For too long the issue of oral health has been neglected and has been separated from issues of primary care and general health. As a result of this neglect, large disparities in oral health exist by race/ethnicity and social class. Despite scientific and technological advancements, basic oral health prevention and care elude many Americans, particularly the uninsured and underinsured, low-income populations, and communities of color. It is within these communities that we continue to see high rates of oral disease and low rates of utilization of oral health services. Children represent a special problem. Twenty-five percent of children, namely those who are poor or are children of color, experience 80% of all dental decay occurring in permanent teeth.1 The problems of children are not the only crisis that the nation faces as the oral health status of poor adults, and their access to any care, including restorative care at the moment, appears to defy solution or priority in policy dialogue (Figure 1).

While the oral health recommendations of the Task Force on Community Preventive Services (the Task Force) do not target any specific population, they are a starting point for the concomitant task of identifying community-based interventions along the continuum of addressing oral health disparities including disparities in access to care. The next step however is to identify where the needs are, factor in the economic and social impact of the oral health disparities, and design appropriate points of intervention and service to effectively address the oral health of underserved communities.

The W.K. Kellogg Foundation through its Community Voices: Healthcare for the Underserved Initiative and other funded activities has focused on improving access to oral health for vulnerable populations as a way to improve oral health for all. A basic tenet underlying Kellogg’s investments is that oral health care must be integrated within a primary healthcare system that is accessible, acceptable, and available to all. While the Task Force has focused on three disease-oriented issues—dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries—the Kellogg-funded oral health activities focus on complementary issues related to the health delivery system and health policy. The Kellogg-funded work addresses the overarching issues of accessibility, finance, education, workforce, and infrastructure/organization. The work ultimately attempts to integrate activities that remove barriers in a manner that does not leave segmented and separate answers for different communities based on, for example, service gateway, payment, and willing provider availability.

Kellogg’s Community Voices Initiative involves thirteen diverse communities—or learning laboratories—across the country that serve as working centers to identify and implement strategies and interventions that address the needs of those who currently receive inadequate or no health care. The lack of any, adequate, or appropriate oral health care has been a major focus of their overall work in addressing the need for a comprehensive primary care system. These learning laboratories serve some of the hardest-to-reach populations, including those living in poor rural and urban communities, immigrants, children of the poor, communities of color, women attempting to make the transition from welfare to work, adult men, and the homeless.

Prevention Through Early Service

Prevention, one of the strategies embraced in the Task Force recommendations, is clearly the first step in maintaining health, and prevention conducted at the population or community level is the key to reaching the greatest number of people. The Task Force strongly recommends, among other things, school-based or school-linked dental sealant delivery programs. In 1994, the Kellogg Foundation provided funding for the development of the Community DentCare Network at the Columbia University School of Dental and Oral Surgery. Community DentCare is the best-developed model of community-based care that uses schools to serve children, some family, and community members. Through Community DentCare, the Northern Manhattan Community Voices Collaborative provides preventive and basic dental services to children at six school-based sites regardless of ability to pay2 (Harris S, et al., 2002).
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Several Kellogg-funded Community Voices sites are tackling barriers to oral health services for adults. Lack of coverage or financial resources are major barriers to dental care for low-income adults. States have the option of whether or not to provide dental coverage through Medicaid for adults. Even when states do provide coverage, it is most often limited to partial or emergency care. Only 15 states provide full coverage for adults, 18 states provide partial coverage with many limitations, and in 18 states, no services or only emergency services are available for adult dental care. Expanded publicly financed coverage is necessary if we are to address the oral health needs of adults. Toward this effort, West Virginia Community Voices in partnership with several organizations including the WV Welfare Reform Coalition successfully advocated for the use of Temporary Assistance for Needy Families (TANF) dollars to support oral health services for TANF recipients. Similarly, Denver Health was successful in a bid to provide dental restorative services to adults utilizing TANF dollars. Unfortunately, due to budget constraints the Denver TANF Dental Fund was discontinued. Over 200 adults were seen in the 16-month period that the funds were available (Whitley E, Denver Health and Hospital Corporation, Denver, CO, personal communication, 2002). Getting dental services for this population has been essential to helping to get people back into the workforce who have been marginalized due to issues related to dentition. The Voices of Detroit Initiative (VODI) is working with the Chamber of Commerce and owners of small businesses in Detroit to develop a health maintenance plan for employees not covered by dental insurance. They have also opened new dental treatment chairs for adults using funding from public and private sources. Asian Health Services, a partner of Community Voices—Alameda County, through a managed care plan is adding dental services to the primary care services that they offer primarily to low-income immigrants regardless of their ability to pay. Asian Health Services is also planning to open a new dental health clinic. Each of these sites is not only concerned with the delivery of services, but also the financing and policies that will make their efforts sustainable. All of the Community Voices sites report that oral health services are the most often requested component of any service or treatment plan, a fact that has not apparently resonated with payers, providers, or with policy.

