



ORAL HEALTH CARE
Science and Law Brief

Policy Options to Increase Access to Oral Health Care and Improve Oral Health by Expanding the Oral Health Workforce


This brief outlines current concerns for oral health and explores policy options to increase access to oral health care and improve health by expanding the oral health workforce. It is designed to help policy-makers, public health professionals and community members translate proven public health science into public health law and community practice at every level of government.

The Challenge of Oral Health

Oral health is integral to overall health.¹ The first Surgeon General's Report on Oral Health was published in 2000. Its purpose was to "alert Americans to the full meaning of oral health and its importance to general health and well-being."² Yet nearly 15 years after the Surgeon General addressed concerns about a "silent epidemic" of untreated oral disease in the United States, much remains to be done to ensure good oral health across the nation.

Untreated oral health problems in children may result in attention deficits, trouble in school, and problems sleeping and eating.³ For adults, poor oral health may contribute to difficulty obtaining a job and forming relationships. Employed adults lose more than 164 million hours of work each year due to dental disease and dental visits, and in 2009 over 830,000 emergency room visits were the result of preventable dental conditions.⁴ Poor oral health is also associated with a number of other diseases, including diabetes, stroke and respiratory disease.⁵ The burden of oral disease is unequally distributed, with minorities and low-income people significantly more likely to report oral health problems.⁶ In older adults, poor oral health is significantly associated with disability and reduction in mobility.⁷

The proportion of children, adolescents, and adults who used the oral health care system in the past year has been identified as a leading health indicator in the Healthy People 2020 process.⁸ Nationally, about 43 percent of children, adolescents, and adults had a dental visit in 2009.⁹ The low percentage of people who receive regular dental care is troubling. According to the Centers for Disease Control and Prevention, most oral



diseases are avoidable with the timely administration of preventive care, such as dental sealants.¹⁰ Failure to address oral health with timely preventive care may result in costly visits to hospital emergency rooms, especially for children in low-income households.¹¹ The national goal under Healthy People 2020 is to increase the proportion of people who used the oral health care system in the past year to at least 49 percent.


Recognition among key stakeholders of the importance of preventive oral health care to general health and well-being is on the rise. Policy proposals to improve oral health and access to oral health care have proliferated. Leading national organization across the public health spectrum have conducted research and issued recommendations, including:

- American Academy of Pediatrics¹²
- American Academy of Pediatric Dentistry¹³
- American Dental Association¹⁴
- American Dental Education Association¹⁵
- American Dental Hygienists' Association¹⁶
- American Public Health Association¹⁷
- Association of State and Territorial Health Officials¹⁸
- Association of State and Territorial Dental Directors¹⁹
- Centers for Disease Control and Prevention Oral Health Program²⁰
- Children's Dental Health Project²¹
- Commission on Dental Accreditation²²
- Community Catalyst²³
- County Health Rankings and Roadmaps²⁴
- Department of Health and Human Services²⁵
- The Institute of Medicine²⁶
- Kellogg Foundation²⁷
- National Academy for State Health Policy²⁸
- National Conference of State Legislatures²⁹
- National Governors Association³⁰
- Oral Health America³¹
- Pew Center on the States and Pew Charitable Trusts³²
- Public Health Foundation³³
- Public Health Law Research³⁴
- The Robert Wood Johnson Foundation³⁵

While there are a variety of strategies to be considered in efforts to improve oral health, some of these have been addressed previously by the Network for Public Health Law. For example, the Network published an [issue brief](#) analyzing provisions of the Affordable Care Act related to oral health and recommendations made by the Institute of Medicine in two 2011 reports related to oral health.³⁶ Other strategies, such as community water fluoridation, have demonstrated substantial contributions to public health but are not the focus of the present analysis.³⁷

This Science and Law Brief is informed by four broad conclusions reached by the IOM with respect to improving access to oral health care for vulnerable and underserved populations:

1. Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities.
2. The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans.

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3. Sources of financing for oral health care for vulnerable and under-served populations are limited and tenuous.
 4. Improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings.

Guided in particular by the fourth conclusion drawn by the IOM, this brief focuses upon strategies to expand the oral health workforce as a means to increase access to oral health care, especially preventive care, and thus improve health. By taking steps to expand the oral health workforce, public health officials, policy-makers, and community members can improve oral health, and thus overall health.

