

### Major sections of this module

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- Private Practice and Public Health Dentistry: Complementary Roles – Shared Objectives
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### Learning Objectives

- Identify the role that dental public health plays within dentistry.
- Identify the role that the private practice dentist plays within the dental public health infrastructure and delivery of care systems.
- Identify the core functions and accomplishments of public health and how they align with the ADA Strategic Plan.

### What is Dental Public Health?

Dental Public Health is that part of dentistry providing leadership and expertise in population-based dentistry, oral health surveillance, policy development, community-based disease prevention and health promotion, and the maintenance of the dental safety net. DPH and the private practice model of care delivery together bear the responsibility of assuring optimal oral health for all Americans - individuals and populations.

Having been an ADA recognized dental specialty since 1950, Dental Public Health (DPH) is unique among the specialties in that it is not primarily a clinical specialty; it is a specialty whose practitioners focus on dental and oral health issues in communities and populations rather than individual patients.

DPH has been defined in many ways, from “the science and the art of preventing and controlling disease and promoting dental health through organized community efforts” to “a non-clinical specialty of dentistry involved in the assessment of dental health needs and improving the dental health of populations rather than individuals.”<sup>1</sup> While these definitions capture some of what DPH does, they fail to completely define the scope of what DPH professionals do and how they fit into the matrix that is today’s dental profession.

### Dental Public Health and the ADA

The specialty of Dental Public Health supports the ADA’s vision and mission, which highlight the Association’s commitment to the oral health of the public. Dental Public Health’s regular assessment to determine need, development of community-based prevention and treatment programs, and ongoing surveillance of populations bring to light the magnitude of those communities and populations that, for whatever reason, do not or are unable to access oral health care.

**ADA Vision Statement:** The American Dental Association: The oral health authority committed to the public and the profession.

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<sup>1</sup> <http://aaphd.org/docs/whydentalpublichealth2.pdf>

**ADA Mission Statement:** The ADA is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.

The introduction to the ADA's 2011-2014 Strategic Plan states that, "the Association's decisions are informed by listening to the public, to devoted practitioners, and to the various communities of interest which serve, support or impact the health care environment and delivery of oral health care" and that "Associations are expected to operate transparently in a culture of trust and commitment." Dental Public Health provides the ADA and its Board of Trustees with the capacity to communicate and collaborate with the full span of public health and health care delivery systems.

The ADA and Dental Public Health are inexorably linked by these Strategic Plan goals, as suggested by these further explanations of each goal:

**1. Provide support to dentists so they may succeed and excel throughout their careers.**

This goal will expand the knowledge that every dentist has a role to play in strengthening the DPH infrastructure. It recognizes that every dentist chooses his/her career path and the ADA supports those dentists who choose dental public health as a career pathway.

**2. Be the trusted resource for oral health information that will help people be good stewards of their own oral health.**

This goal includes an understanding that at the federal, state and local levels, dentists with knowledge of dentistry and public health should have the ability to inform policies and programs impacting community oral health. It will ensure that both the individual and the dental professional understand their unique roles and responsibilities in managing the oral health of an individual or a community.

**3. Improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders.**

A robust dental public health infrastructure should exist at all levels to ensure that the entire profession of dentistry is working toward common goals to improve the public's health through strategies that include improved health literacy; efficient, effective delivery systems; adequate workforce (quantity and distribution) to meet the public's oral health care needs; and building the scientific body of knowledge related to oral and systemic health.

**4. Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.**

This goal encourages all dentists involved in dental public health to be active and supporting members of the American Dental Association. It is important to have the voice of Dental Public Health at the table when decisions affecting the oral health of all Americans are discussed.<sup>2</sup>

### **The Dental Public Health Infrastructure**

The dental public health infrastructure is a broad-based, informal, and widely disseminated network of

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<sup>2</sup> For more information, see [https://www.ada.org/members/sections/about/doc\\_strategic\\_2011.pdf](https://www.ada.org/members/sections/about/doc_strategic_2011.pdf).

public and private organizations, as well as individuals, dentists and non dentists alike, committed to improving oral health through organized community-focused policies and programs. It is sometimes referred to informally as “the dental safety net.” While details differ within the public health community, the general definition of “safety net” is the sum of the individuals, organizations, public and private agencies and programs involved in delivering oral health services to people who for reasons of poverty, culture, language, health status, geography and/or education are unable to secure those services on their own. But the sum of these entities does not constitute a whole. They are often disparate, inconsistent, chronically underfunded and lack coordination. Additionally, the dental public health infrastructure is responsible for monitoring the oral health status of communities, overseeing community-based dental disease prevention programs and establishing policies to maintain and improve oral health and access to care.

### Components of the Dental Public Health Infrastructure

In the broadest sense, primary components of the dental public health infrastructure include, but are not limited to:

**Government:** State and local health departments, as well as federal agencies such as the Indian Health Service (IHS), Federal Bureau of Prisons (BOP), the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), the Agency for Children and Families (ACF), and National Institutes of Health (NIH). Other entities here would include the Commissioned Corps of the U.S. Public Health Service (USPHS) and Federally Qualified Health Centers (FQHCs).