Figure 1. Percentage of untreated decayed teeth in adults Source: NCHS 1996.17

Northern Manhattan Collaborative, Columbia University, NY, personal communication, 2002). Clearly school-based or school-linked dental sealant delivery programs play an important role in reaching children who otherwise might not receive care. Moreover, providing dental screening and restorative services is important if dental sealant programs are to be successful particularly for high-risk children who potentially have large numbers of decayed teeth at early ages that must be treated before the sealant can be applied. Sadly, identifying willing providers for children covered by Medicaid is a major barrier to their care.

The shortage of providers willing to accept Medicaid reinforces the need for public pediatric dental clinics. FirstHealth of the Carolinas (Community Voices North Carolina site), with support from The Duke Endowment and The Kate B. Reynolds Charitable Trust, has opened three pediatric dental clinics. Nearly three fourths of the children they see have never seen a dentist or have not been to a dental clinic for over a year. By combining enrollment efforts with dental visits they ensure that all eligible children who come for services have coverage. Since the first clinic’s opening in 1998, over 21,000 sealants have been placed to protect posterior teeth from decay. School-based dental screenings have documented a 50% decrease in the percentage of children with decay and a 15% increase of sealants in fifth graders in just 3 years.5 Denver Health (Community Voices Denver) with support from the Caring for Colorado Foundation is also expanding their dental capacity to provide services to children and adults.

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Developing an Appropriate Workforce

Minority communities have a disproportionate burden of dental problems and a short supply of minority providers and willing providers. A 1996 survey by the American Dental Association showed that minority dentists are likely to provide a significant amount of care to members of their own minority community. For American Indians, the proportion of dentists to population (1 to 35,000) is staggering. Less than 5% of practicing dentists are under-represented minorities (blacks, Latinos, and American Indians), a figure that is less than their percentage (23%) in the population. The lack of providers is also a problem faced by low-income rural and urban communities. In general, low-income communities must deal with a lack of willing providers due to issues such as low Medicaid reimbursement.

Clearly the supply of providers for populations such as minorities or low-income rural and urban communities is related to education and pipeline issues, and issues of finance (incurred debt and earning potential). The Kellogg Foundation is partnering with the Robert Wood Johnson Foundation, the American Dental Education Association, the National Dental Association, and others to address some of these pipeline issues. Specific Kellogg Foundation funds will be used to provide scholarship or loans that will be targeted to those students most likely to serve the poor and who, as a result will experience a lower lifetime earning potential, given the construction of our current payment system that in effect penalizes providers serving those with greatest need.

Several Community Voices sites are working on the issue of provider shortage. For instance, New Mexico ranked 48th in national ratings with 43 dentists per 100,000 population. In 1997, the national average was 60 dentists per 100,000 population. Only six of New Mexico’s counties fall within the recommended 1:2000 ratio of dentists per population. Two New Mexico counties have no dental services and the other twenty-five fall below the 1:2000 ratio. To address the dental provider shortage, collaborators of Community Voices–New Mexico supported the passage of a Collaborative Practice Act that allows dental hygienists to work under the supervision of medical directors of primary care facilities, thereby integrating dental providers into the primary care team. This model has the potential to provide dental services in rural areas where dentists are scarce. They are also examining licensing and credentialing rules while continuing to explore recruitment incentives for public providers. FirstHealth of the Carolinas is also examining what changes could be made to their state Dental Practice Act to encourage more providers to come to North Carolina to serve their rural and traditionally underserved populations. FirstHealth was represented on the North Carolina Institute of Medicine’s Task Force on Dental Care Access, which provided the North Carolina General Assembly with recommendations on how to address issues related to inadequate access to dental care including the lack of available providers for low-income adults and children. Where there is a shortage of dental providers, communities are looking to medical providers to provide screening and preventive care. Denver Health and FirstHealth of the Carolinas work with their physicians to provide basic screening, fluoride varnishes, and referral to dentists.

The need for linguistically and culturally competent providers persists for all levels of dental professionals. This is in addition to needing providers for rural areas. FirstHealth of the Carolinas is actively working with their local community college to find funding for the development of a dental assistant and dental hygienist training program. The Northern Manhattan Collaborative through Community DentCare recognized the need to address training/pipeline development and incorporates strategies that help individuals move from welfare-to-work to dental professions. A dental assistant training program was developed that channels community residents into dental careers.

The Kellogg Foundation is also exploring the unique principle of Community Benefit. The national meetings convened to date have been designed to determine if the taxes paid by the poor and the tax status of institutions should be redirected to a greater extent in the provision of in-kind services to the poor, in recognition of their tax support of these institutions. A further point of exploration is to determine if the educational process should be more diverse, based on the diverse population that provides tax support for education. This work, while at an early stage, may reframe service and education to a position that incorporates community as a stakeholder and key informant in workforce development and service design.

