Evidence for the Need for Change in the Dental Workforce of the Future:
Costs and Culture Impede Access

Building Leadership Teams for a Diverse Dental Workforce
Washington, DC
June 12-13, 2014
OVERALL OBJECTIVE:

Making the case that the current oral health workforce is not addressing the oral health needs of the public.

But there is another solution besides more dentists!
Case Presentation
Deamonte Driver

• On Jan. 11 2007 Deamonte Driver, a 12 year old male and Medicaid recipient, came home from school complaining of a headache.

• Subsequently admitted to Children's Hospital, where he underwent emergency brain surgery for an abscess that originated from an infected tooth.

• In need of two surgeries and more than six weeks of therapy.

• On Saturday, their last day together, Deamonte refused to eat but otherwise appeared happy, his mother said. They played cards and watched a show on television, lying together in his hospital bed. But after she left him that evening, he called her. "Make sure you pray before you go to sleep," he told her.

• The next morning at about 6, she got another call, this time from the boy's grandmother. Deamonte was unresponsive. She rushed back to the hospital. "When I got there, my baby was gone," recounted his mother.

1. **DISPARITIES**- There are significant numbers of the population who are not receiving dental care and this results in lots of untreated oral diseases and consequences.

2. **NUMBERS OF DENTISTS**- There is a quantitative shortage and mal-distribution of the oral health workforce that impacts access to care.

3. **CULTURE**- The current oral health workforce does not represent the socioeconomic and racial/ethnic diversity of the patients they need to serve. And there are consequences of this issue.

4. **COSTS**- Access to quality dental care is impeded by high costs of care.

5. **CONSEQUENCES**- Lack of access to oral health care has consequences, some of which we have covered.

6. **APPROACHES**- What can we do address disparities? IOM recommendations with focus on Literacy and Workforce.
1. **DISPARITIES**- There are significant numbers of the population who are not receiving dental care and this results in lots of untreated oral diseases and consequences.

1. What Constitutes a Disparity? What constitutes a sufficient “difference” to be considered a disparity? Statistical significance? Certain number of percentage points.
When we use the term “disparities,” what are we referring to?

Disparity = Inequality

US Public Law 106-525- A population is a health disparity population if . . . there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population.

Minority Health and Health Disparities Research and Education Act of 2000

Healthy People 2020- A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx
“Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”
Institute of Medicine (2002)
http:www.nap.edu/books/030908265X/html/
This is now “old” news, but worth reading!
“Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”

Finding 1-1: Racial and ethnic disparities in healthcare exist and are associated with worst outcomes.

Finding 2-1: Racial and Ethnic disparities occur in context of broader historic and contemporary social and economic inequality.

Finding 4-2: While some racial and ethnic minorities refuse treatment, refusal rates are generally small and do not explain disparities.

What are the potential sources of disparities in care:

- **Patient-level Variables**: Preferences, Treatment Refusal, and Clinical Appropriateness of care

- **Healthcare system-level factors**: Language, location

- **Care process-level Variables**: Bias, stereotyping and Uncertainty
Figure 1: Percentage of Publicly Insured Children Enrolled at Least 6 Months who Received an Oral Evaluation, Stratified by Age, CY 2010 (Program 1) & CY 2011 (Program 2)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Program 1</th>
<th>Program 2</th>
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<tbody>
<tr>
<td>&lt;1 year</td>
<td>0.3%</td>
<td>18.7%</td>
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<tr>
<td>1-2 years</td>
<td>5.8%</td>
<td>58.8%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>28.0%</td>
<td>73.6%</td>
</tr>
<tr>
<td>6-7 years</td>
<td>37.3%</td>
<td>76.3%</td>
</tr>
<tr>
<td>8-9 years</td>
<td>40.1%</td>
<td>76.2%</td>
</tr>
<tr>
<td>10-11 years</td>
<td>36.7%</td>
<td>75.1%</td>
</tr>
<tr>
<td>12-14 years</td>
<td>32.3%</td>
<td>71.5%</td>
</tr>
<tr>
<td>15-18 years</td>
<td>27.1%</td>
<td>62.0%</td>
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<tr>
<td>19-20 years</td>
<td>15.7%</td>
<td></td>
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</table>
Minority children have more untreated tooth decay (regardless of income)

Vargas, Crall, Schneider: JADA 1998;129:1229-1238.

