The Integration of Social Work into a Postgraduate Dental Training Program: A Fifteen-Year Perspective

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Abstract: In 1993, Eastman Dental Center partnered with the Social Work Division of the University of Rochester Medical Center to develop a social work model of care with the goal of addressing the biopsychosocial needs of the dental population. This article will describe the gradual integration of social work within dentistry and its subsequent impact on resident education, clinical care, research, and program development. Examples of social work's contributions in the dental setting include resident/faculty education on critical psychosocial issues such as child maltreatment and intimate partner violence; the development and implementation of grant-funded projects that utilize trained paraprofessionals to address oral health disparities; interdisciplinary collaboration with dental residents and faculty members on research activities; patient advocacy; oral health promotion within the community; and the creation of a patient assistance fund to meet uncovered care-related expenses. This fifteen-year model demonstrates the viability and sustainability of a social work presence within the academic dental setting.

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Despite the medical establishment's widespread adoption of social work's role in health care, the field of dentistry has been slow to follow suit. Among the few exceptions is Eastman Dental Center, an academic postgraduate training program in Rochester, NY. Eastman Dental Center's fifteen-year partnership with social work has resulted in positive contributions to dental education, clinical care, research, and the community at large. It offers a biopsychosocial-oriented model that addresses particular gaps in patient care and resident education within an academic dental environment. The purpose of this article is to describe the evolution of this model, provide specific examples of its impact on the institution, and discuss its relevance to the dental community's goals of reducing oral health disparities.

The Social Work Model at Eastman

In 1993, Eastman Dental Center (EDC) introduced a social work model driven by an institutional need to address critical psychosocial issues including the identification and assessment of child abuse/neglect and intimate partner violence. To accomplish this, EDC's director approached the Social Work Division of the University of Rochester Medical Center to help design an on-site part-time position. In its preliminary stage, the social worker focused on the development, implementation, and training regarding the new policies and procedures to address suspected child abuse/neglect and intimate partner violence and educated EDC about the social work profession's history and relevance to health care, its

knowledge of the community and patient population, and the skills and services social workers provide to impact health outcomes and quality of care. Although on-site in a limited capacity (approximately eight hours per week), the social worker's availability by pager and close proximity to EDC provided full-time coverage for urgent consultations. Within a short time, the social worker developed relationships with key faculty and staff, created a referral system, and began collecting data to quantify and qualify the services rendered that were biannually reported to EDC. Once EDC staff, residents, and faculty understood how to utilize social work services, appropriate referrals ensued.

Over the years, the referral patterns of providers/divisions and the referral problems themselves have been remarkably consistent. Approximately 70 percent of social work referrals emanate from the Divisions of Pediatric Dentistry, Community Dentistry, and Orthodontics. Remaining referrals come through the Divisions of General Dentistry, Periodontics, and Prosthodontics at EDC and Strong Memorial Hospital's adult dental clinic. The two most common referral problems are poor adherence to treatment and inadequate resources, followed by family issues, systems issues, and barriers to care, including unreliable transportation, insufficient food, shelter, or clothing, and cultural or language differences. Interestingly, most of the referred children have insurance, typically Medicaid or SCHIP, whereas most of the referred adults lack insurance coverage and tend to need the most help securing resources to cover the costs of treatment and medications.

When insured children present with extensive dental disease, we operate from the assumption that there are compelling contributory social factors at work. Most referrals, upon closer scrutiny, encompass many interdependent factors that require psychosocial assessment and planning before treatment is likely to resume. It is not simply a matter of "health literacy" or concrete barriers so much as a complex web of issues that conspire against preventive health practices. It has been our experience over the past fifteen years that individuals and families made vulnerable by poverty, loss, and illness need significant and ongoing support to follow through on recommendations for themselves and their children. If parents/caregivers are not supported and/or held accountable for the oral health of their children, our experience suggests that their children do not receive the dental care they require. If dental schools/clinics do not advocate on behalf of such children, who are typically minors and unable to seek care and/or make decisions for themselves, they may inadvertently contribute to poor oral health. At EDC, the social work staff have made pediatric oral health and dental neglect an important focus of their work and have been instrumental in the development of supportive services for at-risk families. Additionally, social work staff members act as patient advocates, collaborating with providers and social work colleagues in hospital outpatient clinics and in-patient settings to ensure comprehensive health care for patients. Typically, it is the social worker who partners with practices and specialty clinics in the coordination of preoperative requirements, tandem surgeries, insurances, family transportation and accommodation for long-distance travel, and safe discharge.