**Education:** Traditionally, academia involved in oral health includes schools of Dentistry, Dental Hygiene, and Public Health. In recent years in light of a greater emphasis on an interdisciplinary approach to patient care and increased medical/dental collaboration, this area has expanded to include Schools of Medicine, Nursing, and other allied Health Sciences. It also includes preschool programs such as Head Start, primary and secondary schools, trade schools, vocational educational programs, dental residencies, and dental public health fellowships.

**Workforce:** Dentists, dental hygienists, dental assistants, all members of the dental, and many traditional non-dental providers: physicians, nurse practitioners, physician assistants, midwives, pharmacists, nurses, home health aides, water plant operators, teachers, parents, school administrators, health boards, community health workers, and *promotoras* (culturally competent or ethnically affiliated liaisons that bridge the gap within health care for the underserved).

The dental public health infrastructure is a component of the larger public health infrastructure. The federal government has been monitoring the public health infrastructure through the *Healthy People* 2010 and 2020 national health objectives.<sup>3</sup> For example, in 2009, 55 percent of State Health Departments indicated that they had adequate epidemiological capacity to monitor health status and investigate health hazards in the community. The *Healthy People* goal is to increase this number to 100 percent of State Health Departments by the year 2020.<sup>4</sup>

As mentioned previously, this infrastructure stands in need of enhancement. In his article “An Assessment of the Dental Public Health Infrastructure in the United States,” Dr. Scott Tomar concluded:

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<sup>3</sup> The Healthy People program provides science-based, ten-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of prevention activities. For more information, see [www.healthypeople.gov](http://www.healthypeople.gov).

<sup>4</sup> For additional information, see <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=35>.

Findings suggest the U.S. dental public health workforce is small, most state programs have scant funding, the field has minimal presence in academia, and dental public health has little role in the regulation of dentistry and dental hygiene. Successful efforts to enhance the many aspects of the U.S. dental public health infrastructure will require substantial collaboration among many diverse partners.<sup>5</sup>

Many organizations contribute to the enhancement of the dental public health infrastructure with two of the principal players being the [Association of State and Territorial Dental Directors](#) (ASTDD) and the [American Association of Public Health Dentistry](#) (AAPHD). Others include the [American Public Health Association](#) (APHA), the [Medicaid/SCHIP Dental Association](#) (MSDA) and the [National Network for Oral Health Access](#) (NNOHA).<sup>6</sup>

ASTDD was organized in 1948 and is one of 17 affiliates of the Association of State and Territorial Health Officials (ASTHO).<sup>7</sup> ASTDD formulates and promotes the establishment of national dental public health policy, assists state dental programs in the development and implementation of programs and policies for the prevention of oral diseases; builds awareness and strengthens dental public health professionals' knowledge and skills by developing position papers and policy statements; provides information on oral health to health officials and policy makers, coordinates efforts of many community level oral health paraprofessionals and conducts conferences for the dental public health community.

AAPHD was founded in 1937 and serves as the sponsoring organization for the American Board of Dental Public Health. The mission of AAPHD is to improve access to dental care and reduce the burden of oral disease of the public through education and leadership based on the principles of dental public health. To meet the challenge of improved oral health for all, AAPHD is committed to:

- Promotion of effective efforts in disease prevention, health promotion and service delivery;
- Education of the public, health professionals and decision-makers regarding the importance of oral health to total well-being; and
- Expansion of the knowledge base of dental public health and fostering competency in its practice.

The challenge for dental public health, and dentistry in general, is to create a shared vision of optimal oral health for widely diverse groups; inform and educate these groups as to their potential role in improving oral health and to be better stewards of their own oral health; assessing the oral health status of differing communities of interest; designing, implementing and coordinating activities and programs; and evaluating outcomes.

In 2000, the U.S. Surgeon General released *Oral Health in America*, which summarized the state of the nation's oral health.<sup>8</sup> In that report, it was noted that "the public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups and integration of oral health and general health programs is lacking."

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<sup>5</sup> [J Public Health Dent](#). 2006 Winter; 66 (1):5-16.

<sup>6</sup> For additional information, see [www.astdd.org](http://www.astdd.org), [www.aaphd.org](http://www.aaphd.org), [www.apha.org](http://www.apha.org), [www.medicaidental.org](http://www.medicaidental.org) and [www.nnoha.org](http://www.nnoha.org).

<sup>7</sup> Other ASTHO affiliates include the Association of Maternal and Child Health Programs (AMCHP) and the National Association of Chronic Disease Directors (NACDD). For additional information, see <http://www.astho.org/About/Affiliates/>.

