performed by hygienists.

TX H 3193; SPONSOR: URESTI

Allows dentist to delegate application of sealants to assistants if dentist is a Medicaid provider and practices in underserved areas.

CA H 1346; AUTHOR: CLAPP

Improves public oral health services to seniors (60+).

CT H 5612; AUTHOR: BERGER

Reduces licensing fees for retired dentists who volunteer in public health settings.

CT S 212; AUTHOR: HANDLEY

Improves administrative processes of Medicaid services.

KS H 2155; AUTHOR: HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

Creates temporary licenses for volunteer dental providers in public health settings.

MD H 237; AUTHOR: DONOGHUE

Allows board to waive education requirements for limited licenses to practice in public health settings for children.

MD S 341; AUTHOR: FROSH

Establishes volunteer and teacher licenses for public health settings and educational institutions.

OK H 1140; AUTHOR: PETERS

Authorizes issuance of special volunteer licenses for dentists.

WI S 243; AUTHOR: ROESSLER

Waives certification requirements for volunteer health care providers.

WY H 149 & WY H 97; AUTHOR: LAW

Establishes volunteer licenses for public health settings; provides immunity for volunteers health care professionals.

LOAN REPAYMENT PROGRAMS

MS H 1232; AUTHOR: MOODY

Improves loan repayment conditions.

ND S 2282; AUTHOR: KILZER

Requires students to be a resident of state for at least one year before entering dental school; removes parents' ability to pay in determining financial need of student.

SD S 137; AUTHOR: SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Requires dentists to serve in an underserved area for three years to receive tuition reimbursement.

2002

LICENSURE

AL S 312; AUTHOR: DIXON

Waives certain continuing education licensure requirements for out-of-state dentists.

AZ H 2029; AUTHOR: HUPPENTHAL

Establishes licensure by credentials and reciprocity.

DE S 240; AUTHOR: DELUCA

Allows out-of-state dentists and hygienists to be licensed if they have passed the state exam and submit three years of active practice.

DENTAL PROVIDERS' SCOPE OF PRACTICE AND/OR SUPERVISION REQUIREMENTS

CA SB 1589; AUTHOR: PERATA

Allows registered hygienists to practice in primary care settings, public health settings and hospitals.

DELAWARE; AUTHOR: DELUCA

Allows a hygienist to practice under a dentist's general supervision.

KY H 467; AUTHOR: PALUMBO

Allows a hygienist to practice under a dentist's general supervision; expands scope of practice for both hygienists and assistants under a dentist's direct supervision.

MI S 1009; AUTHOR: SHUGARS

Maintains that a hygienist must practice under the direct supervision of a dentist.

TN S 2726; AUTHOR: PERSON

Outlines acceptable services to be performed by hygienists and assistants under the direct supervision of a dentist.

ORAL HEALTH ACCESS/SERVING UNDERSERVED POPULATIONS

AZ H 2029; AUTHOR: HUPPENTHAL

Creates restricted permits for hygienists serving in public health settings.

CA AB 1045; AUTHOR: FIREBAUGH

Creates the Licensed Physicians and Dentists from Mexico Pilot Program to serve underserved populations.

ID H 553; AUTHOR: HOUSE HEALTH & WELFARE COMMITTEE

Expands rural health care access grant program to oral health care providers.

KY S 153; AUTHOR: STIVERS

Creates temporary licenses for out-of-state providers who provide voluntary care for the indigent.

MN H 3200; AUTHOR: GOODNO

Creates guest licenses for adjacent out-of-state providers to practice in public health settings.

VA H 1055; AUTHOR: MELVIN

Creates temporary licenses to dental graduates to serve in public health settings or underserved areas.

VT H 761; AUTHOR: HOUSE GOVERNMENT OPERATIONS COMMITTEE

Creates a non-resident volunteer license for out-of-state dentists who provide services at clinics for free or at a reduced fee.

DE H 382; AUTHOR: SCHROEDER

Allows volunteer dentists and hygienists to be exempt from liability.

MN H 3350; AUTHOR: ABELER

Creates a volunteer health care provider program and volunteer.

LOAN REPAYMENT PROGRAMS

VA S 414; AUTHOR: RERRAS

Ensures that students in the dental scholarship and loan repayment program participate in the state's Medical Assistance Services Program and the Family Access to Medical Insurance Security Plan.

INCENTIVES

LA H 225; AUTHOR: DURAND

Provides for an income tax credit for dentists who practice in designated underserved areas and provides for an exclusion from sales and use taxes for certain dental devices.

ME H 1574; AUTHOR: BERRY R

Increases dental reimbursements under Medicaid; further funding to maximize federal reimbursement for oral health services.

VA S 303; AUTHOR: EDWARDS

Allows health providers who provide free services to receive tax credits.

APPENDIX C
RELEVANT ORAL HEALTH LITERATURE REVIEW

TABLE OF CONTENTS

GENERAL ORAL HEALTH.....C-2

UNDERSERVED POPULATIONS.....C-3

RURAL DENTIST SURVEYSC-3

ACCESS TO CARE.....C-4

WORK FORCE DIVERSITYC-6

LOW-INCOME POPULATIONS:.....C-9

WORK FORCE TRENDS:.....C-12

OTHER MODELS OF ORAL HEALTH SERVICE DELIVERYC-14

LOAN REPAYMENT PROGRAMS.....C-16

CULTURAL COMPETENCEC-17

CHILDREN'S ORAL HEALTH.....C-18

GENERAL ORAL HEALTH

Title: Improving Oral Health Care Systems in California (12/00)

By: E. Mertz, et al.