Historical Overview of Social Work and Dentistry

Health disparities and social inequalities have been, and continue to be, important foci of the social work profession, whose roots can be traced to the settlement houses of New York City and Chicago toward the end of the nineteenth century. Working within settlement houses and living amongst poor immigrant families informed the profession, in its early stages of development, how to design and tailor services that would best address the health and social welfare needs of the community. The profession's acquired experiences were particularly germane to health care settings, and by the early 1900s, social workers began functioning in hospitals in New York City, Boston, and elsewhere. Hospital social workers were viewed then, much as they are today, as important liaisons between the health care provider, the patient/family, and the community because of their knowledge of the environment, their understanding of patient populations, and their interest in health promotion and disease prevention. The distinct contributions made by hospital social workers became integral to the delivery of health care and ultimately led to a proliferation of hospital social work departments throughout the country.[1]

During the twentieth century, as social workers became increasingly visible in hospital and other health care venues, there were a number of documented efforts to integrate professional social workers into dental programs. Perhaps the first dental

program to introduce a social service component was the Rochester Dental Dispensary (later named Eastman Dental Center). When the program first opened its doors in 1917, its founder and principal benefactor, George Eastman, insisted that he wanted all indigent children within the community to be able to receive dental services. To that end, he established a social service component within the dispensary using means testing to ensure that resources would be directed toward those most in need. Although it is unclear from available documentation how long the social service program existed, its inclusion was an early acknowledgment that social class, access to care, and oral health status were intricately linked.[2]

In a similar vein in the 1930s, a medical social worker was incorporated into the Walter G. Zoller Memorial Dental Clinic of the University of Chicago, where she conducted psychosocial assessments of children and families to assess their readiness for a preventive dentistry program that would require behavioral change and adherence to treatment protocols.[3] In the 1960s, the University of Maryland's Dental School faculty included a social worker whose scope of responsibilities included teaching/mentoring dental students as well as providing direct services to patients especially with the advent of community dentistry.[4] By the late 1970s, the University of Washington had embarked on a project that included social workers in the educational, clinical, and research domains of the dental school.[5] In the 1980s, the State University of New York at Stony Brook School of Dental Medicine incorporated a part-time social worker into its clinical and educational approach toward the care of the developmentally disabled.[6] By the end of the twentieth century, several dental programs actively employed a social worker, including three in the state of New York (University at Buffalo School of Dentistry, New York University College of Dentistry, and Eastman Dental Center).[7,8]

Social Work and Postgraduate Dental Education

From a social work perspective, the difference between working in dentistry or medicine is nearly imperceptible. Patients' psychosocial risk factors accompany them wherever they seek care—and students/residents of both professions often struggle with how to best address them. Therefore, the role of the social worker and the approaches utilized are fairly identical across settings. First and foremost, social workers in health care venues, whether medical, behavioral, or dental, utilize a biopsychosocial approach in their assessment of individuals and families. Sometimes referred to as the person-in-environment or an ecological perspective, this approach presumes that individuals are continuously influenced by a combination of internal and external forces such as personal traits, family histories/dynamics, communities, cultural and social norms, religious beliefs, policies, etc. These influences play a key role in self-assessments of health and how health care services are perceived and utilized.

At EDC, a biopsychosocial approach to clinical care is routinely practiced by its social work staff and promoted in various contexts, including community-based experiences, didactic seminars, and clinical consultations. When an individual or family is referred to social work, the social worker systematically seeks information from the referral source, the clinical record, and the patient regarding the patient's perspective on the presenting problem; history of the presenting problem and/or attempts to resolve it; barriers to treatment; family constellation; social supports; resources; other health concerns (medical, dental, behavioral); school/employment; geographic location; and other agency involvement. This information is then shared with the dental staff and integrated into the treatment plan, providing a comprehensive view of what is possible. As low-income families have fewer options for dental care and, consequently, are often seen by professionals in training, their opportunities for continuity of care are greatly diminished, which further underscores the relevance of the biopsychosocial assessment. Not only does the information lead to valuable insights; the process of gathering it allows a patient to feel heard and understood—a critical step in forging relationships.

