

**Annual Synopses
of
State and Territorial
Oral Health Programs:
Five-Year Trends Report
1998 to 2002**

August 2004

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Supported by Cooperative Agreement U58/CCU723036-02 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

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Executive Summary

Introduction and Overview

In the early 1990's, the Association of State and Territorial Dental Directors (ASTDD) began compiling one-page summaries or synopses of oral health activities conducted in each state. By 1997, the Synopsis was a more structured questionnaire. In December of 1997, ASTDD requested assistance from the Centers for Disease Control and Prevention in providing technical assistance to plan, analyze, and present the Synopses in a summary and on a web site. This activity became part of the 1998-2002 cooperative agreement between ASTDD and CDC. ASTDD's Synopses Committee, comprised of four to five dental directors and two CDC scientists who provided technical assistance to the Committee, guided it. The Synopses contain information on each state's demographics, oral health infrastructure and workforce, the state oral health program's administration, and programs or activities.

Printed summaries were compiled each year for review at the ASTDD annual meeting. The Synopses web site was launched in early 2000 and continues to be updated each year. The content changed somewhat from year to year from 1998-2002; however, for many items there was enough consistency to assess trends during this period.

The Executive Summary includes:

- Introduction and overview (page 2)
- Report scope (page 3)
- Highlights of trends 1998-2002 (page 4)
- Summaries by section (pages 5-9)
- Conclusions (page 10)
- Future directions for the synopsis (page 11)

The full report includes:

- Trends summary overview (pages 13-16)
 - Content of the synopses by section
 - Data collection
 - Limitations
- Appendix A: Trends by section: tables
- Appendix B: Technical notes
- Appendix C: Non-response summary

Report Scope

From the items asked on the Synopses from 1998-2002, we focused on items for which the Synopses are the primary source. The items included in this report are listed below by the section of the Synopsis in which they appeared.

Demographics

All 10 items asked in the demographics section are available from other data sources and are not addressed in this report.

Infrastructure

- Community-based low-income dental clinics
- School-based or linked dental clinics
- School-based health centers with an oral health component
- Tribal, state and local agencies with a service population of 250,000 with a dental program
 - Of these programs, those directed by a dental professional with advanced education in public health

Workforce

- Dentists
- Dental hygienists
- Dentists participating in Medicaid and SCHIP

Administration

- Full-time dental director
- Dental director turnover
- Time spent on and compensated for regarding Medicaid issues
- Full-time and contracted full-time equivalent employees (FTEs)
- Budget range
- Funding

Programs

- Ten programs originally listed
- Increases and decreases in programs
- Number of states with programs
- Median number of programs

Highlights of Trends 1998 – 2002

- ↑ **Community-based low-income dental clinics.** The number of community based low-income dental clinics in participating states increased almost three-fold. The median number of these clinics per state rose from 7 in 1998 to 18 in 2002.
- ↓ **Number of local health departments with a dental program.** The number decreased over the five-year period.
- ↑ **School-based or school-linked dental clinics.** The number of school-based or school-linked dental clinics in responding states increased by over 50%.
- ↓ **School-based health centers with an oral health component.** The number of school-based health centers with an oral health component dropped by approximately 24%.
- ⇔ **Dental programs directed by a dental professional with a Master's Degree or higher in public health.** About half of the programs in service areas of 250,000 are directed by a dental professional with a master's degree or higher in public health.
- ⇔ **Number of dentists.** While the median number of dentists in a state increased from 1998 to 2002, it was lower in 2002 than its highest point in the five-year period.
- ⇔ **Number of dental hygienists.** While the median number of dental hygienists in a state increased from 1998 to 2002, it was lower in 2002 than its highest point in the five years.
- ↑ **Dentists participating in Medicaid.** Between 1998 and 2002 the median number increased. The number of dentists participating in Medicaid increased in 33 states and decreased in 14.
- ↓ **Full-time dental director.** Only 20 states had the same dental director for this 5-year period, while 20 states had from one-four turnovers in the position. Eight states had a vacancy for at least one year.
- ↑ **Oral health program budget.** The distribution of states has shifted away from budgets of under \$500,000 to budgets of over \$500,000 and over \$1,000,000.
- ↓ **Full-time equivalent workers.** From 1998 to 2002, the total number of FTEs in oral health decreased by at least one third.
- ↑ **Contracted workers.** While the number of states with contracted FTEs dropped, the states that did employ them saw an increase of over one third. This was due mostly to increases in three states.
- ⇔ **Number of programs.** In 2002, states had a median number of six programs.
- ↑ **Type of program.** Programs in abuse/neglect, dental screening, sealant, ECC prevention, mouth guard/injury prevention, and tobacco cessation increased.
- ↓ **Type of program.** Programs in fluoride mouth rinse and supplement, needs assessment/oral health surveys, and oral health education/promotion decreased.