Percent of children

Ethnic groups
- White
- African American
- Mexican American

Fed. Poverty level

At/below - Above

2-5 years 6-12 years 6-14 years 15-18 years

Primary dentition

Permanent dentition
Race could be a factor in Head and Neck Cancer (HNC) survival rates.

The researchers analyzed data from 1973 to 2010 on 247,310 HNC patients nationwide. They found that the incidence of HNC was higher in African-Americans than in Caucasians, Hispanics, Asians and Pacific Islanders, or Asian-Indian and Alaskan natives.

Except for the African-American group, all other groups showed improved five-year survival rates over a 40-year period.

African-Americans had a significantly decreased five-year overall survival rate of 41.8%, compared with 60.8% survival for Caucasians, 59.3% survival for Hispanics, 62% survival for Asians and Pacific Islanders, and 50.2% survival for Asian-Indian and Alaskan natives.

Oral health care is a major component of health care in which striking disparities exist (from published literature).

- More than 50% of population do not see a dentist annually.

- Poor and minority children are less likely to have access to care than non-poor and non-minority peers.

- Americans in rural areas have poorer oral health status and more unmet dental needs than urban counterparts.

- Older adults have a high prevalence of oral health problems and difficulties accessing care.

- Disabled individuals uniformly confront access barriers.

- Examples include differences in access or utilization of services, caries rates, unfilled versus filled, periodontal disease, cancer rates, cancer mortality, etc.
Table 4: Children age 1-20 enrolled in EPSDT for at least 90 continuous days who received any dental services, a preventive dental service, or a dental treatment service in FY 2011, by state. 
Source: FY 2011 CMS-416 Reports.

<table>
<thead>
<tr>
<th>REGION</th>
<th>Total children receiving any dental services</th>
<th>Total children receiving a Preventive dental service</th>
<th>% Children receiving a Preventive Dental Service</th>
<th>Total children receiving a dental treatment service</th>
<th>% Children receiving a dental treatment service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida*</td>
<td>447,315</td>
<td>257,012</td>
<td>13.8%</td>
<td>146,602</td>
<td>7.9%</td>
</tr>
<tr>
<td>Florida, Last in the country</td>
<td>447,315</td>
<td>257,012</td>
<td></td>
<td>146,602</td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>15,196,594</td>
<td>13,550,097</td>
<td>42.2%</td>
<td>7,466,214</td>
<td>23.3%</td>
</tr>
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Dental Care Utilization Declined among low-income adults, increased among low-income children in most states (BUT NOT FLORIDA) from 2000-2010 (ADA Health Policy Resource Center)

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Children</th>
<th>Children</th>
<th>Adults</th>
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<tbody>
<tr>
<td>2000</td>
<td>27%</td>
<td>23%</td>
<td></td>
<td>54%</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>41%</td>
<td>22%</td>
<td>-7%</td>
<td>43%</td>
<td></td>
<td>-17%</td>
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<tr>
<td>% Change</td>
<td></td>
<td></td>
<td>-10%</td>
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</table>

US overall
Florida
2. NUMBERS OF DENTISTS - There is a quantitative shortage and mal-distribution of the oral health workforce that impacts access to care.
A dramatic growth in Dental Health Profession Shortage Areas (DHPSAs) from 1,300 to 4,600 over the last ten years and 51 million people living in these shortage areas. There is a projected need for 9,900 additional dentists to eliminate the DHPSAs.
Even with the growth in dental schools (which may be the most expensive/least cost effective way to add more dental personnel), the US population growth is increasing even faster because of retiring baby boomer dentists. According to ADA, there is an expected 2% per year growth in dental activity, primarily from children. Who will treat them?
“In 2014, as part of the Affordable Care Act, an additional **5.3 million children** will be entitled to dental coverage under Medicaid, according to the Pew Charitable Trusts. Yet, few dentists treat Medicaid patients now and there have been wide reports of children on Medicaid waiting months to get care.”

And a surprise effect of ACA- Many medical plans are offering **adult dental benefits**! Who will treat them?
Fourth-year dental school students with high levels of educational debt were more likely to express an interest in choosing to go into private practice, although the magnitude of this effect was relatively small. For each $10,000 increase in debt, the likelihood of choosing government service was 8.4 percent lower than for choosing private practice.