One example of how the biopsychosocial approach was used and promoted in the educational setting occurred in 2001, when the EDC Division of Pediatric Dentistry received a three-year U.S. Health Resources and Services Administration (HRSA)-funded pediatric residency expansion grant. The expansion grant contained an educational/experiential component designed by the social worker to enhance residents' sensitivity to the stressors and social contexts of families living in poverty. First-year pediatric dental residents were allotted time with the social worker, who facilitated community-based ex-

periences to augment their resident education. Their experiences included visiting a battered women's shelter, a shelter for homeless youth, a juvenile detention center, and the Department of Social Services; shadowing pediatric primary care staff at a foster care clinic; accompanying social workers and paraprofessionals on home visits; using public transportation to navigate the city of Rochester; and attending ad hoc meetings within the community. These experiences placed the residents in environments and situations they would not ordinarily encounter. They had little awareness of the costs and intricacies of using local public transportation or how imprecise schedules impact punctuality or school absences that precede and/or follow health care appointments. They had never set foot in a medical clinic for foster children or a youth detention center, though they provided dental care to these children in EDC clinics. Their perceptions of poverty and how people live, or "should" live, were explored throughout the year as a way to uncover and discuss biases that impact the delivery of care. Throughout these exercises, residents were prompted to consider their professional responsibility toward reducing oral health disparities and how they might choose a subgroup in need (e.g., detained youth or children in foster care) as a discrete group to focus on upon completion of their residency. Given that the majority of dental residents choose a life of private practice rather than public service, encouraging them to consider a discernible way to become engaged in their future communities has practical and meaningful application.

Other forums to enhance dental education include formal didactic lectures and chairside consultation. At EDC, annual in-services on the identification and assessment of child abuse/neglect and intimate partner violence are integrated into an institution-wide orientation for all first-year residents and new staff. Because residents often express discomfort with these topics and usually have little to no experience addressing them prior to their residencies, the importance of these services within the orientation is underscored. Moreover, we have learned that our required training and available on-site social work consultation have directly contributed to an increase in the number of referred and accepted reports of suspected child abuse/neglect, further reinforcing the value of the lectures and immediate access to professional social workers. In less urgent situations, the social worker provides education and guidance to residents, faculty members, and staff whenever consultation is requested. Whether the consultation involves a question about whether and how a foster parent can consent for treatment on behalf of a foster child, how to assist a self-paying patient who cannot afford much-needed treatment, or what to do with a parent who would rather extract than restore the dentition of a child, the social worker is in a position to assist residents and faculty members with decision making based on knowledge of child welfare policies and procedures, health and human service infrastructures, health care financing, existing and potential resources, and prior experiences. Without input from social workers, decisions made in clinical scenarios complicated by salient social issues are often uninformed. Thus, timely referrals and on-site consultation are preferable as they have greater potential for positive resolutions and consumer satisfaction and maximize "teachable moments" with residents. It is not uncommon for the social worker and resident to meet with a patient or family together, once consultation has been sought, to ensure that the resident is supported and assisted in the ensuing discussion and the patient/family's interests are appropriately addressed. This can be especially valuable if residents are not yet adept at reserving judgment or rely too heavily on professional terminology when discussing diagnostic and treatment options. In these instances, the social worker models for the resident how to approach a sensitive or charged issue. For families, the social worker models how to effectively interact with a health care professional.

Social Work and Clinical Care

Advocacy is a long-standing role of social workers in health care settings, given the profession's focus on health parity and social justice. Representing the interests of consumers who are underserved and/or marginalized is an essential element of the profession's repertoire and can occur in forums such as quality improvement committees and other institutional processes that address clinical care, ethics, policies, and procedures. When effective, advocacy leads to discussions and decisions that are inclusive of patients' perspectives. At EDC, the social work staff has successfully addressed important patient care-related issues through regular attendance in faculty and staff meetings, participation in quality improvement meetings, membership on community advisory panels, grant writing, and professional