For: California HealthCare Foundation

Location: www.futurehealth.ucsf.edu/publications/index.html

To address California's challenges with respect to oral health, the report suggests the following guidelines for action: responsibility for improving health care must be shared through community and institutional partnerships; leadership in oral health promotion is crucial; targeted funding increases, both private and public, are necessary; oral health care needs evidence-based demonstration models in delivery settings; information technology can be used to revolutionize the processes of professional and community education, care delivery, and health monitoring; integrating dental services into primary health care; dental work force shortages much be addressed with creative new solutions; and evaluation of efforts is key to providing future direction.

The authors give the following recommendations: (1) increase percentage of California residents, particularly children and underserved populations, receiving preventive oral health services; (2) reduce the level of untreated dental decay and periodontal disease in underserved populations in the state; (3) increase the number of completed "episodes of care (sequence of dental visits needed to complete a treatment plan and restore dental health)" by increasing access to quality, affordable, dental treatment.

Title: Improving Oral Health: Promises and Prospects (6/03)

By: J. Ryan

For: National Health Policy Forum

Location: www.nhpf.org/pubs/pubs.htm

This background paper examines a variety of issues affecting access to oral health care in the United States. It considers the possibilities and challenges presented by public financing sources for dental care for low-income children and families – including Medicaid, SCHIP and other safety-net programs – and reviews a sampling of privately funded efforts at improving oral health access. The paper illustrates some of the major barriers to dental care, particularly the shortage of dentists willing to serve low-income and uninsured patients and the overall lack of growth in the dental work force. It also considers the changing roles of other providers, such as dental hygienists and primary care providers, in providing oral health education, preventative care and referrals to dentists. Finally, this background paper touches on more global or population-based approaches to improving oral health.

Title: Oral Health For All: Policy for Available, Accessible and Acceptable Care (9/99)

By: R. Warren

For: Kellogg Foundation

Location: www.wkkf.org/pubs/Health/CommunityVoices/Pub678.pdf

Oral health must be considered as part of the comprehensive health care continuum of total well-being. If general and oral health services are integrated into the necessary continuum of health care, then promoting oral health means promoting overall health. This report suggests several action steps with respect to financial factors, sustainability, capacity, cultural competence and infrastructure to achieve widespread availability, accessibility and acceptability of oral health.

UNDERSERVED POPULATIONS

Title: Evaluation of Strategies to Recruit Oral Health Care Providers to Underserved Areas of California (7/04)

By: E. Mertz, et al.

For: California Program on Access to Care

California's dental provider supply is declining and current providers are maldistributed. In order to address underserved areas of oral care, the Center for California Health Workforce Studies recommends expanding and further developing a positive dental practice environment, dental education resources, applicant-pool strategies and new models of care.

RURAL DENTIST SURVEYS

Title: California Rural Dentist Survey (2003)

By: WWAMI Rural Health Research Center

For: Health Resources and Service Administration's Federal Office of Rural Health Policy

Location: www.fammed.washington.edu/wwamirhrc/

The Washington, Wyoming, Alaska, Montana & Idaho (WWAMI) Rural Health Research Center, in cooperation with the California Dental Association, the California Oral Health Program and the California Rural Health Association, conducted a survey of all dentists practicing in rural California. The survey was designed to provide a comprehensive look at California's rural dental work force, including its demography, practice staff, practice characteristics and job satisfaction. Additionally, dentists were asked to provide their opinions on several ideas for addressing unmet dental care needs. Surveys were sent from May 2002 until September 2002 to 845 dentists. The study had a final response rate of 71 percent.

Title: Missouri Rural Dentist Survey 2003

By: WWAMI Rural Health Research Center

For: Health Resources and Service Administration's Federal Office of Rural Health Policy

Location: www.fammed.washington.edu/wwamirhrc/

The WWAMI Rural Health Research Center, in cooperation with the Missouri Dental Association, conducted a survey of all dentists practicing in rural Missouri. The survey was designed to provide a comprehensive look at Missouri's rural dental work force, including its demography, practice staff, practice characteristics and job satisfaction. Additionally, dentists were asked to provide their opinions on several ideas for addressing unmet dental care needs. Surveys were sent from May 2002 until September 2002 to 534 dentists. The study had a final response rate of 73 percent.

ACCESS TO CARE

Title: Access to Oral Health Services for Low-Income People – Policy Barriers and Opportunities for Intervention

By: S. Gehshan & T. Straw

For: The Robert Wood Johnson Foundation

Location: <http://www.ncsl.org/programs/health/forum/rwjoral.pdf>

National Conference of State Legislatures (NCSL) has documented multiple policy barriers to access to oral health services including: (1) supply, distribution and practice pattern of dentists; (2) federal and state policy and programmatic barriers; (3) dental education; (4) research issues; (5) leadership; (6) advocacy; and (7) public education.

Some recommendations to address the problem of dental access include: (1) increase the supply of dentists; (2) develop a new mid-level provider similar to a nurse practitioner or physician's assistant; (3) explore the use of expanded function dental auxiliaries; (4) research and report on scope of practice and supervision requirements for dental hygienists and dental assistants; (5) research state dental practice acts for restrictions they impose on medical providers delivering dental screening and fluoride treatments, and for the impact of the corporate practice of dentistry; (6) improve advocacy efforts on behalf of water fluoridation; (7) research and write about dental economics and how they differ from medical economics; (8) educate governors or governors' health staffs on oral health; and, (9) engage in leadership development among dental associations or dentists.

The three areas where The Robert Wood Johnson Foundation (RWJ) investment would be most useful to breaking down policy barriers so that states could move forward more forcefully to solve their access problems are: defining the policy problem -- there is much disagreement in states about the nature and dimensions of the oral health access problem; developing policy solutions -- assuming that a common definition of the problem has been accepted, states lack realistic and achievable policy solutions; and building political support -- oral health is a low priority for policymakers.

