Meeting Summary

June, 2008

Expanding Access to Primary Care:
New Oral Health Workforce Models

The Santa Fe Group met at New York University's College of Dentistry in June 2008 to explore ways to expand access to oral health care in America and develop priority recommendations toward that end. Invited experts set the stage for discussions of alternative workforce models by providing a perspective on the state of the healthcare workforce worldwide and presenting evidence for the need for a paradigm shift in America's healthcare policies and practices. Speakers also introduced a number of social, cultural, economic, and ethical issues that must be addressed if a truly transformative change in access to oral health care is to be achieved.

The dental school meeting was the setting for the First Annual Meskin Symposium, honoring Dr. Larry Meskin, the distinguished researcher and educator who inspired the formation of the Santa Fe Group, composed of thought leaders in dentistry. Dr. Larry Meskin served as Dean of the Dental School and Vice President for Academic Affairs and Research at the University of Colorado and had served as editor of JADA for close to a dozen years. His adobe house in Santa Fe, "with curving walls and no sharp edges--like the man himself"-- according to former NYU College of Dentistry Dean and current NYU Executive Vice President, Dr. Michael Alfano, had been the venue for planning sessions that led to the formation of the SF Group in 2000. The Group acts as a "neutral convener" of meetings "to help shape the future of health through policy recommendations and social change." Dr. Meskin's widow, Estelle, attended the New York meeting, where SFG President Dr. Linda Niessen announced a new program of

Meskin Fellowships. Promising early- or mid-career dental professionals recruited on the basis of their interests in future symposium topics will be awarded stipends for a year in which they will work with Santa Fe members in the planning and research activities pivotal to the success of future meetings.

A Global Health Workforce Crisis

Keynote speaker Dr. Jo Ivey Boufford of the New York Academy of Medicine described the ongoing shortage of healthcare workers worldwide as a crisis, which is no more evident than in sub-Saharan Africa, which is devastated by HIV, tuberculosis, and malaria. We have an unprecedented ability to cure and prevent disease, significant political will, and well-funded private and government programs, she noted, but there is a wall that blocks getting care to the people most in need. The weakness is in systems—especially in developing parts of the world, where many countries are showing sharp declines in life expectancy. But even some developed countries like Russia are seeing life expectancy drop to 58 years. Elsewhere, shortages in the workforce are occurring in tandem with the aging of populations, many of whom will need long-term care for diabetes, heart disease, cancers, and other chronic diseases of aging. Through a Joint Learning Initiative supported by the Rockefeller Foundation begun in 2002, the Academy has engaged partners across the globe in consultations, advocacy initiatives, and analytic studies to describe the global workforce landscape and recommend what needs to be done.

The data indicate that as the number of healthcare workers per 1,000 population increases, deaths of mothers, infants, and children under 5 decline. An estimated 2½ workers per 1,000 population is considered the minimum to achieve health goals, but in 46 African countries the number of workers per 1,000 is less than 1. Other studies document, not surprisingly, that healthcare worker density correlates with GDP (high in North America, Europe and Western Pacific regions), but not necessarily with health outcomes. Resolving global health workforce shortages is not just a question of increasing the numbers, however. There needs to be the right mix of professional skills and an equitable distribution of the workforce so that rural and underserved areas are not shortchanged. Healthcare workers themselves need a positive work environment, along

with the respect and resources that will allow them to carry out their duties responsibly. This can be a challenge in developing countries where in order to qualify for international loans governments may be forced to cut or cap public sector expenditures. In turn, developed countries must address their own workforce shortages, among other reasons, to constrain the mass migrations of health professionals from poor countries. The U.S., for example, has become a magnet for nurses trained in the Philippines.

Dentistry *not* at the table

Dr. Boufford stressed that "*…dentistry is not a prominent voice at the global health table*." Indeed, 95 percent of the world's people have no access to oral health care, she reported. Yet dentistry could play an important role in primary care with its emphasis on cost-effective prevention and early detection strategies. The lessons learned and recommendations arising from the Joint Learning Initiative led to a World Health Organization report on the global health workforce in 2006, calling for a decade of action in which participating countries are asked to generate strategies for resolving workforce issues by 2015. They will need to determine their training needs, not just in terms of how many dental and medical schools are necessary, but what should be the educational requirements for new "functional" categories of health workers appropriate to the healthcare priorities of the country. Better linkages between health professional educators and providers are needed, as well as the participation of a range of government agencies—not just the health ministry, but those setting fiscal policies, or involved with social services, economic development, and others. These strategic planning issues are of direct relevance to the symposium topic. Dr. Boufford ended her talk questioning whether entry level educational requirements for careers in oral health care need be at the master's or doctoral level. Finally she broached an issue familiar to the audience: why is it that dentistry exists in a state of "apartheid" in relation to the other health professions—and seems to enjoy it.

