

Report of the  
**Ohio Dental Workforce Roundtable**



May 2006

## Message from the President of the Health Policy Institute of Ohio

Our Institute's recent 2005 report *Does Oral Health Matter?* challenged Ohio's policymakers to consider the consequences of overlooking the importance of good oral health. In Ohio, researchers have found that more than 50% of Ohio adults have had some teeth removed due to dental disease, while 9% have had all of their teeth removed due to tooth decay or gum disease. And more than one third of Ohio's 6 – to 8-year olds from poor families had untreated dental disease – twice the rate of children from families who earn more than 185 percent of the poverty level. A growing body of evidence points to the relationship between oral diseases and medical conditions such as coronary artery disease, stroke, pre-term delivery, low birth weight, pneumonia, osteoporosis, and diabetes. In Ohio, disparities in oral health and access to care have been linked to low family income, residence in an Appalachian county, and race.



In 2005, the Ohio Department of Health and the Health Policy Institute of Ohio convened representatives from the oral health professions; public and private associations, foundations, and coalitions; dental schools; and government to dialogue about strategies to deploy Ohio's oral health care workforce more effectively. The Ohio Dental Workforce Roundtable met throughout 2005 and developed a set of core values to guide dental workforce policy implementation in Ohio, as well as a set of recommendations to present to the Director of the Ohio Department of Health. Those values and recommendations, as well as background and contextual information, are included in the report that follows.

I would like to thank a number of individuals for their contributions to this important initiative. Dr. Mark Siegal, Chief of the Bureau of Oral Health Services, Ohio Department of Health, provided us with the opportunity to move forward as partners to explore these critical workforce issues. His faith in our ability to provide a neutral, safe setting for informed dialogue provided us one of our first strategic visioning efforts as a new Institute. I want to thank Chris Kloth, author of this report and professional consultant from ChangeWorks of the Heartland, for his endless creativity, his sharply-honed facilitation skills, and his dedication to the goal of this initiative. I am indebted to Jill Huntley of my staff for her expert management of the project and Vicki Twining of the Ohio Department of Health for her thoroughly professional administrative support. And I want to express my sincere gratitude to the members of the Roundtable – their willingness to make time for the project, travel from around the state to attend four full day sessions, and participate in dialogue that was challenging and thought-provoking.

The recommendations included in the report represent a starting point for action in a number of areas. There remain, however, workforce issues where consensus was not reached and where further discussion is needed – as well as a willingness to break down barriers to move toward a future where Ohio's most vulnerable citizens receive the care they need. I hope the work of the Roundtable has provided awareness and guidance for the challenges ahead and, importantly, planted seeds toward true innovation.

Thank you for your attention to this report and its call to action.

A handwritten signature in black ink that reads "William D. Hayes". The signature is written in a cursive, slightly slanted style.

William D. Hayes, Ph.D.

## Executive Summary

Significant gains in oral health at the national and state levels have been achieved over the last fifty years. Despite those gains, millions of Americans still suffer from preventable oral diseases. According to the findings of the *Access to Dental Care in Ohio Report, 2000*, many Ohioans, particularly those who are minority, low-income, or live in rural areas, have significant oral health needs and limited access to dental care. In 2003, the Director of the Ohio Department of Health, Dr. J. Nick Baird, reconvened the Director of Health's Task Force on Access to Dental Care to update recommendations made in 2000. The resulting *Recommendations of the Director of Health's Task Force on Access to Dental Care, 2004* summarized accomplishments and made additional recommendations that were grouped in four areas: financial barriers; system capacity to serve the vulnerable; community partnerships; and awareness of the public and decision makers.

A key long range recommendation related to the system's capacity to serve the vulnerable included the establishment of a Dental Workforce Task Force. Workforce concerns involve a complex range of public policy and professional practice issues that have received relatively little thoughtful action at both the national and state levels. The challenges are daunting and range from state budget cutbacks to the increased need for cultural competence to adequately serve ethnically diverse populations.

Throughout 2005, The Health Policy Institute of Ohio, in partnership with the Ohio Department of Health, hosted a series of "Roundtable" dialogues to consider how Ohio might be more effective in utilizing its oral health care workforce to address the oral health needs of Ohio's most vulnerable citizens. Roundtable membership was inclusive and diverse, including representatives spanning the oral health care workforce. Additional representation came from the public and private not-for-profit sectors. Representatives from the following organizations and associations participated in the Roundtable and share credit for this report (a complete list of participants is included in Appendix A):



- Association of Ohio Health Commissioners
- Ohio Dental Expanded Functions Association
- Case School of Dental Medicine
- Ohio Department of Health
- Health Policy Institute of Ohio
- Ohio State Dental Board
- Ohio Coalition for Oral Health
- The Ohio State University College of Dentistry
- Ohio Dental Association
- Saint Luke's Foundation of Cleveland
- Ohio Dental Hygienists' Association
- ODH Director's Task Force on Access to Dental Care

The sessions included information and perspectives based on a literature review, presentations by guests, and topics presented by members of the group (a summary of the literature review is included in Appendix B). The challenging backdrop against which the process took place is candidly described in the *Statement of Conditions*. The dialogues, including the agreement on core values, were far-reaching and spirited. The recommendations that received broad agreement and minor opposition were those that involved relatively small changes to the status quo.

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While there was general agreement that meeting the needs of vulnerable Ohioans will require more than workforce strategies, the group agreed on a number of approaches for consideration along with the other non-workforce options recommended by the Director of Health's Task Force on Access to Dental Care. Although the literature on the impact of workforce approaches on access to dental care is not exhaustive or definitive, some approaches would appear to have greater potential than others. Some approaches require more investment than others and some may require considerable adaptation before they can be implemented in Ohio. The Roundtable proceedings provide insights that may guide policymakers, professional associations, funders, advocates, political candidates, and innovators as they consider how to prioritize effort and resources.

In its deliberations, the Roundtable agreed on the following principles and facts:

- Workforce strategies for addressing access to oral health care by vulnerable Ohioans should be considered one element of a broader range of other strategies addressing access to oral health care in Ohio;
- Any workforce strategy adopted, adapted, or pilot-tested in Ohio should be values-based and data-driven. More specifically, strategies should be consistent with the core values that are identified in this report and supported by the Roundtable participants;
- There are workforce deployment options permitted by current Ohio law and regulations that are not being used effectively or fully;
- There are applicable alternative workforce strategies that have been tried in other parts of the United States, although there is limited evaluation research to assess their impact where they have been tried or how they might be adapted in Ohio;
- Workforce strategies that involve changing

roles or supervision should maintain appropriate quality of care and accountability; and

- Public clinics (also referred to as safety net dental clinics) are valued as one essential element in addressing access to oral health care for vulnerable Ohioans, including workforce strategies.

### Recommendations:

Among the many approaches considered, the following recommendations received broad agreement without significant dissent. Within the body of the report, they are grouped into three broad themes: 1) Number, variety, and deployment of human resources in all settings; 2) Private, public, and other community partnerships; and 3) Innovations. (A summary of the ranking process is included in Appendix C).

#### RECOMMENDATION 1

Expand the scope of practice for oral health care personnel by increasing allowable duties/functions so as to increase the capacity of dental practices and clinics.

#### RECOMMENDATION 2

Develop strategies to increase the number of all oral health care personnel able and willing to work in underserved areas.

#### RECOMMENDATION 3

Increase the number of dental students, general practice residents (GPRs), and advanced education in general dentistry (AEGD) students who provide care in safety net dental clinics (e.g., expand the Ohio State University College of Dentistry's OHIO Project).

#### RECOMMENDATION 4

Recruit more students from underserved populations into dental schools.

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### RECOMMENDATION 5

Expand the focus of dental schools to include cultural competence as an important element of providing quality care in any setting.

### RECOMMENDATION 6

Expand the focus of dental schools to teach dentists how to most effectively work with EFDAs and other allied professionals in practices.

### RECOMMENDATION 7

Actively encourage volunteerism by practicing and retired dentists and allied oral health care personnel, particularly in public health settings.

### RECOMMENDATION 8

Adopt financial incentives for oral health care personnel able and willing to work in settings that serve the most vulnerable Ohioans. Examples of incentives include increasing loan repayment/scholarship opportunities; offering tax incentives; and establishing local oral health workforce opportunity zones.

### RECOMMENDATION 9

Develop an information clearinghouse for practice opportunities available in underserved communities, as well as programs that assist in placement.

### RECOMMENDATION 10

Collect data to monitor dental workforce trends through surveys that accompany licensure renewal.