Title: Access to Oral Health Services in the U.S.: 1997 and Beyond (12/97)

By: R. Isman, et al.

For: Oral Health America

Location: www.oralhealthamerica.org/Resources.htm

Access to oral health services is limited by such factors as the availability of providers; state dental practice acts that limit who can provide oral health services; a plethora of federal programs intended to increase access that are not held accountable for doing so; a limited number of school-based health centers that provide dental services; not having a regular source of care; and not having health or dental insurance.

Solutions lie in using known, effective preventative interventions, increasing the use of school-based dental programs, supporting expansions of community clinics, better integrating oral health with primary care, instituting Medicaid reforms, increasing the productivity of the dental work force and using non-traditional providers, strengthening the dental public health infrastructure, and using multiple public and private partners. Policy change will require creativity, experimentation and resources. These, in turn, will require political will.

Title: Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program (12/02)

By: L. Jones

For: The California Endowment

Location: www.familiesusa.org/site/DocServer/DentiCalRpt.pdf?docID=2606

This report documents several barriers to accessing dental services in California's Denti-Cal Program including: denial of services, a burdensome bureaucratic process, language barriers between patients and service providers, and general misconceptions about what the program covers. The authors give numerous recommendations to address these issues including clarifying the extent of Denti-Cal services, simplifying the bureaucratic structure and process of Denti-Cal eligibility and services, and increasing cultural competency.

Title: The Distribution and Composition of Arizona's Dental Workforce and Practice Patterns: Implications for Access to Care (7/04)

By: E. Mertz, et al.

For: U.S. Bureau of the Health Professions and U.S. Bureau of Primary Health Care, Health Resources and Service Administration

Location: www.futurehealth.ucsf.edu/publications/

A survey of Arizona's dentists found that its work force and pattern of practice closely mirrors national trends. Dentist to population ratio is 1:1985 and actual FTE dentists to population ratio is probably closer to 1:2200. The distribution of these providers is uneven in relation to the population, and particularly uneven in relation to underserved populations, including rural communities, DHPSAs and communities where there are high numbers of "vulnerable populations."

The report makes the following recommendations: (1) examine types of practices in underserved areas and provide better incentives for current programs serving underserved populations; (2) develop auxiliary dental providers by expanding scope and reducing supervision requirements; (3) focus on the elderly as an underserved group, particularly with Arizona being a popular retirement destination; (4) examine and ensure there is adequate culturally competent care; (5) considering the average age of dentists (48), monitor the supply and distribution of providers; (6) the Arizona Board of Dental Examiners should institute a mandatory licensure survey in order to monitor work force trends; and, (7) additional questions should be added to future surveys to further address work force policy questions and concerns.

WORK FORCE DIVERSITY

Title: Professional Motivation and Career Plan Differences Between African-American and Caucasian Dental Students: Implications for Improving Workforce Diversity (6/02)

By: J. Butters, et al.

For: Journal of the National Medical Association

Location: www.nmanet.org/

Vast disparities in oral health status, coupled with projected decreases in African-Americans enrolling in and graduating from dental school, have heightened concern about the underrepresentation of African-Americans in the dental profession. The purpose of this study was to explore differences between African-American and white dental students regarding demographics, professional motivations and career plans. African-American (n =104) and white (n=226) dental students completed a biographical data survey instrument, which included information about family background and professional motivations and plans, and rated descriptions of three practice arrangements. African-American students were more motivated to become a dentist to serve the public, plan to specialize, work in an urban area and work part-time. White students were more motivated to become a dentist based on factors related to family commitments. Race was a significant predictor for student ratings for both solo and employee practice. Study results have implications for health professions educators, administrators and policymakers in their efforts to improve the recruitment and retention of African-American students, shape dental curricula to meet diverse student needs and implement loan forgiveness programs to enhance minority student recruitment.

Title: Strategies for Enhancing the Diversity of the Oral Health Profession (3/01)

By: L. Cavazos, et al.

For: Journal of Dental Education

Location: www.jdentaled.org/

To enhance the diversity of the dental profession, the author recommends examining programs which the medical profession has used. In conjunction with ADEA, The Association of American Medical Colleges (AAMC) has introduced several initiatives to increase the numbers of underrepresented minorities including the Minority Medical Education Program (MMEP), a six-week week summer enrichment program to augment academic skills for undergraduate and postbaccalaureate students seeking entrance to medical school; 3000 by 2000, which sought population parity for under-represented minorities in medicine; and the Health Professions Partnership Initiative (HPPI), a program linking academic health centers with institutions responsible for educating future minority health professionals.

The report also states that there must be some broad steps taken in dental schools to increase diversity. Deans must take a leadership role by acknowledging that there is a deficit of diversity and must raise the faculty's awareness of the lack of diversity and seek their commitment to enhancing diversity. Also, the entire dental community needs to be involved.

Title: The Big Cavity: Decreasing Enrollment of Minorities in Dental Schools (3/01)

By: Community Voices

For: Kellogg Foundation

Location: www.communityvoices.org/PolicyBriefs.aspx

Minority communities have a disproportionate burden of dental problems and a short supply of minority providers. This gap adds to already existing access problems created by inadequate insurance coverage, low Medicaid reimbursement rates and provider location. According to some, people tend to select health providers from their own racial group. Increasing the number of minority dentists will be critical to serving the health needs of underserved communities. However, minority dental enrollment has been noticeably decreasing. The shortage is particularly acute in Native-American communities.