In the question and discussion period that followed, participants cited some positive signs abroad, e.g., the Gates Foundation is funding training at all levels at a hospital in India, and in some countries like Brazil, health care is firmly "embedded" in the government. There was mention of a possible creation of a Community College as part of the City

University of New York to prepare students for careers in health professions. But others commented that schools of higher education, which received tax breaks, give nothing back to the communities they serve. Others questioned what should be the right numbers and balance of care professionals, lamenting that once upon a time professionals worked more closely with nurse practitioners and community health workers. In response, Dr. Terry Fulmer, Dean on NYU's College of Nursing, noted that the tradition has now been reborn at NYU because of the recent establishment of the former Division of Nursing at NYU's Steinhardt School of Education as the College of Nursing at the College of Dentistry, a move which promotes collaboration between dental faculty/students and nurse practitioners at the school's dental clinic.

Changing the Paradigm

Further setting the stage for discussion, Dr. Edward O'Neill, of the University of California San Francisco Center for the Health Professions, provided an overview of health care in America. He noted that government involvement in health systems only began after WWII, with initial positive results. But over time, the government's role has escalated through policies and programs that essentially keep shoveling money into a paradigm which is no longer sustainable, given that:

- 16.5 percent of GDP now represents health care
- $2 trillion was spent on health care in 2005
- 15 percent of Americans are not insured
- As many as 100,000 deaths a year may be avoidable
- Hospitalization is the 4th leading cause of death (i.e., deaths that are not associated with the reason for hospitalization)
- By 2011 the first boomers turn 65

He cited the following as drivers for changing the paradigm:

- Cost—the need to lower costs
- Demographics—an increasingly diverse population living longer
- Epidemiology—the increase in aging populations with chronic diseases
- Technology—the growth of tools which can be used to prevent and manage disease over diagnosis and treatment
- Consumers—an increasing activism, making consumers the drivers for health care
- Globalization—Americans are becoming medical tourists, traveling abroad for cheaper treatments.

The transition from today's dysfunctional model to tomorrow's paradigm equates to a passage from:

- Acute → to chronic conditions
- Cost blindness → to price competitiveness
- Professional prerogative → to consumer responsibility
- Routine in-patient care → to ambulatory, home, or community care
- Solitary practitioner → to team practice
- Information as record → to information as tool
- Patient passivity → to consumer management and responsibility

Propelling the change will be a number of factors, including the failure of today's system to cover growing numbers of un- and under-insured; the political power of the increasing numbers of older Americans; changes in regulatory policies; changes in financial arrangements; and the use of new technology. People will opt to go to the local Wal-Mart for routine diagnostic tests, O'Neill suggested, rather than depend on high-priced laboratories. Telemedicine may bridge the gap between underserved rural areas and academic medical centers. Online training courses may swell the number of new categories of health workers.

Where does this leave dentistry? Traditional dentistry remains the "bungalow" if not the "Ft. Apache," O'Neill said—still adhering to the model of the solitary practitioner, perhaps even with the siege mentality of the fort.

The questions and comments that followed spoke to the importance of consumer literacy as a pre-primary care essential. Others agreed on the need to re-vitalize the dental profession, while pointing to orthodontics and, in particular, craniofacial anomaly teams, as areas of dentistry where the team approach is the norm. One participant reminded the group that health care is an industry in America where 12 percent of the labor force is employed and that healthcare reform could have serious consequences. O'Neill responded by asking whether it was necessary to continue to drive a Lincoln Navigator over a more affordable model. Others urged that oral health workforce issues be linked to the fundamental need for healthcare reform.

