COMMENTARY

On Common Ground
Keynote Address at the Joint Annual Meeting of the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors

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Ladies and gentlemen, friends and colleagues, and collaborators—more precisely "co-laborers" in the endeavor to improve the oral health of the American public—good morning and good wishes as you inaugurate your first joint meeting of ASTDD and AAPHD and bring into your midst the ADA, AAPD, ADEA, Medicaid dental program directors, ADHA, and so many others. How refreshing it is to officially recognize an activity that codifies something each of you already knows—that coalition building begins at home and that we are us.

Sometimes unkind things are said about people who talk to themselves; but in our case, getting ourselves together to talk with ourselves is the essential first—albeit definitely not sufficient—condition for meaningful work toward accomplishing our shared mission.

Exactly how shared is our mission?

Quoting directly from organizational Web sites, which dental organization do you believe lists the following in describing its purpose:

> This Association fulfills its public and professional mission through initiatives in education, research, advocacy, and the development of standards. (ADA)

Which organization touts:

> Our mission is to address contemporary issues influencing education, research, and delivery of oral health care for the improvement of the health of the public. (ADEA, formerly AADS)

How about:

> We seek to improve total health for all citizens through promotion of effective efforts in disease prevention, health promotion, and service delivery. (AAPHD)

Try this—an easy one:

> We are dedicated to improving and maintaining the oral health of infants, children, adolescents, and persons with special health care needs. (AAPD)

Lastly:

> This association formulates and promotes national dental public health policy, assists in the development of programs and policies to prevent oral diseases, and provides information on oral health to policymakers. (ASTDD)

Oh, and let me throw in my own organization, the Children's Dental Health Project, with its mission statement:

> Dedicated to assisting policymakers, health care providers, advocates, and parents improve children's oral health and increase their access to dental care.

Apologies to ADHA—my partner in this keynote address. I recognize that they share profoundly a commitment to the oral health of the public. I wasn't, however, able to find their particular public health proclamation on their Web site, which listed the mission appropriately as representing the interests of dental hygienists.

So, with your permission, I am pleased to proceed on the assumption that whether we are talking about organized dentistry in the form of ADA, ADHA, AAPD, dental schools, or classic dental public health organizations, we do indeed share a common mission—the mission of improving oral health. At least from the outside looking in, we claim to share that mission. From the view that we portray individually and collectively to the world at large and in particular to the subset of that world—policymakers—we are all of one stripe, one color, one mode, one concern, and one mission.

Why do I single out policymakers? Because these are the people to whom the public has granted political power and authority to allocate our shared and common resources. Dollars. Programs. People. These are the people who in large measure determine what we are and are not able to accomplish on behalf of the public they represent. If they care, if they "get it," and if they champion our cause, we are empowered with the public's resources to serve that public. This is true whether we are talking about making it possible for a child insured by Medicaid or SCHIP to obtain comprehensive, continuous, and competent dental care from the private dentist and hygienist on the corner, or whether we are seeking to fluoridate Los Angeles, train more dentists, improve oral care in nursing homes, meet the needs of special needs citizens, convey information about personal health responsibilities to the populace, or any other effort to improve human welfare through oral health promotion and dental care.

Now from the inside we may see, or sense, or know, or feel that our greater whole—our collective—our supposedly shared commitment—is often, so very often, hard to find because our collective is robustly flawed by a splin-

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tered panoply of organizations with individual self-interests, narrowness of perspectives, internal organizational constraints, and subtle differences that play out as almost unbridgeable divides. Interorganizational relationships often are tainted with suspicion, poor communication, and simple prejudice. These differences, rather than our commonality of mission, become our obsessions unless we actively elect to do something about it. Unless we force ourselves back to basics, back to commonality, back to what we are here for in the first place.