### RECOMMENDATION 11

Conduct pilot projects in one urban site and one rural site that create a sustainable model for broad service delivery of comprehensive needs.

### RECOMMENDATION 12

Expand existing workforce and economic development strategies in Ohio to include education and training for oral health care personnel, as well as incentives to develop appropriate local business strategies to increase access to care.

“The Oral Health America National Grading Project, an organization that releases state-by-state report cards measuring the status of oral health across the nation, gave the nation an overall grade of C for oral health in 2003. The state of Ohio fared somewhat better, achieving a grade of B-. Although Ohio was the only state to receive an A for prevention, access to dental health care was a significant area of concern.”

—from *Does Oral Health Matter?*

In addition to the approaches that received broad agreement at this time, other approaches that had significant agreement along with significant dissent may become feasible in the future if conditions change.

## Introduction and Background

### Why Consider Dental Workforce Issues?

The publication and distribution of *Access to Dental Care in Ohio, 2000* by the Ohio Department of Health (ODH) and the Ohio Department of Job and Family Services (ODJFS) made clear what many already knew:

- Oral health means much more than healthy teeth;
- Oral health is integral to general health; and
- There are profound and consequential oral health disparities within the population.<sup>1</sup>

In 2003 the ODH Director, Dr. J. Nick Baird, reconvened the *Director of Health's Task Force on Access to Dental Care* to update recommendations made in 2000. The resulting *Recommendations of the Director of Health's Task Force on Access to Dental Care, 2004* summarized accomplishments and made additional recommendations that were grouped in four categories:

- Financial barriers;
- System capacity to serve the vulnerable;
- Community partnerships; and
- Awareness of the public and decision makers.<sup>2</sup>

The system capacity category included a number of short range recommendations related to education of oral health professionals, safety net clinics, and piloting dental health care case management for low income Ohioans. Long range recommendations included the establishment of a Dental Workforce Task Force. The focus of the task force was intended to include, but not be limited to, the following areas:

- The adequacy of dentists to meet the dental care needs of all Ohioans;
- Development of a model for the most appropriate types of providers and auxiliaries and the scopes of their work in order to create efficiencies that will improve access to dental care for underserved Ohioans;
- Creation of a cadre of primary care dentists with a significant portion of their clinical training in safety net clinics and obliged/inspired to serve low-income Ohioans;
- Recruitment of under-represented minorities into the respective professions; and
- Creation of local dental workforce opportunity

zones to provide incentives for professional practices that accept Medicaid or locate in underserved geographic areas.

In calling for the establishment of a dental workforce task force, Dr. Baird recognized that all four categories of recommendations in the 2004 document are important and, to some extent, interdependent. He also recognized that workforce concerns involve a complex range of public policy and professional practice issues that have received relatively little thoughtful action.

## The Ohio Dental Workforce Roundtable

In response to the 2004 Director's Task Force recommendations, the ODH partnered with the Health Policy Institute of Ohio (HPIO) to convene the Ohio Dental Workforce Roundtable. The primary goal of the Roundtable was to develop a set of recommendations to present to the Director of Health regarding workforce-related approaches to improve access to oral health for vulnerable Ohioans. This report describes those recommendations and may be considered for inclusion in the Director's next Task Force report.

The Roundtable approach was selected for this work specifically to encourage an environment of dialogue. Keeping in mind the long range context of the 2004 recommendations, participants were encouraged to consider:

- Changing beliefs and assumptions about how quality care might be provided in the future;
- Potential innovations in delivery of care; and
- Potential changes in law, public policy, or professional practice.

In addition, recognizing their wide range of experience and perspectives, participants were invited to influence the range of topics to consider during the process.

Over the course of four meetings, the Roundtable heard presentations on trends and approaches used or recommended by professionals throughout the United States and engaged in spirited conversation about what they heard. They clarified core values that they believe should create a context for future allocation of resources on workforce issues.

Staff members from ODH and HPIO reviewed a considerable amount of research on workforce issues in preparation for



## An Integrated Approach to Planning and Change

Research on planning and change frequently takes note of the significance of two distinct perspectives: *moving away from* the past or present and *moving toward* the future. Many planners and change leaders agree that “moving away” is a useful perspective rooted in recognizing problems and addressing them in the planning processes. Others believe that “moving away” sometimes is so rooted in reactions to past problems that it remains bound to the past and fails to account for creative options that might work in the future – especially if some of those options were tried unsuccessfully in the past.

Alternatively, the “moving toward” approach is rooted in aspirations and desired outcomes. Some suggest that real change must be driven by a compelling vision rooted in the future, while others think this is naïve and unrealistic.

A third view, reflected in this summary, acknowledges both perspectives. While reflecting learning from past experience, it starts by articulating future policy outcomes rooted in shared values. These outcomes inform the selection of options in the present and are the basis for evaluating progress over time.

the process and between sessions. Roundtable input helped to focus the review process. Staff also conducted a telephone survey of selected state boards of dentistry to gain added insight into concerns raised during the process, especially from the consumer perspective. Summaries of the research can be found in Appendix B of this report. They are provided to show the range of practices and perspectives on dental workforce issues in the United States. In addition, they may provide a starting point for subsequent activities that address workforce issues in Ohio.

The Roundtable reached broad agreement on some issues and less agreement on others. A key area of agreement included the need to develop a set of core values linked to workforce issues. Roundtable members felt strongly that these core values guide the work of change agents, ODH, and other stakeholders in their future efforts to (1) identify options that have the potential to gain broad support in Ohio, (2) identify options that may need to be adapted to gain support in Ohio, and (3) develop possible indicators of success when new initiatives are undertaken.

It’s important to reiterate that the work of the Roundtable must be considered in the context of the 2004 report to the Director. Workforce issues are only one aspect of what limits the access of vulnerable persons to oral health care. Further, the Roundtable does not view workforce issues as the most significant obstacle. Many participants expressed the concern that, in an era of limited resources, investing in workforce innovations may undermine efforts to address other major obstacles, including those related to funding and finance.

## Core Values

Whatever one’s theory of change, it is generally understood that a successful planning process starts with the identification of core values. Collectively and separately, we all assess options based on how they are more or less consistent with our values. Our values emerge from many sources: personal, professional, political, cultural, spiritual, and others.

While some think of values as theoretical or abstract, their implications are always both practical and tactical. Any time we want to achieve important outcomes that require the active support and involvement of others, our plans must identify the shared values that allow the participants to stay focused, to make decisions, and to build understanding and trust.

## Core Values

The following core values were discussed at length and are supported by the Ohio Dental Workforce Roundtable:

1. All people living in Ohio, especially children, should have access to reasonable and adequate health care, including oral health services;
2. Assuring access to reasonable and adequate health care, including oral health services, is in the public interest and, therefore, a shared concern of all health professionals, government, community-based organizations, and consumers;
3. Providing access to reasonable and adequate oral health services is the shared responsibility of a well-trained, talented, interdependent, interdisciplinary community of oral health professionals (dentists, dental hygienists, EFDAs, etc.), as well as other community partners, including physicians, nurses, public health professionals, and community-based agencies;
4. With respect to a continuum of all possible health care options that might be provided to any patient:
  - a. Society cannot afford to provide an optimal level of care to all of the most vulnerable, but
  - b. Society cannot afford to deny any person access to reasonable and adequate care;
5. A two-tiered health care delivery system is unacceptable;<sup>3</sup>
6. Adequate and reasonable oral health services
  - a. Include:
    - i. Basic diagnostic services;
    - ii. Services that result in being free of pain and infection;
    - iii. Basic restorative services that preserve or restore function;
    - iv. Basic aesthetics; and
    - v. Prevention and education.
  - b. Are provided by trained oral health professionals
    - i. With a level of proficiency that equals established professional standards of practice, and
    - ii. To everyone they serve, regardless of the barriers faced by the person or group being served.
7. The oral health community is committed to:
  - a. Developing and implementing strategies that address barriers to access by the most vulnerable. Barriers might include, but are not limited to,
    - i. Low income;
    - ii. Residential settings (institutions, homebound, urban/rural, homelessness, etc.); and
    - iii. Other circumstances such as age, having developmental disabilities, limited English speaking ability, lack of transportation, etc.
  - b. Collaborating with private and public partners to:
    - i. Increase access to reasonable and adequate oral health services by the most vulnerable people living in Ohio;
    - ii. Promote innovation in addressing barriers, where innovation is consistent with achieving access to reasonable and adequate oral health care; and
    - iii. Increase flexibility in public and private oral health service delivery systems in ways that:
      1. Are responsive to the needs of patients, and
      2. Ensure the quality of care.
8. Goals should be values-driven; strategies should be data-driven.