Summaries by Section

Infrastructure

- Among states responding to the question in any year (49) from 1998 to 2002, the **number of community-based low-income dental clinics** almost tripled (394 to 1138). Among states responding to the question every year (27), the number of clinics almost quadrupled (260 to 921). In the first and last years that the question was asked, the number of community-based low-income dental clinics increased in 33 states, decreased in nine states, stayed the same in seven states, while one state had insufficient data. For states that responded to the question in any or in all years, the **median number** of community-based low-income dental clinics rose from 7 in 1998 to 18 and 20, respectively, in 2002.
- Among states responding to the question in any year (47) from 2000 to 2002, the **number of school-based or school-linked dental clinics** increased by 64% (from 288 to 471); among states responding to the question every year (29), the number increased by 49% (from 133 to 198). The number of school-based or school-linked dental clinics increased in 16 states, decreased in 9 states, and stayed the same in 16 states; there were insufficient data in nine states. The **median number** of clinics (1) showed a slight drop from 1.5 in 2000 for states responding to the question in any year and stayed the same as the median in 2000 for states responding to the question every year.
- The number of **school-based health centers with an oral health component** dropped by about 24% in only two years (2001-2002) that the question was asked. The median remained at 0 among states responding in either year and increased from 0 to 1 among states responding in both years. The number of school-based health centers with an oral health component increased in five states, decreased in two states, and stayed the same in 22 states; there were insufficient data in 21 states.
- From 1998 to 2002, **the number of local health departments with a dental program** decreased by almost 17% for states responding to the question in any year (49), and decreased by 6% for states responding to the question every year (28). The median number (3) of local health departments with a dental program, however, has remained fairly constant in the five years between 1998 and 2002. This is very low considering the number of counties in most states.
- The percent of **tribal, state, and local health agencies with service populations of 250,000 and with a dental program** increased by 9% in states responding in both years, and by 4% for states responding in either year that the question was asked. The **median number** (2) stayed the same for states responding to the question in either or both years.
- **Of these programs, the percent directed by a dental professional** decreased from 93% to 89% in states responding in either 2001 and 2002, and decreased from 94% to 88% in states responding in both years (see graph and table in Appendix A: Infrastructure). Of the dental professionals directing these programs in 2002, just over half had a **master's degree or higher in public health**.

Workforce

- Whether states responded to the question in all five years (28) or in one or more years between 1998-2002 (49), the **median number of dentists** increased during that time period, but was less in 2002 than its highest point in the five years. Almost all states showed mixed results over the five-year period; 16 states had more dentists in 2002 than in 1998, 14 states had fewer dentists in 2002 than in 1998, and 20 states did not report in either 1998 and/or in 2002.
From 1998-2001, the ADA reported a steady increase in the number of dentists in the United States. The same time period resulted in a steady decrease in the number of applicants to dental schools. In the fifteen years between 1974 and 1989, the number of applicants to dental schools decreased from 16,000 to 4,500 (<http://www.ada.org>).
- Whether states responded to the question in all five years (24) or in any year between 1998-2002 (49), the **median number of dental hygienists** increased during that time. The **number of dental hygienists** increased in 19 states, decreased in 7 states, and 24 states did not report in either 1998 and/or in 2002.
From 1998 to 2002, the U.S. Department of Labor and Statistics web page reported an overall increase in the number of dental hygienists (excluding self-employed).
- From 1998-2002, the **median number of dentists participating in Medicaid** increased in states responding in all years and in one or more years. The **median percent of dentists participating in Medicaid** also increased in states reporting every year (from 28% to 37%) and in any year (from 31% to 38%). The number of dentists participating in Medicaid increased in 33 states and decreased in 14 states; three states had insufficient data.
- A question on the **median number and percent of dentists participating in SCHIP** was asked for three years (2000-2002). Among states responding in all years (18), the **median number** of participating dentists decreased by over 6%; in states responding in at least one year, the median number increased by about 4%. The **median percent** of dentists participating in SCHIP increased by about 3% in both groups. Small increases may be due to having data for only three years, or to a lack of response to this question (14 states did not respond at all, and six responded in only one of the three years).