The report recommends: recruitment as early as elementary school coupled with mentoring programs; improving salaries, status and working conditions for teachers; identifying barriers to dental education specific to minorities; tax incentives for minorities to work in underserved areas; collaborations with lending institutions to help young practitioners purchase homes and start a practice; community-backed scholarships to support local students committed to returning to their homes; and giving it more public attention so people are aware of the problem.

Title: Creating an Environment for Diversity in Dental Schools: One School's Approach (5/03)

By: A. Formicola, et al.

For: Journal of Dental Education

Location: www.jdentaled.org/

Recent reports have indicated the need to improve the diversity in the dental profession's work force. The enrollment of underrepresented minority students in the nation's dental schools must increase to accomplish this goal. A complex change process within dental schools is required to prepare schools to enroll a more diverse student body. While each dental school in the United States is unique, a product of its history and institutional culture, and will, therefore create an environment for diversity in different ways, it is appropriate to describe lessons learned in individual schools as they strive for diversity. The purpose of this paper is to describe how one dental school, the Columbia University School of Dental and Oral Surgery, approached diversity, so that appropriate strategies can be shared among schools.

Columbia has since instituted four initiatives to improve diversity in its faculty and students: a D.D.S. Minority Admissions Program, a Postdoctoral Minority Admissions Program, a Science and Technology Entry Program (STEP) for Middle and High School Students and a "Zero" Tuition Minority Dental Assistant Training Program. Critical to these initiatives are two complementary efforts: recruitment of diverse faculty and staff and a "Climate Study" to determine ways the school can be more hospitable to a diverse student body.

These initiatives and efforts have helped to increase Columbia's diversity. However, most gains have been made in the enrollment of women and Asian/Pacific Islander students.

Title: Strategies for Improving the Diversity of the Health Professions (8/03)

By: K. Grumbach, et al.

For: The California Endowment

Location: http://futurehealth.ucsf.edu/pdf_files/StrategiesforImprovingFINAL.pdf

This report identifies several strategies for improving the diversity of the health professions. These recommendations include: (1) place in the national limelight the widening gap between the racial and ethnic composition of the U.S. population and the composition of the health work force; (2) convene a national working group on health work force diversity that meets regularly to coordinate activities among the many program sponsors and to develop a national strategic plan for promoting Underrepresented Minorities' (URM) academic achievement and entry into the health professions; (3) develop a strategic plan, with assistance from professional associations, at every health professions school to improve the racial and ethnic diversity of the school's student body; (4) for funders that have the specific objective of increasing the number of URM and other disadvantaged students matriculating in health profession schools, develop a strategy of working from downstream to upstream in terms of prioritizing funding along the educational pipeline; (5) for health professions funders: continue to consider funding programs that target more upstream, early educational stages (e.g., academic health center/K-12 school partnerships) as demonstration projects with rigorous evaluations; (6) form coalitions between organizations and institutions committed to racial and ethnic diversity in the health professions and advocates for educational opportunity along all stages of the educational pipeline; (7) target more resources specifically at interventions to increase the number of URM students in nursing programs; (8) maintain growth in financial aid per recipient to the rate of inflation of the costs of higher education, and place more emphasis on grants and paid, on-campus internship opportunities for URM and disadvantaged students as opposed to student loans; (9) establish a national clearinghouse to offer technical assistance to health professions schools about formulating flexible admissions policies that are in compliance with judicial rulings and state and federal laws; and, (10) prioritize funding of rigorously conducted evaluation research, in addition to funding interventions themselves.

Title: The Need for Diversity in the Health Professions (7/03)

By: A. Noonan, et al.

For: Journal of Dental Education

Location: www.jdentaled.org/

The Surgeon General's Report on Oral Health remains a baseline document for addressing the issues of oral health disparities in America. With the problem of access to care and quality of care, cultural differences, history of discrimination and ongoing severity of poverty, today there are many disturbing disparities in oral health status between people of color and the majority population. While the number of people of color is increasing, the number being prepared to provide quality oral health care is declining. The nation, the dental profession, and dental schools have not made adequate progress in the effort to develop a work force that can address the disparities in oral health problems based on race and ethnicity. The Office of the Surgeon General is developing a National Oral Health Action Plan to help address these problems, but the role of dental schools is critical. Building a pipeline that will bring diverse people to the dental work force must be a high priority for all involved. A substantial improvement in the diversity of the oral health student body and eventual work force is a critical and essential element to achieving the goals of improving oral health and quality of life and eliminating health disparities.

Title: Advancement of Women in Dental Education: Trends & Strategies (1/03)

By: J. Sinkford, et al.

For: Journal of Dental Education

Location: www.jdentaled.org/

There are many efforts which have helped increase the representation of women in the dental profession. These include the establishment of the National Institutes of Health Office of Research on Women's Health (ORWH) to focus attention on women and research and to support advancement of women in health careers; the Federal Glass Ceiling Commission, a bipartisan group of members of Congress which identified barriers that women face as they approach the top of the corporate hierarchy; the Commission on Graduate Medical Education, which has addressed issues from various health-related fields and promoted awareness of issues facing women and minorities; the Association of American Medical Colleges' Increasing Women's Leadership Project, which has devised strategies to develop leadership roles for women in the health profession; and the Institute of Medicine's 2001 report "Exploring the Biological Contributions to Human Health: Does Sex Matter?" which validated the scientific basis for gender-based biology – the idea that gender is an "important basic human variable that should be considered at all levels of health-related research."

