



# The Role of Safety Net Providers in Delivering Oral Health Services for People With Special Needs

Neal A. Demby, DMD, MPH

## Abstract

The U.S. health care system, best suited to acute care for adults, struggles to accommodate vulnerable populations (such as the elderly, disabled, and mentally ill), and struggles even more to find or put in place a system to care for special needs populations. Special needs populations require a protective and preventive system – one that helps families anticipate upcoming needs as patients transition through life cycles, and monitors problems as they arise while coordinating services. Developing such a system, using a life cycle methodology, is a critical health policy frontier.<sup>1</sup>

**W**hile the United States spends dramatically more on health than most industrialized countries, comparable health status indicators are not reflective of this difference. Some have suggested four basic options for slowing trends in health care spending. These include increasing the financial incentives for patients to limit their use of services; increasing the efficiency of health care delivery; increasing administrative controls on the use of services; and limiting the resources available to the health care system. These are not easily managed, and success will not come without challenge. For one thing, all health care spending represents someone else's income and those who are facing a loss of income will work to block efforts to contain costs. In addition, each of these options, with the possible exception of the first, requires some people to get fewer health services than they would like.<sup>2</sup> This brings front and center the all-too-familiar scenario of rationing. For

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**Author** / Neal A. Demby, DMD, MPH, is director of Dental Medicine at Lutheran Medical Center in Brooklyn.

the most part, decision makers have been unwilling to acknowledge the inherent trade offs between health care costs and peoples' access to care. Or to put another way, serving as a safety net provider while still functioning as a business remains a challenge.<sup>3</sup>

Current efforts to improve system efficiency give priority to improving the quality of care and have an uncertain effect on costs. For example, efforts to increase the rate of conformity to practice guidelines may increase rather than decrease the use of services. Pay-for-performance initiative awards for improving quality are increasingly being utilized throughout the country. Blue Shield of California recently awarded more than \$24 million to 95 medical groups for improved health care quality and patient satisfaction, as well as technology investments to support patient care.

### Special Needs, Vulnerable Populations, and Primary Care

The central focus of addressing the health of special needs patients, particularly children, rests with the provision of primary care.<sup>4</sup> Recommendations to improve the health of children with complex needs have relied on programs with strong primary care services that offer high continuity of care and increased competence in coordinating linkages with subspecialty services, community-based support groups, and hospital-based care sites, more recently referred to as "medical homes."<sup>5</sup> Recent surveys have documented this model characterizes the care of only about 50 percent of children with special health care needs.<sup>6</sup> Other studies of children with specific chronic disorders such as asthma, cystic fibrosis and sickle cell disease have also found major deficiencies in the quality and coordination of services.<sup>7</sup> Further, reimbursement patterns of Medicaid and the State

Children's Health Insurance Program continue to generate disincentives to "medical homes" or other comprehensive approaches to care for the chronically ill.<sup>8</sup> Neither Supplemental Security Income nor managed care attempts at financing have made provisions for systems of care. It is informative to consider the following to gain perspective:

■ There is a growing body of evidence that many important adult diseases such as obesity, hypertension, diabetes, and cardiovascular diseases are



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affected by events during gestation and early childhood. In addition, the development early in life of health-related behavior, such as eating preferences, exercise, and tobacco use may extend into adulthood and affect the risk for a variety of adult-onset diseases.<sup>9</sup>

■ Hispanics have the highest and fastest-rising uninsured rates among all major racial/ethnic groups.<sup>10</sup>

■ SCHIP was passed to provide health insurance to children of low-income and working families. The current state fiscal environment has put that goal in jeopardy. This, despite a large multistate study that demonstrated a reduction in unmet health needs for enrolled children and adolescents. These reductions continued for spe-

cial needs populations. While special needs children and adolescents tend to have higher unmet needs regardless of their insurance, states can pursue strategies to minimize them including needs assessment, risk-adjusting capitation rates and expanding benefits, or arranging for wraparound services from other agencies. More importantly, there has been great improvement of the long-term uninsured after SCHIP enrollment. In summary, SCHIP has improved access to and satisfaction with care for all enrollees, even the most vulnerable.<sup>11</sup>

■ Despite the above, a Kaiser study found that SCHIP enrollment was down in the second half of 2003, the first decrease since program inception. Enrollment reductions were attributed to shifting children to Medicaid, the addition of new premiums, eligibility cuts (500,000 dropped), reduction of benefits and other administrative changes.

