# Access to dental care: The role of the oral health workforce

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**An Association of State and Territorial Dental Directors (ASTDD) Best Practice Approach Report** presents examples of successful/innovative implementation of public health programs, as a resource for public health professionals to:

- Increase awareness and knowledge of the need for improved access to oral health services through workforce development and offer strategies to achieve this.
- State oral health programs will use the Best Practice Approach Report (BPAR) with broad-based partnerships to adapt and implement recommended strategies.

## Background

Oral health is an essential component of overall health and quality of life. Improving oral health requires the ability to access dental care, and access is partly dependent on an adequate dental workforce. The ability to access health care is a multifactorial process[1]:

| | |
|---|---|
| **Accessibility** | The relationship between physical location of dental services and the location of people who need them. Geography and transportation resources are factors that contribute to an increase or decrease in accessibility. |
| **Availability** | Providers' ability and willingness to see those who are seeking care |
| **Acceptability** | An individual's perception of provider treatment, including dignity and respect |
| **Affordability** | A patient's ability to pay for dental services or their perception that dental care may be too costly (direct and indirect costs) |
| **Accommodation** | Delivery of healthcare to meet the needs of patients (i.e., extended office hours, translation/audiovisual services, adjusting for cultural barriers) |
| **Awareness** | Provider's understanding and/or appreciation for the unique needs of a community (i.e., cultural differences, health literacy, and continually assessing the changing needs). Patients knowledge of services provided in their area and an understanding of the value of oral health? |

Our report focused on two factors that influence access to care that are impacted by the oral health workforce: accessibility and availability.

Racial and socioeconomic status (SES) disparities play a role in the ability to access dental care and oral health status. Racial/ethnic minorities and populations with low SES are less likely to use dental care compared to white, high-SES groups resulting in a prevalence of dental disease and tooth loss that is disproportionately high.

**How does the oral health workforce influence access to care?**

## Methods

In consultation with ASTDD, authors completed a comprehensive review of published peer-reviewed and unpublished literature, and publicly available data. Authors examined trends in dental workforce composition, approaches to future workforce development, and current dental safety net capacity to determine how these elements influence access to dental care. Findings were used to update an existing ASTDD BPAR addressing workforce.

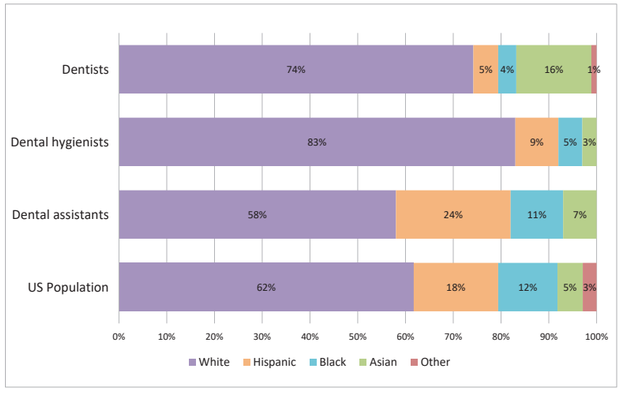
## Results

**Several factors influence accessibility and availability of the oral health workforce. Factors highlighted in our report include:**

- Workforce composition and projected supply
- Recruitment and preparation of the future oral health workforce
- Capacity of the dental safety net.

The US population is becoming more diverse; however, the oral health workforce does not reflect the population.[2-5] This may influence access to care for underserved communities due to the fact that under-represented minority providers are more likely to treat racial/ethnic minority, less educated, and lower-income patients compared to their White counterparts.[6]

**Figure 1.** Race/ethnicity of the U.S. oral health workforce in comparison with the U.S. population




**How is the oral health workforce providing care for underserved individuals and a more diverse US population?**

**1. Expansion of the traditional dentist, dental hygienist, and dental assistant oral health workforce model to include:**

- Dental health aide therapists: Providers from Alaska, working in remote Alaskan villages.[7]
- Dental therapists: Working in settings that serve low-income, uninsured and underserved children and adults.[8]
- Medical practitioners: Providing oral health education and services outside traditional dental settings.
- Community health workers: Trusted members of the community who are a link between health services and the community to increase access and to improve the quality and cultural competence of service delivery.[9]
- Promotoras de salud: A Spanish trained community health worker serving the communities they live in, often Hispanic communities.[10]

**2. Recruitment and education of future oral health providers:**

- Innovative dental school models such as: The Robert Wood Johnson Foundation Pipeline, Profession & Practice: Community-Based Dental Education Initiative, which sought to emphasize community-based education and recruit additional under-represented minority, low-income students into dentistry.[11]
- Cultural competency: Schools offer cultural competence education to better prepare students for interacting with diverse populations.[12]
- Interprofessional Education (IPE): The Smiles for Life: A National Oral Health Curriculum provides oral health education for medical professionals, dentists, midwives, and frontline health care workers.[13]

**3. Dental safety-net:**

- Federally Qualified Health Centers: Required to offer patients living at or below 200% of the Federal Poverty Level a sliding fee schedule based on income and family size, while those residing below 100% FPL pay only a nominal fee.[14]
- Teledentistry: Use of digital technology to provide services in non-traditional settings. California's Virtual Dental Home model, treated more than 3,000 patients from 2010-2016. This model is expanding elsewhere.[15]

## Conclusions

**Numerous factors impact the ability of the dental workforce to meet population demand for care. Our findings provide potential action steps that could address workforce-related factors affecting access to dental care.**

## Recommendations

1. Explore ways of using "new members of the dental team" to increase access.
2. Expand incentive programs to practice in underserved areas or with underserved populations through loan repayment programs.
3. Identify ways to involve oral health professionals' expertise after retirement such as: mentoring and teaching.
4. Expand extramural and other outreach programs in curricula.
5. Recruit low-income and minority students.
6. Encourage low-income and minority students from rural and inner-city areas to consider dental careers by introducing them early to oral health opportunities.
7. Ensure that all members of the oral health team receive cultural competency and health literacy training.
8. Create learning opportunities to increase confidence and the skills in caring for diverse populations in multiple patient settings.

**More recommendations can be found soon at ASTDD.org**

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