ADEA's ongoing efforts include the ADEA/Pfizer Inc./Enid A. Neidle Scholars Program; Women Liaison Officers; the Women Administrators' Breakfast at the ADEA Annual Deans' Conference; the Second ADEA International Women's Leadership Conference; the Women's Health Information Network; the ADEA Annual Session which includes workshops on women's issues; and, the Hedwig van Ameringen Executive Leadership Program in Academic Medicine. In addition, a greater percentage of ADEA Leadership Programs have been female participants.

LOW-INCOME POPULATIONS

Title: A "Health Commons" Approach to Oral Health for Low-Income Populations in a Rural State (1/02)

By: S. Beestra, et al.

For: American Journal of Public Health

Location: www.ajph.org/

Oral health needs are urgent in rural states. Creative, broad-based and collaborative solutions can alleviate these needs. "Health commons" sites are enhanced, community-based, primary care safety-net practices that include medical, behavioral, social, public and oral health services. Successful intervention requires a comprehensive approach, including attention to enhancing dental service capacity, broadening the scope of the dental skills of locally available providers, expanding the pool of dental providers, creating new interdisciplinary teams in enhanced community-based sites, and developing more comprehensive oral health policy. By incorporating oral health services into the health commons primary care model, access for uninsured and underserved populations is increased. A coalition of motivated stakeholders includes community leaders, safety-net providers, legislators, insurers, and medical, dental and public health providers.

Title: Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations (9/00)

By: The Government Accountability Office (GAO)

For: Congress

Location: www.gao.gov/new.items/he00149.pdf

While several factors contribute to the low use of dental services among low-income persons who have coverage for dental services, the major one is finding dentists to treat them. Some low-income people live in areas where dental providers are generally in short supply, but many others live in areas where dental care for the rest of the population is readily available. Dentists generally cite low payment rates, administrative requirements, and patient issues such as frequently missed appointments as the reasons why they do not treat more Medicaid patients. Although many states have taken action to address these concerns, use remains low. Raising Medicaid payment rates for dental services – a step 40 states have taken recently – appears to result in a marginal increase in use but not consistently. As expected, states that paid higher rates relative to the average fees dentists charge were more likely to report increases in dental utilization. While 20 states use managed care to provide some dental services for Medicaid patients, state officials reported mixed results in terms of the extent to which this approach improves access. And although states have not yet evaluated the access to dental services under SCHIP, the majority of states have modeled their SCHIP dental services on their Medicaid programs and management, and therefore expect to find similar utilization issues. The impression of some officials in states that have departed from Medicaid in designing their SCHIP dental programs, such as using private insurance plans that pay higher rates, is that there are fewer access problems.

The four other major federal programs that target services or providers to underserved or special populations with poor dental health – the Health Center program, National Health Service Corps (NHSC), Indian Health Service (IHS) dental program, and IHS loan repayment program – currently have a limited affect on increasing the access to dental services that low-income and vulnerable populations have. The Health Center program supports community and migrant health centers in medically underserved areas, while the IHS loan repayment program provides incentives for health professionals, including dentists, to practice in sites serving American Indians and Alaskan Natives. However, these programs are not able to meet the dental needs of their target populations. NHSC was able to fill only one of every three vacant dentist positions in underserved areas in fiscal year 1999.

Title: Increasing Dentists' Participation in Medicaid and SCHIP (2001)

By: S. Gehshan, et al.

For: Forum of State Health Policy Leadership, National Conference of State Legislatures

Location: <http://www.ncsl.org/programs/health/forum/oralhealth.pdf>

Low-income children and families who meet state eligibility requirements receive their health care through Medicaid or the State Children's Health Insurance Program (SCHIP). If they are uninsured, they receive the health services that are available through the local public health system and charity providers. However, dental and medical services are delivered largely through separate systems. Under SCHIP, states that choose to establish a non-Medicaid program are not obligated to include oral health services in their benefit packages although

all state programs except Colorado, Delaware and one of Florida's three programs include some degree of dental coverage. However, states are required by federal law to provide comprehensive oral health services for all children through age 20 who are enrolled in the Medicaid program. In 1998, only 19 percent of children eligible for preventative dental services under Medicaid received them: This is a decrease from 21 percent in 1996. States are not required to provide any services for dental problems other than emergency medical care for adults who are covered under Medicaid. However, many states provide other diagnostic, restorative and preventative dental services as well. Few states provide public health dental services for adults, although some services are available through individual counties or philanthropic groups.

Both the problem of poor access to oral health care and the solution are complex. A big stumbling block is the low rate of participation by dentists in Medicaid and SCHIP. To gather information about steps states have taken to improve access to oral health services, the Forum for State Health Policy Leadership at NCSL surveyed dental contacts in state Medicaid and SCHIP programs in 1998 and 2000. This paper provides data from the 2000 survey on dentists' participation, compares data from both years' surveys, describes findings on selected state initiatives designed to increase participation and gives background on access to dental care for low-income people.

States have had a great deal of difficulty ensuring that children and adults who are enrolled in Medicaid programs receive the dental benefits to which they are entitled. There are problems with inadequate and slow reimbursement, unwieldy administrative procedures, poor communication with state dental societies, a paucity of participating providers, maldistribution of providers and cultural and behavioral differences between dental practices and low-income patients. The NCSL survey shows that, although these problems are far from solved, states are taking them seriously and are working on many fronts to correct them. More than half have raised reimbursement rates, which may be the single largest barrier to dentists' participation. In many states, however, rates are so far below the cost of providing care that this must be viewed as incremental progress rather than a final solution to the problem. Despite all state efforts, the survey shows that two-thirds of the states for which data is available lost ground in expanding the pool of dentists who actually provided dental care for Medicaid patients. In contrast, nearly half of all states experienced an increase in the number of dentists who billed the state for more than \$10,000 of care. It is clear that, although progress has been made, much work remains to be done to comply with federal requirements to ensure access to dental services for Medicaid and SCHIP beneficiaries.

