1996 AAPHD ANNUAL MEETING

President's Welcome and Address: Building on a Legacy of Leadership

Robert J. Collins, DMD, MPH

I would like to express my appreciation to the officers, Executive Council members, and committee chairs who have helped me through what has been a difficult year for us all. Thanks also to the Dohertys in our National Office for their many contributions made during the course of this past year and every year. I also extend my appreciation to all who participated in the election process. Elected or not—you have made a positive contribution to our association. Finally, I offer my congratulations to our award winners as well as those who competed in and assisted with this important growth process.

The president's address is generally given by the outgoing president. Due to the untimely death of President Dennis Leverett, I find myself today in the unusual position of delivering a presidential address at the beginning of my year as president. I have tried to ascertain what Dennis Leverett would have said today had he been here to deliver what should have been his president's address.

A hint may come from his initial editorial for the *JPHD* in 1987 entitled, "DFS, a Hard Act to Follow." In it, Dennis thanked the previous editor, Dave Striffler, for his gift of a volume called "How to Edit a Scientific Journal." Dennis noted that he looked quickly in the index for advice on how to write an editorial, but found no such section. With self-deprecating humor, he indicated that discovery was his first lesson as editor: He was on his own! Dennis then went on to write:

> There will be changes (in the journal); no two footprints are alike. We who live in the Snowbelt (Rochester, NY) know that the first one out the door in the morning has a rough walk to the garage. Those who come along later have an easier time. My journey has been made easier—by the footsteps of Dave Striffler.

In turn, I would argue that Dennis' footsteps have done the same for us in the overall world of dental public health. None of us is alone in the pursuit of improving the public's oral health. Certainly, notable personal contributions are made; but these are still components of the total tapestry we call public health. Dennis Leverett's professional life was filled with accomplishments; but I would guess that, if he were here today, he would give credit to many others for fostering his career in dental public health.

It has been said that "those who don't learn from history are bound to repeat it." The corollary to this, however, recognizes there is much that is positive in history that can be used as a foundation for further growth. As we attempt to move the goals and ideals of dental public health forward, I believe one way to become more effective is to appreciate our history. This is especially important for an almost completely volunteer organization like the AAPHD. Many past-presidents' addresses contain gems of insight and provide us with a sense of where we have been and might be going. Let me give you a brief sampling—a mini-literature review, if you will—of presidents' addresses from the past 20 years—with apologies to those whose texts were not in my library.

Robert J. Collins

In 1976, Bob Mecklenburg called for more membership involvement and stated that the primary responsibility of the AAPHD was to provide leadership and to participate in a variety of forums and engage in organized political action.

In the following year, Dick Murphy stressed the importance of exercising leadership by providing input to the ADA and its various councils.

Ken Elwell, president in 1978, noted three problems throughout the history of AAPHD: not enough money, small potential member base, and volunteer staff.

In 1979, John Elliott called for an action-oriented AAPHD. He cited the considerable changes in the AAPHD with the acceptance of RDHs as full voting members. He also noted that AAPHD needed a central office with an executive director as soon as possible.

John Hughes in 1980 articulated his view that the AAPHD is about leadership in improving oral health and enhancing the relationship between the public and the profession.

In 1981, Gene Lewis assumed the presidency and, in his address, focused on the need for the association to have increased visibility.

Ray Mullins in 1982 presented a very thorough analysis entitled "Dental Public Health's Future Depends on AAPHD's National Visibility and Performance." He suggested that the specialty of dental public health could control its destiny only if capable of providing the leadership to guide change and to increase its visibility within the profession by helping to solve national dental issues and problems. Although he felt that the addition of a national office would allow the energy of AAPHD members to be

focused on broader goals, he stated that, without the creation of a significant fund to support the participation of officers, committee members, and others in national and state activities, the association would not be able to significantly improve its national visibility.

In 1983, Bob Faine noted that AAPHD's most important contribution to improving the oral health of the public is providing leadership to increase the effectiveness of dental public health programs. This was reflected in the new mission statement of the association. President Faine anticipated that the new management arrangement with the Cate Corporation would free officers to do more to provide that leadership.