## Statement of Conditions in 2005

Providing access to reasonable and adequate oral health care is affected by a wide variety of interdependent factors. Effective development and deployment of the oral health workforce is only one element in achieving full access to adequate and reasonable oral health care for the most vulnerable in Ohio. With respect to the current status of workforce issues and access by the vulnerable in Ohio, the following conditions were explicitly or implicitly raised by Roundtable participants during the process.



1. From a workforce perspective,
  - a. Increasing the number of dentists practicing in Ohio, by itself, is not a sufficient solution to overcome barriers to access, however
  - b. If other interventions (for example, more efficient practice models, increased use of safety nets, increased identification and referrals by professional and community partners) significantly increase the number of vulnerable people seeking care then, in the future, there may be a need for more care providers to respond to increasing demand.
2. There may be “disincentives” for private dental practices that might otherwise choose to provide services to the most vulnerable:
  - a. Some of the disincentives are related to the fact that a substantial portion of the vulnerable population is covered by Medicaid:
    - i. The extent to which the Medicaid budget varies, in whole and in part, affects reimbursement rates and the extent to which some portions of the vulnerable population are given higher priority for services;
    - ii. Budget changes also limit the extent to which providers can do financial planning for their practices; and
    - iii. Paperwork is considered a burden.
  - b. Many of the most vulnerable are not covered by Medicaid or any other form of insurance. Among the additional challenges to providers are:
    - i. The extent to which they are unable to recover the costs of providing services;
    - ii. Higher “no-show” rates due to lack of transportation, child care, and other life challenges;
    - iii. The amount of time spent with each patient; and
    - iv. The cost of maintaining offices in some urban locations or remote rural locations.
3. There are workforce deployment options permitted by current Ohio law and regulations that are not being used effectively or fully.
4. There are applicable alternative workforce strategies that have been tried in other parts of the United States, although there is limited evaluation research to assess their impact where they have been tried or how they might be adapted in Ohio.
5. There is not an unambiguous, consistent body of qualitative or quantitative data that provides clear insight into the potential of workforce options to address access issues.
6. There is resistance to some workforce options based on:
  - a. Lack of familiarity with or confidence in data to support the efficacy of the alternatives if implemented in Ohio;
  - b. Funding, statutory and regulatory limits to implementing some strategies;
  - c. Ambivalence related to the role of government in making policy related to oral health practices;
  - d. Limited reliable information regarding the effective uses of technology for diagnosis, assessment, treatment, and prevention;
  - e. Professional association commitments to

constituents that prevent consideration of research into some options or review of some legal and regulatory barriers; and

- f. Apparently conflicting constituent interests among the professional associations for oral health care professionals.
7. Some Roundtable participants expressed concern that *changing* how supervision is conducted is the same as *reducing* supervision and quality of care.
8. Understanding the amount and type of supervision required in any situation, as well as when and how it might be changed, involves the extent to which the supervised activity entails:
  - a. Diagnosis;
  - b. Treatment;
  - c. Prevention; and
  - d. Education.
9. Public clinics:
  - a. Provide quality care that consistently meets or exceeds the adequate and reasonable level of care;
  - b. Are considered one effective strategy for addressing access barriers, one that should be further developed; and
  - c. Have the potential to more fully utilize and experiment with expanded duties, supervision practices, and case management, especially in urban areas.
10. Allied oral health care professionals (i.e., dental hygienists, dental assistants, EFDAs)
  - a. See themselves as being in the business of promoting dentistry; and
  - b. Are willing to share responsibility for finding ways to increase access to reasonable and adequate quality care while:
    - i. Increasing training,
    - ii. Assuring effective supervision in forms new to Ohio,
    - iii. Expanding some roles within clear standards, and
    - iv. Sharing accountability and liability for providing services.
11. The Board of Trustees of the American Dental Association (ADA) has addressed Dental Workforce issues as part of the President's Think

Tank. Board Report 15 submitted by that group indicated shifting views on the roles of allied oral health personnel, including:

- a. Expanded roles;
- b. Innovative education and training programs;
- c. Encouragement of pilot projects in selected states; and
- d. Resolutions consistent with these shifts that have been approved by the ADA House of Delegates.<sup>4</sup>

## Policy Options

The lack of access to oral health services for many Americans has led to consideration of a wide variety of changes in policies and practices nationwide. While research on the impact of many of these potential changes is very limited, and while it is understood that conditions vary from state to state, the Roundtable process was designed to provide a setting for exploring a broad range of possibilities. Some approaches considered by participants were presented by guest experts or were identified in a literature review. Others were identified by members of the Roundtable.

What follows is a summary of options discussed during the process. At least three broad themes provide a framework for understanding the interdependence of the options. They are:

- Number, variety and deployment of human resources in all settings;
- Private, public and other community partnerships; and
- Innovation.

These broad categories are neither discrete nor mutually exclusive. Some options have the potential to be studied, evaluated, piloted or implemented in the short term. Others are longer term strategies. Some may be of interest to private or public funders, while others may require legislative or other policy waivers or changes in order to be tried or adopted. Additional training and education may be required to support some options.

Keeping in mind that the results of the Roundtable discussions will be used to elaborate on the *2004 Access to Dental Care* report, considerable progress has been made in (a) clarifying the range of workforce strategy options that this group of leaders is and is not willing to recommend for further

attention in the future and (b) specific core values to consider when evaluating options. The following list of options is provided for the review and future consideration by others who are committed to further exploration of workforce concerns in Ohio. These options were discussed and debated thoroughly. The list is comprehensive and does not represent a consensus of opinion among the participants. Those options in this section for which there were broad support, however, are highlighted in the next section and are presented as the final recommendations of this report.

## Number, variety and deployment of human resources in all settings

1. Expand the scope of practice for oral health care personnel by *increasing allowable duties/functions* so as to increase the capacity of dental practices and clinics. Look into
  - a. Increased use of EFDAs and other auxiliaries,
  - b. Increased consideration of ways to assure that the physical space in facilities is configured for the most efficient use of staff, and
  - c. The ODA Workforce Task Force recommendations on delegable duties.
2. Expand the scope of practice for allied dental providers by *reducing supervision* so as to increase the capacity of dental practices and clinics. In keeping with the spirit of exploring a broad range of approaches, regardless of the extent to which there might or might not be local support, some options discussed include:
  - a. Unsupervised practice of RDH in public health programs
  - b. Alternative supervision
  - c. Independent practice
  - d. Alternative practice, such as
    - i. Collaborative agreements with DDS
    - ii. Rx from DDS (or MD).
3. Develop a cadre of true mid-level professionals modeled after the dental therapist and public health nursing. However, this approach may represent an expanded scope of service without a dentist *and* may cross the line into restorative care traditionally reserved for the DDS. Additionally, they are examples of approaches from which an Ohio model might be developed – the Roundtable would only support approaches adapted to conditions in Ohio. Some options include:
  - a. DHAT (New Zealand Dental Therapist)
  - b. Community Oral Health Provider (COHP) – Proposed for Alaska by ADA<sup>5</sup>
  - c. ADHA Advanced Dental Hygiene Practitioner (ADHP)
  - d. An emerging ADA model.<sup>6</sup>
4. Develop strategies to increase the number of all oral health care personnel able and willing to work in underserved areas.
5. Increase the use of qualified foreign-trained dentists and other oral health professionals as
  - a. Dentists
  - b. RDHs
  - c. EFDAs.
6. Increase the use of dentists-in-training (dental students, AEGD, and GPR) for outreach to underserved populations, with proper supervision, so they get the experience of working with the vulnerable in a variety of settings and may choose to continue to do so. They might serve as:
  - a. Dentists
  - b. RDHs
  - c. EFDAs.
7. Increase the number of dental students, AEGD, and GPR rotations in safety net dental clinics (expand the Ohio State University College of Dentistry’s OHIO Project).
8. Expand PGY – 1 programs (requiring additional GPR/AEGD programs).
9. Dental schools should recruit more students from underserved backgrounds:
  - a. They may need to support mentoring programs to assist, work with, or be role models to recruits and
  - b. They may need to start awareness programs as early as elementary or middle school.
10. Dental schools should expand their focus on how dentists can most effectively work with allied professionals in any setting.
11. Dental schools should expand their focus on cultural competence as an important element of providing quality care in any setting.