My purpose in airing these not-so-generous aspects of human nature—a nature that constantly seems to seek differences rather than commonality—what Dr. Seuss called the distinction between "star-bellied sneetches and plain-bellied sneetches" in his attempt to warn young children about the dangers of focusing on our differences rather than our similarities—the purpose in airing this point is to issue a warning and to make an observation that may help shape your thinking, your deliberations over the next few days, and your actions back home.

The warning is that legislators and governors and agency officials—those folks who allocate the resources that we need to meet our goals for the public—love nothing more than a squabble that leaks out of an otherwise coherent community because it gives them a ready-made excuse to do nothing ... to say, "Come back when you've got your internal differences settled. Come back when you can give us reason to believe that the support we give you won't get wasted, but will come together for the common purpose you claim." They have no reason to distinguish among dental groups—whether public health focused or private practice focused—because to them we are all "dental." And if dental doesn't know what it is doing, they know not to put money where people's mouths are.

The observation is that the one thing that had always distinguished public health from all other dental groups, the very defining characteristic of dental public health, the thing that makes ASTDD ASTDD and AAPHD AAPHD, that thing is no longer exclusively the province of public health. You all know what that thing is—what our claim, our special perspective, our unique niche has always been. It is, of course, our insistence that dental public health uniquely takes the population perspective rather than the individual perspective.

I suggest to you today, at the beginning of your millennial meeting, your "coming together for the new millennium" sessions, that you no longer hold the distinction of that critical perspective. In fact, whether you and the greater public health community have successfully sold the population perspective or whether it was simply appropriated out from under you by the private finance and delivery systems, the HMOs, the health networks, information systems, accountability gurus, the health care financiers, and the health management corporations, the entire universe of American health care has discovered population-think and has accepted it as an element of modern health care.

For example, my daughter and her medical school colleagues are introduced to a population perspective in their first clinical rotations as they weigh various costs and benefits impacting not only the patient, but also the health system and society in learning clinical decision making. My dental students are introduced to Bayes theorem and the notion that the odds of correct decision making in reading bitewing radiographs relates to the population from which their patients are drawn. My partners in private pediatric dental practice use both numerators and denominators in evaluating practice performance and consider how the practice relates to all the children in the towns they serve. Health plans increasingly provide direct feedback to providers about how their practice profiles compare with their peers serving the same community.

At the organizational level, the word population shows up or is directly implied in the mission statements of the ADA, AAPD, and ADEA, as well as the ASTDD and AAPHD. Accountability is the vogue in health care today, and assessing accountability relates to populations.

The HRSA-HCFA oral health initiative, the Surgeon General's Workshop and Conference on Children and Oral Health, the new Secretary's Initiative on Oral Health and the Healthy People 2010 program, the new 416 Medicaid reporting measures, the MCH-mandated sealant performance measure, the ADA's AIM conference report, the GAO's new report on low-income populations, some provider incentives in Medicaid programs, and increasing numbers of commercial dental insurance programs all relate to populations or, at the very least, enrolled or captured populations—both those who receive dental care and those who do not.

So, now that the word is out and you've won the battle and the "P" word is on everyone's lips, what becomes the role of dental public health? Perhaps you have become more relevant and more important and more valuable than ever before.

Why?

- Because you are the population message makers and message takers. You have the background, the tools, the expertise to make sense out of population-think and to express how the population perspective informs public policy and clinical care.
- Because you are the information source—providing baseline information, performance measurement, patient satisfaction outcomes, and perspective for the new converts to population-think.
- Because you know more than any other dental groups about using data, about social organizing, about risk assessment and triage, about differential interventions, and about outcomes.
- Because you know about monitoring programs, measuring systems, and evaluating not just input, not just process, but outcomes, as well.

With these skills, what opportunities present that may appear novel, yet are comfortably rooted in your long and valuable past? The opportunity to inform, to educate, to lead, and to facilitate true coalitions. The opportunity to meet the needs of the larger dental community in assessing performance and advocating policy.