Administration

Full-Time Dental Director

- Among states responding in all five years from 1998-2002 (29), the **number of states with a full-time dental director** rose from 19 to 24. Among states responding to the question in one or more years (49), the number of states with a full-time dental director decreased by one (29 to 28).
- In 20 states, the same person was the dental director (whether full-time or part-time) for the whole five-year period from 1998-2002. Twelve states had one **turnover** in the position, five states had two turnovers, two states had three turnovers, and one state had four turnovers. Data was missing in ten states for at least one year.
- From 1998-2002, eight states had an acting dental director for at least one year and eight states had a position vacancy for at least one year.
- Among states responding in the two years (2001 and 2002) that the question was asked, the median **percent of time that a dental director spends on Medicaid or SCHIP issues** was 10%. The median **percent of time compensated by Medicaid or SCHIP**, however, was 0.
- The **number of programs** decreased in nine of the 20 states having different dental directors during the five years from 1998-2002, and in five of the 20 states with the same dental director. The number of programs stayed the same or increased in about the same number of states, regardless of change in dental directors.

Staffing

- In the five years between 1998-2002, the **total number of full-time equivalent (FTE) oral health workers** decreased. There were about one third fewer FTEs in states that answered this question in all years (29) and 43% fewer FTEs in states that answered this question in any year (49). It should be noted, however, that the question wording changed significantly over the five-year period (see Appendix B-Technical Notes). In 2002, the **median number of full-time FTEs** was four among states responding in all years (29), and three among states responding in one or more years that the question was asked (49). In both groups, the median temporarily dropped by one in 2000 and/or 2001.
- Among states responding in both years (2001-2002) that the question was asked, the **number of states with contracted FTEs** decreased from 16 to 13; among states responding in either year, the number of states with contracted FTEs decreased from 19 to 14. While fewer states had contracted FTEs, in those that did, the **total number of contracted FTEs** increased by over one third. The median number of contracted FTEs in states reporting in both years increased from 4.5 to 5; the median number of contracted FTEs in states reporting in either year increased from 2 to 4.75.

Budget

- In the five years between 1998 and 2002, the **total oral health budget** increased in most states. Among states responding to the question in all years (22), 17 had an increase in their budget range category and two states had a decrease. Among states responding in two or more years during the five-year period (47), 26 states had an increase in their budget range category and 13 states had a decrease. The shift was toward budget ranges of over \$500,000 and over \$1,000,000.
- Among states responding to the question in all years (18), the **median percent of State funding** rose from 49.5% in 1998 to 62% in 2002, with mixed results in interim years. Among states responding to the question in any year (49), the median percent of state funding had a much steeper decline (from 60% in 1998 to 27.9% in 2001) before reaching 62% in 2002.
- More states maintained the same **level of Maternal and Child Health and/or Preventive Health and Health Services Block Grant funding** from 2001 to 2002.

Programs

The ten programs originally listed in the Synopsis were abuse/neglect, dental screening, dental sealants, early childhood caries/caries prevention, fluoride mouth rinse, fluoride supplements, mouth guard/injury prevention, needs assessment/oral health surveys, oral health education/promotion, and smoke/spit tobacco cessation. Water fluoridation was placed in different sections over time, and questions about fluoride varnish programs and access to care were added in later years.

Response to the Program section was very high in all five years (94%-100%). Among states that reported having each program, response rate for questions about the number of people served in each program was lower (25%-97%).

- Among states responding to the question in all years from 1998-2002, there was an increase in the **number of states with programs** in abuse/neglect, dental screening, dental sealants, and Early Childhood Caries prevention. There was also an increase in the number of states with programs in smoke/spit tobacco cessation for states responding in any year. For states responding in all years, fewer states had programs in fluoride mouth rinse, and fewer states had programs in fluoride supplements, needs assessment/oral health surveys, and oral health education/promotion for both groups.
- By 2002, 78% of states responding in all years had dental screening and dental sealant programs; 86% of states responding in one or more years had fluoride mouth rinse programs and 81% had dental screening programs.
- Among states responding in all years, the **greatest increases** were in early childhood caries prevention and abuse/neglect programs (11%). Among states responding in one or more years, the greatest increases were in dental sealant (17%) and abuse neglect programs (13%).
- States answering the question in at least one year or in all years had a **median number** of six programs, with fluctuations in the median (by one) over the five years. The same number of states (19) had increases or decreases in median number of programs; nine states had the same median number and three states had insufficient data to determine a trend.