Ethical issues in Access

Following the initial talks that put health workforce issues in a global perspective and posed the need for healthcare reform in America, Dr. Frank Catalanotto, Professor at the University of Florida College of Dentistry, raised concerns about ethics within dentistry itself. He sees a decline in the social contract and a sense of responsibility in new generations of oral health professionals. "Access to oral health care should be seen as a human right," he noted. "We need to address ethics not just in terms of the provider-patient relationship, but as an obligation to the community." He questioned whether dental schools are recruiting the right students. While there has been much talk of recruiting a diverse student body, he noted that at the University of Florida, 34 percent of Florida's students come from families with annual incomes over $184 thousand. Florida's restrictive practices with regard to licensing out-of-state dentists (ostensibly to preserve standards, but in effect conserving/increasing local dentists' incomes) can further constrain the growth of dentistry, he said. The American Dental Association itself is partly to blame, he added, by its assertion that dentists have the right to choose patients and its opposition to the development of alternative care systems for the past 40 years. He concluded with recommendations to re-think the admissions process, implement an ethics curriculum, and model professional behaviors to promote greater sensitivity.

Many in the audience agreed with Dr. Catalanotto's sentiments, indicating that not just Florida, but all dental schools share the problem, remaining at the "crossroads" alluded to in an Institute of Medicine report on dental education over a decade ago. Others said that the solution to the access problem was not in voluntarism or the pro bono efforts of individual dentists (because such "band-aid" solutions are random and not driven by population needs).

Access problems also reflect the historic separation of medicine from dentistry, which discouraged the two professions from working together in the community. Another addressed several themes arising from the presentations: Why is dentistry exclusionary? Is it fear? Concerns about the future? Anti-intellectualism? Why do we have restrictive

licensing policies? One participant underscored Dr. Catalanotto's comments with an anecdote. "25 years ago when freshmen were asked whether they would treat a patient who couldn't pay for dentures, 75 percent said they would, and would work something out with regard to payment; 25 percent would not do the work. Today those percentages are reversed," noted the speaker.

The States' Role: Battlefield or Playground

The discussion of state policies with regard to dental licensing was a natural lead-in to the next speaker. Shelly Gehshan, of the National Academy for State Health Policy, described the three key health roles of states: regulation, education, and public health. Theoretically, regulation is designed to serve the public interest by protecting the consumer, preventing monopolies, and promoting competition, enacting legislation accordingly. She, too, criticized the profession, saying that dentists are highly territorial, ready to defend their turf. It makes no sense for one group of professionals to control another group, she said, as is the case with dentistry's dictating what dental hygienists can or cannot do, without supervision by a dentist. She went on to say that legislators hate "scope of practice fights" and explained how words like "irreversible procedures" are used to frame practice issues in frightening terms. She admonished dentists not to bring their internal battles to the state but work out their differences ahead of time.

Following her talk, some in the audience said that fear can paralyze the profession and may have contributed to the ADA's opposition to change over the years. In fairness, however, an ADA staff member present noted that the ADA no longer can "just say no." Positive signs include the collaboration between ADA and the American Association of Public Health Dentistry in an Oral Health Future Task Force. In drawing this session to a close, Dr. Dominick DePaola, incoming Santa Fe President, remarked on the fluid state of dental education today: a dozen or more deanships are available; twenty years ago, 6 dental schools closed; and now 10 or 12 new schools may open- two in association with schools of allopathic medicine, several others in association with schools of osteopathic medicine. Thus the possibilities for change are very real.

Need vs. Demand

Day two of the meeting followed a format of facilitated discussions in which pairs of Santa Fe members and special guests introduced selected topics.

Topic A, led by Dr. Jay Gershen (University of Colorado) and Dr. Frank Catalanotto, (University of Florida) was the "Need & Demand for New Workforce Models to Improve Health & Expand Access to Care". Questions to be considered concerned the reliability of workforce numbers, whether there are different needs for specific subgroups, and differences between needs and demands. Dr. Gershen began by citing a study in California in the 1980s which indicated that 1/3 of the state's counties did not have a single dentist who would accept state funding for dental care through Denti-Cal (the state's version of Medicaid for dental care). The result was a class action suit, which increased Denti-Cal funding from $60 million to $600 million. The belief was that now many more dentists would enter the system--but few did. Dr. Gershen stated as reasons for the failure the misperceptions about patients who have Denti-Cal, problems with identifying dentists, traveling to the dental offices, perceived "administrative" difficulties.

In the discussion that followed, one member commented that the California class action suit had an additional counterproductive effect: The few dentists who began accepting Denti-Cal patients reduced clientele at community clinics, forcing them to close. Others raised general questions about perceived vs. actual need, re-visited ethical issues and the need for system reform, and asked whether we were preparing the "right" workforce for the future. One participant said that dental schools have only one class of consumer—the students themselves. "Society gives us the privilege of training the elite who will learn on the same patient they will ignore in their practice." One Santa Fe member commented that we need to educate dentists and students to make them aware that by 2050 there will 400 million Americans, 20 percent over 65 and many under 15: *100 million are not being served.* How long can you ignore these 100 million people?