The optimism was short-lived. Tom Fields' address in 1984 described a year of dealing with crisis. The national office management arrangement under the Cate Corporation had quickly proven to be a failure—with management costs absorbing nearly all of the association's dues income. So, management of daily operations was transferred to the AAPHD secretary-treasurer and a part-time executive secretary was employed. This was the beginning of the Doherty National Office era—to which I'll return later. In reviewing the ADA's "Future of Dentistry" report, Fields also concluded that the expertise and leadership of the AAPHD would be needed to implement many of the portions of that report and that a coalition of the public and private sectors of dentistry was an "absolute prerequisite to success."

In 1985, Myron Allukian made many recommendations for enhancing leadership. Among them were working to a greater degree with the ADA and improving our resource base. He was followed by Jim Beck in 1986, who emphasized strategic planning as a way to be ready for the future.

President Linda Niessen in her 1989 address, "Sharing Visions and Voices: Oral Health Advocacy in the Future," described past inaction on the advocacy front (visibility) as a future opportunity. She noted that, with new association goals, updated educational objectives, plans to develop a dental public health research agenda, and a future of dental public health report, the AAPHD was well positioned to meet the challenges of the 21st century—if it strengthened its financial position!

Gary Rozier's 1990 address was entitled "The Heart is not the Mind: the Scientific Basis for the Practice of Doctor of Public Health," and referenced the rich scientific foundation on which dental public health rests. He spoke of the need to bridge the gap between research and service programs by decreasing tension among research, teaching, and service programs in academic institutions, and effectively communicating new research findings to health service providers in order to work toward a dental practice firmly based on science. He indicated that AAPHD played a major role in this arena through its position papers and guidelines on such subjects as infectious diseases, fluorides, sealants, and many others.

In 1991, Joe Alderman, in "Dental Lessons Learned—Communication Works," emphasized collaboration between public and private dental sectors and the need for dental public health to document current programs and resources.

Alice Horowitz's 1992 address, "Vital Signs—AAPHD 1937–92," celebrated 55 years of AAPHD by describing its historical development. She also emphasized the need to support resources for dental public health residency training, the profile of dentistry in the Health Resources and Services Administration, and integrating oral health in health care reform—all leadership and visibility issues, I would argue.

Jack Dillenberg in 1993 cited the great strides that had been made in collaboration—especially citing activities with the Coalition for Oral Health, the Dental Specialties Group, and on the international front. He saw health care reform as an opportunity to expand AAPHD leadership in the political arena.

Hermine McLeran (1994) noted the value of strategic planning for the "Future of Dental Public Health Report" and the value of health care reform as a vehicle for AAPHD and the Coalition for Oral Health to define a basic set of dental services that was eventually included in most proposed legislation.

Last year, Rhys Jones (1995) stressed oral health professionals as points of entry for primary health services. He also described progress regarding the Strategic Plan for the Future of Dental Public Health Report and asked for a personal commitment to seek opportunities to earn support from the public, policy makers, administrators, and the dental community; to share information; and to mentor promising young colleagues.

This brief historical summary indicates that, in one way or another, nearly every AAPHD president's address over the past 20 years has identified leadership and visibility as the key roles for the association. Additionally, there have been calls for a strong national office and a resource base that would allow officers and council and committee members to exercise that leadership, and focus on increasing the association's visibility.

Given our limited resources, I believe that the AAPHD has done a remarkable job of demonstrating leadership in issues related to improving the public's oral health. Nonetheless, I believe the consistent legacy of presidential recommendations regarding leadership, visibility, and resources remains extremely important to our current situation.

In my mind, the number one issue we face in 1997 is critical to maintenance of our leadership role. AAPHD's original administrative structure and operations were in the home/office of a current officer—usually the president. This situation was subsequently replaced in 1983 by a contract for administrative services with the Cate Corporation, which proved to be more costly than expected and was nearly life-threatening to the association.