African American dental school students were approximately twice as likely as were white dental school students to intend to enter advanced education or government service compared with private practice and more than three times more likely to choose public health.

Conclusions. Although educational debt was statistically significant for predicting intended activity after graduation, the magnitude of influence of other variables such as sex, race and whether a parent is a dentist was substantially larger.
3. CULTURE-The current oral health workforce does not represent the socioeconomic and racial/ethnic diversity of the patients they need to serve. And there are consequences of this issue.
Who are these people with disparities of access and oral health?

- The first and most obvious group are those in POVERTY, patients on Medicaid, CHIP.

- Racial and Ethnic minorities

- Traditionally, children, the elderly, rural, single mothers.

- Increasingly in this recession, lower middle class and middle class families.

- The uninsured.

- Any who do not understand the importance of optimal oral health
“Many of us have no real understanding of what poverty is. We may be broke most of the time, in debt, unsure of how we’ll pay the phone bill. But those particular definitions can apply to middle class. Poverty is something else. Missed meals, a reliance on government aide, homes without power or telephone services- these are the earmarks of the culture of poverty.”

J. Kevin Tumlinson, Online Magazine. www.viewonline.com, 2/13/08
1. Investigate the influence of patient’s race on dentists decision to extract or retain a decayed tooth.

2. 297 dentists from Recife, Brazil.

3. Two case scenarios, both with extensively decayed tooth that could be treated with conservative treatment. Both patients labeled as poor. One case had photograph of white patient and another with a black patient. Cases presented two months apart to all dentists. Results validated with small subset.

4. The dentists’ decision varied significantly according to race, with dentists extracting more frequently in black patients (25.5% vs 16.2%, p<0.001).

5. Racial variation occurred regardless of demographic or socioeconomic variables of dentist/ age, gender, income, PG training.

6. Practice setting influenced results. Public settings, company settings or private practice settings showed racial variation whereas military setting did not show variation.

Cabral, ED et al, Influence of the patient’s race on the dentist’s decision to extract or retain a decayed tooth. Community Dentistry and Oral Epidemiology 2005; 33:461-6
Concordance between patient satisfaction and the dentist’s view.

Good News: Overall, patients were satisfied with their experiences and most of the time, dentists correctly predicted this outcome.

Bad News: Among patients who were less satisfied, there was a substantial subset of cases in which dentists were not aware of the dissatisfaction. There were aware in 42 cases and unaware in 684 cases.

Implications: If this occurred with an overall patient population, might it be exacerbated with differences in race and ethnicity where a lack of cultural competency might increase dissatisfaction/discordance?
Excellent Reference on Social and Cultural Issues

Reducing Oral Health Disparities: A Focus on Social and Cultural Determinants

Patrick, DL et al, BMC Oral Health 2006, 6 (Suppl 1) 54

Very good review of the literature and a framework for addressing oral health disparities.
How do some dentists feel about treating these patients who are underserved?

1. Social Justice

2. Ethnic and Racial Perspectives

3. Attitudes Towards Medicaid
1. Dentists who came from poorer/lower socioeconomic backgrounds were more likely to provide care to underserved patients.

2. The following themes influence a dentists’ sense of social responsibility: economics, professionalism, individual choice and politics.

3. Some dentists argued that professional autonomy entails discharge of social responsibility and questioned the excessive emphasis on economics by other dentists.

We surveyed 882 Florida dentists including pediatric dentists and general dentists who self-reported that they treated children to determine the demographic and practice characteristics of Medicaid-participating dentists:

1. More than 2/3rds of sample are not participating in Medicaid and will not consider doing so in the future.

2. Black Dentists across the state and Hispanics in South Florida were more likely to participate in Medicaid than other groups of dentists. (Cultural Competency)

3. Non-Medicaid providers are more likely to report not being busy enough in their practices than Medicaid Providers. They have room for patients - so why not?

Logan, Guo, Dodd, Seleski and Catalanotto, 2013, Demographic and practice characteristics of Medicaid-participating dentists. JPHD
Results Consistent with Okunseri at al
Social Responsibility Attitudes Towards Medicaid

We surveyed 882 Florida dentists including pediatric dentists and general dentists who self-reported that they treated children to determine the demographic and practice characteristics of Medicaid-participating dentists.