It is incumbent upon leaders at the federal, state, tribal, and local level to assess the legal, political, cultural, and economic environment in their communities in order to assess which of these interventions is most likely to be feasible and effective. In many jurisdictions, combining multiple interventions may provide the greatest impact. The Network for Public Health Law is prepared to assist with these assessments, and to provide legal technical assistance to move from goal to strategy to implementation.

Shortage of Dental Health Care Providers

As noted above, fewer than half of Americans receive oral health care in a given year. Multiple factors contribute to difficulty in accessing dental services.³⁸ These factors include low income, lack of insurance coverage for dental care, and low health literacy. Another factor is the distribution and number of dentists and lack of other providers of primary dental care.


The Health Resources and Services Administration (HRSA) of the Department of Health and Human Services prepares an annual list of designated “health professional shortage areas,” which includes shortages of health professionals who provide dental care.³⁹ Health professional shortage areas may include geographical areas, population groups within an area designated as not receiving adequate care, or public or nonprofit private medical facilities.⁴⁰ In general, dentists and the dental workforce are concentrated in urban and suburban areas, and are underrepresented in rural areas.⁴¹ There are over 4000 dental health professional shortage areas, and approximately 10% of Americans live within one of them.⁴²

Innovative Means to Expand the Oral Health Workforce

The remainder of this Science and Law Brief will examine a variety of innovative means to expand the oral health workforce. Some of these innovations would require action by state legislatures, though others may be implemented by state health departments, state regulatory boards, tribal and local governments, or by schools, universities, professional associations, nonprofit organizations, or by those implementing federal programs such as WIC and Head Start.

Expand the Role of Other Dental Professionals, Including Community Dental Health Coordinators, Community Health Workers, Dental Hygienists, and Dental Therapists

Perhaps the area with the widest range of potential policy approaches for states to consider is that of expanding the role of other dental professionals, who may be referred to generally as “alternative dental health care providers,” “mid-level dental providers”, “allied dental professionals” or “dental auxiliaries.”⁴³ For this reason, the Network will provide a fact sheet for each state, setting forth basic oral health statistics and the roles of other dental providers in the state, including supervision and licensure requirements. There is an emerging base of evidence for policy-makers to consider, and efforts to deepen the analysis of the effectiveness, safety, quality, and cost of various approaches are underway.⁴⁴



Although the Affordable Care Act authorized appropriations for an alternative dental health care provider demonstration program, funds have not been appropriated or awarded.⁴⁵ However, states may be able to use funds from the State Innovation Models (SIM) initiative available through the Center for Medicare and Medicaid Innovation to explore and expand the role of emerging professionals, including mid-level dental providers.⁴⁶ For example, Minnesota is using its SIM grant to provide grants to providers to integrate members of emerging professions, including dental therapists, into their teams.⁴⁷

The discussion below offers brief descriptions of several types of dental auxiliaries and sets forth several factors that states, tribes, or other jurisdictions may want to consider when making policy decisions about whether and how to expand the oral health workforce in their state by expanding the role of allied dental professionals.⁴⁸

Community Health Workers and Community Dental Health Coordinators

Community health workers (CHWs) are members of the urban and rural communities they serve.


They offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.⁴⁹

A 2002 report from the Institute of Medicine recognized community health workers as a community-based resource to increase equitable access to health information and health care, including preventive care, in low income communities and communities of color.⁵⁰ Several states have created regulatory structures to regulate or certify community health workers, or are in the process of doing so.⁵¹ Some hospitals and clinics may use community health workers to facilitate diversion of patients presenting in emergency rooms with oral health issues.⁵² Pilot programs for “dental diversion” may be supported by grants from dental insurance providers and related foundations.⁵³ While community health workers do not typically provide direct medical or dental care, they can increase access to care by assisting with selecting providers, scheduling appointments, helping to reduce missed appointments, assisting patients with understanding medical and dental information and instructions, and modeling skills of self-advocacy for patients, including with respect to insurance and access to public benefits.

The American Dental Association (ADA) has championed community dental health coordinators as a specific type of community health worker.⁵⁴ Community dental health coordinators provide oral health education, prevention, and patient navigation assistance in their communities. Preventive services may include dental health screening and assessment, fluoride treatments, and application of dental sealants. Over the past five years, the ADA has partnered with several universities and dental schools on a pilot program to train a small cohort of community dental health coordinators. New Mexico has passed a law to recognize community dental health coordinators.⁵⁵ Open questions include the extent to which it would be possible to scale up from the pilot program to train many more community dental health coordinators, the nature and amount of preventive care community dental health coordinators would be able to provide, the nature and amount of supervision that would be required, and what education and training would be needed to enable current CHWs to serve as community dental health coordinators.