Conclusions

The trends revealed some good news in the years from 1998 and 2002. More states reported an increase in the number of dentists and dental hygienists and in the number of dentists participating in Medicaid. While there was a change in the question over the years on the number of community-based low-income dental clinics, the number of clinics still showed considerable increase from 1999-2002 (this increase may be due, at least in part, to guidelines from the Health Resources and Services Administration on inclusion of dental services in community health centers).

While the number of school-based or school-linked dental clinics increased from 2000-2002, the number of school-based health centers with an oral health *component* (important in schools with no dental clinic) decreased in the two years the question was asked. If this question continues to be asked, it would be useful to more specifically define “component” in future Synopses. The number of local health departments with a dental program also decreased, which is unfortunate since the number of large metropolitan areas in many states is increasing. There are also fewer dental professionals directing programs in service areas of 250,000 or more, and less than half of these dental professionals have a Master’s degree or higher in public health.

While there were many combinations of full-time, part-time acting directors, vacancies, and/or appointment of a contact person over the five years from 1998-2002, less than half of the states had a full-time or part-time dental director for the entire five years. What are the reasons for this amount of turnover and change in the position of dental director? Does salary, budget, few FTEs within the oral health program, and/or lack of trained dental public health professionals for positions in oral health programs affect dental director turnover, and if so, to what degree? Does the amount of fluctuation in the state dental director’s position, in turn, affect the longevity of other employees in positions in state oral health programs, and is the effect magnified in states with one or two FTEs in the oral health program? Given the sustained effort often needed from a state dental director to develop and implement policy, secure funding, get programs underway, and secure FTEs, another area of further study might be whether a relationship exists between the amount of fluctuation in position status and/or turnover and increases/decreases in oral health program budgets, FTEs and number of programs.

The job structure in state oral health programs also appears to be shifting. While the number of FTEs decreased substantially, the number of contracted workers increased by over 35% in the two years that the question was asked. Are there fewer benefited, secure, full-time positions in oral health, and if so, is this a reason for the increase in the number of contracted FTEs? If this is the case, it could affect the ability to attract dental professionals into additional education in dental public health. Another area of study would be any effect on programs from increases or decreases in FTEs. Growth or loss of FTEs in oral health programs could be tracked in several ways; one example is by permanent and temporary status (it may be important to identify an FTE representing management of a one-year grant as temporary rather than representing a loss in positions in the following year).

Over three-fourths of the states have programs in dental screening, dental sealants, fluoride mouth rinse, and oral health education/promotion; it may be helpful to track the sustainability and longevity of these programs, and develop ways for oral health programs to evaluate them.

There appears to be a decrease in the number of states with active oral health surveys; perhaps this is because many states have collected survey information in the recent past.

Future Directions for the Synopsis

The Synopsis has demonstrated its value as a descriptive annual summary of oral health program infrastructure, administration, and programmatic activity in each reporting state, and now as the first nationwide, comprehensive, five-year trend data available for individual states as well as for the country as a whole. Collection of Synopsis data should continue; among many potential uses, aggregate-year trend analysis and reporting could help to prepare for adequate dental public health infrastructure in the future.

The easiest method of distribution for the administrators of the Synopsis was through e-mail attachment. It seemed easier for respondents to complete the Synopsis once ongoing development allowed respondents to add to the requested information a little at a time and save their work before sending in the completed survey. The timing of the distribution of the Synopsis questionnaire and the length of time allowed to return also seemed to have an effect on the timing of its completion.

The importance of participation of every state every year cannot be emphasized strongly enough, as participation or absence of a state in a given year of a five-year period can significantly affect the total. It may be useful to consider development of a mechanism to assist new or acting dental directors, or oral health programs without a dental director to complete the Synopsis.

Consistent participation should be expanded within territories and U.S. jurisdictions so that they may have trend data about their oral health programs. Perhaps a module could be added for the territories and U.S. jurisdictions with questions specific to their unique oral health programs.

