SPECIAL REPORT

Report of Recommendations from the National Dental Public Health Workshop, February 10–12, 2002, Bethesda, MD

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Abstract

A two-and-a-half day workshop was held beginning February 10, 2002, to review the current state of dental public health training in the United States with the aim of creating recommendations that would address identified problems and lead to improvements in the quality of dental public health training. This workshop, held in Bethesda, Maryland, was sponsored by the Health Resources and Services Administration (HRSA) through a contract with the American Association of Public Health Dentistry (AAPHD). Workshop invitees included the program directors of all accredited dental public health residency programs in the United States and Canada, selected dental public health residents, and additional consultants invited based on their expertise in dental public health education. The recommendations have been placed into three categories: training, financing, and workforce development. Along with background and process summaries, these recommendations are reported here. [J Public Health Dent 2003;63(4):258-62]

Key Words: dental education, public health dentistry, dental specialties, dental residency.

The United States continues to experience a disparity of oral health status mediated in large part by limited access to professional dental services for many poor and minority populations. Many Medicaid-eligible children have no access to dental services and traditional safety net providers, such as community and migrant health centers, are not at present adequately meeting demand. Furthermore, HRSA's plans to expand the dental service delivery infrastructure have been and will likely continue to be limited by the current lack of an adequately trained workforce to staff new clinical facilities. There is also concern at all levels of government (local, state, and national) that oral health issues receive little representation or advocacy. This is, in part, attributable to a lack of properly trained dental public health professionals in critical policy-making and service-delivery positions. Dental public health is the only recognized specialty of dentistry focused on improving access and preventing disease for vulnerable populations. Consequently, oral health remains a critical unmet health care need nationally, and oral health disparities continue to increase among those individuals least able to access traditional dental services.

Unfortunately, dental public health is experiencing a shortage of qualified applicants at all levels of training. After reviewing the workforce literature, Wotman et al. (1) concluded there was a serious shortage of trained dental public health specialists in the United States, yet anticipated increasing demand for dental public health services. Similarly, Schulman et al. (2) concluded that more dental public health personnel was needed in nearly every employment category (e.g., academic, administration, health education, clinical). Both reports (1,2) recommended strategies to improve the dental public health shortages, based principally on changes in the financing and structure of dental public health training programs. It may be concluded, based on the best evidence currently available, that the dental public health workforce is inadequate in both size and distribution to meet national needs. Moreover, the rate at which dentists (both recent graduates and experienced practitioners) seek dental public health training appears to be declining.

To begin to address the dental public health workforce issues, HRSA issued a request for proposals to conduct a workshop focused on identifying critical issues and to recommend strategies to alleviate dental public health supply shortages. This contract was awarded to the American Association of Public Health Dentistry (AAPHD). In accordance with the specifications of the contract, the workshop was convened in Bethesda, MD, February 10–12, 2002. The invitees included representatives from most dental public health residency programs, government, professional organizations, and dental public health resident trainees.

Process

During the two days of the workshop, attendees engaged in a nominal group process by participating in both plenary and smaller breakout groups, where key problems were identified and recommendations for remediation were developed. The breakout groups were organized around three keynote themes: training, financing, and workforce development. Each group was led by a facilitator, cofacilitator, and recorder. Attendees were given the opportunity to participate in any two of the three breakout sessions. After completing work in the small group sessions, attendees came together for a final plenary session in which the initial recommendations were edited and prioritized.

Over the course of the two months following the workshop, the final prioritized list of recommendations was distributed back to workshop participants and other key individuals. Sug-

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gested revisions were collected and reviewed by the project director (Weyant), an HRSA project officer, and the expert panel. A final draft of the recommendations was distributed to all dental public health residency program directors and was discussed during a special meeting held during the AAPHD annual meeting in Danvers, MA (April 28–May 2, 2002). The final recommendations resulting from this process are reported here.

Recommendations

Training Recommendations

Initial Recommendation 1: Create a dental public health coordinating center.