presentations. For example, to address the oft-cited transportation barrier to care, social work staff coordinated a system with the county Department of Human Services allowing EDC to directly distribute bus tokens to Medicaid-eligible patients. This service, funded under Title XIX, enables EDC to provide on average 250 bus tokens per month at no cost to the dental center. To address other associated costs, such as medications not covered by insurance plans, parking garage fees, and miscellaneous expenses, the social work staff utilized the program development office to create a hardship fund, known as the Sponsor-A-Smile Fund. Contributions from alumni, staff, faculty, and the community make it possible to offset these costs for referred patients and have financed a number of enhancements to the pediatric clinic waiting room as well, thereby improving the quality of families' experiences. Other direct examples of social work's contributions to clinical care at EDC involve two grant-funded projects, primarily authored and managed by the social worker, that utilize oral health project counselors to address the needs of low-income children and families.

The first project, funded by the New York State Department of Health, is a collaboration between the pediatric dental clinic at EDC and the ambulatory pediatric primary care clinic at Golisano Children's Hospital at the University of Rochester Medical Center. The goals of the project are to 1) train pediatric medical residents and clinic staff to perform oral health screenings during well child visits; 2) institute systematic referrals of identified children/families to EDC's pediatric dental clinic; and 3) utilize a trained health project counselor to facilitate entry into the dental care system and/or provide case management as needed. Evaluation of this project demonstrated that referrals from the pediatric clinic more than doubled following the integration of outreach services; perhaps more important, the percentage of referred children who entered care significantly increased (11 percent pre-outreach vs. 35 percent post-outreach). Recent data reflect a continued increase in the percentage of referred children who entered care (51 percent during grant year 7/1/06–6/30/07 and 55 percent during grant year 7/1/07–6/30/08).

The second endeavor, funded by HRSA's Maternal Child Health Bureau and one of the Healthy Tomorrows Partnership for Children Projects, focuses on children who tend to receive sporadic and urgent dental care only, resulting in ongoing disease, incomplete treatment, intermittent pain, and premature loss of dentition. This project operates on the premise that poor oral health is more often than not a consequence of psychosocial factors that need intervention, and consequently utilizes a trained health project counselor to assess and address barriers to care, improve oral health literacy, and enhance utilization by providing case management services, transportation as needed, and additional reminders about upcoming appointments. Prior to the creation of the program, data were collected for children in the targeted age range in order to describe patterns of care within this population. At that time, it was noted that 33 percent of scheduled appointments were kept, while 27 percent were not attended, close to 6 percent were cancelled or rescheduled, and 22 percent were unscheduled (walk-in or emergency). These rates are depicted in Figure 1, showing a trend for an increase in kept appointments over time and a decrease in failed appointments.

When pre-project patterns of care were compared to the overall means for all project years combined (Figure 2), a greater proportion of kept and rescheduled appointments and fewer no show and cancelled appointments were observed. This strongly supports the conclusion that enrollment in a program like the Dental Home for Children project will encourage more appropriate patterns of care among higher risk patients.

Both demonstration projects, despite their modest budgets, have impacted how oral health is viewed in a pediatric medical setting, enhanced the delivery of services within the pediatric dental clinic, improved communication between the pediatric primary care and dental care systems, and strengthened collaborative partnerships.

Social Work and Research

Although members of the social work staff at EDC are not formally trained to conduct research, they are sufficiently educated and skilled to generate working hypotheses and ideas for research projects and to contribute to faculty-led efforts. Just as importantly, their extensive network within the medical center and the community enables them to identify potential partnerships, venues, and mentors with respect to research. For residents who must fulfill a research requirement but are intimidated by the process or lack enthusiasm, the social workers, in concert with dental faculty members, have been instrumental in helping them select, develop, and implement research projects. One such project