Title: Dental Service Supply and Demand for the Indigent Populations in Rural Pennsylvania (5/04)

By: M. Schwartz and L. Davis

For: Center for Rural Pennsylvania

Location: athens.pop.psu.edu/chcpr/FacPubs.cfm

Pennsylvania is experiencing a declining supply of dentists that is projected to continue into the future. Low dentist supply affects access and use among indigent populations in two ways. First, any absolute low supply affects access for all, but even a more marginal shortage will inhibit the participation of dentists in Pennsylvania's Medical Assistance (MA) program, since

these dentists have an abundant supply of high-paying patients. Second, when the MA program dentist supply is low (or non-existent in some areas), program enrollees maintain the expectation that care is unavailable or difficult to obtain, which contributes to a perception that oral health is not important. Because low use among the low-income population is a consequence of the relationship of supply and demand factors, improvement efforts must incorporate both. Two goals on the supply side include not allowing the general supply of dentists to decline any further and increasing the participation rates of dentists in the MA program. On the demand side, eliminating the structural barriers that contribute to low care-seeking behavior and increasing the cultural importance of dental care in this population are necessary for achieving equality in use.

WORK FORCE TRENDS

Title: Trends in the Dental Health Work Force (12/99)

By: L. Brown, et al.

For: Journal of the American Dental Association

Location: www.ada.org/prof/resources/pubs/JADE/index.asp

Using data from various American Dental Association projects, the authors analyzed trends and projections for the dental work force. The article presents work force projections overall and by gender, when available, through the first 20 years of the 21st century. The number of women practicing dentistry has been increasing rapidly, while the increase in the number of male dentists has been more modest. In the future, the number of female dentists is projected to increase while the number of male dentists is projected to decrease. Estimates based on the ADA census data place the overall growth in the number of active private practitioners at 19.1 percent between 1982 and 1997. This growth signifies a substantial expansion of capacity to produce dental services in the United States. Growth will be slower in the future. Changes in the dental work force capacity and demographic distributions merit careful monitoring and analysis, because they no doubt will determine the dental profession's future ability to deliver needed dental services and influence practitioner's level of business.

Title: Racial/Ethnic Variations of Practicing Dentists (12/00)

By: L. Brown, et al.

For: Journal of the American Dental Association

Location: www.ada.org/prof/resources/pubs/JADE/index.asp

In recent years, the dental school population has changed from being predominantly white men to a more diverse racial and ethnic makeup. Noting this change in the student population, the American Dental Association undertook an in-depth study of the various racial/ethnic groups. Questionnaires were sent to approximately 8,000 dentists nationwide. Samples were drawn for each of the following racial/ethnic groupings: white, black, Hispanic, Native-American and Asian. The survey instrument asked questions about personal characteristics, work and private practice issues, household and practice income, and patient characteristics; it also asked for dentists' opinions. A final adjusted response rate of 57 percent was achieved.

The majority of all students responded that they were "very satisfied" with their profession, but the survey found variations in patient mix, employment history and provision of free or discounted care. The survey examined dentists by race/ethnicity to identify differences and

similarities. Cultural and ethnic minorities are the fastest growing segment of the U.S. population. As the profession becomes more diverse, practice patterns will affect the overall dental profession.

Dentists' racial/ethnic backgrounds may change the provision of care as patient mix varies, with each dentist group treating a specific group of patients in regard to family income, racial/ethnic background and subgroups for whom they offer free or reduced rate dental care. The findings show that the race/ethnicity of the dentist seems to influence the race/ethnicity of patients.

Title: Geographic Distribution of Dentists in California

Dental Shortage Areas, 1998 (1/00)

By: E. Mertz, et al.

For: Center for Health Workforce Information and Analysis, US Bureau of the Health Professions, HRSA

Location: futurehealth.ucsf.edu/cchws/publications.html#Dentists

This report provides information on the numbers and distribution of “active” dentists in the state of California. The purpose of this report is to highlight current areas of clear “shortage” where the number of dentists is below the federal level to be considered a Dental Health Professional Shortage Area (DHPSA).

Increasing the supply of dentists in underserved areas will require focused efforts at many levels. Issues that need to be addressed are diversity in the dental work force, the disproportionately low supply of dentists serving poor and minority populations, the availability of dental services in community clinics, and the lack of fluoridated water supplies.

While this report deals mainly with supply side issues of access to dental care, demand affects access as well. The prevalence of dental insurance coverage, the use of dental auxiliaries, and teledentistry are also important factors in the overall equation. More research is needed on current access to dental care and the options for increasing access.

Many MSSAs qualify for a DHPSA designation but are not designated. The state should make efforts to develop an easy and efficient process for DHPSA designation, to inform potentially qualified areas of their options and to provide technical assistance in applying for a DHPSA designation and HHSC placements.

Research on access to other health professionals, physicians in particular, may yield some clues as to strategies that may work for increasing access to dental care services. It has been suggested that a comprehensive strategy aiming at all phases of dental education and practice may be the key to success.

