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WHAT PREDICTS ATTITUDES TOWARD NEW WORKFORCE MODELS AMONG UNDERREPRESENTED MINORITY DENTISTS?

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Research Objective: The American Dental Association (ADA) and others have organized strong opposition to one new type of dental worker – dental therapists (DTs), while advocating for another – Community Dental Health Coordinators (CDHCs). Both of these new dental workforce members are intended to enhance care provision in underserved and minority communities. Underrepresented Minority Dentists' (URM) have long served these communities yet little is known about these providers' opinions on adding members to the dental team. This study examines predictors of URM dentists' attitudes toward these new workforce models.
Population Studied: A 2012 nationally representative stratified sample survey was conducted of 4386 Black, Hispanic and American Indian/Alaska Native dentists assessing demographics, education, practice details, and professional opinions. The survey received a 34% response rate.
Study Design: Attitudes toward each new type of worker was assessed on a 5-point likert scale. Independent variables of theoretical relevance were tested for correlation with these outcome measures. In order to model attitudes toward the new workers, binary variables were created for *disagreement* measured as strongly agree agree neutral=0 vs. disagree strongly disagree=1, and *agreement* measured as strongly disagree disagree neutral=0 vs. agree strongly agree=1. Logistic regressions were run to predict providers' attitudes both for and against new models.
Principal Findings: The preliminary model (n=1152, F-stat 5.21) showed opposition to DTs was predicted for URM respondent dentists by membership in the American Dental Association (OR 2.18; CI 1.61-2.95) and being a US-born provider (OR 1.65; CI 1.16-2.35.) Census region variation existed, with providers in Mountain and West North Central most likely to oppose DTs. Older dentists (OR 0.98; CI 0.97-0.99), dentists who practice collaboratively with non-dental practitioners (OR 0.91; CI 0.84-0.98), and those who take public insurance (OR .75; CI .55-1.02) are less likely to oppose DTs. Race, income, and educational debt were not found predictive. Additional analyses that examined support for DTs and support/opposition for CDHW found variability in the importance of factors by race. Items that predict opposition do not necessarily predict support.
Conclusions: Organized dentistry is a fundamental avenue for providers to connect and advocate for their profession, so the importance of ADA membership and geographic variability are not surprising. However these findings indicate a wide array of perspectives that should be included in the ongoing discussion about emerging workforce models, particularly in relationship to serving racially diverse patient populations.
Implications for Policy or Practice: Providing access to affordable high quality dental care is ever more important as the Affordable Care Act expands dental coverage, particularly for Medicaid enrollees. Minority dentists provide a disproportionate share of dental care to underserved communities and have had a strong voice in policy and practice related to serving these populations. Their attitudes and receptivity to changes in the workforce composition of those treating underserved populations is particularly salient for efforts to advocate for access to care and reductions in health disparities.