Integrating oral health and primary care. Beyond assuring the availability of dental providers is the need to integrate oral health into primary care. The linkage between medical, dental, and social services must be encouraged if we are to sustainably eliminate disparities in health and access to care. While the lack of willing providers remains a barrier to care particularly for the underserved, Community Voices sites such as Denver Health and FirstHealth of the Carolinas are working with their medical providers to conduct dental screenings and to provide fluoride varnishes. Based on the needs of their patients, the medical providers will make referrals to dentists as necessary. The University of New Mexico has implemented a dental rotation for its emergency room residents so that resident graduates are now able to perform emergency dental procedures in rural emergency departments.

Co-location of services may also reduce barriers to
care. Community Voices–Miami worked with Camillus House to offer dental services to the homeless and undocumented residents in their facilities that offer human, mental health, and medical services. In Baltimore, Vision for Health (Community Voices Baltimore) and the Baltimore City Health Department established the Men’s Health Center, which provides oral health services to uninsured adult men as part of their primary care services. While co-location is not always possible, it potentially allows for care coordination to readily occur. Community health workers or promotoras can help individuals access needed services and assist individuals with navigating complex health and human services.

Several of the Community Voices sites as a result of a collaboration with the American Legacy Foundation and the Kellogg Foundation are also linking their tobacco control efforts with their oral health work. For instance, VODI and Community Voices El Paso are developing Continuing Medical Education (CME) courses for medical and dental providers to educate them on issues of oral health (oral cancer in particular) and tobacco. These sites are not only working at the provider level, but also at the community level to educate and inform both programmatic and policy efforts.

Adopting Community-Based Interventions and Strategies

The importance of community-based work underscores the fact that most solutions are local. By working with community members, practitioners, faith organizations, policymakers and decision makers, tailored interventions can be developed that maximize the assets and resources available at the local/regional level. What has been lacking in the field of oral health is the recognition that oral health is a health issue of concern to the community at large. Oral health is not simply an issue for the field of dentistry, but must involve those who have traditionally neglected the mouth as part of the body. Numerous Community Voices sites including Community Voices–Ingham County have, and continue to have, community dialogues involving different sectors of their communities toward the broad goal of improved oral health. Ingham County’s Action Plan, which was generated from community dialogues involving consumers, employers, providers, and insurers, identified key actions for oral health including ensuring that new funds are maximized by drawing down additional matching Disproportionate Share Hospital (DSH) funds to support expanded access to dental services, working with schools to develop and deliver oral health education to both students and families, and addressing low Medicaid reimbursement rates and reducing administrative inefficiencies in the Medicaid process.15 The WV Oral Health Policy Task that was formed due to the collaborative efforts initiated by Community West Virginia has successfully supported the creation of a state oral health program within the bureau of public health. This office will be charged with working with health professions, school educators, volunteer agencies, and others to address issues including oral cancer, access to health services for low-income residents, and the geographic distribution of providers.16

The Kellogg Foundation finds it increasingly important to incorporate provider availability and attitude, and payment to the variables that must be taken into account in designing interventions. Both provider willingness/availability and payment streams are elemental to current community-based approaches to improve access to care. Indeed the Community Voices sites are encouraged to examine strategies that involve identifying and supporting new programs, but also the institutional and public policies that lead to sustainable population-based change. Toward these policy efforts, Kellogg supports the Children’s Dental Health Project in their work to implement a national oral health policy center to inform the private and public sectors of the needs of underserved communities and provide strategic policy and program options to improve access to care.

The Task Force recommendations are a building block for communities to address oral health. They promote prevention at the community level and integration of oral health into primary care and primary prevention. A role of foundations is to promote and foster innovation in improving the health and well-being of individuals, families, and communities. Foundations can exercise leadership by supporting communities in their efforts to identify the interventions and strategies that are most effective for the individual needs of their communities and secondly to then share successful strategies with other communities. It is also the responsibility of foundations to work to inform policy of strategies that work and ways in which needed services can be provided. The Kellogg Foundation works with other foundations, governmental agencies, professional organizations, businesses/corporations, and other entities to inform oral health policy and practice.

Many strategies must be employed to improve the oral health of the nation. The Task Force recommendations represent a holistic substrate upon which practice, workforce, and policy may be developed. Community voice and action must continue to be key informant of the work that is developed, as the public is ultimately the source of resources for research, workforce development, and support of much of the public and private practice in the nation. A focus on children, adults, providers, training programs, and policy all represent important parts of the whole. The whole, improved and
unrestricted access by all, regardless of ability to pay is a goal that remains as a core and fundamental principle policy of Kellogg Foundation program and mission.

References