Three of the 17 Social Responsibility Scale items were significant predictors of Medicaid participation. Medicaid participants were more likely to express stronger agreement with these three items:

1. Other dentists will think less of me if they know I see Medicaid patients. Social Stigma?

2. The traditional model of private dental practice adequately addresses the oral health needs of underserved patients.

3. If I become a Medicaid participant, I could help prevent tragedies like the death of Deamonte Driver.

Logan, Guo, Dodd, Seleski and Catalanotto, Barriers to Medicaid Participation Among Florida Dentists. In Preparation
4. **COSTS**- Access to quality dental care is impeded by high costs of care.
Nationally, an estimated $120 billion is currently being spent on dental treatment services.

School days lost – estimated 51 million hours/year (2000). School nurses in Florida report that dental problems are one of the leading causes of missed school days.

Work days lost – estimated 164 million hours/year (2000).

As people live longer and keep their teeth longer, and the relationship between oral health and systemic health becomes clearer, there will be a greater need for access to dental care services.

Does not include issues such as pain and suffering, hospitalization, and tragically, several deaths due to poor dental health over past four years.
Costs of General/Overall Health Care

Overall Background: The US spends about twice as much for health care than other countries but has significantly lower rankings in terms of:

a) Access to care
b) Efficiency of the system
c) Patient satisfaction
d) Health Outcomes

Why?

a) Higher prices for goods and services
b) Higher administrative costs
c) Inefficiency
d) Estimated that 1/3rd of costs in US are waste!

How affordable is health care in the US and other countries?

JADA May 1, 2014, Vol 145, no. 5, 482-83
Is there any logical reason to think that dentistry is different than the rest of the health care system in terms of cost?

• ADA Health Policy Institute- The decrease in adults seeking dental care cuts across economic groups with reductions in upper income, middle income and 6% lower income groups. **REASON-COSTS.**

• Recent HARRIS- Oral Health America Poll. Almost half of older adults with incomes of $35,000 or less have not been to the dentist in 2 years and 35% of all lower income older adults have not sought dental care in the last four years. **REASON- COSTS**
Figure. Percentage of adults with financial barriers to care. Data are based on the percentage of respondents who indicated that they did not see a physician when they were sick or that they did not get recommended care because of cost in the past year. The figure also shows the percentage of respondents who indicated that they skipped dental care or checkups because of cost in the past year. Source: The Commonwealth Fund.²

Vujicic, M. JADA 2014;145:5:482-483
5. CONSEQUENCES- Lack of access to oral health care has consequences, some of which we have covered.
Figure 2: Trends over Time in Various Components of Dental Emergency Department Use for Dental Services in the United States, 2000 to 2010 (Indexed to 100 in Year 2000)

Sources: National Hospital Ambulatory Medical Care Survey, NCHS; Medical Expenditure Panel Survey, AHRQ; Census Bureau.
Hospital-based emergency department visits involving dental conditions. Allareddy et al. JADA 145(4), April 2014 331-337

• Study period 2008-2010; Nationwide Emergency Department Sample of the Healthcare Cost and Utilization Project (AHRQ)

• 4,049,361 ED visits, about 1% of all ED visits.

• About 40.4% uninsured; 8% Medicare; 30% Medicaid; 19% private insurance.

• Mean ED charges were $760; $2.7 BILLION
Hospital-based emergency department visits involving dental conditions. Allareddy et al. JADA 145(4), April 2014 331-337

- Mean age 33 years
- 94% routine discharge
- 4.8% discharged to another hospital/facility
- 92% DID NOT involve a Charlson comorbidity
- 71% resided in a low income geographic area
- ED charges increased as the Charlson comorbidity index increased.
Hospital-based emergency department visits involving dental conditions. Allareddy et al. JADA 145(4), April 2014  331-337

• 101 deaths; following are characteristics of those who died.

• Mean age 46.6 years

• Nearly 85% did not have other comorbidity

• Medicare 36%, private insurance 30.5%; uninsured 26%.

• 75% lived in low income areas.
Outcomes of hospitalizations attributed to periapical abscess from 2000 to 2008: a longitudinal trend analysis.