Discussion: As dental public health training programs are few in number and comprise a small number of individuals, often with relatively limited resources, there was a consensus that combining a number of activities under a funded "coordinating center" would result in increases in efficiency, with all programs potentially benefiting from shared resources and innovations. Examples of activities that would fall under the direction of a coordination center include:

- Function as a clearinghouse where residency projects could be listed for new residents.
- Develop and disseminate dental public health marketing information designed to recruit students into MPH programs and dental public health residencies.
- Develop and disseminate dental public health educational resources to residency programs.
- Coordinate training funds (e.g., HRSA stipends) so that programs that do not have residents can shift stipends to other programs.
- Coordinate faculty development for program directors and for dental school faculty in need of additional dental public health education.
- Sponsor national conference calls as part of a cross-program training initiative.
- Create and manage a dental public health training-oriented Web site.

Financing of the coordinating center was discussed, with options such as HRSA and foundations being the two most likely funding sources. An analogous model exists with the CDC's support of a coordinating center for the prevention research center program.

Final Recommendation 1: HRSA should review whether Title VII legislative authority exists under current legislation to permit the funding through a competitive request for applications of a dental public health coordinating center. If not, legislative authority should be sought for such funding when Title VII is reauthorized.

Initial Recommendation 2: Predoctoral core competencies in dental public health should be developed and disseminated to the dental schools.

Discussion: Presently, there are no broadly adopted dental public health competencies for predoctoral dental curriculum. Dental schools, as a result of the current approach to accreditation, create their own competencies and are evaluated accordingly. Thus, the predoctoral dental curriculum is potentially quite varied among schools. The curriculum differences are possibly magnified by the fact that many schools have no dental public health-trained faculty, with few having dental public health departments. The workshop participants stated there would be an advantage to having a broadly accepted dental public health curriculum guide available that all schools could work from when creating their predoctoral dental public health curriculum and associated competencies. This curriculum would be particularly important to schools having no dental public health-trained faculty.

The main concern associated with this suggestion is that there may be no incentive for schools to adopt the suggested curriculum and thus it may never be implemented. One suggestion was to use the National Board Examination Part II to serve as a motivator for curriculum adoption in dental public health. However, the contents of the examination are not readily available and control of the contents is difficult. Nevertheless, there was general agreement that a suggested dental public health predoctoral curriculum would be of value.

Final Recommendation 2: AAPHD and ADEA should develop a joint task force charged with developing and disseminating a curriculum guide for predoctoral dental public health education. This process will likely require funding from outside of the organizations.

Initial Recommendation 3: Dental public health should explore expanding its role in clinical care during residency training and wider professional understanding of these roles.

Discussion: There was discussion as to how dental public health should broaden its role with regard to the provision of clinical care. Some discussants stated that a nonclinical perception of the specialty harmed our ability to recruit trainees and to provide clinical services. One model would be the development of a clinical preventive dentistry track analogous to that found in preventive medicine specialty training. Another alternative would be to develop joint training programs with other clinical specialties and general dental programs (e.g., general practice residencies, pediatric dentistry residencies, geriatric residencies). A third model would be to provide components of training in community-based dental programs including primary dental care.

A critical issue in the financing of dental public health residencies is the ability to tap into Medicaid graduate medical education funding. As the provision of clinical care is a requirement of this funding, there are important financial implications with regard to the provision of services by residency programs wishing to tap into graduate medical education funds. The option to provide clinical care to patients currently exists in many residency programs, and some dental public health residencies are now receiving graduate medical education funding. It is important that administrators include dental public health residencies in such funding arrangements. Unfamiliarity with the full scope and skills of dental public health may cause them not to do so.

Final Recommendation 3: It should be made clear to federal policy makers and dental school administrators that dental public health residency training programs provide a wide range of patient services and essential support thereto. Therefore, dental public health residencies should be considered for inclusion in future graduate medical education funding, as preventive medicine residencies currently are.

Initial Recommendation 4: Meetings of dental public health residents should be conducted annually.

Discussion: The residents in attendance at either of the last two national

workshops reported finding great value in meeting other residents during both previous dental public health workshops to which residents were invited. Many residents are the sole trainee at their site and have no other trainees with which to discuss training issues. There was a general consensus among the trainees that any means to improve interaction among residents would be valuable and would enhance the quality of their educational experience.