What we know today as the National Office (or NATOFF for e-mail devotees!) began in 1984 when Joe and Helen Doherty began their labor of love at 10619 Jousting Lane in Richmond, Virginia—a building that, on occasion, also serves as their home! Joe claims that Helen did most of the work then and still does. I like to think that I have always appreciated Helen's efforts on behalf of AAPHD, but as program chair for last year's annual meeting, I received a first-hand demonstration of Helen's dedication. As many of you know, Helen gave us all a scare when, in the middle of the meeting, she was rushed to the hospital with cardiac symptoms that required her to have an angioplasty before leaving Las Vegas. When I reached Joe in the

emergency room to check on Helen's condition, he expressed appreciation for my concern and then, at Helen's insistence, proceeded to relay some key information that Helen felt I should have regarding the meeting! How's that for commitment!

Suffice it to say that we have had an immensely dedicated, capable, and stable National Office for the past 12 years. Helen has been the "rock" for us since 1984. Since Joe's retirement from the state of Virginia, he has been playing an increasing role in the association as executive director/special consultant to the president.

Indeed, most of the operational duties that previously were borne by the officers now are attended to by the National Office. For example, the National Office produced the program book for this meeting, ensured that the appropriate documentation for our continuing education sponsorship was in place, and served as point of contact with the hotel. Except for the actual writing of the officer and committee reports, the preparations for Executive Council meetings are handled by Joe and Helen. I would argue that the absorption of these and other critical, but time-consuming, tasks by the National Office has allowed us the time to better focus on our objectives and to move forward in increasing our visibility as an association.

Progress in expanding the visibility of dental public health is exemplified in the following examples:

- Maintenance of a high-quality *Journal of Public Health Dentistry* and an informative newsletter, *Communique.*
- The development of a "Research Agenda for Dental Public Health."
- The development of the strategic plan for dental public health. One of the offshoots of the plan occurred in April of this year, when a conference called "Public/Private Leadership in Improving Access to Oral Health Care" was held in Bethesda, MD. Sponsored by a grant from the HRSA, the meeting was coordinated by Immediate Past-president Rhys Jones and staff from the University of Iowa. Its purpose was to bring together dental leaders to discuss problems associated with access to oral health care issues for vulnerable populations. Although reform legislation had earlier failed to pass in the Congress, I believe the private/public meeting was a direct outcome of our efforts in conjunction with the coalition to include oral health in health care reform.

I approached the meeting with a certain degree of skepticism, but came away hopeful that this may be a valuable opportunity for dental public health to work in concert with the ADA leadership to address the access problem in a meaningful way. The problem, as always, is to maintain the momentum. The ADA's Council on Access, Prevention and Institutional Relations (CAPIR) is part of the ADA standing council structure charged with pursuing further prevention efforts and improving access to dental services for underserved communities. The council has ADA staff at its disposal and appears eager to coordinate a public/private initiative to address the access issue. The AAPHD needs to continue to work closely with this council to ensure that it doesn't waver in its ongoing commitment to this effort.

- A major contribution to the IOM report "Dental Education at the Crossroads" and its implementation.
- The periodic process of updating the "Competency Objectives for Dental Public Health."
- Collaborating with a wide variety of groups to ensure that oral health is part of the primary health care agenda—whether in health care reform, Medicaid, Medicare, or managed care programs.
- The development of various guidelines and position papers relative to improving the public's oral health.
- Support for the "Healthy People 2000" objectives and "Oral Health 2000."
- A firm and continuing commitment to the anti-tobacco efforts coordinated by the National Tobacco-free Steering Committee and associated federal and state agencies and programs.
- Participation in a variety of ADA councils and task forces.
- Working with the ASTDD and the ACDP to promote dental leadership and programming at the state and local levels.
- Working with appropriate agency heads and chief dental officers to ensure that oral health programming concerns are addressed in the federal sector. These concerns include dental leadership and adequate resources for oral health research, services, and education efforts.
- Maintenance of continuing education sponsorship requirements under the ADA's CERP program.
- Continued collaboration with the American Dental Hygienists' Association, the Hispanic Dental Association, and the Federation of Special Care Organizations in Dentistry.
- Working with the FDI's new Section on Public Health and the World Congress on Preventive Dentistry (WCPD) to promote dental public health on an international level. Examples of this new visibility include our joint activities with the FDI this week and AAPHD cosponsorship of the sixth WCPD in Capetown in South Africa in October 1997.