Dental Hygienists

Dental hygienists are the most numerous and well-known of the alternative dental health care providers. Indeed, in their most familiar setting, a private dental office, they generally assist dentists and might not be



considered alternative providers at all. Yet there is a great deal of variety in state laws with respect to scope of practice, practice settings, and amount of supervision required for dental hygienists.⁵⁶ Thus, states interested in expanding the oral health workforce may wish to review their laws and regulations with respect to dental hygienists.

The National Governors' Association (NGA) recently made recommendations to increase the role of dental hygienists in providing access to oral health care.⁵⁷ The NGA observed that states may want to consider whether their laws enable dental hygienists to engage in the full range of preventive and restorative practices for which they are trained and licensed. States that have not already done so may wish to specifically authorize certain preventive practices, such as application of dental sealants in public health settings including schools, WIC offices, and Head Start offices with less supervision by a dentist. It is helpful for such state laws to clearly state whether a dental hygienist may provide preventive care without a prior examination by a dentist. This is sometimes referred to as "direct access," and it authorizes dental hygienists to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist and maintain a provider-patient relationship.⁵⁸


Some states have recognized dental hygienists as mid-level providers, sometimes under specified conditions or in specified settings. For example, California has advanced dental hygienist practitioners and registered dental hygienists in extended functions.⁵⁹ Colorado and Maine allow independent practice by dental hygienists.⁶⁰ Oregon permits expanded practice dental hygienists to work in numerous public settings without supervision.⁶¹ Massachusetts recognizes public health dental hygienists, who may operate independently within a local or state government agency or institution or when practicing in a mobile or portable prevention program licensed or certified by the department of public health.⁶² Arizona authorizes dental hygienists to enter into affiliated practice with dentists without general or direct supervision in public health settings, frequently supported by teledentistry.⁶³ Minnesota authorizes dental hygienists to engage in collaborative practice with dentists in order to reach underserved populations.⁶⁴

Dental Therapists

Dental therapists are mid-level, primary care providers who provide basic preventive and restorative oral health care.⁶⁵ The U.S. Government Accountability Office described dental therapists as mid-level providers because they can perform intermediate restorative procedures, such as drilling and filling a tooth, under remote supervision of a licensed dentist.⁶⁶ An analogy is often drawn to physicians' assistants and nurse practitioners.⁶⁷ Dental therapists are frequently recruited from and work with vulnerable and underserved populations, including low-income communities, communities of color, and rural areas.⁶⁸ In this way, the expansion in the oral health workforce benefits both patients and the community, by providing jobs and role models as well as expanding access to care.

Dental therapists are an emerging profession in the United States, first recognized by the Alaska Native Tribal Health Consortium in 2005, then in Minnesota in 2009, and in Maine in 2014.⁶⁹ Evidence regarding the quality and safety of care provided by dental therapists is encouraging, though preliminary.⁷⁰ At least one study assessed the economic impact and cost-effectiveness of use of dental therapists, though it was not published in a peer-reviewed journal.⁷¹

Alaska's dental health aide therapists are part of the state's community health aide program, which is a collaborative program of the Indian Health Service, the state, and the Alaska Native Tribal Health Consortium.⁷² The federal law authorizes nationalization of the community health aide program, except for the dental health aide therapist program.⁷³ However, an Indian tribe or tribal organization located in a state (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider



services is authorized under state law may elect to supply such services in accordance with state law.⁷⁴ Tribes interested in adopting a policy to utilize dental therapists are encouraged to work with legal counsel to explore their legal authority and ability to access federal funds.⁷⁵

One of the first dental health aide therapists in Alaska described his duties as encompassing, “evaluations, fluoride treatments, cavity excavations, fillings, and simple extractions,” noting that these duties were performed as part of a dental team, while in close communication with a supervising dentist.⁷⁶ Alaska’s Community Health Aide Program Board has set forth practices and procedures for dental health aide therapists.⁷⁷