It was difficult to compare results when questions changed substantially over the five-year cycle. If aggregate trend data is one of the goals of the Synopsis, then it is recommended that the wording and instructions for the core questions be identified at the beginning of each aggregate-year cycle and not changed for the duration of that cycle. At other times, there weren't enough data because questions were included for only two years and then compromised further by low response rates. These instances suggested that perhaps no *less* than five years should be considered for an evaluation of trends. One-time modules, not meant to reflect aggregate-year trends, could be added to address limited focus areas or interests from other organizations.

Some questions may have a low response level because states may not have the capacity to collect the requested data. Response may also be affected if it is difficult to get the most recent data and then complete the questionnaire. Pre-filled data from other sources should continue to be used for as many questions as possible, and the core should continue to represent key elements with a good response.

A comprehensive evaluation plan should be developed to include the Synopsis analysts and project managers, and end-users of the information (one indicator may be the number of "hits" on the Synopsis web pages), particularly since interested parties are directed to the Synopsis for information. Evaluation could also include a review of the ways that the Synopsis is used to

support or encourage the growth of state oral health programs. An evaluation of the Synopsis was sent to the dental directors at the end of the five-year cycle; this tool should be assessed for further use.

The first five years of standardized data collection has demonstrated that the Synopsis is a valuable tool in collecting information on trends in oral health programs over time. This system of collection and analysis should be stabilized further and continued as a priority for the state and territorial dental programs.

Trend Summary Overview

This overview includes:

- Content of the Synopses by section
- Data collection
- Limitations

Content of the Synopses by Section

Demographics

All 10 items asked in the demographics section are available from other data sources, including the U.S. Census Bureau, Centers for Medicaid and Medicare Services (CMS), the U.S. Department of Agriculture (USDA), or the Water Fluoridation Reporting System (WFRS). These are not addressed in this report (check with ASTDD data committee whether to include in trends report).

Infrastructure

Of the 8 items appearing in the Infrastructure section, three are available from the American Dental Association's Web site – number of accredited dental schools, dental hygiene schools and programs in dental assisting. The remaining 5 items included in this report are:

- Number of community-based low-income dental clinics
- Number of school-based or school-linked dental clinics
- Number of school-based health centers with an oral health component
- Number of local (district, county or local) health departments with a dental program
- Tribal, state and local health agencies with a service population of 250,000 with a dental program directed by a dental professional with a masters or higher degree in public health

Workforce

Five items were included in the Workforce section between 1998 and 2002. Number of dental assistants was asked only in 2002, so is not discussed here. The other 4 items included in this report are:

- Number of dentists in the state
- Number of dental hygienists in the state
- Dentists participating in Medicaid
- Dentists participating in SCHIP

Administration

Eight items appeared in the Administration section between 1998 and 2002. The question “Do you have a Medicaid dental managed care program?” was asked only in 1998 and is not included here. The remaining 7 items discussed here are:

- Dental Director Turnover
- Full-time dental director
- Time spent/compensation for time spent on Medicaid or SCHIP issues
- Full-time equivalent workers
- Budget range
- Funding sources
- Changes in dental budget
- Changes in funding sources

Dental Director Turnover

The Synopses database does not store data on past dental directors, only on the current dental director for each state. The dental director turnover data were compiled from a manual review of paper copies of the Synopses submitted for the years 1998-2002. This summary is incomplete to the extent that some states did not participate in some years, and in some cases, paper copies may have been missing. The ASTDD on-line membership listing was consulted on February 23, 2004 for current dental director status.

Programs

The programs section is treated as one multi-part question. Thirteen programs have been included in the programs section between 1998 and 2002, as well as an “other programs” category. The Community Water Fluoridation program was shifted between sections of the Synopsis over the 5 years, and the data are available from WFRS, so it will not be addressed as part of the programs trend section. Access to Care and Fluoride Varnish programs were added later. The 10 programs included in this report are:

- Abuse/Neglect or PANDA
- Dental screening
- Dental sealants
- Early Childhood Caries prevention
- Fluoride mouthrinse
- Fluoride supplements
- Mouthguard/Injury prevention
- Needs assessment/oral health survey
- Oral health education promotion
- Smoke and spit tobacco cessation

Data collection

All 50 states were invited to return a Synopsis each year; in some years, the District of Columbia, Puerto Rico, and six territories were also included. The Synopsis was distributed between November and March each year. The surveys were mailed, e-mailed, and/or faxed to each state; completed questionnaires were accepted through the same avenues. The survey instruments are available on the Synopses Web site under “About the Synopses” at <http://www2.cdc.gov/nccdphp/doh/synopses/AboutV.asp>.