The National Office is critical to maintaining or expanding the activities I have just described. As our activities have increased, National Office management expenses have grown. However, National Office expenditures over the past 12 years have averaged only 17 percent of AAPHD expenditures. This compares to 40 percent for salaries/benefits alone in many other associations. We are getting extremely good value for this expenditure; however, much more will be needed for 1998 and beyond.

Today, we are at a critical juncture that may determine the level of leadership and advocacy that AAPHD is able to exert as we move into the next millennium. Helen and Joe Doherty have announced that they will retire after the mid-year Executive Council meeting in the spring of 1998. That may sound a long way off, but it is not. An ad hoc committee led by the efforts of Ray Kuthy, Kim McFarland, Mary Tavares, and Alex White has produced a request for proposals to identify a new locus for National Office activities. The deadline for applications is January 15, 1997. Committee members will be available during this meeting to provide additional information to prospective applicants. Interviews with candidates will be held in conjunction with the Executive Council meeting next spring. Our goal is to make a selection by mid-1997—a date that would allow for a transition period beginning with the annual meeting in Washington, DC, in the fall of next year.

The identification of adequate resources for an executive director and National Office has been an issue for

several years in meetings of the Executive Council. I am not sure the membership has fully appreciated what a true bargain we have had since 1984. Joe and Helen spend hours on association business far in excess of the compensation they receive. In a word, we have been "spoiled."

Will we be able to afford a similar level of National Office services in 1998 and beyond? Unless another arrangement appears that is similar to our present one with the Dohertys, I am concerned that our resources may not be adequate to sustain an increased expenditure level over time. While we won't know what that level is likely to be until we begin to examine the proposals, it seems clear to me that the recurring costs associated with the National Office will increase. Therefore, I am making the following recommendations to improve the association's revenue picture.

1. Membership: AAPHD voting member dues now stand at $75/year; however, there are three other levels of voluntary participation that generate some additional income for the association. These are: contributing member ($100), sustaining ($150), and sponsoring ($200). I am asking that every member be at least a contributing member—more if you can. The additional $25 is more than you would spend for an afternoon at Universal Studios; yet if every member participated, it would generate an amount nearly equal to the current costs of running the National Office. I have asked Executive Council members to lead the way by being at least sustaining members.

Whether you can or cannot make an additional financial commitment to the association, please commit to recruiting one or more members this year. Membership has been hovering in the low- to mid-700s for the past few years and an infusion of new members combined with retention of current members would bring both talent and financial resources.

2. Meeting attendance: Even as membership has increased from 600 in 1987 to almost 800 in 1995, meeting attendance has been relatively flat at about 200. We will continue to pursue cost-sharing arrangements with other organizations that may cosponsor certain events during the annual session. Increasing registration by 25–50 persons and adding a few more exhibitors and sponsors would help our financial picture tremendously. To help us, I encourage you to: First, come to the meeting each year and encourage others to come. Second, while you are here, visit our exhibitors and express your appreciation for their support. Make it a point to say thanks to our sponsors when you see them. These companies and individuals are listed in the program and are important contributors to successful meetings. Many have been with us a long time.

3. Last year, the AAPHD Assembly approved a recommendation to seek 501(c)(3) status and the application is nearly ready to go to the Internal Revenue Service. If approved, the tax deduction benefits associated with attainment of this status should aid our efforts to generate additional revenues.

4. To generate additional support, I have asked the AAPHD Finance Committee to develop a plan to identify other possible means of increasing income.

To summarize, my goals for the year are:

- Selecting a new national office for 1998.
- Identifying ways to increase our resource base.
- Encouraging continued collaboration with public and private sectors—in both the United States and internationally—to promote dental public health's goals.
- Creating an AAPHD home page on the Internet

The AAPHD will celebrate its 60th anniversary in 1997. Sixty years represent a considerable legacy of leadership in dental public health. If we maintain our awareness of that legacy, Dennis Leverett, Bill Jordan, Charles Gillooly, Bill Kroschel, and many other leaders of dental public health will always be with us. As I look back on my 21 years of affiliation with this organization, I feel fortunate indeed to have been chosen to serve as your president. I pledge my best to continue to build on our legacy of leadership and ask your help in doing so.