Since 2009, Minnesota law has provided for dental therapists and advanced dental therapists.⁷⁸ Passage of the bill was supported by a broad coalition.⁷⁹ Assessments of the early impacts of dental therapists have been favorable.⁸⁰ Dental therapists work under general supervision of a dentist for basic procedures and indirect supervision for more advanced procedures.⁸¹ Advanced dental therapists work under general supervision of a dentist. All dental therapists in Minnesota must enter into a written collaborative management agreement with a dentist.⁸² Dental therapists in Minnesota must practice primarily in settings that serve low income, uninsured, and underserved patients or in a dental health professional shortage area.⁸³ Some hospital clinics may use dental therapists to facilitate diversion of patients presenting in emergency rooms with oral health issues.⁸⁴

In 2014, Maine passed legislation to authorize practice by dental hygiene therapists.⁸⁵ In Maine, dental hygiene therapists may provide services, not beyond those provided by a dental hygienist, to a patient without a prior examination by a dentist, if a supervising dentist has given the dental hygiene therapist written authorization and protocols for the services and reviews the patient records at least once in a 12-month period.

There are differing approaches to the training, education, supervision, and regulation of dental therapists, both within the United States and internationally.⁸⁶ In Minnesota, earning a bachelor’s (dental therapist) or master’s (advanced dental therapist) degree is a prerequisite to practice. Under the model employed by the Alaska Native Tribal Health Consortium, two years of education and training following high school is sufficient for beginning dental therapists, who may subsequently seek advanced education or be required to participate in continuing education and recertification. The Alaska tribal model is informed by a desire to make the education accessible to community members and to ensure any separation from the community for educational purposes is temporary.⁸⁷

The Commission on Dental Accreditation (CODA), which provides accreditation services for dental and dental-related education, has published proposed accreditation standards, upon which it will accept comments until December 1, 2014.⁸⁸ The Federal Trade Commission submitted a comment which was generally supportive of an earlier version of the CODA proposal, though it raises some concerns with respect to the potential for restraint of trade by dentists.⁸⁹ A group of academic leaders has been striving to develop more uniform standards for dental therapy education.⁹⁰ Community Catalyst has proposed alternative standards from a community-based perspective.⁹¹ As long as these proposals are being debated, states appear to have substantial flexibility with respect to educational and other requirements for dental therapists and other alternative dental health providers. To the extent that states continue to adopt different approaches, they will create “natural experiments” about which researchers and evaluators may gather evidence in order to assess the effectiveness of the approaches in expanding the oral health workforce and expanding access to oral health care.



Address Medicaid Reimbursement

One barrier to an expanded oral health workforce, and in particular, to more dental health care providers who provide care to low-income and underserved populations is the difficulty of obtaining reimbursement from the Medicaid program for oral health services. The challenges include state choices in whether or not to provide coverage for dental services (though oral health care is recognized as an essential health benefit for children under the Affordable Care Act), recognition of alternative dental care providers, especially when providing services under the supervision of a dentist, as well as administrative burdens, and reimbursement rates.⁹²

Despite these challenges, important progress has been made in this area. Early and Periodic Screening, Diagnostic and Treatment (EPSDT), the Medicaid benefit for children and adolescents, includes dental coverage for “medically necessary” dental care, including maintaining dental health, pain relief, and restoring teeth.⁹³

The American Academy of Pediatrics engaged in advocacy on this issue, in collaboration with the Pew Children’s Dental Campaign and other partners. As a result of these and other efforts, the number of states in which Medicaid covers oral health screening and application of fluoride varnish by physicians increased from 25 to 44.⁹⁴ The Academy produced a chart in 2013 that depicted responses from state Medicaid programs regarding coverage for cavity prevention services provided by non-dental professionals.⁹⁵

About one-third of states have aligned laws authorizing direct access or independent practice by dental hygienists with laws setting forth state Medicaid reimbursement policies.⁹⁶ The American Dental Hygienists’ Association has created a variety of resources that set forth state scope of practice acts which authorize direct reimbursement of dental hygienists by state Medicaid offices⁹⁷ and set forth best practices in order to obtain reimbursement.⁹⁸


Dental health aide therapists in Alaska are able to receive direct reimbursement from the Medicaid program, pursuant to a federal agreement.⁹⁹ Minnesota authorizes reimbursement under state medical assistance for dental services provided by dentists, certified community health workers, dental therapists, advanced dental therapists and for EPSDT services provided by primary care providers such as doctors, physicians’ assistants, nurse practitioners, and public health nurses.¹⁰⁰

Encourage Oral Health Education and Care in the Primary Care Setting

One possible mechanism to expand access to oral health care may not require an expansion of the oral health workforce as such. Greater incorporation of oral health education, assessment, care, and referrals into the primary care setting could leverage medical visits that are already occurring and utilize health care professionals to expand access to oral health care. This approach is not a substitute for primary dental care, but could provide a means to deliver some preliminary guidance and care as well as foster a cultural norm in which having a primary dental home is viewed as being as fundamental as having a primary medical home.