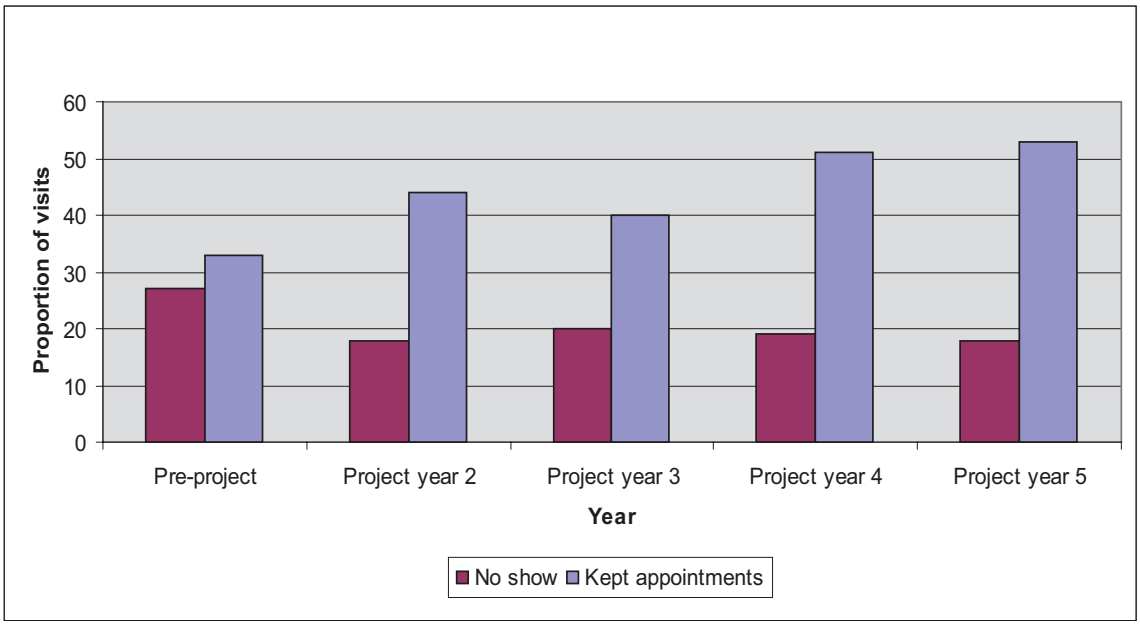


Figure 1. Appointment-keeping history over time in Eastman Dental Center's pediatric dentistry project

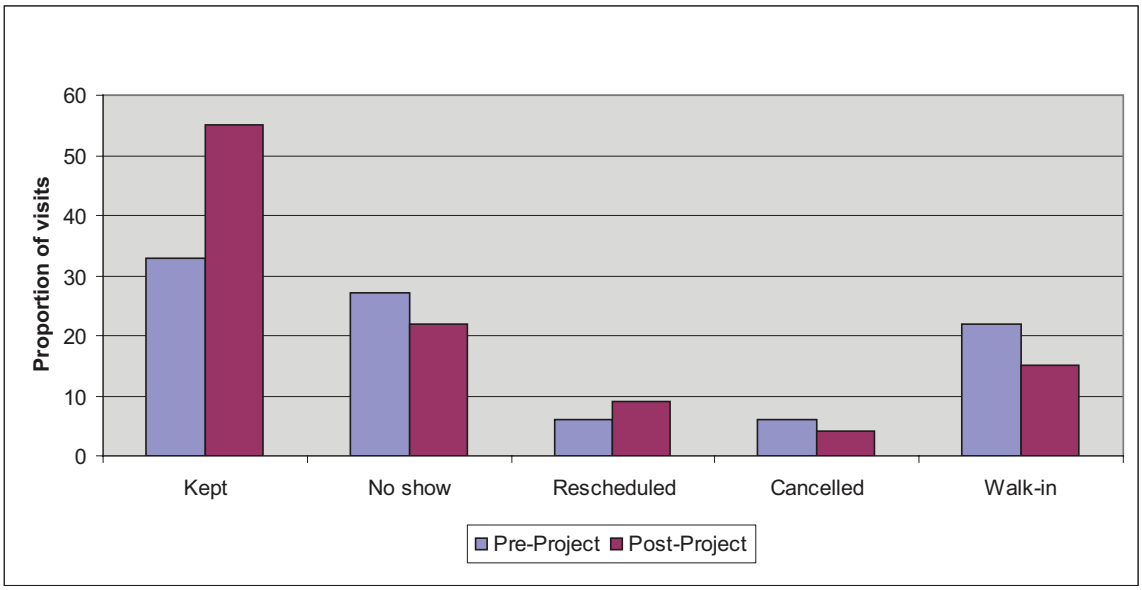


Figure 2. Patterns of care over time in Eastman Dental Center's pediatric dentistry project