OTHER MODELS OF ORAL HEALTH SERVICE DELIVERY

Title: Policy on Mandatory School Entrance Oral Health Examinations (2003)

By: Council on Clinic Affairs

For: American Academy of Pediatric Dentistry

Location: www.aapd.org/members/referencemanual/pdfs/02-03/P_SchoolExms.pdf

Early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness. Recognizing the relationship between oral health and education, the American Academy of Pediatric Dentistry (AAPD) supports legislation mandating a comprehensive oral health examination by a qualified dentist for every student prior to matriculation into school. The examination should be performed in sufficient detail to command respect and with appropriate consideration to provide an education experience for both the child and the parent. Because a child's risk for developing dental disease changes, and oral diseases are cumulative and progressive, the AAPD also supports such legislation to include subsequent comprehensive oral examinations at periodic intervals throughout the educational process. In addition, the AAPD encourages state and local public health and education officials, along with other stakeholders such as health care providers and dental/medical organizations, to document oral health needs, work toward improved oral health and school readiness for all children, and address related issues such as barriers to oral health care. The AAPD recognizes that, without appropriate follow-up care, requiring oral health examinations is insufficient to ensure school readiness. Thus, the AAPD encourages local leaders to establish a referral system to help parents obtain needed oral health care for their children. The AAPD opposes regulations that would prevent a child from attending school due to non-compliance with mandated examinations.

Title: Strengthening the Oral Health Safety Net: Delivery Models That Improve Access to Oral Health Care for Uninsured and Underserved Populations (5/04)

By: A. Formicola, et al.

For: American Journal of Public Health

Location: www.ajph.org

The Kellogg Foundation's Community Voices initiative has three new innovative delivery models for oral health:

Northern Manhattan: Community DentCare Model

The three major components of the Community DentCare Network are seven public middle school-based dental programs; one mobile dental clinic to reach the Head Start population during the school year and the elderly population during the summer; and four community health center sites offering comprehensive dental services.

New Mexico: The 'Health Commons' Model

A community partnership model of enhanced primary care includes medical, behavioral, social, public health and oral health services. Since many of New Mexico's underserved communities have health problems rooted in the consequences of historic, social and economic factors, these health issues cannot be addressed adequately by a single health provider group or by the health sector as a whole. Better solutions emerge when different sectors of society, including government agencies, educational institutions, businesses, and public and private stake

holders, collaborate rather than compete. The cornerstones of the health commons model are the neighborhood care sites that serve as the safety net for underserved. At these centers, medical, behavioral, social, public health and oral health services are co-located. Each component of health care delivery improves with better coordination of services and information. In the health commons model, patient centered oral health care is delivered by an interdisciplinary team.

Central North Carolina: The FirstHealth Model

FirstHealth, a private not-for-profit, developed an integrated model of dental service delivery. An oral health task force was created to identify strategies to address the oral health crisis. The task force prioritized improving access for children through a public model based on a private practice setting. FirstHealth opened a community-based dental care center in three underserved counties. Two of the three use existing medical centers as their home sites.

The common core elements of these three successful models are: involving the community in planning and implementation; building upon the existing health safety net to link dental services with primary care; and changing public or institutional policy to support the financing and delivery of dental care.

Title: Implementing a Community-Based Oral Health Care Program:

Lessons Learned (1/03)

By: R. Diamond, et al.

For: Journal of Public Health Dentistry

Location: www.aaphd.org/default.asp?page=journalcontributors.htm

The objective of this paper is to report key findings of a process evaluation that may be useful to other institutions seeking to implement a community-based oral health care program targeting children in dentally underserved communities. By partnering with community-based organizations, public schools and community health care providers, the Columbia University School of Dental and Oral Surgery (SDOS) established the Community DentCare Network in the Harlem and Washington Heights/Inwood neighborhoods of northern Manhattan. These low-income neighborhoods are characterized by poor oral health and have been designated by the federal government as health profession shortage areas. The method used in the process evaluation was open-ended qualitative interviewing by a sociologist with extensive experience in this methodology aided by a participant-observer within the DentCare program.

The heterogeneity of the two communities required different strategies and resources to gain trust and acceptance. Fundamental changes were required of SDOS over a 10-year period, beginning with prioritizing community service as a primary mission. Collaborating with medical clinics facilitated the implementation of the network when the partners shared the same philosophical goals. Faculty and staff with different skills were needed during the start-up and the sustained development phases of the program.

All low-income neighborhoods are not identical, and each requires distinctive strategies and resources. Dental schools that are developing community-based programs should make community service its primary mission. If this requires a change in the school's mission, it will take several years and must have the support and oversight of a committed dean.

Collaborating with existing medical clinics that share the dental school's goals is a win-win situation especially for the patients. The start-up phase requires goal-oriented staff who can overcome unexpected obstacles. Once the program is up and running, it is important to have standardized procedures and staff who can maintain a financially self-supporting operation. Dental schools partnering with community service programs may provide a partial solution to the lack of access to dental care within their cities and neighborhoods.

LOAN REPAYMENT PROGRAMS

Title: California Dental Loan Repayment Program: A Feasibility Study (8/02)

By: Office of Statewide Health Planning & Development

For: California Legislature

Location: www.oshpd.cahwnet.gov/pcrcd/professions/pilot/AB668Rpt.pdf

This report finds that there is one full-time dentist for every 1,700 Californians. The U.S. Census Bureau projects that the California state population will grow at 1.9 percent per year. In order to maintain a constant ratio of dentists to population, the number of dentists would have to increase at least by 1.9 percent. According to the report, it is doubtful that the growth rate in dentists will equal population growth. The adequacy of the current ratio is also open to debate, especially when considering rural and low-income inner city areas, where there is a geographical maldistribution of dentists. According to data from the California Health Manpower Policy Commission (CHMPC), in rural areas, there were 1.8 general practice dentists for every 5,000 rural residents and 3.1 dentists for every 5,000 urban residents. In addition, many urban and rural communities are eligible to be considered federal "dental health provider shortage areas" but are not on the list because no one has invested the considerable time, resources and effort to obtain the designation.