The 2011 IOM report, *Advancing Oral Health in America*, recommended the use of evidence-based preventive services in oral health, including through Federally Qualified Health Centers, Indian Health Service, and state and local health systems.¹⁰¹ The 2011 IOM report, *Improving Access to Oral Health Care*, recommended development of a core set of oral health competencies for health care professionals.¹⁰²

In furtherance of the IOM recommendations, the Health Resources and Services Administration (HRSA) has implemented an initiative to promote the integration of oral health and primary care practice.¹⁰³ A report on the initiative stated that its goal was to facilitate change in the clinical practice of primary care practitioners in the safety net setting. The report further recommends developing the necessary infrastructure to incorporate oral



health care into primary health care settings, modifying payment policies to encourage integration, and developing strategies to implement and evaluate the initiative.

In fact, the Society of Teachers of Family Medicine has developed a “Smiles for Life” curriculum to teach medical professionals how to perform dental screenings.¹⁰⁴ It has been endorsed by the American Dental Association.¹⁰⁵ Others have issued calls to action for greater inclusion of oral health issues in inter-professional education for medical professionals, and for inclusion of dental hygienists and dental hygiene students in inter-professional education.¹⁰⁶

The American Academy of Pediatrics recommends that pediatricians promote the integration of preventive oral care into nondental health practice by ensuring that every child has a “dental home” or providing dietary and hygiene education and care until a dental home is established.¹⁰⁷ For example, North Carolina has a program, Into the Mouths of Babes, which has demonstrated favorable impacts on oral health by training pediatricians and other primary care providers to provide preventive dental services to children enrolled in Medicaid, and reimbursing them for those services.¹⁰⁸

The Association of State and Territorial Dental Directors has facilitated collaboration between state oral health programs, primary care associations, and health centers, as well as preliminary efforts to evaluate such projects and identify best practices.¹⁰⁹ The Robert Wood Johnson Foundation and ICF International have conducted pre-evaluations of programs that provide preventive oral health care to children in primary care settings in order to determine which workforce programs, interventions, policies, and models were ready for a full evaluation.¹¹⁰

Target Recruitment to Address Geographic and Cultural Gaps

As discussed above, HRSA designates Health Professional Shortage Areas, including dental health professional shortage areas. A variety of federal programs, most prominently the National Health Service Corps, provides grants to states to offer loan repayments, scholarships, and other financial incentives for dental health professionals to practice in these shortage areas or to engage in a variety of other activities to expand oral health services.¹¹¹


One effort to increase diversity in the dental profession has been the Dental Pipeline National Learning Institute. The Institute seeks to increase recruitment and retention of students from low-income and underrepresented groups by dental schools, in partnership with community-based dental education programs. It also strives to increase the cultural competence of all students.¹¹²

Expand Geographic Reach of Existing Workforce

One challenge in providing oral health care is that dentists are not distributed in such a way as to provide equal access to oral health care for all persons. This is not the only challenge in access to oral health care, but it does suggest that approaches which enable dental providers to provide care from a remote setting may help to fill at least some gaps in access to care.

Teledentistry

Teledentistry is one such approach.¹¹³ Teledentistry involves the use of technology such as videoconferences to facilitate the provision of dental care when the patient and dental care provider are not in the same location.¹¹⁴ It may also be used to enable dentists to provide supervision to alternative dental health care providers. National Health Service Corps grants may be used to support teledentistry.¹¹⁵ This may include



policy initiatives to address scope of practice, supervision, and practice of persons licensed in one state in another state.

Examples of states with laws to facilitate the use of teledentistry include Arizona and New Mexico.¹¹⁶ A bill passed in California as this brief was completed will expand that state's Virtual Dental Home Demonstration Project, which utilizes teledentistry to provide oral health care in underserved areas, to a statewide program, and allow use of state Medicaid funds to pay for services supported by teledentistry.¹¹⁷

Mobile Dentistry

Mobile dentistry utilizes portable equipment and dental health care providers who travel to various settings, such as schools, Head Start, WIC offices, and senior centers to provide oral health screenings, preventive care, and referrals. Substantial evidence demonstrates that dental sealants provide effective preventive oral care, including when applied in school settings.¹¹⁸ However, the Association of State and Territorial Dental Directors has noted that mobile dentistry involves complex issues on both a practical and policy level.¹¹⁹ State, tribal, and local health departments, as well as preschools, schools, and school districts are encouraged to consult legal counsel when designing a mobile or portable dental program.