involved a retrospective medical record review of pediatric patients who underwent oral rehabilitation in the operating room to assess the medical providers' opportunities and documented attention to dental disease prior to surgery. The results were very illuminating, shared with the pediatric clinic, and ultimately translated into a poster presentation at a national academic pediatric meeting. Another project assessed the oral health of a sample of foster children who receive their primary medical care at a foster care clinic. This project grew out of the residents' experiences shadowing foster care clinic staff and was made possible because of the positive relationships that developed within that venue. In collaboration with the Division of Social Work and the Department of Pediatrics, a current resident project aims to compare oral and general health status and utilization patterns of children named in substantiated child medical neglect cases using a pediatric clinic population with similar demographic and socioeconomic characteristics. By doing so, criteria can be established to differentiate cases of willful medical and dental neglect from those involving involuntary and presumably insurmountable barriers to care.

In addition to assisting with residents' research projects, the social work staff has collaborated on faculty-led research activities as well. On a recently completed National Institutes of Health/National Institute of Dental and Craniofacial Research (NIH/NIDCR)-funded R21 Exploratory grant, the social work staff developed a strategy to identify and retain subjects for a clinical trial. Retention was especially important given past efforts to retain a similar sample of children treated for early childhood caries. The social work staff designed a screening tool, a subject retention protocol, and a data collection system that were successfully employed and contributed to approximately 85 percent retention. The preliminary outcomes of that trial, along with social work's demonstrated ability to retain subjects, have led to a larger scale multicenter clinical trial currently being planned.

Social Work and the Community at Large

Social workers in health care sites routinely interface with many agencies and providers, which makes them ideal for identifying potential avenues and creating new opportunities for dental education and/or dental services. Once the social work staff at EDC became knowledgeable about oral health disparities, the inequities of dental health care financing, and the hardships caused by a variety of preventable factors, they felt compelled to educate other colleagues who would be equally alarmed and invested in creating change. They identified groups within the medical center and the community that would benefit from the same information and arranged for in-services to be provided. As an outgrowth of their multifaceted roles and professional network, the social work staff at EDC became major contacts for local health care providers, organizations, and community-based agencies requesting oral health education. When EDC social workers were solicited, they approached residents or faculty members whose background and skill set were appropriate for the targeted audience, coordinated the educational activities, and accompanied the dental resident/faculty member to the event.

Over the past fifteen years, social work has played and continues to play a critical role in facilitating and integrating oral health into the following: the curriculum of the nurse practitioner program at the University of Rochester School of Nursing; the curriculum of the Maternal Child Health Leadership Education in Adolescent Health Program; the education of Child Protective Service Supervisors of the Monroe County Department of Human and Health Services; the education of early childhood program staff within the Rochester community; the education of adolescent prenatal care clinic staff and their patients; and numerous maternal-child health projects serving low-income mothers through the provision of oral health promotional materials and hygiene supplies.

Implications for Dental Education and Practice

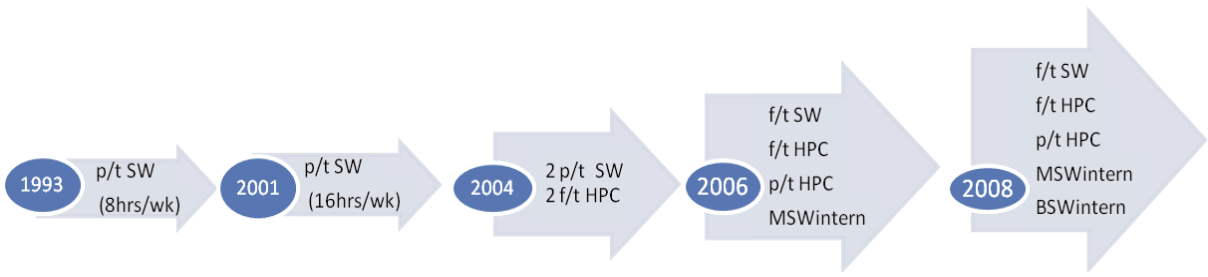
It would appear from a review of the literature and the small number of programs that currently incorporate social workers that dentistry has been slow to utilize social workers as part of a biopsychosocial approach toward dental education and clinical practice. In light of the increased attention to health disparities in general, and oral health disparities in particular,[9] it seems reasonable to assume that there would be some significant changes in the education of practitioners and the structure and delivery of dental services. And yet, the overwhelming majority

of dental clinics affiliated with dental schools and postgraduate training programs continue to practice with little to no assistance from professions such as social work. While these same clinics make up the fabric of oral health safety nets throughout the country, they are not staffed or funded to manage the plethora of issues that can complicate the delivery and receipt of comprehensive dental services to low-income populations.