12. Increase the use of EFDAs and other allied professionals by physicians in medical practices and clinics.

## **Private, public and other community partnerships**

13. Encourage volunteerism (generally in safety net dental clinic settings)
  - a. Potential target recruits should include
    - i. Active DDSs
    - ii. Retired DDSs
    - iii. Active allied oral health care personnel
    - iv. Retired allied oral health care personnel
  - b. Volunteerism is seen by some as a low impact/high investment option, not a “home run”
  - c. Licensed dentists and dental hygienists who volunteer are not liable for damages in a tort or other civil action arising from an action or omission of the volunteer in the provision to an indigent and uninsured person of dental diagnosis, care, or treatment unless the action or omission constitutes willful or wanton misconduct<sup>7</sup>
  - d. There may be some potential policy issues/options to address to ease the process, such as fee waivers, continuing education credits, etc.
14. Financial incentives should be available for all personnel able and willing to work with underserved Ohioans, such as
  - a. Increasing loan repayment/scholarship opportunities
  - b. Offering tax incentives
  - c. Establishing local oral health workforce opportunity zones.
15. Develop an information clearinghouse on practice opportunities in underserved communities and programs that assist in placement.
16. Collect data to monitor dental workforce trends through surveys that accompany licensure renewal.

## **Innovations**

17. Increase the use of technology to support

- a. Supervision
- b. Expansion of duties
- c. Training.

18. Conduct a pilot project in one urban demonstration site that creates a sustainable model for broad service delivery of comprehensive needs:
  - a. Acute care
  - b. Public health interventions (churches, schools, etc.)
  - c. Part of the community.
19. Conduct a pilot project in one rural demonstration site that creates a sustainable model for broad service delivery of comprehensive needs:
  - a. Acute care
  - b. Public health interventions (churches, schools, etc.)
  - c. Part of the Community.
20. Expand existing workforce education programs to
  - a. Train students to use existing workforce strategies in Ohio law and policies more effectively
  - b. Partner with the State Workforce Policy Board and local Workforce Investment Boards to access additional resources for training and to support local business development (such as dental practices and clinics).<sup>8</sup>

## **Recommendations**

After exploring this broad range of possible workforce approaches for addressing the oral health needs of Ohio’s most vulnerable citizens, the Roundtable engaged in a process of ranking the ideas for further consideration in Ohio. These rankings are intended to provide guidance to a broad range of stakeholders who may, in the future, consider how to address Ohio’s challenges. State agencies such as ODH and ODJFS might choose to allocate resources for pilot programs or set standards related to publicly-funded clinics. Dental schools might provide new elements in their curricula and in the experiences they provide students. Professional associations might encourage members to consider adopting some already allowable practices and advocate in the General Assembly for changes that support more effective use of resources. Funders might adopt criteria for the types of projects they fund and the levels of funding they are willing to allocate. Political

candidates may find policy options to propose.

The following recommendations represent those options that had the most support and little or no opposition in the rankings. Although some of them were seen as harder to adopt or adapt in Ohio under current conditions, they were all viewed as important for future workforce conversations. For those options that generated significant opposition or where no agreement could be reached, please refer to the Policy Options section and Appendix C of this report. The recommendations are grouped into the three thematic categories described in the Policy Options section. These categories were part of the Roundtable discussion and it is our hope that they provide a useful framework for future innovators.

### **Number, Variety, and Deployment of Human Resources in All Settings:**

#### **RECOMMENDATION 1**

Expand the scope of practice for oral health care personnel by increasing allowable duties/functions so as to increase the capacity of dental practices and clinics.

#### **RECOMMENDATION 2**

Develop strategies to increase the number of all oral health care personnel able and willing to work in underserved areas.

#### **RECOMMENDATION 3**

Increase the number of dental students, general practice residents (GPRs), and advanced education in general dentistry (AEGD) students who provide care in safety net dental clinics (e.g., expand the Ohio State University College of Dentistry's OHIO Project).

#### **RECOMMENDATION 4**

Recruit more students from underserved populations into dental schools.

#### **RECOMMENDATION 5**

Expand the focus of dental schools to include cultural competence as an important element of providing quality care in any setting.

#### **RECOMMENDATION 6**

Expand the focus of dental schools to teach dentists how

to most effectively work with EFDAs and other allied professionals in practices.

### **Private, Public, and Other Community Partnerships:**

#### **RECOMMENDATION 7**

Actively encourage volunteerism by practicing and retired dentists and allied oral health care personnel, particularly in public health settings.

#### **RECOMMENDATION 8**

Adopt financial incentives for all oral health care personnel able and willing to work in settings that serve the most vulnerable Ohioans. Examples of incentives include increasing loan repayment/scholarship opportunities; offering tax incentives; and establishing local oral health workforce opportunity zones.

#### **RECOMMENDATION 9**

Develop an information clearinghouse for practice opportunities available in underserved communities, as well as programs that assist in placement.

#### **RECOMMENDATION 10**

Collect data to monitor dental workforce trends through surveys that accompany licensure renewal.

### **Innovations:**

#### **RECOMMENDATION 11**

Conduct pilot projects in one urban site and one rural site that create a sustainable model for broad service delivery of comprehensive needs.

#### **RECOMMENDATION 12**

Expand existing workforce and economic development strategies in Ohio to include education and training for oral health care personnel, as well as incentives to develop appropriate local business strategies to increase access to care.

## Endnotes

<sup>1</sup> M. Siegal, C. Farquhar, and C. Afkhami, Access to Dental Care in Ohio, 2000, Ohio Department of Health and Ohio Department of Job & Family Services.

<sup>2</sup> Ohio Department of Health (ODH). “Recommendations of the Director of Health’s Task Force on Access to Dental Care—2004.”

<sup>3</sup> The American Dental Association’s position is that a two-tiered system exists when there is one level of care for the more fortunate (care provided by professionals trained to provide optimal dental care) and another level of care for the underserved (care provided by those with very limited education and training). Other oral health professionals define a two-tiered system as one where the delivery system limits or entirely prevents access to care for some individuals and not others. Another variation of this definition maintains that some individuals are able to choose care options beyond an “adequate and reasonable level,” while others cannot afford those options. Despite the complexity and lack of a consensus definition for “two-tiered system,” the Roundtable did agree that for purposes of establishing core values, the following tenets are essential:

- Every health care professional is obliged to treat each individual to whom s/he provides care with the same degree of personal proficiency for each service provided and to demonstrate the same degree of compassion and respect, regardless of circumstance, and
- There is an “adequate and reasonable level” of care that can be defined and delivered and every person cared for has a right to expect that level of care.

<sup>4</sup> The month following the final Roundtable meeting, the ADA House of Delegates adopted two resolutions with significance for the work of the Ohio Roundtable.

- o Resolution 48H (Model Curriculum to Facilitate Development of Dentists Trained with a Focus on Community-based Dentistry) by which the ADA will work with the dental education community to develop a model for curriculum changes and/or apply existing models that would facilitate the development of dentists trained with a focus on community-based dentistry. The model would be field-tested by one or more pilot projects that would deliver not only acute care to patients, but also work to provide public health interventions to maximize prevention of oral disease before it is manifest.
- o Resolution 85H (Access to Oral Health Care for the Underserved Populations) called for the formation of an ADA Task Force to collect and review existing data (including but not limited to Board Report 15), develop additional information, if needed, and report to the 2006 ADA House of Delegates on the following issues:
  - The adequacy of the current workforce to serve the population groups with unmet oral health care needs, and the oral health of the general population;
  - The rationale and feasibility of additional duties for allied dental personnel and the possible realignment of roles, including the analysis of existing programs where additional duties are in place;

- The impact on access to care in states where expanded duties or independent practice of dental auxiliaries have been granted to members of the dental team;
- The disparity between need and demand for oral health care and the real and perceived causes of any unmet needs;
- The development of strategies to increase oral health literacy and utilization; and
- Economic factors including, but not limited to, development of business models and financial incentives that would attract and retain dental practitioners to underserved areas.

Resolution 85H also stated the Association’s support for the study of possible new types of allied dental personnel and realignment of roles for existing personnel to perform their duties.

<sup>5</sup> Resolution 85H stated that for the duration of the Task Force it created in 85H (at least until the House of Delegates meeting in the fall of 2006), the ADA supports community-based oral health provider (COHP) programs – that don’t include Atraumatic Restorative Technique (ART) and local anesthesia – as a viable alternative to the dental health aide therapist (DHAT).

<sup>6</sup> This was suggested in Board Report 15 and included in the charge to the Task Force created in Resolution 85H, adopted after the final Roundtable meeting.

<sup>7</sup> Section 4715-22-01 of the Ohio Administrative Code allows retired dentists and dental hygienists to make application to the Ohio State Dental Board for a volunteer’s certificate. This certificate allows them to provide free services to indigent and uninsured persons on the premises of a nonprofit shelter or health care facility. It also grants them certain immunities. At the time of publication of this report, no applications had been submitted or are pending, suggesting a better marketing strategy is needed.