■ One of every three disabilities experienced by the U.S. population are a result of conditions that arise during childhood.<sup>12</sup> Serious emotional and behavioral disorders affect at least 11 percent of youth by adolescence and are likely to persist into adult life.<sup>13</sup>

■ Children of mothers with depression are one of the highest risk groups for development of serious psychiatric disorders, academic failures, lower social competence, and higher utilization of health services.<sup>14</sup>

■ The strongest predictor in one long-term study by the National Institute of Child Health and Human Development of children's cognitive and social competence was the quality of maternal care giving.<sup>15</sup>

■ Over the past four decades, the percentage of children with limitations in their activities because of chronic health problems has more than tripled.<sup>16,17</sup>

## The Safety Net and Conflict

There is evidence the public is becoming more apprehensive about the value and costs of programs serving vulnerable populations.<sup>18</sup> Too often, and demonstrably over the past several years, reductions in oral health services have occurred in many states. Ten states with the largest number of uninsured are, to no one's surprise, California (11 million); Texas (7.6 million); New York (5 million); and Florida (4.6 million), followed by Illinois, Ohio, Pennsylvania, Georgia, North Carolina, and Michigan. Nearly four in five individuals who went without health insurance were employed in 2002. Of the people uninsured during 2002, 22 percent were not in the labor force because they were disabled, chronically ill, family caregivers, or for other reasons.<sup>19</sup>

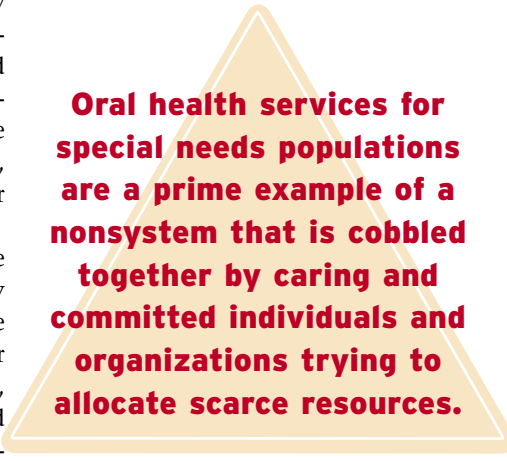
There is also evidence that income inequality and health are strongly related. To put another way, income inequality or those living at lower economic levels as opposed to higher, have a poorer health status. States and localities that are more income inequitable have poorer health as measured by a variety of indicators. Further, advocates for child health care argue they have become an unwitting casualty of an intergenerational conflict that pits the most vulnerable segments of our population, the young and the old, against one another in the competition for increasingly scarce social welfare dollars and resources. Unfortunately, this reinforces a portrait of generational spending that has been one of tension, cleavage, and competition.

## The Safety Net: Voltage and Voltaire

### *Voltage Drops*

The health care safety net for the

nation is stretched thin. Oral health services for special needs populations are a prime example of a nonsystem that is cobbled together by caring and committed individuals and organizations trying to allocate scarce resources within a framework of voltage drops and power outages. Eisenberg and Power adopted the term "voltage drops."<sup>20</sup> Voltaire, on the other hand, was an 18th century French writer and philosopher, who the author will return to further along. Just as an electrical system loses voltage when



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currents pass through resistance, the health care system loses people as they confront barriers in six areas:

- Access to insurance coverage,
- Enrollment in available insurance plans,
- Access to covered services and providers,
- Consistent access to primary care/the "medical or dental home,"
- Access to referral services, and
- The delivery of high quality services.

The interplay and combinations and permutations of these six "voltage drops" create a conundrum and continuum of uncertainty and challenge for special needs populations and their families, caregivers, and

providers.

## Voltage Drops and Primary Care

Starfield and others have long argued that access to a consistent source of primary care (inclusive of oral health services) was found to be the most important factor associated with receiving preventive care services. The stronger the primary care base of health systems, the lower the cost for health services.<sup>21</sup> Children and special needs patients within a "medical home" system are half as likely to experience delayed or foregone care (they receive care in a timely manner); and the same children are less than half as likely to have unmet health needs for family support services than those outside the "medical home" environment.<sup>22</sup> In addition, there were statistically significant decreases in parents missed workdays and hospitalizations.<sup>23</sup> Clearly, the conceptual basis of the "medical home" provides an approach to care that is accessible, continuous, comprehensive, family-centered, compassionate, culturally effective, and coordinated.