Although there are many possible explanations for the overall absence of social work in dentistry, it seems likely that the cost of funding a social work position and the lack of professional exposure to social work are the biggest barriers. However, the cost need not be prohibitive, and it is possible to start on a small scale if necessary, much as EDC did. It is also possible to survey dental patients to assess whether they identify unmet needs that impact access, utilization, and health outcomes as the University at Buffalo School of Dentistry so aptly did.[7] At EDC, the financial costs to the institution have been reasonable, and the sustained social work presence ultimately contributed to state and federal grant support for demonstration projects and other funded endeavors.

However, beyond the costs and the potential deliverables that could be measured, it is important to consider the added value in supporting dental students, residents, and faculty with additional resources when working with low-income populations. Social workers provide a distinct point of view, are trained to evaluate and manage critical social issues, are knowledgeable about community resources, and are skilled at advocacy. Their integration into dental settings not only has the potential to enhance the overall educational experiences of students/residents but also provides much-needed attention to the plight of vulnerable children and adults who seek treatment, but often need so much more in order for treatment to be successful. In the end, the success of social work integration within dentistry will largely depend on the endorsement it receives from its leadership. When the leadership sanctions its value and relevance to the field, it sets a tone and an expectation of interprofessional education, collaboration, and practice—themes that are promoted in the dental education literature and are consistent with recommendations made by the U.S. surgeon general's report in 2000 and the Institute of Medicine.[9,10]

Fifteen years and over 2,000 referrals later, it is clear that there is a place for social workers in dentistry. The gradual expansion of services that occurred at EDC (Figure 3) reflects social work's ability to recognize opportunities for intervention and collaborate effectively with many disciplines, while assuming the roles of clinician, advocate, educator, and liaison—all of which have positively impacted dental education, clinical care, and research. The expansion of social work services is also a reflection of the critical support and guidance provided by EDC's leadership, faculty, and staff. What began as a modest, part-time position in 1993 evolved into a multifaceted, full-time role, extending its reach through the addition of oral health project counselors on grant-funded projects and social work undergraduate and graduate students in dental clinics.



SW=Social Worker (Licensed Master's of Social Work)
HPC=Health Project Counselor/Outreach Worker (paraprofessional)
MSW intern=Master's of Social Work candidate
BSW intern=Bachelor's of Social Work candidate

Figure 3. Expansion of social work services at Eastman Dental Center, 1993–2008

Services have expanded beyond EDC and now encompass the nearby dental clinic at Strong Memorial Hospital as well as those of the Division of Community Dentistry, which operates satellite clinics in urban and rural sites, three SMILEmobiles (targeting inner-city schools), and a permanent school-based clinic. In addition, the EDC social worker has become a member of the Center for Craniofacial Anomalies at Golisano Children's Hospital at Strong, a multidisciplinary team of medical, dental, and behavioral health professionals who evaluate and treat patients with an array of congenital or acquired craniofacial anomalies.

The fifteen-year history of the relationship between social work and dentistry at EDC exemplifies what is possible when there is both a philosophical and a financial commitment by leadership to this endeavor. To more fully address the social determinants of oral health disease, the dental workforce must think critically and compassionately about the underserved. Partnering with the social work profession may be an especially efficient way to accomplish this. If dental educators and practitioners reach out to graduate social work programs, social work divisions in hospital settings, and/or community-based agencies, they are likely to find prospective willing colleagues, much as their predecessors have over the past 100 years. To have a lasting impact and a presence that can evolve based on the needs of the setting, consistent institutional support is crucial. When dental programs create a safety net for themselves, they are better positioned to provide a safety net for those they treat. EDC's successful fifteen-year partnership with social work is testament to its commitment to the underserved. By providing its residents and staff with resources and its patients with support services designed to reduce barriers, enhance adherence to treatment, and improve health outcomes, EDC demonstrates that it is not only possible, but highly valuable, to integrate social workers into the dental setting.

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