During the 9-year study period (2000-2008), a total of 61,439 hospitalizations were primarily attributed to periapical abscesses in the US. Average age was 37 years, and 89% of hospitalizations occurred on an emergency/urgent basis. Mean length of stay was 2.96 days, and a total of 66 patients died in hospitals. Medicare, Medicaid, and private insurance plans paid for 18.7%, 25.2%, and 33.4% of hospitalizations, respectively. Uninsured patients accounted for 18.5% of hospitalizations.
ORAL HEALTH EMERGENCY ROOM SPENDING IN FLORIDA
AN AVOIDABLE $88,000,000 HEALTHCARE COST
115,000 ER VISITS IN 2010 INCLUDING 8,935 KIDS UNDER 13 YEARS OF AGE

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>$16,183,133</td>
<td>$22,778,112</td>
<td>$29,751,241</td>
</tr>
<tr>
<td>Commercial</td>
<td>$10,217,540</td>
<td>$11,167,301</td>
<td>$11,042,899</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>$31,238,410</td>
<td>$31,834,927</td>
<td>$35,281,035</td>
</tr>
<tr>
<td>All Other</td>
<td>$9,841,638</td>
<td>$12,473,446</td>
<td>$12,769,028</td>
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FLORIDA ORAL HEALTH EMERGENCY ROOM VISIT CHARGES BY PAYOR 2008-2010
ORAL HEALTH EMERGENCY ROOM SPENDING IN FLORIDA 2011-12 (FPHI, February, 2014)

- The tragic trend continues with 130,951 visits in 2011 and 139,298 in 2012 (a slight change in methodology so direct comparisons of numbers is not possible)

- 2012 costs of $115,592,378.

- Self-Pay/uninsured accounted for $52,591,929-that means you and I paid in higher hospital costs and premiums!

- Medicaid accounted for $49,240,459- we paid in tax dollars

- Young adults aged 20-34 accounted for the largest population group at 70,243, about half!
Dental Crisis in America
The Need to Expand Access

A Report from Chairman Bernard Sanders
Subcommittee on Primary Health and Aging
US Senate Committee on Health, Education, Labor and Pensions
February 29, 2012

Link to Hearing and Report
http://www.help.senate.gov/hearings/hearing/?id=a4b31ccd-5056-9502-5d8c-93b8b9da5d60
OBJECTIVES: Participants in this Seminar will be able to:

1. Describe various aspects of disparities in oral health including a definition of health disparities and examples of disparities.

2. Describe the effects of lack of access to oral health care and oral health care disparities.

3. Discuss some of the causes of oral health care disparities. What are the barriers to oral health care access? Today’s focus will be on Workforce/Oral Health Literacy!

4. What can we do to improve access to oral health care? List the Institute of Medicine recommendations about how to address oral health disparities.

5. Discuss the goals for UFCD to produce a culturally competent oral health workforce- our graduates.

My real goal is to stimulate faculty discussion about these important issues, not to convince you about any particular
Sanders Report

- 100,000,000 people in USA do not have dental insurance versus less than 40,000,000 without medical insurance.

- More than 47 million people live in DHPSAs and over 9,500 new dental providers are needed to meet these needs.

- About 17 million children had no dental services in 2009.

- About ¼ of adults 65 and older have lost all their teeth. But this number is improving!
Sanders Report

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- More than 47 million people live in DHPSAs and over 9,500 new dental providers are needed to meet these needs.

- About 17 million children had no dental services in 2009.

- About ¼ of adults 65 and older have lost all their teeth. But this number is improving!
Current Utilization in Medicaid Patients

Current national data from CMS for 2012 estimates that only 41% of Medicaid enrollees receive a preventive dental benefit, i.e., an examination or a fluoride treatment and that only 23% received a treatment visit. In some states such as Florida, the prevention utilization rate is only 18%. You can check out your state at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf
Periodontal Disease and Adverse Pregnancy Outcomes

- High prevalence of oral disease: 50 million people in the U.S. have periodontal disease

- In 1995 epidemiological data demonstrated an association between low birth weight and maternal periodontal disease (PD).

- In a case-controlled study, it was found that the greater the PD, the smaller the baby.

- Causality not yet demonstrated but a high degree of association.
Total First Year Costs

Full-term and Late-preterm Infants

Mclaurin, KK et al, Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. Pediatrics 2009;1232:653-659
Impact of poor oral health on children's school attendance and performance

- Children who missed school days because of dental problems did less well in school than children who missed school for other reasons.