Access to oral health services for special needs patients is affected by many parameters including the number of providers in underserved or other communities, the choice and education of those providers, the availability of school-based health services, and cultural sensitivity of caregivers. The compelling priority is to find and reinforce programs that have the most effective and efficient coordination methods. Access also implies a ready availability of timely referral sources, feedback, and tracking. About 15 percent of American children have special health care needs, with asthma and attention deficit hyperactivity disorder accounting for 40 percent.<sup>24</sup>

The widespread implementation

of “medical and dental home” programs is essential. Such efforts can create a seamless and comprehensive life cycle model, analogous to community health centers.

### Safety Net Providers: Who Are They? (Table 1)

In Tables 2-12 are data summarizing Health Resources and Services Administration and Bureau of Primary Health Care programs. These programs provide access to vulnerable populations and those with special needs.

### Community Health Centers

Started in the 1960s as a central element of Presidents Kennedy and Johnson’s “war on poverty,” federally funded community health centers remain one of the most successful and enduring programs in the country. Founded on principles of community governance, a life cycle approach to health services supported by an interdisciplinary primary care team, these centers form an environment that serves as a “medical/dental” home (many years ahead of its time) for the most vulnerable in society. Importantly, they are located within health professions shortage areas. The community health centers model suggests strongly that one can breed and replicate successful practices that include oral health services for special needs patients through 1) community involvement; 2) building an interdisciplinary team that integrates oral health and primary care; and 3) altering institutional, social and health policy to support the financing and delivery of dental services, in nontraditional ways (Tables 12 and 13).

### Emergency Departments

A word on hospital emergency department capacity suggests the following: More than 100 million visits are

<b>Table 1</b>	<b>Safety Net Providers</b>
	■ Community health centers
	■ Hospitals
	■ Emergency departments
	■ State and local health departments
	■ Dental schools
	■ Dental hygiene school
	■ Other community health resources

<b>Table 2</b>	<b>HRSA Bureaus</b>
	■ Bureau of Health Professions
	■ Maternal and Child Health Bureau
	■ HIV/AIDS Bureau
	■ Bureau of Primary Health Care

<b>Table 3</b>	<b>HRSA/BPHC Programs</b>
	■ Consolidated Health Center Programs
	● Community health centers
	● Migrant health centers
	● Homeless health centers
	● Public housing primary care
	● Healthy schools, healthy communities

made each year to emergency departments in the United States, generating some 10 million admissions. The media reports that hospitals are closing their emergency departments and reducing access to emergency department services, raising concerns they are not sustainable under competition and managed care. Contrary to popular belief, the trend in California belies this suggesting, according to a study in health affairs, there is a robust market and

hospitals are adding to their emergency departments’ capacity to meet increased demand and access.<sup>25</sup> Supporting economic analysis shows that emergency departments are sustainable since they generate a sizeable and growing portion of inpatient admissions, which contribute to economic viability.

### Common Threads

Safety net providers of oral health services for special needs patients are

beset by the same voltage drops previously mentioned, only with profoundly greater severity. While 45 million Americans have no health insurance, more than 100 million have no dental coverage. Most uninsured, underserved, and special needs populations rely on Medicaid, yet states are cutting budgets and often eliminating dental benefits. Though special needs populations often have public or private insurance, obtaining oral health services remains a significant problem due to the complexity of their needs; the lack of a system in place (dental home) providers; the lack of education and experience of the dental workforce in this specialized arena; as well as financing issues. If this were not enough, there are wide differences in spending by states for people with developmental disabilities. It is clear that models offering basic oral health services in connection with community-based primary care services may ensure comprehensive health care for our most vulnerable and underserved populations.<sup>26</sup>

### Strengthening the Oral Health Safety Net

#### Some Recommendations

##### Education

There has been a historical lack of education in how to care for special needs patients at the pre- and postdoctoral levels. The need for significant education and hands-on learning is essential, as well as the need to target those providers more likely to treat patients with special health care needs. These include dentists in small communities, those who accept Medicaid, and older dentists.<sup>27</sup> This may include mini-residencies, distance education and learning, and career tracks and alternatives in special care dentistry. A recent example includes the recogni-