The Synopsis was completed in each responding state by the dental director or acting director, the staff, or other assigned contact person. The responses were to reflect the most up-to-date information available for each question, at the time the survey was completed. In most cases, this was the fiscal year most recently concluded before that year’s synopsis (for example, most of the 1999 Synopsis data are from fiscal year 1997 [July 1997 through June 1998]). Exceptions to the time frame requested were noted.

The dental director is the best, and often only, source of information for most of the items on the Synopses. A few items that are available from other central or standard sources were included, such as state population from the U.S. Census Bureau, number of accredited dental schools from the American Dental Association, and number of people receiving fluoridated water from CDC’s Water Fluoridation Reporting System. These others sources are listed on the Synopses Web site under “About the Synopses” at <http://www2.cdc.gov/nccdphp/doh/synopses/SourcesV.asp>. This report focuses primarily on items available only from the Synopses.

After collection of the questionnaires each year, the states were given an opportunity to review their responses and provide corrections. A summary report distributed at the ASTDD annual meeting. The data set used in this report may differ slightly from printed reports and earlier versions of the one-year data sets because changes requested by states after reviewing the printed summaries and the Web site have been included in this data set.

Limitations

The Synopsis, like any survey, has some limitations. The following is a short description of the extent to which these issues may impact analyses of the data. Further notes on the questions can be found in Appendix B: Technical Notes.

- *Changes in questions included or wording.* Each year the Synopsis Committee fielded many requests for changes or inclusion of new items; consequently changes occurred in most years. We compared reports for these items to see if wording seemed to affect the response. A comparison of items across years is available in Appendix B. Not every question was asked in every year. We limit analysis to questions asked in at least two of the five years. The survey instruments are available at the Synopses Web site, under “About the Synopses” (<http://www2.cdc.gov/nccdphp/doh/synopses/AboutV.asp>).
- *Non-response.* Not every state participated in the Synopsis every year. We refer to this as “Unit Non-Response”. Some states did not provide information for a given item in a given year; we refer to this as “Item Non-Response”. Appendix C contains

a report of non-response of both kinds. We describe trends among states reporting in any year, and among states responding in all years an item was asked.

- *Availability of data for responses.* Some states reported the same estimate for the same item in consecutive years. This may be because states did not have new estimates every year. While we would expect some items to stay the same from year to year (i.e., the number of dental schools in the state), some items that we would expect to change at least a little did not. We compare estimates for the same items from the same states across years to see where the estimate was unchanged, and discuss whether or how this would impact analysis.
- *Data Time Frames.* The Synopses were fielded early in each year, and participants were asked to report the most recent data available at the time, which was typically from the most recent complete state fiscal year. For example, data reported on the 2002 Synopsis was most likely from the July 2000-June 2001 time period. There are, however, numerous exceptions.
- *Estimates from standard sources.* In 2001, the Synopsis Committee decided to use estimates from standard data sources for some items to reduce the burden of data collection on the states. Examples of standard sources are the U.S. Census Bureau, the Bureau of Labor Statistics, the Water Fluoridation Reporting System, and the American Dental Association Website. Use of standard sources was successful for some questions but not others. Sometimes the estimate reported by the state/territory differed from the standard source because in many cases the state/territory had access to more recent data than was available through standard sources. In some cases, the definition for the item differed between the standard source and the source the state/territory reported (i.e., accredited dental assisting programs vs. all dental assisting programs in a given state). The standard sources used by the Synopses are available at the Synopses Web site, under “About the Synopses” (<http://www2.cdc.gov/nccdphp/doh/synopses/SourcesV.asp>).
- *Information from territories.* Seven territories and U.S.-associated jurisdictions were invited to respond to the Synopsis from 1998-2002: American Samoa, Guam, the Federated States of Micronesia, The Commonwealth of the Northern Mariana Islands, the Republic of Palau, Puerto Rico and the U.S. Virgin Islands. More information on participation among this group is included in Appendix C: Unit and Item Non-Response.

Of 31 items asked on the Synopses during 1998-2002, we focus on trends in 17 items not available from other data sources with a national scope.

Synopses items are grouped by topic: Demographics, Infrastructure, Workforce, Administration, and Programs. We review all but the first topic, and we add a topic on dental director turnover.