Signs of change are occurring, however. A participant from Michigan noted that Delta Dental has been in operation for 8 years funding dental care for over half the state's low income children in a public-private partnership. He said we need first to design a system to meet the needs of subgroups from the bottom of the pyramid. The dental school model will be obsolete, he suggested. Another proposed that states pass legislation *requiring* dental providers to accept Medicaid patients, saying that dental licensing should be considered a privilege to practice. Others raised questions about insurance, and whether opening more dental schools and turning out more debt-ridden graduates was an answer. In reply, others said increasing the workforce with more dentists is not the answer, since we are not preparing them to see the populations most in need. We need to integrate oral health with existing social and health services, conduct pilot programs, and generate the concept of a dental "home" – which may not be the dental office as we know it today.

Several in the audience discussed programs such as one in California providing training to social workers and promotoras (community health educators) so they are able to go into homes and ask families about oral health and other health related questions. The idea is to take prevention to the community. The wisdom of this approach was echoed by a New Yorker who said that going into settings like Senior Centers in high-need areas generates high demand. The NYU model in which nurse practitioners work with dentists in the clinic is another example. Using appropriate risk assessment tools, the approach could bring dentistry much closer to medicine. Summing up the discussion, one participant saw the various examples as ways to turn subgroup-specific needs into demands. Professionals cannot drive demands, he said, especially in the context of the larger issue of healthcare reform.

Building the Workforce

Drs. Kathleen O'Loughlin and Ronald Inge facilitated discussion of the second topic of the morning: "Barriers and Solutions—Impediments to Workforce Development". Participants cited the ADA as impeding new workforce models. But the facilitators also addressed economic, regulatory, legislative, and educational barriers, as well as the

influence of competition and of perceptions—dental treatment vs. oral health promotion and disease prevention models. One audience member said that we have two-tiered system with 68 percent served by the current DDS workforce and 32 percent left out. Some members pointed to models currently in place that are overcoming barriers.

In San Francisco, for example, an "entrepreneurial" dental hygiene program allows hygienists to go into elementary schools and nursing homes. Dr. Inge stressed the importance of communities coming together. An example of community action is the "Kentucky Smiles" program, funded by a local utility company. Others cited examples of change occurring because a pediatric-driven community came to a dental school and asked for services. Dr. Inge also noted that Delta Dental has had the ability to facilitate integration. Elsewhere, members reiterated the value of bringing care into the community. New York City consists of many neighborhoods, one member said. People don't want to leave their home area, so you have to go there, work with case managers, peer counselors. He mentioned a program called Health Intervention Target Service – HITS -- which "knocks on doors," going into senior centers, condominium recreation rooms, and other venues where community members congregate.

Addressing the two-tiered system, one participant said we have a two-tiered book access system, which is not stigmatized—public libraries vs. Barnes and Noble, so we ought to be able to develop similar non-stigmatized systems for oral health care. Dr. Gehshan proposed that Foundations be enlisted: "You need to go to foundations with ideas and get support. That is what the nurse practitioners did and then the federal government stepped in". Another commented, "That will require developing a tool kit for how dental schools can approach foundations—they need something to raise their fund-raising and coalition-building I.Q." One participant reported that the American Dental Hygienists' Association is working to overcome barriers in its new strategic plan. It calls for collaborating with the ADA and working to reverse the trend that has been separating dental hygiene education from dental schools.

In summarizing the discussion, the facilitators spoke of the need to re-build the oral health care safety net, assure that it be patient-centric within the community and provide continuity of care over the life span.

Four Workforce Models

The formal presentations of the meeting concluded with descriptions of four alternative oral health workforce models, with discussion moderated by Dr. Arthur Dugoni, Dean Emeritus, University of Pacific, Arthur A. Dugoni School of Dentistry.