<b>Table 4</b>	
<b>HRSA/BPHC Programs</b>	
■ Other Programs	
● Native Hawaiian health care	
● Black lung clinics	
● Radiation exposure screening and education	
● Hansen's disease	
● Immigration health services	
● Drug pricing program 340B	
■ Service Expansion	
● Mental health	
● Substance abuse	
● Pharmaceutical services	
● Oral health	

<b>Table 5</b>	
<b>HRSA/BPHC Programs (2002)</b>	
■ Grantees	843
■ Delivery sites	4,621
■ Workforce	69,956 FTEs
● MD/DO	5,735
● NP/PA/CNM	3,170
● DDS/DMD	1,230
● Dental hygienists	383
● Dental assistants	2,291

<b>Table 6</b>	
<b>HRSA/BPHC Programs (2002)</b>	
■ Grantees	843
■ Delivery sites	4,621
■ Workforce	69,956.33 FTEs
■ Patients	11,318,727
● Medical	10,075,994
● Dental	1,644,917
■ Encounters	44,777,627
● Medical	34,455,073
● Dental	3,787,923

<b>Table 7</b>	
<b>HRSA/BPHC Programs (2002)</b>	
■ Grantees	843
■ Delivery sites	4,621
■ Total income (all sources)	5.2 billion
● Medicaid	44%
● Medicare	9%
● Other public insurance	4%
● Private insurance	12%
● Self-pay	31% → Uninsured = 4,405,301

<b>Table 8</b>	
<b>Health Centers (2002)</b>	
■ Health center programs with on-site dental programs: (77% of all programs)	<b>530</b>
■ Dental users: (14% of all health center users)	<b>1,644,917</b>
■ HP 2010 goal: <b>90%</b> of all health centers to provide on-site access to primary oral health care services	

<b>Table 9</b>	
<b>Oral Health Care Professional Staff (2002)</b>	
■ In health center programs:	
● 1,052 dentist FTEs	
● 316 dental hygienists FTEs	
■ 5 physician FTEs to 1 dentist FTE	

<b>Table 10</b>	
<b>Health Center visits (2002)</b>	
■ Dental program visits: (14% of all health center visits – 100% of dental visits)	<b>3,787,923</b>
■ Dentist visits: (86% of dental visits)	<b>3,349,319</b>
■ Dental hygienist visits: (14% of dental visits)	<b>438,604</b>

tion of diplomate status in special care dentistry.

#### Accreditation Standards

Standards must be reviewed and changed to incorporate competencies that will assure a workforce with experience in caring for patients with special needs. The dental education community must look at how caring for special needs populations can fit within revised accreditation standards at both the pre- and postdoctoral levels.

#### Safety Net Providers and a Continuum-Based Perspective

Safety net providers are often recent graduates. They may be National Health Service Corps assignees and without benefit of any residency training in general dentistry. It is critical, because of the populations they care for, to develop a significant educational process for them in caring for special needs patients. Workforce recruitment and retention remains a critical challenge for community health centers and developing strategies must consider issues ranging from indebtedness and lifestyle choices, to the nature of practice and equity considerations. Community health centers have been conceptualized to move oral health care away from its isolated “solo cottage practice” model, allowing it to be integrated with the health care system in ways that both improve access and quality, create “medical/dental” homes, and encourage interdisciplinary life cycle approaches to case and disease management. This continuum-based perspective, already in place at community health centers for some 40-plus years, helps ensure that contemporary advances in biomedical, population and behavioral and evidence-based sciences are integrated with patient care and education at all levels.

#### The Dental Home

This has been described as an accessible family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent source of care that may offer a striking opportunity, for both the public and private sector, to impact access and quality management indicators for special needs patients.<sup>28</sup> A recent study suggested that efforts to reduce disparities in access to dental care and establish dental homes should include programs to increase patients' trust in dental professionals.<sup>29</sup>

**Social Marketing/Alliances**

Exploration of social marketing and how to create alliances among obvious and not-so-obvious partners is essential in order to create consumer, patient and provider awareness. The formation of state oral health plans is an opportunity to bring stakeholders together. The New York State Task Force on Special Care Dentistry, sponsored by the governor and the Office of Mental Retardation and Developmental Disabilities, is another example of bringing together an empowered group to work on issues of education, access, quality management, pain and anxiety control, and publications to support and improve care for special needs patients in New York state. Whether these types of initiatives can foster the partnerships and collaboration needed to translate words into resources and ongoing organizational commitment and infrastructure, particularly in a period of scarce resources, remains a challenge for the future.