Children's dental health, school performance, and psychosocial well-being.


• **OBJECTIVE:** To assess the effects of dental health on school performance and psychosocial well-being in a representative sample of US children, authors analyzed data from the 2007 National Survey of Children's Health for 40,752,988 children.

• **RESULTS:** Dental problems were significantly associated with reductions in school performance and psychosocial well-being:

  • Children with dental problems were more likely to have problems at school (OR = 1.52; 95% CI: 1.37-1.72) and to miss school (OR = 1.42; 95% CI: 1.23-1.64) and were less likely to do all required homework (OR = 0.76; 95% CI: 0.68-0.85).

  • Dental problems were associated with shyness, unhappiness, feeling of worthlessness, and reduced friendliness. The effects of dental problems on unhappiness and feeling of worthlessness were largest for adolescents between 15 and 17 years.

• **CONCLUSION:** Preventing and treating dental problems and improving dental health may benefit children’s academic achievement and cognitive and psychosocial development.
6. APPROACHES- What can we do address disparities? IOM recommendations with focus on Literacy and Workforce?

1. IOM Recommendations on care systems change

2. Oral Health Literacy/ Cultural Competency

3. Workforce
What are the factors causing health problems?

The Determinants of Health Status

- Quality of access to health care: 10%
- Genetics: 20%
- Environment: 20%
- Behavior: 50%
Figure 1. Life-course effects and influences on oral health and health disparities.


It’s complicated!

• “…the committee uncovered decades of effort that have been insufficient in eliminating significant disparities in access to oral health care.”

• “This report presents a vision for oral health care in the United States where everyone has access to quality oral health care throughout the life span.”

• “Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities.”
Improving Access to Oral Health Care for Vulnerable and Underserved Populations, 2011 Institute of Medicine and National Research Council

Recommendation 2. State legislators should amend existing state laws, including practice acts, to optimize access to oral health care.

- Allow allied dental professionals to practice to full extent of their education & training.
- Allow allied dental professionals to work in a variety of settings under evidenced-based supervision levels.
- Allow technology supported remote collaboration and supervision
Improving Access to Oral Health Care for Vulnerable and Underserved Populations, 2011 Institute of Medicine and National Research Council

Recommendation 3- Dental professional education programs should

-Increase recruitment and support for students from URM, lower-income and rural backgrounds

-Require all students to participate in CBE rotations with opportunities to work in interdisciplinary teams

-Recruit and retain faculty with experience in caring for underserved and vulnerable populations.
Recommendation 8- Increase funding for oral health research and evaluation related to underserved and vulnerable populations.

- New methods and technologies such as non traditional settings, non-dental providers, new provider types & telehealth

- Measures of access, quality and outcomes

- Payment and regulatory systems.
Improving Access to Oral Health Care for Vulnerable and Underserved Populations, 2011 Institute of Medicine and National Research Council

Recommendation 10- To expand the capacity of FQHCs to deliver essential oral health services, HRSA should

-Support the use of a variety of oral health care professionals

-Enhance financial incentives to attract and retain more oral health care professionals

-Provide guidance to implement best practices in management, operations and efficiencies

-Assist FQHCs to operate programs outside of their physical facilities and to implement new systems of care
*The association between low oral health literacy and poor oral health outcomes is well documented.

*Low oral health literacy may be associated with barriers to accessing care and oral health.*

*This study looked at the relationship between oral health literacy and patient-dentist communications and dental care patterns and self-reported oral health status.

*Beyond the often-reported effects of gender, race, education level and financial status, there is an influence of oral health literacy and quality of the patient-dentist communication on oral health status. For improved oral health, better communication appropriate for the target population is needed.*

Semi-structured individual interviews were conducted with 100 low socioeconomic status, rural, minority adolescents to explore their perceptions of oral health and dental care access. The sample was 80% Black and 52% male. Respondents were asked to describe any difficulties faced when seeking dental care, specifically a cleaning and check-up. Responses were rapid, specific and include the following categories:

1) **FINANCES**- Adolescents described “added costs” of dental care—transportation, childcare costs, and unpaid time away from work. Adolescents with access to regular dental care referenced the cost of dental care in general, or the cost of dental insurance. Adolescents without dental insurance described non-emergency dental care, as placing an “extra burden” on their family budget.