<sup>8</sup> Since the final Roundtable meeting, Chris Kloth, Roundtable Facilitator, participated in the work of the State Workforce Policy Board and local Workforce Investment Boards. It is noted here due to its potential to assist those who move forward with recommendations contained in this report.

# APPENDIX A

## Members of the Ohio Dental Workforce Roundtable

Dr. J. Nick Baird	Ohio Department of Health
Carrie Farquhar	Ohio Department of Health
Dr. Henry Fields	Ohio Dental Association
Leah Gary	Saint Luke's Foundation of Cleveland
Dr. Jerold S. Goldberg	Case School of Dental Medicine
Burnadette Green	Ohio Dental Expanded Functions Association
Dr. William Hayes	Health Policy Institute of Ohio
Linda Hewetson	Ohio Dental Hygienists' Association
Dr. Lawrence Hill	Ohio Coalition for Oral Health
Rebecca Hockenberry	Ohio State Dental Board
Clifford Jones	Ohio Dental Hygienists' Association
Dr. Jan Kronmiller	The Ohio State University College of Dentistry
Dr. Ron Lemmo	Ohio Dental Association
Gene Nixon	Association of Ohio Health Commissioners
David Owsiany	Ohio Dental Association
Dr. David Rummel	ODH Director's Task Force on Access to Dental Care
Dr. Mark Siegal	Ohio Department of Health
Anne Stephens	Ohio Dental Hygienists' Association

### **Facilitator**

Chris Kloth	ChangeWorks of the Heartland
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### **Staff**

Jill Huntley	Health Policy Institute of Ohio
Vicki Twining	Ohio Department of Health