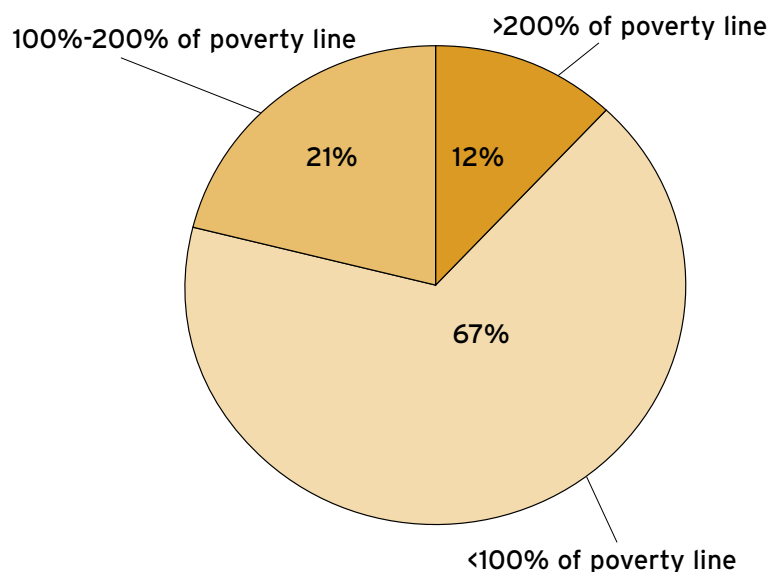
**NO MONEY/NO MISSION or NO MARGIN/NO MISSION**