The community dental health coordinator. The ADA's model of a new oral health workforce member is a Community Dental Health Coordinator (CDHC), defined as a community health worker with dental skills. Dr. Amid Ismail (University of Michigan) described the model, saying that the ADA did not envision a single solution to workforce problems, but foresaw many possibilities. Some solutions might be "upstream" (dependent on economic development, educational systems, health policies, and the organization of healthcare systems), while others, such as the use of fluorides or dental sealants, are downstream. The CDHC would be a fully paid community member of an integrated team led by dentists working for dental clinics in underserved areas. CDHC training emphasizes health promotion and is at the level of dental hygienists. Coordinators would advise and advocate for patients, allay fears, promote health and nutrition literacy, and coordinate care with medical/social care providers. Their dental skills would include screening for dental disease and emergency situations, conducting triage, taking digital radiographs, applying topical fluorides and sealants, and improving oral hygiene. Both dental hygienists and dental assistants with additional training could be certified as CDHCs. High school graduates could enroll in a 12-month training program to become CDHCs, much of which would be conducted online through 14 modules. All trainees would then work for 6 months as an intern at a CHC or other Federally Qualified Health Center (FQHC). The ADA is providing $2 million to cover the cost of demonstration projects, along with local funding sources, conducted at Native American sites and sites associated with the Universities of Michigan and Oklahoma. The

process and outcomes of the program will be evaluated by an independent national organization. Among outcomes to be weighed will be the efficiency of the program, whether disease is reduced or prevented, the level of patient satisfaction and quality-of-life improvements, and the strength of networks established between the community and professional organizations. The ADA characterizes the risks of such programs in terms of remote supervision, quality of care, capacity to meet increasing demand, turnover and cost of care, and uncompensated care.

ADHA Hygienists' Model: Advanced Oral Health Practitioner (ADHP/OHP). Jean Connor, RDH, President of the American Dental Hygienists' Association, described this model as a state-based initiative that has become a reality in Minnesota through the actions of the Minnesota Safety Net Coalition. The coalition promoted the passage of legislation supported by the Minnesota System on Colleges and Universities, the Minnesota Dental Hygienists' Association and the Minnesota Nurse Practitioners, to establish ADHPs. These are dental hygienists who would receive advanced training and work in collaboration with a dentist via a collaborative management agreement. They are to be state licensed, with additional certification for advanced practice given by the state Board of Dentistry. Following further discussions in spring, 2008, the legislature agreed to change the name ADHP to Oral Health Practitioner, OHP, establish the position in statute and further stipulate that OHPs would work in underserved areas. ADHP/OHP training would be at the Master's level with competencies to perform preventive and restorative services, temporary placement of crowns, pulpotomies, and extractions, along with limited prescriptive authority. In describing the program, Connor outlined the position of dental hygienists in the workforce. There are some 156,000 dental hygienists in the U.S. today, with an expected growth to 200,000 by 2016. Many like the idea of advanced training and ADHA has been working in states to expand the scope of practice, as well as allow direct access to hygiene services and reimbursement through Medicaid. "The future demands that the oral health community come together," she said, "make the curricular changes and the enabling state and federal legislation needed to expand the workforce and employ new workforce models to address public health needs—not only among the underserved, but for an increasing population of older adults."

Alaska Dental Therapist Model

Dr. Ronald Nagel described a program for Native Americans that was initiated following the release of the Surgeon General's Report, *Oral Health in America*, in 2000, which documented the poor dental health of many ethnic and minority groups. The program was driven by the Alaska Native Tribal Health Consortium, which held a stakeholders' meeting in 2000 during which the participants (essentially patients) listed their "wants":

- Cultural competence
- Year-round care
- Care providers who were resident in the area

The stakeholders further specified that what mattered to them most was relief of pain, relief from infection, and restoration of function. At the same time, public health advocates argued for patient education and prevention services. To meet these needs, authorities looked to a model that has been in operation in New Zealand for some time: the use of dental therapists (DTs). In 2003, the Consortium, with the support of the Indian Health Service, sent 6 Alaskan Natives to New Zealand for training as dental therapists at the University of Otago. There are now 10 federally certified DTs working with Alaska tribes in programs that are seen as complementary and not competitive to the practice of dentists. Two-thirds of the cost of care is reimbursed by the federal government. Dental Health Aide Therapists operate under Alaska's legislated Community Health Aide Program, are certified by a Board to work within a defined scope of practice and receive general supervision by a dentist. They are part of the dental team that also includes other dental health aides such as dental assistants, expanded duty dental assistants and dental hygienists.

The New Zealand model is one of the oldest alternative oral health workforce models in the world, beginning in 1921 with the training of "school dental nurses" (later called dental therapists). Candidates received two academic years of training in preventive and restorative dentistry, which allowed them to provide dental care for New Zealand children in a School Dental Service, with oversight by district dental officers. Alaska

DTs are currently being trained at a facility in Anchorage, in a program developed by the University of Washington School of Medicine MEDEX (physician assistants training program) in cooperation with the Alaska Native Tribal Health Consortium.