Final Recommendations 4:

- HRSA should review whether Title VII legislative authority exists under current legislation to permit HRSA to continue to sponsor annual dental public health workshops—perhaps with one focused on residents' issues and concerns, encouraging broader resident participation. If not, legislative authority should be sought when Title VII is reauthorized to accomplish this recommendation.
- If developed, a dental public health coordinating center should be tasked with facilitating resident interaction and communication through conference calls, listserv, Web sites, and other means.

Financing Recommendations

Initial Recommendation 1: Additional dental public health workforce needs analysis should be conducted.

Discussion: The initial recommendation received considerable support during the initial prioritization process. However, after further review and discussion, it became evident that the most recent studies to examine workforce needs (1,2) were likely quite adequate. Thus, it was generally agreed that little would be gained by an additional workforce review. Moreover, the conclusion that more dental public health personnel is needed was not likely to change with a new study.

Final Recommendation 1: Existing reports (1,2) are adequate for planning purposes and should be used to direct efforts to enhance the dental public health workforce.

Initial Recommendation 2: Incentives to enter dental public health training need to be developed.

Discussion: It is ironic that dental public health practitioners who work to improve dental services to those most in need, who reduce society's overall cost (including governmental costs) of health care expenditures through development of population-based prevention programs, and who improve the general oral health of the nation through policy development are the lowest compensated practitioners of any dental specialty. As a result, there is great difficulty in recruiting individuals into dental public health. Discussants provided several ideas as to effective programs that might help reduce the "disincentives" to a career in dental public health. These include loan-repayment programs and financial support during residency that is at least comparable to other dental specialties.

Final Recommendations 2:

- HRSA should review whether Title VII legislative authority exists under current legislation to develop a series of loan repayment strategies for dental students pursuing dental public health training and upon entry into dental public health practice. If not, legislative authority should be sought when Title VII is reauthorized to accomplish this recommendation.
- HRSA should review whether Title VII legislative authority exists under current legislation to create funding programs that allow individuals to pursue dental public health training at no cost (tuition support for the MPH) and provide stipend support during the MPH, and not just for the residency period. If not, legislative authority should be sought when Title VII is reauthorized to accomplish this recommendation.

Initial Recommendation 3: Fund training for USPHS Commissioned Corps and other federal employees; HRSA-funded dental public health training programs currently do not cover dental public health training for these people.

Discussion: Perhaps the largest reservoir of potential MPH candidates and/or dental public health residents is the USPHS Commissioned Corps dental officers, with Department of Defense dentists a close second. HRSA funding currently does not cover dental public health training for these people. It was suggested that these individuals, as well as the federal programs in which they serve (PHS, IHS, DOD, etc.) would benefit from having more of these officers pursue dental public health training (either MPH and/or residency). Presently, however, there is no mechanism for support from HRSA for training federal employees. Furthermore, these individuals often lose significant income (e.g., federal continuation pay) upon entering training. These financial barriers were stated to be a disincentive to additional dental public health training.

Final Recommendations 3:

- HRSA should review whether Title VII legislative authority exists under current legislation to provide financial support to Commissioned Corps and DOD dental officers during dental public health training. If not, legislative authority should be sought when Title VII is reauthorized to accomplish this recommendation.
- Federal agencies should explore whether current legislation allows Commissioned Corps officers to continue to receive full pay during dental public health training. If not, legislative authority should be sought to accomplish this recommendation.

Workforce Recommendations

Initial Recommendation 1: Develop and evaluate alternative models of dental public health advanced education for dental hygienists.

Discussion: Given the present difficulties in recruiting and training dentists to diplomate status, alternative training models that will serve to improve the availability of dental public health services should be explored. One possibility is the training of dental hygienists through the MPH degree and dental public health residency programs.

Final Recommendations 1:

- AAPHD (as a function of the dental public health coordinating center) should explore dental public health training models (including MPH and residency programs) for bachelor-level dental hygienists and develop competencies for these programs.
- Upon completion of this process, AAPHD should provide guidance to potential funders for this program, including HRSA and foundations.