- Now that dental societies for the first time know how important it is to address how their members impact a community, they need you and your guidance to show them the way.
- Now that there is interest in Head Start and WIC to be adopted by local dental societies, you can inform clinicians about working with groups.
- Now that individual practitioners are coming to understand that they may be isolated, but are still part

of a system that can be enhanced through effective information feedback, they need you and your guidance to show them the way.

- Now that dental disparities and access have made it into the agendas of the National Conference of State Legislatures and the National Governors Association and the National Association of State Medicaid Directors and the Association of Maternal and Child Health Programs, these organizations also need you and your guidance to show them the way.
- Now that we in dentistry are on policymakers' radar screens, now that we have effective champions in federal and state legislatures, now that the larger communities of interest are thinking systems and caring about performance, they need you and your guidance to show them the way.

You are not unempowered by the sharing of your unique perspective. Rather, you have gained a new tactic in tying your interests to those of others in the broad dental community. If you try to continue solo ownership of the population perspective, you will lose—sooner or later. You will hunker down into issues of turf and control and will miss the point. If you extend your perspective, expand the availability of your expertise, share not only your knowledge, but also the utility of your knowledge broadly, you become the change agents. You become the facilitators working across multiple groups, you become the messenger about the big picture and you effectively influence those policymakers I spoke of before—those people who control resources.

In fact, collaboration is your natural medium, your primary tool, but not your product. What you do when you bring people together—dentist and hygienist, dental providers and health services researchers, dental delivery systems and public finance systems, public-level interventions with individual-level interventions, medical providers with dental providers; what you do when you bring people together is what makes it possible to develop valuable products: political will, enhanced clinical policy, and effective public policy that improves the oral health of all, while helping dental care become a more rational—yes, evidence-based—and effective service.

My particular bias is kids. I want to know that you in dental public health see dentistry as sentinel, as a marker for coverage and enrollment and for moving beyond a coverage card into meaningful care. I want to know that you are change agents who bring prevention to the most vulnerable children in our society and effectively reduce their disease burden. I want to know that dentists and dental hygienists who specialize in the population perspective can make that perspective meaningful for the whole community of dentists and hygienists so that dentistry's responses to the access problem, the disparity problem, the workforce problem, the financing problem, the administrative problem, the accountability problem, the quality problem, the evidence problem, and the barriers problems can all be well informed and can all hold real promise for both effectiveness and efficiency.

The world of health care and of dental care has, in a real sense, begun to catch up with you. Perhaps you've been out front too far for too long. Now is your chance—as academic public health dental professionals and as state-level practitioners, as researchers, and as program administrators—now is your chance to rally with your colleagues from across the dental profession and the entire community of health professionals to inform, to lead, to teach, and to move dentistry truly forward in this, the 21st century.

You have begun this year by formally getting together and talking to yourselves. I wish you the greatest of success as you take the benefits of your expanded dialogue into the larger health care world and grow more and deeper relationships with all who care about equity, performance and, indeed, complete health as they emerge into an information-driven century that asks them what they are doing to improve the health of the public. Public health, or increasingly more apropos, the health of the public is the name of the game today. You, better than anyone, can inform this perspective and lead coalitions and collaborations into a healthier era.

Abraham Lincoln wrote that it is "essential to develop the habit of observation and reflection." To habitually—that is, regularly and faithfully—stop in your own tracks to observe closely and reflect broadly, to learn from your own activities. I suggest that each of you heed Mr. Lincoln's advice and stop repeatedly throughout the next four or five days to observe how your sacred population perspective is playing out in your deliberations and to reflect thoughtfully on how that special perspective can be applied usefully to those outside of your immediate community—to those who, like you, are committed to improving the oral health of the people who comprise the public.

May you go from strength to strength ... from your past effectiveness, calling for a population perspective, to your future role, making that perspective relevant to all who care for our populace. By combining the power of information with the power of coalitions you can lead, excite, and engage others and help shape a coherent and committed group of professionals into this new decade, century, and millennium.