**PARTNERSHIPS/COLLABORATION and INNOVATION**

Particular kinds of innovations have been called disruptive. However, associ-

**Table 11**

**Health Center Patients by Income Level (2002)**



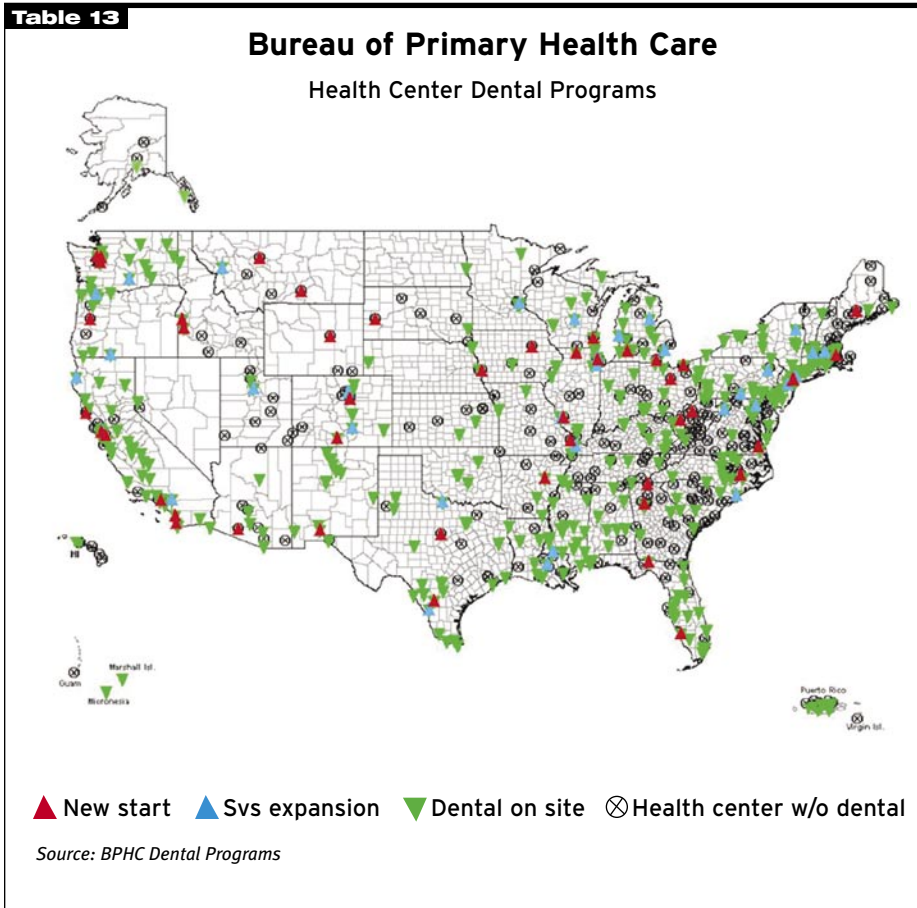
**Table 12**

**Safety Net Providers**

**National Association of Community Health Centers summary**

- CHCs are providing primary care to 15 million Americans.
- Number of health center uninsured patients grew by 11% during 2003 alone.
- 110.2 million visits to emergency department (ED) in 2002 up from 89.8 million in 1998.
- 10% to 50% of all ED visits are for nonurgent and avoidable conditions. Savings between 1.6 to 8 billion if seen at CHCs.
- Number of primary care physicians per capita is shrinking.
- Cuts in direct funding and Medicaid challenge health centers.

*Source: National Association of Community Health Centers*



ated with that premise lies a strategy that can reap great harvests. In the following case study, disruptive innovation has been utilized within a safety net and postdoctoral training environment to increase access to vulnerable populations and ameliorate recruitment and retention (workforce) issues for many of the nation's community health centers.

Lutheran Medical Center, a 476-bed teaching hospital in Brooklyn, N.Y., is one of the oldest and largest federally qualified health centers in the country. Since its inception, it has housed a growing Department of Dental Medicine providing more than 50,000 oral health visits annually. The health center operates as a hospi-

tal-based multispecialty group practice generating more than 600,000 encounters yearly. There are four postdoctoral training programs in general practice residency, advanced education in general dentistry, pediatric dentistry, and endodontics with a total of more than 75 residents.

In a nontraditional and innovative approach to dental education, Lutheran Medical Center has pioneered collaborative partnerships (Table 14 and 15) partnered with community health centers, the Indian Health Service and other safety net providers throughout the country, establishing a service learning environment for full-time resident training. Adjusting and titrating the balance between service and learning

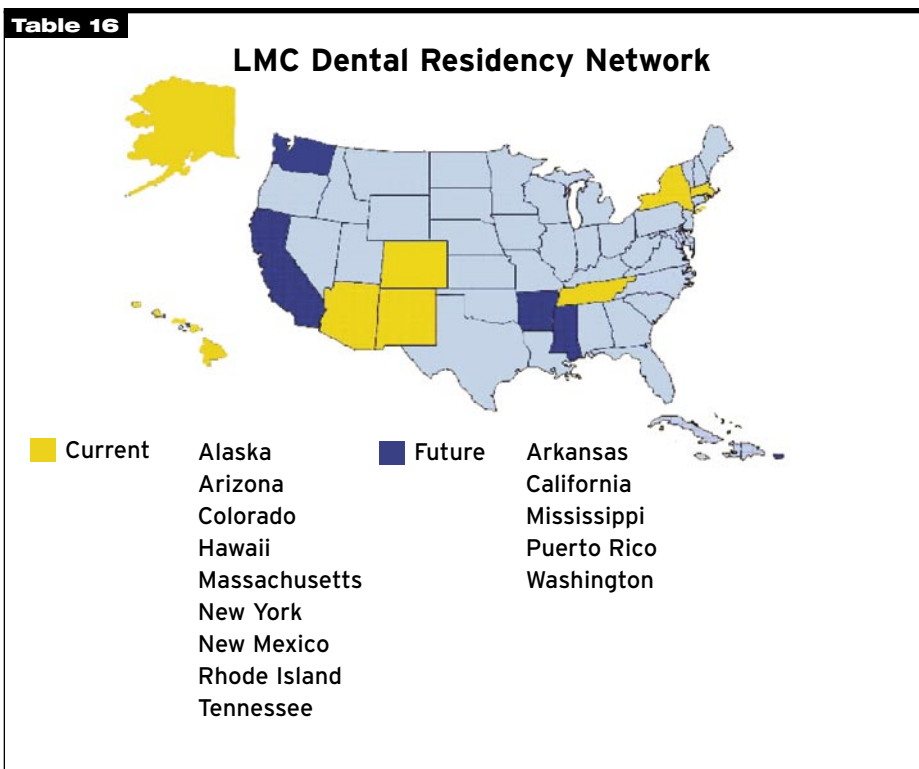
in programs that had been historically service-oriented proved disruptive and challenging at times; however, it is always worth the trade off and outcome. Health centers are linked through a comprehensive synchronous and asynchronous distance-learning curriculum that satisfies accreditation standards and allows the use of advanced telecommunications methodologies in dental education. Ongoing faculty development initiatives and caring for those most vulnerable have created an environment that is unusual and stimulating for all involved. Special needs patient visits account for 25 percent to 30 percent of the 100,000-plus visits generated each year by residents serving in safety net organizations. Close to 50 dental residents are currently located in approximately 50 extramural sites in New York, Rhode Island, Massachusetts, Colorado, Arizona, Alaska, Hawaii, and Tennessee (Table 16). This is an example of how one institution, with a distinct mission and focus, has made a difference.