Initial Recommendation 2: Recruit dental public health trainees from dental clinic/community health clinic providers.

Discussion: In response to the continuing perception that there are too few dental public health practitioners, a recommendation was made to develop alternative recruitment strategies. One population, current clinical dentists in community-based treatment facilities, was stated to be a

promising group to target for additional dental public health training. Workshop participants stated that these individuals may benefit from dental public health training, as would their treatment facility. Such facilities might find that having a dental public health-trained staff dentist would improve their ability to care for their patient population through new programs, a greater focus on prevention, policy advocacy, and other means. Concern was expressed that the costs of the training would not be recovered through additional salary, especially if the dentist had to personally pay for the dental public health training. Nevertheless, the discussants generally agreed that targeting mid-career clinicians would be worthwhile and that additional dental public health training would add value to their professional practice.

Final Recommendation 2: AAPHD should develop strategies for marketing dental public health training to clinical dentists currently working in community-base dental treatment settings and other types of mid-career settings. Consideration should be given to developing a demonstration project that creates an innovative and flexible executive dental public health training program (using the existing executive MBA programs as a model). This program would target mid-career individuals and allow them to continue with their present employment (e.g., clinician in community-based clinic).

Initial Recommendation 3: Dental student issues.

Discussion: Dental students were recognized as a crucial population in need of innovative marketing approaches designed to attract them into dental public health careers. The move from dental school to a dental public health training track represents the largest constriction in the training "pipeline." It was suggested that one reason many dental students fail to consider dental public health training is a lack of understanding among many predoctoral dental students about what a career in dental public health includes. Dental public health is often viewed as either a career for dentists who want to treat "poor" people or a track for people who are "not good with their hands." Consequently, the specialty suffers from low prestige among many students as a result of its low visibility in the predoctoral curriculum, misperception of what dental public health practitioners do, and, in many dental schools, from a negative portrayal of the specialty by dental clinical faculty.

Another area of concern is that the current training model now requires students, upon graduation from dental school, to enroll in another degree program (MPH), thus incurring additional tuition costs. Following the MPH, the student must then enroll in a dental public health residency to complete his or her training. Many times this requires students to relocate two times after dental school graduation as they pursue the MPH and residency training in various cities. The current dental public health training model thus creates both financial and logistical barriers for many dental students.

Several strategies were explored to help to remedy this situation. One approach targeted to predoctoral dental students would be the development of a marketing campaign to improve the visibility of dental public health in schools without dental public health faculty. This could take on the form of a speakers' bureau or electronic means to enhance visibility (e.g., videos, CD-ROM, Web site).

Strategies directed toward improving dental public health postdoctoral training included various ways to "bundle" training. For example, some dental schools have the option of offering a combined dental degree/MPH joint degree option, such as is currently available at the University of Pittsburgh, where students may attain both a dental degree and MPH within four years at the same tuition as the cost of the dental degree alone.

Alternatively, a combined MPH and residency program would also provide cost savings and possibly allow students to avoid relocating for residency training after their MPH. The University of Iowa model is one approach that may be instructive in this regard.

In seeking to maximize the pool of applicants for dental public health residencies, the residency directors propose that the ABDPH give guidance on "MPH or equivalent" degrees as a component of educational eligibility, while recognizing and retaining the value of flexibility in such a provision. The policy may remain unchanged that only the board may make a determination as to eligibility of any individual. The guidance requested by residency directors need not be included formally, but take the form of a guidance memo.

Examples of guidance sought for:

- Candidates with MPH degrees from a school in the preaccreditation phase.
- Candidates with master's-level degrees or enrolled in master's degree education programs largely comparable to the MPH who may, as part of the residency, make up course deficiencies and document this to the satisfaction of the board.

There was also some discussion as to alternatives to the MPH, such as an MBA or MPP (public policy) degree. The notion that dental public health could "expand" its scope—somewhat analogous to preventive medicine—to include several tracks (prevention, policy development, finance/business, management) in addition to the traditional MPH training was stated to be an idea worthy of additional investigation.