The Nursing Model

Dr. Terry Fulmer, Dean of the College of Nursing at NYU, described in more detail how NYU's Division of Nursing and College of Dentistry had come together. The three principles that guided this change were communication, negotiation, and compromise, she noted, stressing the schools' willingness to communicate as the most important. The times were favorable: The College of Dentistry was extremely successful; its dean visionary; administration officials nodded their approval. In the background was the *Bridge to Quality*, the Institute of Medicine Report on health professions, urging that the "silos" of health professional schools be connected. But first and foremost was the shared vision of a new paradigm in primary health care and prevention. The 150,000 dentists in the country are arguably among the most visited of care providers, she observed. Yet few dental patients receive a physical assessment, have their blood pressure taken, or urine sampled for sugar and acetone. That was also the case for the 1,200 or so dental patients who were seen at NYU's dental clinic every day. That has changed now, so that the opportunities for the two professions "to create synergistic practice models are enormous" -- to the greater benefit of patients. Collaboration also can be the basis for partnerships in research, guide curriculum development, improve practice standards, and inform healthcare policy and financing.

The workforce model representations were followed by a fourth facilitated discussion on ***Evaluating Current Best Practices and New Approach to Workforce Development***, led by Drs. Fulmer and Jerold Goldberg (Case Western University). The facilitators and members of the audience provided additional examples where integrated approaches to care are being adopted. One member said that dentists at his school were being trained with an eye to make medical referrals; others described clinics where every dental patient has an option to see a nurse practitioner. An NYU faculty member mentioned that a

curriculum committee had been formed composed of PhD nurses, MDs and DDSs. However, Dr. Goldberg also commented that a 5-year program to develop an integrated MD-DDS degree at Case Western University School of Dental Medicine had "no takers." Dr. Goldberg believes this will be rectified in the future as more people learn about the program and its expectations.

Sometimes the move to integrate oral health into primary care comes from medicine. This was the case with a movement fostered by pediatricians that became the "Into the Mouths of Babes" program in North Carolina. One Santa Fe Group member admonished the group to be careful how they framed any proposed moves to integrate separate health professional schools. It was noted that opposition to the move to join nursing and dentistry at NYU was based on the proposed new name of the institution. The situation was resolved when NYU made it clear to the communities of interest that the College of Nursing would be put *in* the College of Dentistry.

Several audience members raised questions on reimbursement and hiring: Who can hire whom? Who can own a business? How can you work out Medicaid reimbursement of community health workers who provide oral care? One member noted that 25 states currently reimburse MDs for providing certain oral health treatment.

Another spoke to progress in medical education saying that at her school students are being trained to look at oral health. However, she was concerned about the "two different personae"—the public health advocate vs. the clinician. Dr. Goldberg commented that there have been foundation-sponsored public health initiatives allowing first-year dental students to place sealants at community sites. Others re-visited issues of how much training is necessary for certain clinical skills and suggested altering the length of dental school education. Still others reported that some dental residents saw no difference between the term "oral health" and "dental care." The group was reminded once again about how words can inflame discussion, citing the indignation aroused among allied health professionals by the term "auxiliary."

Recommendations and Action Plans

In the final plenary session, Drs. Alfano and Bertolami invited group discussion on the best courses of action to pursue to resolve problems of access and workforce issues. Over the course of the hour, members of the audience presented a range of ideas and comments. There was general agreement that:

- **Pilot studies** should be conducted to test alternative workforce models, with independent evaluations, not only of health outcomes, but also of efficiency, cost-effectiveness, etc. Implementing pilot studies will require getting the necessary waivers from state legislatures, a process that ideally should be promoted by coalitions of outside groups (i.e., not dental professionals, but other professional organizations, academic institutions, patient and consumer groups, and organizations fostering economic development). Resources and funding are critical, and supporters might consider government agencies such as the Health Resources and Services Administration or private foundations. Approaches to foundations should be made by an appropriate coalition of groups who do not represent the ADA or other professional dental groups. A few members thought the whole issue of expanding access should be addressed within the larger context of healthcare reform.

- **Other alternative workforce models** should be considered, including H-visas. Using this vehicle, dentists from Mexico, India, and other parts of Asia will be able to come to the U.S. to provide needed dental services for children in California. Another source for health workers could be public health practitioners: it is estimated that there will be a need for 250,000 public health practitioners by 2020 and there are already programs in place (e.g., in Massachusetts) to infuse oral health into Master's of Public Health (MPH)

programs. The nation's 43,000 school nurses are another resource that could be tapped for additional oral health training.