# APPENDIX B

## Summary of Literature Review

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>A. Increase the supply and/or use of allied oral health care personnel in underserved areas.</p> <p><i>Increasing the “supply” would require expanding/creating/modifying educational programs for various types of allied oral health care personnel. Increasing the “use” might require education of private practice dentists in underserved areas and safety net dental clinic directors.</i></p>	<p>California</p> <ul style="list-style-type: none"> <li>• RDHAP (Alternative Practice)</li> <li>• RDA and RDAEFs can work under direct sup. of RDHAP in safety nets.</li> <li>• RDH: in public health programs (federal, state, local gov.) can screen and provide prev. services (including F and sealants) without supervision.</li> </ul> <p>Alabama Dental Hygiene Program (train in dental offices)</p>	<p>Southeast Regional Center for Health Workforce Studies (UNC) is leading a HRSA-funded process to revise the Dental Health Professional Shortage Area (DHPSA) designation methodology. After reviewing the literature, they developed a white paper saying that the number of auxiliaries in general wasn’t an important factor but that the number of RDHs was. They estimated that each RDH resulted in approximately 60% more patient visits than a dental office would have without one. (They are still in the dental office though; if there are no dental offices, there are no allied providers)</p> <p>An article in JADA stated that a 10% increase in RDHs+CDAs employed is equivalent to adding 160 DDSs (WI had ~3000 at the time). No data to support statement.<sup>1</sup></p> <p>American Dental Education Association (ADEA) opposes preceptorship and other non-accredited methods of training dental hygienists. ADEA is the Association of dental schools.</p>
<p>B. Expand the scope of practice for oral health care personnel by <u>increasing allowable duties/functions</u> so as to increase capacity in dental practices and clinics, particularly in underserved areas.</p> <p>The August 2005 report from the ADA Board of Trustees to the House of Delegates proposed new categories of auxiliary oral health care personal with accompanying duties. This proposal seems most similar to the California approach.</p> <p><i>H.B. 143 includes local anesthetic administration for trained dental hygienists and H.B. 311 includes dental sealant application by certified dental assistants.</i></p>	<p>Various combinations of allowable duties have been done by states. The ODA has a committee that deals with this and the OSDB does, too. I have heard that ODA supports a bill to permit RDHs to administer local anes.</p> <p>California offers an multiple categories of dental hygienists and dental assistants: Unlicensed DA, RDA, Registered Specialty DA (ortho, oral surg, restor), RDAEF (Extended functions), RRAEF (R=Restorative), and RDHEF</p>	<p>GWU Center for Health Services Research &amp; Policy: “The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternative delivery models.”<sup>2</sup></p> <p>ADHA has a table for level of supervision for each type of procedure by state, but it is for RDHs only. <a href="http://www.adha.org/governmental_affairs/">http://www.adha.org/governmental_affairs/</a></p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>C. Expand the practice location opportunities for allied dental providers by <u>reducing supervision</u> requirements so as to increase capacity in dental practices and clinics, particularly in underserved areas. [There is little information about relaxing supervision on personnel other than RDHs]. The primary options include:</p> <ol style="list-style-type: none"> <li>1) Unsupervised practice of RDH in public health programs</li> <li>2) Alternative Supervision</li> <li>3) Independent Practice</li> <li>4) Alternative Practice (Independent, but in limited settings and/or patient types)</li> </ol> <p>* Collaborative agreement with DDS required  # Prescription from DDS (or MD)  @ Responsible for referral to dentist  + Standing orders</p> <p><i>ADEA: "The level of supervision should reflect the education, experience and competence of the allied dental professional."</i></p> <p><i>ADA: "A relatively new occupational choice is that of less supervised or unsupervised practice of dental hygiene at locations remote from the dental office. These range in degree of dentist supervision, from indirect and periodic review of hygiene services performed while a dentist is not in the office to a broad collaborative relationship between a hygienist and a dentist, with the hygienist practicing in a remote location. <u>Truly unsupervised</u> (emphasis added) practice of dental hygiene implies the practice of dental hygiene independent of the dentist and the dental practice. Currently, Colorado is the only state that permits unsupervised dental hygiene practice."<sup>4</sup></i></p> <p>Note: The health policy people who have studied dental workforce issues and were contacted by ODH reacted negatively to this ADA report, assessing that its bias was evident from the research question that it chose. They felt that the expanded use of RDHs via alternative practice models is not likely to be realized through their solo practice but as part of a team.</p> <p>ADHA recommends the relaxation of state practice acts to allow more dental hygienists to provide oral health care to those who are not currently receiving it and to recognize licensed dental hygienists as Medicaid providers. <a href="http://www.adha.org">www.adha.org</a></p>	<p>The numbers and symbols refer to those in the left hand column:</p> <ul style="list-style-type: none"> <li>• Arizona (1)</li> <li>• California (1,4<sup>#</sup>)</li> <li>• Colorado (3)</li> <li>• Connecticut (1*)</li> <li>• Iowa (1*<sup>@+</sup>)</li> <li>• Kansas (1*)</li> <li>• Maine (1*<sup>@+</sup>)</li> <li>• Michigan (1,* or +)</li> <li>• Minnesota (1*)</li> <li>• Missouri (1 Medicaid children)</li> <li>• Montana(1<sup>@+</sup>)</li> <li>• New Hampshire (1, limited services )</li> <li>• New Mexico (2*<sup>@+</sup>)</li> <li>• Nevada(1)</li> <li>• Oklahoma (1,<sup>@</sup>, one visit, very limited)</li> <li>• Oregon (1, <sup>@</sup>, # for some services)</li> <li>• Texas (1-initial visit only,<sup>@</sup>)</li> <li>• Washington (1, <sup>@</sup>)</li> </ul>	<p>"The alternative models we studied had little impact on the preventive oral health care delivery systems in study states (CT, NM, SC)"<sup>2</sup></p> <p>"(1) It is difficult to make changes to the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include and <u>the political viability of such a model.</u>" [emphasis added]</p> <p>UCLA assessed aspects of quality of care provided by RDHs in a California Demonstration Project in which RDHs treated patients without supervision of DDS, although they were required to refer patients to a DDS. The study was funded with a grant from the ADHA. Structure &amp; process evaluated in 9 indep. practices via record review and site visits + pt. satisfaction surveys. Compared with 6 general dentistry practices evaluated for a gov. agency and insur. co. during same period. Conclusion: No increase in risk of health/safety of pt. (per evaluation) from unsupervised practice (as conducted in demo. project).<sup>3</sup></p> <p>ADA report identified 20 RDHs in 17 practices that met ADA defin for "truly independent." Telephone interviews of independent RDHs and of proximate DDS practices. Found indep. RDHs to locate in upper and middle-income areas. Only 1 was in a HPSA. "Unsupervised private dental hygiene practice, as defined in study, has not had a notable impact on access to dental care in Colorado. ...the number of unsupervised hygienists is very limited..."<sup>4</sup></p> <p>ADHA rebuttal to ADA report:  Took issue with limited defn. of "unsupervised," referring to the 19 states it identifies with varying degrees. Also took issue with ADA methodology and generalizability. Pointed out that there were 64 CO RDHs directly billing Medicaid vs. 20 unsupervised RDHs in the study.</p> <p>The August 2005 report from the ADA Board of Trustees to the House of Delegates proposed new categories of auxiliary oral health care personal with accompanying duties. This proposal seems most similar to the California approach. The report mentioned "public health supervision" for dental hygienists but stopped short of recommendations other than possible pilot testing.</p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>D. Develop a cadre of true mid-level professionals modeled after dental therapist and public health nursing. This represents an expanded scope of service without a dentist present <u>and</u> crosses the line into restorative care (traditionally reserved for the DDS).</p> <ul style="list-style-type: none"> <li>• DHAT (IHS-Alaska): aka New Zealand Dental Therapist</li> <li>• <b>Proposed</b> (for Alaska) by ADA: Community Oral Health Provider (COHP). Combines visiting dental teams (DDS, RDH, DAs, dental aides) with the creation of a new COHP that provides screenings, primary and secondary preventive services, ART, and pain &amp; infx control + community-based prevention programs.<sup>7</sup></li> <li>• <b>Proposed</b> ADHA Advanced Dental Hygiene Practitioner (ADHP): Master’s degree RDHs that would provide advanced preventive therapies, diagnosis, treatment (e.g., restorative procedures), and appropriate referrals. In hospitals, nursing homes, public health settings <u>or wherever there is a need for this position.</u> [emphasis added] (<a href="http://www.adha.org/media/backgrounders/adhp.htm">http://www.adha.org/media/backgrounders/adhp.htm</a>; <a href="http://www.adha.org/media/facts/adhp.htm">http://www.adha.org/media/facts/adhp.htm</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Alaska-Indian Health Service</li> </ul>	<p>ADA President’s Commentary in American Journal of Public Health identifies oral health problems of Alaska Native population.; describes barriers; describes current delivery system. Advocates for dentists treating existing disease, enhanced prevention/education, increasing number of dentists and hygienists, using dental health aides but not for caries diagnosis, restorative tx., extractions &amp; pulpotomies.<sup>5</sup></p> <p>University professor’s article in American Journal of Public Health identifies oral health problems of American Indian/Alaska Native children; describes use of model in other countries (New Zealand, Canada, U.S. university pilots), outlines the history of the current situation with IHS and ADA; and defines issue as one of social justice as well as access to care.<sup>6</sup></p> <p>In its statement to Congress, the ADA stated its concern that DHAT training is inadequate to deal with situations that would face (e.g., simple exts. turned complicated and medical condns.)=put pts. at greater risk. ADA believes there is a better solution for AK as recommended by the ADA expert panel—COHP to work on dental team.<sup>7</sup></p>
<p>E. Foreign-trained dentists (in SN/PH settings)</p> <ol style="list-style-type: none"> <li>1) as dentists</li> <li>2) as RDHs (dental students)</li> </ol>	<ul style="list-style-type: none"> <li>• Connecticut</li> <li>• Arkansas</li> <li>• Mississippi</li> <li>• California</li> </ul>	<p>Little empirical evidence exists to judge whether foreign-trained dentists are more likely than U.S.-trained to serve vulnerable pops., particularly in the absence of financial incentives.<sup>8</sup></p> <p>California’s Welcome Back Center is trying to establish a program for foreign dentists to become dental hygienists, since the training programs for dentistry are so expensive. <a href="http://www.welcomebackcenter.org/">http://www.welcomebackcenter.org/</a></p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>F. Increasing use of dentists-in-training (dental students, GPR) as providers (in SN/PH settings)</p> <ol style="list-style-type: none"> <li>1) as dentists</li> <li>2) as RDHs</li> </ol>	<ul style="list-style-type: none"> <li>• Columbia U-NYC</li> <li>• Michigan</li> <li>• Virginia</li> <li>• RWJ Pipeline Grants + California Initiative (15 dental schools, including OSU)</li> <li>• California (RDH)</li> <li>• Massachusetts (RDH)</li> </ul>	<p>It is difficult to evaluate the long-term impact of dental education strategies.<sup>8</sup> In the short term, they provide care to the patients they serve while the student/GPR is in training. In CA, few dental students are working as hygienists, if any. (Mertz)</p> <p>The OHIO Project (OSU)</p> <ul style="list-style-type: none"> <li>• Increase the amount of time students, residents and faculty spend in community sites from 22.5 half days to 60 full days <ul style="list-style-type: none"> <li>◦ In 2004-05, approximately 200 students provided 6700 patient visits, 19 safety net clinics</li> </ul> </li> <li>• Make community-based service learning a college-level rather than departmental-level program.</li> <li>• Modify clinical and didactic curricula to include community-based clinical experiences and didactic offerings on community-based oral health and cultural competency.</li> <li>• Conduct diversity training for faculty, staff, and students.</li> <li>• Expand pre-clinical program to permit exposure to community-based care for first-year dental students.</li> </ul> <p>(<a href="http://www.dentalpipeline.org/">http://www.dentalpipeline.org/</a>)</p> <p>UCLA is evaluating the RWJF Pipeline grants.</p>
<p>G. Encourage volunteerism (generally in PH settings)</p> <ol style="list-style-type: none"> <li>1) active DDSs</li> <li>2) retired DDSs</li> </ol> <p>ODH philosophy in consulting with safety net clinics is that in order to be substantial and sustainable, they need a core of full-time salaried employees around whom they can consider wrapping limited volunteer providers.</p>	<ul style="list-style-type: none"> <li>• Connecticut (waive fee for license renewal)</li> <li>• CDE credits/hr. volunteering</li> <li>• Kansas</li> <li>• Maryland</li> <li>• Oklahoma</li> <li>• Wisconsin</li> <li>• Wyoming</li> </ul>	<p>RWJ Foundation recently stopped funding their volunteers in health care initiative – not really a sustainable option. (Mertz)</p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>H. Financial incentives:</p> <p>1) Increase loan repayment/scholarship opportunities ODH awarded state loan repayment to 6 dentists in 2005. Since 1999, 26 dentists practicing in Ohio have received loan repayment from the National Health Service Corps.</p> <p>2) Tax credits</p> <p>3) Increased Medicaid reimbursement for defined providers (e.g., high percentage of practice is Medicaid, rural)</p>	<ul style="list-style-type: none"> <li>• Maine</li> <li>• Colorado</li> <li>• Minnesota</li> <li>• Virginia</li> <li>• Maryland</li>   <li>• Louisiana (small town, \$5000 limit)</li> <li>• Oregon (frontier county or small town) \$5,000 limit</li> <li>• Colorado (when there is a budget surplus)</li> </ul>	<p>Although these approaches have situational impact, they do not represent a sustainable systemic solution (Mertz).</p> <p>JADA Article: CHC dentists who ranked loan repayment as 1<sup>st</sup> or 2<sup>nd</sup> among reasons for choosing CHC dentistry were 4.8 times more likely to indicate intention to leave than other respondents to survey.<sup>9</sup></p> <p>Colorado: only a couple dentists have received tax credit due to lack of budget surplus.</p>
<p>I. PGY-1 (requiring additional GPR programs) for licensure.</p> <p><i>ADEA: “Dental schools should encourage graduates to pursue a year of service and learning that would not only make the students more competent to provide increasingly complex care but also serve to improve access to oral health care.”</i></p> <p><i>ADA: “that each state continue to require of all candidates for initial licensure satisfactory performance on an individual state or regional clinical examination, or successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty at least one year in length that is accredited by the ADA Commission on Dental Accreditation.”</i></p>	<ul style="list-style-type: none"> <li>• New York (to be required in 2007)</li> <li>• Delaware (required)</li> <li>• Minnesota</li> <li>• CA (proposed in a SB 683)</li> </ul>	<p>The creation of additional GPR programs is expensive but may increase the safety net and provide additional care.</p> <p>If made mandatory (PGY-1), this could greatly expand patient base.</p> <p>Limited funding for graduate dental education? Too few qualified preceptors? Safety net capacity to absorb placements?</p> <p>NCSL: Proposed that CA conduct a pilot study of PGY-1 because evidence from other states is lacking.</p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>J. Dental schools recruit more students from underserved backgrounds. (OHIO Project-like)</p> <p>OHIO Project (OSU)</p> <ul style="list-style-type: none"> <li>• Develop nine-week summer training program for 12th grade students or high school graduates seeking a career in dentistry.</li> <li>• Develop a program for health professions advisors from area colleges in cooperation with other regional Pipeline schools.</li> </ul> <p>Nationally, there are some new efforts: Coming soon is a new and expanded RWJF–sponsored Summer Medical and Dental Education Program (SMDEP), in partnership with the Association of American Medical Colleges (AAMC) and the ADEA. SMDEP will provide six weeks of <b>FREE</b> educational enrichment to pre-medical and pre-dental college freshmen and sophomores throughout the summer. SMDEP is an expansion of the Summer Medical Education Program (SMEP), formerly the Minority Medical Education Program (MMEP), which had a <u>long history</u> as a national academic enrichment program helping promising, highly motivated students gain admission to medical school (63% acceptance rate). Columbia U and U Washington have been the only SMEPs with dental. <a href="http://www.aamc.org/students/considering/smep/">http://www.aamc.org/students/considering/smep/</a></p> <p>W.K. Kellogg Foundation-ADEA-Access to Dental Careers (\$1.4M) supports Pipeline Schools in minority recruitment component</p> <p>ADEA Strategic Plan (includes collaboration with ADA)</p>		<p>Studies have shown that minority dentists are more likely to work in minority communities. The strategy addresses equality and justice reasons, and cultural competence, as well as access. Caveat: Training minority dentists specifically to work in minority communities relegates them to a lower level of income and more difficult practice than their peers, which is not a good strategy in and of itself. <sup>10</sup></p> <p>OSU has implemented two summer programs to recruit more underserved and under-represented. 1) Summer Dental Preparatory Institute (6-week program exposes students to clinical aspects of dentistry. Seven students in 2004, seventeen in 2005); 2) DAT Prep Program aims to help under-represented minorities improve their performance on the Dental Admission Test.</p>
<p>K. Pilot test the training and use of clinical/community dentists who will work in FQHC-like environments as a career choice. Subsidize education costs for these students.</p> <ul style="list-style-type: none"> <li>o Subset of a class (5%-25%)</li> <li>o 75% + of clinical work done in community setting</li> <li>o New competencies (community dentistry skills—e.g., working with partners, grantsmanship, planning, management)</li> </ul> <p>Pilot implementation in at least one urban and one rural demonstration site that creates a sustainable model for broad service delivery of comprehensive needs:</p> <ul style="list-style-type: none"> <li>• Acute care</li> <li>• Public health interventions (e.g., churches, schools)</li> <li>• Part of the community</li> </ul>		<p>This idea was presented to the ADA Workforce Task Force by UCSF (Ed O’Neil and Beth Mertz). The proposal received such favorable response that it was included in the report from the ADA Board of Trustees to the House of Delegates in August 2005.</p> <p>UCSF would like to do a pilot with a dental school in CA and one elsewhere (e.g., OSU, CSDM).</p>