Finally, the difference in the training model for dental public health, as compared to other dental specialty residency training models, was discussed. Dental public health, with its requirement for an MPH through a school of public health, loses some control over the training pipeline. Students must pay tuition to a school of public health for their MPH degree and then seek residency training afterwards. This creates a difficult training pathway for many students. Discussants stated that through new funding mechanisms, whereby the MPH degree was funded under a combined training program that included both the MPH and residency, these costs barriers could be addressed effectively.

Final Recommendations 3:

- Dental schools located on campuses with MPH degree programs should explore the development of a joint degree program.
- AAPHD, ABDPH, and ADEA should explore alternatives to the MPH as preparatory degrees for dental public health training.
- Schools of public health and residency programs should explore combined training programs, coupling the MPH and residency programs.
- HRSA should review whether

Title VII legislative authority exists under current legislation to develop a means to support the MPH training year in programs with joint MPH/residency training programs. If not, legislative authority should be sought when Title VII is reauthorized to accomplish this recommendation.

Initial Recommendation 4: Recruit for dental public health training from pre-dental students.

Discussion: Again, the concern over recruitment surfaced in another strategy designed to interest students in dental public health training prior to enrolling in dental schools. Two approaches were suggested. One was to target dental education to students in MPH training programs. The other was to develop dental degree/MPH training tracks that would be used to target students prior to entry to dental school.

Final Recommendations 4:

- AAPHD should work with the Association of Schools of Public Health to develop marketing information appropriate for MPH students that would inform these individuals about careers in dental public health.
- Dental schools with joint degree programs (dental/MPH) should consider developing a formal "track" into which they can recruit one or two students per year.

Initial Recommendation 5: Update dental public health definition.

Current definition of dental public Health (3):

> Dental public health is the science and art of preventing/controlling dental disease and promoting dental health through organized community efforts. It is the form of practice that services the community rather than the individual. It is concerned with health education, application of research, and administration of programs of dental care for groups, and with the prevention and control of dental disease through a community approach.

Discussion: The original dental public health definition was reviewed. There was concern that the definition was confusing and lacked sufficient detail to inform those unfamiliar with dental public health as to what exactly the practice of dental public health entails. Discussants reviewed the process and consequences of changing the specialty definition. Of primary concern was the fact that the definition is "registered" with ADA and is part of the specialty recognition process. Thus, changing the definition may result in an entire re-review of the specialty. Alternatives to changing the "formal" definition were discussed. One solution that seemed to have wide support was to have a "working" or "marketing" definition that could be used in brochures, on Web sites, etc., that would better explain the specialty

Final Recommendation 5: AAPHD and ABDPH should collaborate on a new "working" definition of dental public health.

Initial Recommendation 6: Increase visibility of dental public health in dental schools.

Discussion: This recommendation responds to comments that there is a lack of visibility of dental public health activity in dental schools as a result of low numbers of faculty and nonuniform names of dental public health departments. As a result, the specialty lacks a coherent image among dental students and some faculty and school administrators.

Final Recommendations 6:

- AAPHD should work with ADEA to advocate for standard naming of departments, using the name of the specialty (dental public health) as is common with other specialty-defined departments.
- AAPHD and ADEA should advocate for the hiring of dental public health at dental schools and advocate where needed that the compensation for dental public health faculty should be equivalent to other dental specialists. Furthermore, as is the case with virtually every other dental specialty, dental public health departments should exist within every dental school.

Conclusions

Dental public health faces a number of challenges if the specialty is to successfully adapt to the rapidly changing health care environment and meet the increasing demand for services. This workshop had made an important contribution by addressing many of these challenges with specific recommendations. Collectively, these recommendations provide a comprehensive approach to remedying many of the identified problems. Not all of the recommendations are likely to be realized in the near future; nevertheless, they should be delineated and incorporated into any long-range strategic and coordinated approach to charting the specialty's future. The reauthorization of Title VII legislation this year provides an important opportunity to address many of these recommendations. Thus, it is advisable for AAPHD to quickly establish a committee to help review the legislative needs of the specialty and to work with policy makers to ensure that those legislative needs are realized. Dental public health workers are a vital national resource and all of the stakeholders concerned with the oral health of the nation need to work collectively to ensure the specialty's continued vitality.

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