- **Integrated/cross-disciplinary primary care** emerged as an important theme. One member mentioned that the American Academy of Pediatrics was making oral health the theme of its annual meeting later this year, and that a white paper updating the Surgeon General's Report on Oral Health was being prepared. Pediatricians should be trained to be able to attend to the oral health of babies and young children and make referrals as appropriate.

- **Dental school roles**: The schools themselves need to devise ways to improve access. Public Health Service scholarships modeled after the military scholarships in which a student's medical or dental school tuition is covered in exchange for time served in the military might be considered. Such a program for dental students would require the student to serve in rural or underserved communities.

- **Getting the message out**. Several participants emphasized the importance of communications, urging the use of the media, special issues of journals, and the Web sites of dental schools and the Santa Fe Group itself to alert stakeholders to oral health issues and actions. One site ought to become the "go-to" place for information, just as the Campaign for Tobacco-Free Kids Web site has become the source website in that area.

Given the wealth of ideas and actions the group generated it was agreed that the matter of setting priorities for recommendations would best be handled through an e-mail survey. The recommendations, in order, that responders rated as *most important* (with 44% as the cut-off point) are illustrated in **ADDENDUM I**. The Symposium participants are listed on **ADDENDUM II.**

The Santa Fe Group is pleased with the enthusiastic level of participation by so many organizations in this dialogue and thanks them for their participation. The Santa Fe

Group will continue to post updates of important news in this area on the Santa Fe Group website www.santafegroup.org.

A survey listing 36 questions in several categories was distributed to all Symposium participants. The recommendations, in order, that responders rated as most important (with 44% as the cut-off point) are as follows:

Legislative & Regulatory Recommendations

1. Increase the pre- or post-doctoral dental student exposure to working in integrated health care delivery teams across disciplines, and across scopes of practice.

Most important 76%

2. Offset graduation debt for the new oral health practitioner with tuition relief tied to service in rural or urban access shortage areas either through federal Public Health Service programs, or through Community Health Center programs.

Most important 72%

3. Insert oral health care service delivery into the healthcare reform debate at a state and at a federal level. (Example: The Older Americans Act: Medicare 1965: Dentistry strategically positioned itself outside of the debate and was excluded from Medicare.)

Most Important 72%

4. Increase use of written media to influence decision maker behavior regarding the importance of oral health, such as the Malcolm Gladwell article in *The New Yorker.*

Most important 56%

5. Identify affinity groups that would rally around a common cause of improving the health of a community at large, and insure that oral health is an important integral component of a healthy community. (School nurses, social workers, community health workers, foundations, employers, senior service agencies, community health centers, legislators, Head Start programs, local governments, etc.)

Most important 56%

6. Mount a public relations campaign similar to the Tobacco Free campaign to influence public behavior regarding oral health status and access to preventive care.

Most important 52%

7. Change the method of state dental licensure in a way that eliminates the live patient clinical examination and substitutes an equivalent measure of competency, such as an additional post graduate year of clinical experience, similar to the New York model.

Most important 48%

New (Reinvigorated) Service Delivery Recommendations

1. Encourage states to fund demonstration projects that expand the dental delivery workforce by broadening the scope of practice and creating teams to deliver primary care services, especially health promotion and disease prevention (examples: pediatric oral health therapist, dental therapist, geriatric dental therapist).

Most important 64%

2. Engage, national, regional, and local foundations in supporting and expanding existing models or developing new models of oral health care service delivery.

Most important 52%

3. Replicate the successful HIV/AIDS model in creating an integrated health care system for high risk individuals that incorporates the use of social workers, case managers, nurses, physicians, dentists, funding sources (Ryan White Act) and public health systems.

Most important 50%

4. Develop enhanced capacity/capability within the Community Health Center system for oral health care delivery.

Most important 48%

5. Rebuild the public health infrastructure, such as the US Public Health Service's National Health Service Corps and regional public health service delivery systems.

Most important 44%

6. Expand the use of Medicaid and Medicare wavers to promote expansion of pilots that test new innovative models of integrated, all inclusive, care that incorporates oral health.