Strategy	Examples From Other States	Evaluation/Supportive Data/Comments
<p>L. Increased use of technology (teledentistry) to support:</p> <ul style="list-style-type: none"> <li>• Supervision</li> <li>• Expansion of duties</li> <li>• Training</li> </ul> <p>Teledentistry is a combination of telecommunications (including the use of computers and the internet) and dentistry, involving the exchange of clinical information and images over remote distances.</p>	<ul style="list-style-type: none"> <li>• California-USC</li> <li>• Baylor-TX</li> <li>• University of Florida</li> <li>• U.S. Army</li> <li>• Marquette-WI</li> <li>• Eastman Dental Center</li> <li>• U Minnesota</li> <li>• IHS (recent)</li> <li>• Arizona Dept of Corrections/AU</li> </ul>	<p>2001 Conference held in Chiba, Japan: “Although teledentistry technology appears ideal to perform this linkage, evidence that demonstrates that teledentistry improves access, reduces cost and affects the quality of care is fragmented and distributed among several federal departments, academic institutions, industry research centers and professional associations.”</p>
<p>M. Develop an information clearinghouse on practice opportunities in underserved communities and programs that assist in placement.</p>		<p>UNC system that ODH will be using for FQHCs? ODA? OSU? CWRU?</p>
<p>N. Collect data on the characteristics and practice patterns of licensed oral health care workforce to monitor trends through surveys that accompany licensure renewal.</p>	<p>IL, MO, WI, RI, WA, AZ, PA are known; NY pending. There may be others.</p>	<p>(Mertz) CA is doing it now in Medicine, very successful.</p>

## Literature Review Notes

1) Beazoglou T, Bailit H, Heffley D. The dental workforce in Wisconsin: Ten-year projections. JADA 2002;133:1097-1104.

2) The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children (1/17/03) GWU Center for Health Services Research & Policy, School of Public Health and Health Services. [http://www.gwhealthpolicy.org/downloads/Oral\\_Health.pdf](http://www.gwhealthpolicy.org/downloads/Oral_Health.pdf).

3) Freed JR, Perry DA, Kushman JE. Aspects of quality of dental hygiene care in supervised and unsupervised practices. J Public Health Dent 1997;57:68-75.

4) Brown LJ, House DR, Nash KD. ADA Health Policy Resources Center. The economic aspects of unsupervised private hygiene practice and its impact on access to care.

5) Sekiguchi E, Guay AH, Brown LJ, Spangler TJ. Commentary: Improving the oral health of Alaska Natives. Am J Public Health 2005;95:769-773.

6) Nash DA, Nagel RJ. Confronting oral health disparities among American Indian/Alaska Native children: The pediatric oral health therapist. Am J Public Health 2005;95:1325-1329.

7) Brandford RM. Statement of the American Dental Association to the Committee of Indian Affairs and the Committee of Health, Education, Labor and Pensions; U.S. Senate on S. 1057 The Indian Health Care Improvement Act Amendments of 2005. July 14, 2005. PDF file/620k [http://ada.org/prof/advocacy/test\\_050714\\_dhat.pdf](http://ada.org/prof/advocacy/test_050714_dhat.pdf).

8) Mertz E, Anderson G, Grumbach K, O’Neil E. Evaluation of strategies to recruit oral health care providers to underserved areas of California. Center for California Health Workforce Studies, University of California, San Francisco. July 2004. [http://futurehealth.ucsf.edu/pdf\\_files/Dental%20Strategies%20Full%20Final%20Report.pdf](http://futurehealth.ucsf.edu/pdf_files/Dental%20Strategies%20Full%20Final%20Report.pdf).

9) Bolin KA, Shulman JD. Nationwide survey of work environment perceptions and dentists’ salaries in community health centers. J Am Dent Assoc 2005;136:214-220.

10) Mertz E, Grumbach K. Identifying communities with a low supply of dentists in California, J Public Health Dent 2001;61:172-177.

### Other References

Gehshan S, Straw T. Access to oral health services for low-income people: Policy barriers and opportunities for intervention for The Robert Wood Johnson Foundation. Forum for State Health Policy Leadership, National Conference of State Legislatures, 2002. <http://www.ncsl.org/programs/health/forum/rwjoral.pdf>.

The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001 April 2004 Center for Health Workforce Studies, University at Albany of the State University of New York and Health Research Inc. <http://bhpr.hrsa.gov/healthworkforce/reports/hygienists/dh1.htm>.

**APPENDIX C**  
Ohio Dental Workforce Roundtable  
Policy Options – Final Rankings

Option	High Value or Potential 4	Some Value or Potential 3	Limited Value or Potential 2	No Value or Potential 1	Active Opposition 0	Whole Average (Rank)
1. Expand the scope of practice for oral health care personnel by <i>increasing allowable duties/functions</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.	$8 * 4 = 32$	$4 * 3 = 12$	$2 * 2 = 4$	0	0	3.4286 (2.a)
2.a. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas  Unsupervised practice of RDH in public health programs	$7 * 4 = 28$	$1 * 3 = 3$	$2 * 2 = 4$	0	$3 * 0 = 0$	2.6923 (14.a)
2.b. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.  Alternative supervision	$6 * 4 = 24$	$3 * 3 = 9$	$1 * 3 = 3$	0	$3 * 0 = 0$	2.7692 (14.a)
2.c. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.  Independent practice	$1 * 4 = 4$	$6 * 3 = 18$	$2 * 2 = 4$	$1 * 1 = 1$	$3 * 0 = 0$	2.0769 (21.a)
2.d. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.  Alternative practice	$4 * 4 = 16$	$5 * 3 = 15$	0	$1 * 1 = 1$	$3 * 0 = 0$	2.4615 (17)
2.e. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.  Collaborative agreements with DDS	$4 * 4 = 16$	$5 * 3 = 15$	$1 * 2 = 2$	0	$3 * 0 = 0$	2.5385 (16)
2.f. Expand the scope of practice for allied dental providers by <i>reducing supervision</i> so as to increase the capacity of dental practices and clinics, especially (but not limited to) in underserved areas.  Rx from DDS (or MD)	$2 * 2 = 4$	$7 * 3 = 21$	$1 * 2 = 2$	0	$3 * 0 = 0$	2.0769 (21.b)