North Dakota has recently appropriated state funds to support mobile dentistry.¹²⁰ Private and nonprofit sector partners such as the Ronald McDonald House Charities have also provided support for mobile dentistry initiatives across the country.¹²¹

Data Collection to Support and Evaluate Policies to Improve Oral Health

Data collection efforts may be a tool to begin or guide discussions of oral health needs and policy options at the federal, state, tribal, and local levels. As noted above, the proportion of children, adolescents, and adults who used the oral health care system in the past year has been identified as a leading health indicator in the Healthy People 2020 process. This is the first time that a leading health indicator has been drawn from oral health. Yet, states seeking to measure their progress face challenges. For example, the data relied upon for the leading health indicator is drawn from the Medical Expenditure Panel Survey (MEPS), for which data is not available at the state level. Other data sources, such as the National Oral Health Surveillance System, the National Survey of Children's Health, and the Basic Screening Survey, provide data at the state level, but may utilize different methodologies or measure different indicators, making comparisons to the Healthy People 2020 goal challenging.¹²² These technical differences are a barrier to successful design, implementation, and evaluation of programs, laws, and regulations to improve oral health. Efforts to harmonize the oral health data currently being collected, identify the data that needs to be collected, and utilize the data to inform innovative policies have already begun. For example, Minnesota has engaged in oral health data collection efforts and explicitly built from those efforts to its state oral health improvement strategy, as well as broader statewide public health goals.¹²³

Conclusion

Federal, state, and tribal governments all have the authority to take steps to expand the oral health workforce in order to improve access to dental care by reversing widespread shortages of dental health care providers. Innovative policy tools available to policy-makers include: expanding the role of other dental professionals, including community dental health coordinators, community health workers, dental hygienists, and dental therapists; addressing Medicaid reimbursement issues for dentists, alternative dental providers, and health professionals; encouraging oral health education and care in the primary care setting; targeting recruitment to



address geographic and cultural gaps; expanding the geographic reach of the existing workforce through means such as teledentistry and mobile dentistry; and intentionally using data collection efforts to inform and shape innovative policies. As observed by the IOM, “improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings.”¹²⁴ Jurisdictions may conclude that implementing several of the policy options discussed above at the same time will have the greatest impact. Bold action is required to increase the oral health workforce, improve access to oral health care, and ultimately enhance overall health at the individual and population levels.

Science and Law Briefs

This brief explores policy options that public health professionals and community members might consider to expand access to oral health care. It is the first in what we intend to be a series of initiatives designed to translate proven health science into community practice at every level of government. Each Science and Law



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Brief will highlight practical steps for moving research into law - and law into practice.

Each Science and Law Brief will address a public health problem ripe for legislative or regulatory action. The Network will gather the data that define the problem, examine a potential policy response and provide resources to help policymakers take next steps. One key resource in each Science and Law Brief will be a collection of the scientific evidence in support of the policy and a demonstration of how public health professionals can use the evidence to support policy change. The Network will expand this analysis by detailing how each initiative can be implemented through legislation, regulation, and administrative action. Network staff will be available to public health professionals as they navigate from idea to policy change in their jurisdiction. Each Science and Law Brief will address the key question: how can our laws better integrate the growing field of public health law research?

Even when research supports adoption of a particular public health measure, understandable concerns may arise. Therefore, each Science and Law Brief will highlight counter-arguments that will likely arise in pursuit of the measure. Often, reasonable reservations can be successfully addressed in the legal process. Science and Law Briefs will include multiple examples of how different jurisdictions have already adapted their laws and regulations to meet these concerns. The Network will work closely with our partner organizations and with public health practitioners, lawyers, and researchers to select Science and Law Brief topics.

Together the Network intends for this document and the accompanying state fact sheets to serve as a starting point for developing policy to improve oral health. Attorneys with the Network are available to assist with direct technical legal assistance to any individuals or organizations interested in exploring policy options to improve oral health through expanded access to dental care.

SUPPORTERS

The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation with direction and technical assistance by the Public Health Law Center at William Mitchell College of Law.

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College of Law. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

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