1) **TRANSPORTATION**- Related to the high cost of fuel, long travel distance, and lack of public transportation.
3) MEDICAID- Lack of Medicaid dental care providers within close proximity compromised ability to arrive on time for appointments. Timely travel was difficult by adolescents who traveled from rural to urban areas. Majority of Medicaid-eligible respondents identified Medicaid-related treatment rules and regulations as barriers. Some adolescents described their frustration when persistence in meeting appointment prerequisites was rewarded not with an appointment, but merely placement on a waiting list and an explanation that the Medicaid dentist is “…booked up and there is no room for you to get in.”

4) PARENTS- Most adolescents described the cost of dental care in general as problematic for family budgets. Accounts by a number of respondents illustrate that even though an appointment is scheduled, lack of family resources can still compromise their ability to attend the appointment.

5) FEAR- Among this sample, 60% of respondents (30 male and 30 female) offered at least one fear statement when describing why people do not go to the dentist
1. Training can improve the knowledge, skills and attitudes of health professionals.

2. Unfortunately, no evidence that this would result in improved patient adherence to therapy or health outcomes or equity of services.

3. Why? Dharamsi proposes “Othering”—distancing oneself, consciously or unconsciously, from those one perceives as different, in terms of gender, sexual orientation, ethnicity, language, social class, etc. This interferes with the doctor-patient relationship if perceived by the patient.
...to enhance the ability of our graduates to meet the oral health care needs of an increasingly diverse, economically needy and dentally underserved population. This proposal contains seven curricular projects...consistent with the purposes of the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordability Act of 2010- to address health professions workforce shortages with an emphasis on general and pediatric dentistry. Titles of the seven projects are: a) Enhancement and expansion of the existing behavioral sciences curriculum; b) Enhancement and expansion of the existing public health dentistry curriculum; c) Enhancement and expansion of the existing UFCD Summer of Learning Program; d) Implementation of an Infant Oral Health Clinic; e) Retention of the University of Florida Area Health Education Centers ATTAC–IT (AHEC Tobacco Training and Cessation – Initial Training); f) Enhancement of the predoctoral dental student community based rotations; g) Evaluation of Changes in Cultural Competency and Ethical Sensitivity.

One of the long term goals of the proposed enhancements of the UFCD predoctoral curriculum in this proposal is to increase the sense of Cultural Competency and Ethical Sensitivity/Social Justice of graduating dentists to better equip them to deal with a more diverse patient population; this should result in improved access to oral health care for underserved patient groups.
Workforce Changes

a) Better utilization of existing workforce- Duh? Dental Hygienists are greatly underutilized, especially in FLORIDA!

b) Lower the costs of care by training and implementing lower cost providers- Dental Therapists, who better represent patients

c) Cultural Competency
What is so special about dental therapists?

**Number/distribution** - They come from the communities they serve! Willing to return to local communities.

**Cost** - Less expensive to educate; less expensive to implement. Several reports demonstrate economic viability.

**Culture** - It is more likely that they are Culturally Competent.

**Behavior** - They focus not only on fixing teeth, but changing behaviors about prevention! More likely to be trusted by local communities.
I have seen Dental Therapists in action and I have reviewed the literature. I know they can work!

W. K. Kellogg Foundation released this article (http://www.wkkf.org/knowledge-center/resources/2012/04/Nash-Dental-Therapist-Literature-Review.aspx), “Most comprehensive review of dental therapists worldwide shows they provide effective dental care to millions of children. Suggests greater role for mid-level dental providers in the United States”. The principal author of this report is David Nash, DMD, MS, EdD from the University of Kentucky College of Dentistry. Dr. Nash states, “There is no question that dental therapists provide care for children that is high quality and safe. None of the 1,100 documents reviewed found any evidence of compromise to children’s safety or quality of care. Given these findings, the profession of dentistry should support adding dental therapists to the oral health care team.”

Personal observations in Alaska. Interviews with therapists and employers in Minnesota.
Dental Therapists can be and should be part of the solution. About 15 states are actively pursuing dental therapy programs.

I have visited Kansas, New Mexico, Illinois, Ohio, Michigan, Maine and other states. You can read about other state coalitions. They all recognize the significant need and the value of adding Dental Therapists to the Oral Health Care Team.

You are the academic leaders of the future-
Help your state be the next on the list!
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