The study concludes with an analysis of costs and policy issues regarding the possibility of a dental loan repayment program in California. Some of the questions posed include: Is it feasible to develop a dental loan repayment program that utilizes a different method of identifying dental areas of need than processes already established by the Shortage Designation Branch of the United States Department of Health and Human Services? Is it feasible to develop a dental loan repayment program not utilizing NHSC funds? Should the state operate a program where private dentists' and part-time dental practices could be eligible sites for service for loan repayment recipients? How might a state dental loan repayment program not using NHSC funds be financed? How will a new state dental loan repayment program interrelate with existing loan repayment activities within OSHPD?

CULTURAL COMPETENCE

Title: Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance (7/04)

By: L. Cooper, et al.

For: The Commonwealth Fund

Location: www.cmf.org/programs/minority/cooper_raceconcordance_753.pdf

Ethnic minorities are poorly represented among physicians and other health professionals. In what is called “race-discordant” relationships, patients from ethnic groups frequently are treated by professionals of a different ethnic background. The research reviewed here documents ongoing racial and ethnic disparities in health care and links patient-physician race and ethnic concordance with higher patient satisfaction and better health care processes and outcomes. Based on this research, the authors make the following recommendations: Health policy should be revised to encourage work force diversity by funding programs that support the recruitment of minority students and faculty. Health systems should optimize their providers’ ability to establish rapport with minority patients to improve clinical practice and health care delivery. Cultural competency training should be incorporated into the education of health professionals. Future research should provide additional insight into the mechanisms by which concordance of patient and physician race, ethnicity, and language influences processes and outcomes of care.

Title: Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals (2003)

By: M. J. Gilbert

For: The California Endowment

Location: http://www.calendow.org/reference/publications/cultural_competence.stm

This report outlines guiding principles for cultural competence: (1) the goals of cultural competence should include increased self-awareness and receptivity to diverse patient populations on the part of health care professionals; clinical excellence and strong therapeutic alliance with patients; reduction of health care disparities through improved quality and cost-effective care for all populations; (2) in all trainings, there should be a broad and inclusive definition of cultural and population diversity including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion or other indices of difference; (3) training efforts should be developmental, in terms of the institution and the individual; (4) cultural competence training is best organized around enhancing providers’ attitudes, knowledge and skills, and attention to the interaction of these three factors is important at every level of the training; (5) while factual information is important, educators should focus on process-oriented tools and concepts that will serve the practitioner well in communicating and developing a therapeutic alliance with all types of patients; (6) cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation and practicum activities as they occur throughout an education curriculum; (7) following on the above, cultural competence education should be institutionalized within a school or health care organization so that when curriculum or training is planned or changed, appropriate cultural competence issues can be included; (8) cultural competence is best achieved within an interdisciplinary framework and context, drawing upon the numerous fields that contribute to skill and knowledge in the field; (9) education and training should be respectful of the needs,

the practice contexts and the levels of receptivity of the learners; (10) education in cultural competence should be congruent with and framed in the context of existing policy and educational guidelines of professional accreditation and practice organization such as the Accreditation Council on Graduate Medical Education, the Liaison Committee on Medical Education, the American Academy of Nursing, etc.; (11) wherever possible, diverse patients, community representatives, consumers and advocates should participate as resources in the design, implementation and evaluation of cultural competence curricula; and, (12) cultural competence should take place in a safe, non-judgmental, supportive environment.

While the content and subject matter of cultural competence training/education are extremely varied, they generally fall into three general categories: attitudes, knowledge and skills. Each of these areas is supportive of the other two. Like a three-legged stool, the structure would fail if one leg were missing. Most importantly, the knowledge and skills related to cultural competence in health care would be seriously reduced in effectiveness if a committed consciousness and receptive attitude did not underlie their use. From a practical standpoint, these three content areas are applicable in the education of all professional health care disciplines and are useful at any state of the developmental learning process. The basic tenets of Professionalism, Patient-Centeredness and Ethics of Practice should be a consideration of all movements in medicine.

CHILDREN'S ORAL HEALTH

Title: Elements of Effective Action to Improve Oral Health & Access to Dental Care For Connecticut's Children & Families (7/01)

By: J. Crall, et al.

For: Connecticut Health Foundation

Location: www.cthealth.org/matriarch/DisplayLinksPage.asp?PageID=101&PageName=pubsreports&LinksPageID=58

The authors list some guiding principles for dental system reform: (1) employ incentives rather than approaches that are coercive or punitive; (2) respect the values, opportunities, and constraints of those being served and those providing service; (3) provide care that is child-and family-centered and culturally appropriate; (4) build upon and maximize the contributions of both private- and public-sector dental delivery systems; (5) maximize the role of the entire dental team – including dental assistants, dental hygienists and dentists – as well as health advisors and educators who promote oral health; (6) encourage integration of oral health into primary health care, community service and social service systems; (7) employ community-level assessments and program planning and encourage integration of local public and private dental care delivery systems; (8) ensure long-term sustainability; and, (9) involve representatives of targeted populations in designing and implementing programs.

Some recommended strategies for dental reform are: reform efforts which maximize the utilization of existing public and private delivery resources and expand the numbers of both public and private delivery resources; the creation of bridges must connect families to dental services; the reduction of disease burden through prevention; and lastly, the implementation of data-driven systems that create accountability and quality improvement systems.

Title: States' Efforts to Improve Children's Oral Health (11/02)

By: B. Krause

For: National Governor's Association

Location: www.nga.org/cda/files/1102CHILDORALHEALTH.pdf

This brief summarizes some of the efforts states are taking to address issues related to children's access to dental care. Oral health issues covered include: promoting education and prevention; increasing coverage and access; enhancing the dental work force; improving finance and reimbursement; and, improving quality of data and surveillance.

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