Most important 44%

2008 First Annual Meskin Symposium Attendees (Page 1 of 2)

Last	First	Company
Abel	Dr. Stephen	Nova Southeastern University College of Dental Medicine
Alfano	Dr. Michael	Santa Fe Group Member
Battrell	Ann	American Dental Hygienists' Association
Bergman	Stanley M.	Henry Schein Inc
Bergman	Dr. Marion	Miracle Corners of the World Inc
Bertolami	Dr. Charles	Santa Fe Group Member
Bloom	Ms. Elyse	NYU College of Dentistry
Bonta	Dr. Yolanda	HealthKnowledge LLC, Consulting
Boufford	Dr. Jo Ivey	New Academy of Medicine
Buischi	Dr. Yvonne	Brazilian Dental Association
Catalanotto	Dr. Frank	Dentistry & Behavioral Sciences
Chan	Kathleen	Columbia Univ. School of Dental & Oral Surgery
Cisneros	Dr. George	NYU College of Dentistry
Connor, RDH	Jean	American Dental Hygienists' Association
Curro	Dr. Frederick	NYU College of Dentistry
DePaola	Dr. Dominic	Santa Fe Group Member & NSU College of Dental Medicine
DeSteno	Dr. Cosmo	NYU College of Dentistry
D'Eustachio	Dr. Richard	Santa Fe Group Member
Dugoni	Dr. Arthur	Santa Fe Group Member
Dunham	Dr. Catherine	The Access Project
Edelman	Dr. Norman	Stony Brook University Medical Center
Edelstein	Dr. Burton	Columbia Univ. School of Dental & Oral Surgery
Eisenberg	Elise	NYU College of Dentistry
Finkelstein	Dr. Allen	7 Hanover Square
Fulmer	Dr. Terry	Santa Fe Group Member
Garcia	Dr. Raul	Santa Fe Group Member
Gehshan	Shelly	National Academy for State Health Policy
Gershen	Dr. Jay	University of Colorado Denver
Glassman	Dr. Paul	Arthur Dugoni School of Dentistry
Goldberg	Dr. Jerold	Santa Fe Group Member
Gray, RDH, MS	Carolyn	Gray Consulting, Inc
Haber	Dr. Judith	NYU College of Nursing
Harris	Tracy	Institute of Medicine
Hirsch	Dr. Stuart	NYU College of Dentistry
Inge	Dr. Ronald	Santa Fe Group Member
Ismail	Dr. Amid	School of Dentistry - D2361
Isman	Dr. Robert	California Department of Health Services
Kamens	Dr. Tracy	NYU College of Dentistry
Kess	Mr. Steve	Santa Fe Group Member
Kleinman	Dr. Dushanka	Santa Fe Group Member
Krol	Dr. David	University of Toledo College of Medicine
Lampiris	Dr. Lewis	American Dental Association
Lamster	Dr. Ira	Columbia Univ. School of Dental & Oral Surgery

2008 First Annual Meskin Symposium Attendees

Last	First	Company
Mertz	Beth	The Center for Health Professions
Meskin	Estelle	Guest
Miller	Christine	University of the Pacific Arthur A. Dugoni School of Dentistry
Mosch	Mr. Jim	DENTSPLY International
Mouradian	Dr. Wendy	Santa Fe Group Member
Nagel	Dr. Ron	Alaska Native Medical Center
Niessen	Dr. Linda	Santa Fe Group Member
Nuckolls	Mr. Desi	The Proctor & Gamble Company
O'Connor	Dr. Michael	NYU College of Dentistry
O'Keefe	Dr. John	Canadian Dental Association
O'Loughlin	Dr. Kathy	Santa Fe Group Member
O'Neil	Dr. Ed	University of CA at San Francisco
Perkins	Dan	Aegis Communications
Price	Mr. Gary	Dental Trade Alliance
Richardson	Hila	College of Nursing, New York University
Shelley	Dr. Donna	NYU College of Dentistry
Sirois	Dr. David	NYU College of Dentistry
Slavkin	Dr. Harold	Santa Fe Group Member
Spielman	Dr. Andrew	NYU College of Dentistry
Terracio	Dr. Louis	NYU College of Dentistry
Uchin	Dr. Robert	Nova Southeastern University College of Dental Medicine
Valachovic	Dr. Richard W.	American Dental Education Association
Vogel	Dr. Richard	NYU College of Dentistry
Volpe	Dr. Anthony	Colgate Palmolive, Co.
Westphal	Prof. Cheryl	NYU College of Dentistry
Wheatley	Dr. Ben	National Academies for Science
Wiggin	Mr. Jack	NYU College of Dentistry