#### Quality Improvement/Disease Management/Access

There is concern about the quality of care being provided to special needs patients. There is a need for quality management guidelines and parameters in oral health for special needs patients. While appropriateness issues, including under- and overutilization need to be explored, opportunity is apparent in assessing and adopting pay-for-performance measures. Some studies suggest a significant barrier to providers in not caring for special needs patients may be reimbursement related. To the extent that access is, and will remain, the most significant problem in providing oral health services to this population and is linked to reimbursement, it is essential to tie performance and quality incentives together. This is a fertile area for

<b>Table 14</b>	
<b>Collaborative Partnerships</b>	
■	Community health centers
■	Public health commissions
■	Indian health services
■	Group practices (profit and nonprofit)
■	Health science centers
■	Prison health systems

<b>Table 15</b>	
<b>Collaborative Partnerships</b>	
■	Managed care organizations
■	Veterans Administration
■	Community hospitals
■	Health departments
■	Liaison with National Health Service Corps
■	Other ambulatory care organizations



research.

**Why Not the Private Sector?**

Managed care organizations and multispecialty organizations are potential organizational structures that may foster the dental home.

**Social, Health Policy and Legislative Activism**

In summary, none of the previously mentioned, while it may appear so, stand alone and are mutually exclusive from one another. They are indeed often inextricably entwined.

**Conclusion**

Perhaps the most powerful policy implications of linking primary care, “medical/dental homes,” and life cycle approaches to special needs patients is that it permits and provides an expanded view of health along a seamless continuum. Life cycle policy is essentially prevention with the longest time horizon possible: from conception to death.

One thing we must learn from the past is that efforts to help special needs patients, especially those from impoverished or immigrant backgrounds, require the cooperation of diverse groups with often differing agendas, but ultimately a common purpose, to construct an effective public health enterprise. There are social architects who can keep an edifice intact, but only with constant labor and attention. Dentists, policymakers, and other health professionals have a major stake in meeting a new century of challenges for those with special needs with creative, fiscally responsible, and culturally sensitive solutions.

The most famous line in Voltaire’s *Candide* is the final one: “We must cultivate our garden.” That is Candide’s response to the philosopher Pangloss, who tries again and again to prove that we live in the best of all possible worlds, no matter what

disaster befalls. Ever since *Candide* was published in 1759, that line has seemed to express a reluctance to get involved, an almost quietist refusal to be distracted by the grand chaos of earthly events. And that reading might make sense if *Candide* hadn't already lived through a lifetime of woe and travail. In fact, that line is the summation of *Candide's* (and perhaps our own) wisdom, his recognition **CDA** no matter how you choose to explain the world, no matter how many voltage drops we need to traverse, the garden still needs cultivating.

**References** / 1. Chung PJ, Schuster MA, Access and quality in child health services: Voltage drops. *Health Aff (Millwood)* 23(5):77-87, 2004.