Option	High Value or Potential 4	Some Value or Potential 3	Limited Value or Potential 2	No Value or Potential 1	Active Opposition 0	Whole Average (Rank)
3.a. Develop a cadre of true mid-level professionals modeled after the dental therapist and public health nursing. (This represents an expanded scope of service without a dentist <i>and</i> crosses the line into restorative care traditionally reserved for the DDS.) <b>DHAT (New Zealand Dental Therapist)</b>	2 * 4 = 8	5 * 3 = 15	4 * 2 = 8	0	3 * 0 = 0	2.2143 (20)
3.b. Develop a cadre of true mid-level professionals modeled after the dental therapist and public health nursing. <b>Community Oral Health Provider (COHP) – Proposed for Alaska by ADA</b>	1 * 4 = 4	7 * 3 = 21	5 * 2 = 10	0	0	2.6923 (14.b)
3.c. Develop a cadre of true mid-level professionals modeled after the dental therapist and public health nursing. <b>ADHA Advanced Dental Hygiene Practitioner (ADHP)</b>	3 * 4 = 12	6 * 3 = 18	1 * 2 = 2	1 * 1 = 1	0	3.000 (11.a)
4. Increase the supply and use of allied oral health care personnel in underserved areas	8 * 4 = 32	2 * 3 = 6	4 * 2 = 8	0	0	3.2857 (7.a)
5.a. Increased use of foreign-trained dentists as dentists	4 * 4 = 16	4 * 3 = 12	3 * 2 = 6	1 * 1 = 1	3 * 0 = 0	2.3333 (19)
5.b. Increased use of foreign-trained dentists as RDHs	1 * 4 = 4	6 * 3 = 18	4 * 2 = 8	0	5 * 0 = 0	1.8750 (22)
6.a. Increasing use of dentists-in-training (dental students, GPR) as providers as dentists	2 * 4 = 8	7 * 3 = 21	4 * 2 = 8	0	1 * 0 = 0	2.6429 (15.a)
7. Dental students and GPR rotations in SNDCs (expand Ohio Project)	4 * 4 = 16	5 * 3 = 15	5 * 2 = 10	1 * 1 = 1	0	2.8 (13)
8. PGY – 1 (requiring additional GPR programs)	6 * 4 = 24	3 * 3 = 9	3 * 2 = 3	2 * 1 = 2	2 * 0 = 0	2.375 (18)
9. Dental schools recruit more students from underserved backgrounds	4 * 4 = 16	8 * 3 = 24	2 * 2 = 4	0	0	3.1429 (10.a)

<b>Option</b>	<b>High Value or Potential 4</b>	<b>Some Value or Potential 3</b>	<b>Limited Value or Potential 2</b>	<b>No Value or Potential 1</b>	<b>Active Opposition 0</b>	<b>Whole Average (Rank)</b>
10.a. Encourage volunteerism (generally in PH settings) Active DDSs	1 * 4 = 4	8 * 3 = 24	4 * 2 = 8	0	0	2.7692 (14.b)
10.b. Encourage volunteerism (generally in PH settings) Retired DDSs	2 * 4 = 8	8 * 3 = 24	3 * 2 = 6	0	0	2.9230 (12)
10.c. Encourage volunteerism (generally in PH settings) Active allied oral health care personnel	0	7 * 3 = 21	6 * 2 = 12	0	0	2.3571 (19)
10.d. Encourage volunteerism (generally in PH settings) Retired allied oral health care personnel	1 * 4 = 4	7 * 3 = 21	6 * 2 = 12	0	0	2.6429 (15.b)
11.a. Financial incentives: Increase loan repayment/scholarship opportunities	4 * 4 = 16	5 * 3 = 15	1 * 2 = 2	0	0	3.3 (5)
11.b. Financial incentives: Tax credits	5 * 4 = 20	6 * 3 = 18	1 * 2 = 2	1 * 1 = 1	0	3.1538 (9)
11.c. Financial incentives: Establishment of local oral health workforce opportunity zones	10 * 4 = 40	2 * 3 = 6	1 * 2 = 2	1 * 1 = 1	0	3.5 (1)
12. Develop an information clearinghouse on practice opportunities in underserved communities and programs that assist in placement	6 * 4 = 24	5 * 3 = 15	3 * 2 = 6	0	0	3.2143 (8.a)
13. Collect data to monitor dental workforce trends through surveys that accompany licensure renewal	2 * 4 = 8	7 * 3 = 21	3 * 2 = 6	2 * 1 = 2	0	2.6429 (15.c)
14.a. Increased use of technology to support: Supervision	5 * 4 = 20	5 * 3 = 15	3 * 2 = 6	1 * 1 = 1	0	3.0000 (11.b)
14.b. Increased use of technology to support: Expansion of duties	5 * 4 = 20	6 * 3 = 18	3 * 2 = 6	0	0	3.1429 (10.b)
14.c. Increased use of technology to support: Training	3 * 4 = 12	7 * 3 = 21	3 * 2 = 6	0	0	3.000 (11.c)

<b>Option</b>	<b>High Value or Potential 4</b>	<b>Some Value or Potential 3</b>	<b>Limited Value or Potential 2</b>	<b>No Value or Potential 1</b>	<b>Active Opposition 0</b>	<b>Whole Average (Rank)</b>
15.a. Pilot one urban demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Acute care	6 * 4 = 24	7 * 3 = 21	1 * 2 = 2	0	0	3.3571 (4.a)
15.b. Pilot one urban demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Public health interventions (churches, schools, etc.)	6 * 4 = 24	7 * 3 = 21	1 * 2 = 2	0	0	3.3571 (4.b)
15.c. Pilot one urban demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Part of the community	8 * 4 = 32	4 * 3 = 12	2 * 2 = 4	0	0	3.2857 (7.b)
16.a. Pilot one rural demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Acute care	6 * 4 = 24	5 * 3 = 15	2 * 2 = 4	0	0	3.3077 (6)
16.b. Pilot one rural demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Public health interventions (churches, schools, etc.)	7 * 4 = 28	4 * 3 = 12	2 * 2 = 4	0	0	3.3846 (3)
16.c. Pilot one rural demonstration site that creates a sustainable model for broad service delivery of comprehensive needs: Part of the community	8 * 4 = 32	4 * 3 = 12	2 * 2 = 4	0	0	3.4286 (2.a)
17. Create an education program that is dedicated to support innovative pilot projects	5 * 4 = 20	7 * 3 = 21	2 * 2 = 4	0	0	3.2143 (8.b)

Appendix C reflects the use of a dialogue tool to help clarify priorities. After considerable conversation, participants in the last session used “sticky dots” to respond to these Likert style statements. Further dialogue occurred after the ranking process. The final recommendations reflect an integration of the rankings and the final dialogue.

The numbers in the columns indicate the number of dots times the number of “points” related to the Likert value indicated for each option in the top row. In the final column the Whole Average reflects the total points in each row, divided by the total dots in that row. The number in parentheses under each average indicates where that value ranked among all the averages. When there was more than one item with the same average value a letter was added.

For example, for Item 1 there 8 dots for High Value, 4 dots for Some Value, 2 dots for Limited Value and no dots for No Value or Active Opposition. The total number of points (48) divided by the total number of dots (14) equals 3.4286. Item 16 also has an average of 3.4286, so a letter was added.

## About the Authors

### Principal Author

#### Chris Kloth

Chris Kloth has over twenty-five years experience in the field with hands-on experience as a manager and executive in both for-profit and non-profit organizations. Governmental experience with the Criminal Justice system further enhances his background. He has published numerous articles and is a frequent presenter at national conferences.

### Supporting Author

#### Jill Huntley, MPA

Jill Huntley has over nineteen years experience working on health policy issues in Ohio for the Ohio Department of Health, the Ohio Department of Job & Family Services, and the Health Policy Institute of Ohio. Her policy expertise is focused on children and vulnerable populations. She holds a Master of Public Administration degree from The Ohio State University.

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**HEALTH POLICY INSTITUTE**  
OF OHIO

37 West Broad Street, Suite 350  
Columbus, OH 43215-4198  
Phone: 614-224-4950; Fax: 614-224-2205  
[www.healthpolicyohio.org](http://www.healthpolicyohio.org)