2. Ginsburg PB, Controlling health care costs. *N Eng J Med* 351(16):1592-3, 2004.

3. Weissman, JS, The trouble with uncompensated care. *N Eng J Med* 352(12):1171-3, 2005.

4. Starfield B, Primary care: Concept, evaluation, policy. Oxford University Press, 1992.

5. Sia C, et al, History of the medical home concept. *Pediatrics* 113(5 Suppl):1473-8, 2004.

6. Strickland B, et al, Access to the medical home: Results of the national survey of children with special health care needs. *Pediatrics* 113(5 Suppl):1485-92, 2004.

7. Shields AE, Comstock C, Weiss KB, Variations in asthma care by race/ethnicity among children enrolled in a state Medicaid program. *Pediatrics* 113(3 Pt 1):496-504, March 2004.

8. Neff JM, Anderson G, Protecting children with chronic illness in a competitive marketplace. *JAMA* 274:1886-9, 1995.

9. Halfon N, Hochstein M, Life course health development: An integrated framework for developing health, policy, and research. *Milbank Q* 80(3):433-79, 2002.

10. Schur CL, Feldman J, Running in Place: How job characteristics, immigrant status, and family structure keep Hispanics uninsured. Commonwealth Fund, New York, 2001.

11. Dick AW, Brach C, Allison RA, et al, SCHIP's impact in three states: How do the most vulnerable children fare? *Health Aff (Millwood)* 23(5):63-75, 2004.

12. Houk VN, Thacker SB, The Centers for Disease Control program to prevent primary and secondary disabilities in the United States. *Public Health Rep* 104(3):226-31, 1989.

13. United States Department of Health and Human Services, Mental Health: A report of the surgeon general, 1999.

14. Downey D, Coyne JC, Children of depressed parents: An integrative review. *Psychol Bull* 108(1):50-76, 1990.

15. National Institute of Child Health and Human Development. Social functioning in first grade: Associations with earlier home and child care predictors and with current classroom experiences, study of early child care. *Child Dev* 74(6):1639-62, 2003.

16. Newacheck PW, Budetti PP, McManus P,

Trends in childhood disability. *Am J Public Health* 77:232-6, 1984.

17. Newacheck PW, Halfon N, Prevalence and impact of disabling chronic conditions in childhood. *Am J Public Health* 88:610-7, 1998.

18. Silverstein M, et al, Solidarity and tension between age-groups in the United States: Challenge for an aging America in the 21st century. *Int J Soc Welfare* 9(4):270-87, 2000.

19. The Robert Wood Johnson Foundation for Families USA. Going without health insurance, 2003.

20. Eisenberg JM, Power EJ, Transforming insurance coverage into quality health care: Voltage drops from potential to delivered quality. *JAMA* 284:2100-7, 2000.

21. Starfield B, Shi L, The medical home, access to care and insurance; A review of the evidence. *Pediatrics* 113(5 suppl):1493-8, May 2004.

22. Strickland B, et al, Access to the medical home: Results of the national survey of children with special health care needs. *Pediatrics* 113(5 suppl):1485-92, May 2004.

23. Palfrey J, Sofis L, Davidson E, et al, The pediatric alliance for coordinated care: Evaluation of a medical home model. *Pediatrics* 113(5 suppl):1507-16, May 2004.

24. Bethell CD, et al, Identifying children with special health care needs: Development and evaluation of a short screening instrument. *Ambul Pediatr* 2:49-57, 2002.

25. Melnick GA, Nawathe AC, Bamezai A, Green L, Emergency department capacity and access in California, 1990-2001: An economic analysis. *Health Affairs Supplement* 136:42, 2004.

26. Formicola AJ, Ro M, Marshall S, et al, Strengthening the oral health safety net: Delivery models that improve access to oral health care for uninsured and underserved populations. *Am J Public Health* 94:702-4, 2004.

27. Casamassimo PS, Sele S, Ruchs K, General dentists perceptions of educational and treatment issues affecting access to care for children with special health care needs. *J Dent Educ* 68:23-8, 2004.

28. Nowak AJ, Casamassimo PS, The dental home: A primary care oral health concept. *J Am Dent Assoc* 133:93-8, 2002.

29. Graham MA, Logan HL, et al, Is trust a predictor of having a dental home? *J Am Dent Assoc* 135:1550-8, 2004.

**To request a printed copy of this article, please contact /** Neal A. Demby, DMD, MPH, director of Dental Medicine, Lutheran Medical Center, 150