<sup>8</sup> U.S. Department of Health and Human Services (DHHS). *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: DHHS, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

The dental private practice delivery system provides care to approximately 65% of the U.S. population. The current national and state discussions regarding the lack of access to dental care revolve generally around the 35% of the population who are not currently receiving at least one dental visit annually. That underserved population represents those living in remote areas with limited access to dental services, increasing numbers of economically disadvantaged persons including the working poor, racial and ethnic minority populations, those with special needs or who are medically compromised, and those with low educational levels. The institutionalized, homebound and the elderly face extreme hardships in obtaining adequate oral health services.<sup>9</sup>

Lack of access to dental care for the underserved is in part a consequence of an inadequate dental public health infrastructure, which includes not only governmental reimbursement programs, such as Medicaid and the Children's Health Insurance Program (CHIP), but also the existing dental safety net attempting to meet the needs of the underserved.

Many of these barriers are dental provider/systems-related issues such as: inadequate financial incentives for dentists to locate in underserved areas, low Medicaid reimbursement rates with currently fewer than 10% of all dentists participating; the administrative burden of treating Medicaid patients; poor diversity among the dental workforce with only 13% of dentists being non-white compared to 22% of physicians; and other issues such as high student loans, an aging dental workforce (the average age of a dentist in the U.S. is 49 years old), fewer new dental graduates than in the 1970s and 1980s, and the need to serve a larger more diverse population.<sup>10</sup> In addition, current dental education is not adequately preparing dentists to care for disabled and medically complex patients.

In 2008, the ADA House of Delegates adopted Association healthcare reform policy (*Trans.2008:429*), which stated that "Improving oral health in America requires a strong public health infrastructure to overcome obstacles to care."

If we can, through prevention efforts, reduce the burden of disease; we can reduce demand for treatment and effectively increase the ability of the dental workforce to meet the remaining need. Community-based prevention is a crucial aspect of the dental public health infrastructure and by its very nature, implementation of these programs decreases demand.

The 2008 ADA healthcare reform policies (*Trans.2008:429*) stated that "Prevention Pays." The key to improving and maintaining oral health is preventing oral disease. Community-based preventive initiatives, such as community water fluoridation and school-based screening and sealant programs, are proven and cost-effective measures, particularly when services are provided by the least resource-intensive professionals who can provide the services safely and effectively. These prevention strategies should be integral to oral health programs and policies as they provide the greatest benefit to those at the highest risk of oral disease.

The current dental safety net cannot solely meet the oral health needs of underserved Americans with regard to dental disease prevention and treatment. Successfully meeting the oral health demands of all Americans depends on the inclusion of a strong private sector, adequately reimbursed, with an appreciation of cultural competency and adequate geographic distribution to treat those people for whom a viable business model capable of supporting that practice exists.

Simultaneously, this model must be complemented by and integrated with a strong public health infrastructure capable of carrying out the core public health functions, which were identified by the Institute of Medicine (IOM) in its 1988 study *The Future of Public Health* as the following:

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<sup>9</sup> Dental Clinics of North America - July 2009 (Vol. 53, Issue 3, Pages 523-535, DOI: 10.1016/j.cden.2009.03.016)

<sup>10</sup> *Ibid.*

- **Assessment:** Regular collection and dissemination of data on health status and community health needs utilizing epidemiologic principles and surveillance systems.
- **Policy Development:** Use of scientific knowledge and data in decision-making affecting the public's health and to establish goals.
- **Assurance:** Implementing the appropriate programs to achieve desired goals.<sup>11</sup>

A 1994 consensus statement entitled *Public Health in America* built upon these core functions to describe what public health does and what services are essential to achieving healthy people in healthy communities. Successful provision of these ten essential services requires collaboration among public and private partners within a given community and across various levels of government.<sup>12</sup>

In a similar fashion, by complementing each other, the private and public aspects of dentistry can support a viable dental public health infrastructure that will be better able to meet the oral health needs of the underserved. If private dentists work with or alongside their dental public health colleagues, including physicians and public health hygienists, the supply would increase to meet the demand. For many component and constituent societies, this collaboration is borne out through participation within local and state oral health coalitions.

Funding of the dental public health infrastructure requires multiple funding streams including federal, state and local grants, public and private foundation grants and service fees. Partnerships and collaboration among the private and public sectors are key to sustaining public health programs.

### **Private Practice and Public Health Dentistry: Complementary Roles – Shared Objectives**

Assuring optimal oral health for all Americans requires close collaboration between the public and private sectors of dentistry. Every individual dentist, regardless of the type of practice, location, or any other variable, is part of the dental public health infrastructure. They may see disadvantaged patients, accept Medicaid, volunteer clinical services, serve on the board of a local health department or an FQHC, serve on local school board health advisory committees, actively participate in local oral health coalitions, mentor students at a local school, advocate for community water fluoridation, provide care in a school-based or school linked dental sealant program, participate in Give Kids A Smile, Mission of Mercy programs or other community activities designed to improve oral health. Yet while every dentist is part of the DPH infrastructure, not every dentist is a public health dentist.

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<sup>11</sup> Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press, 1988. For additional info, see <http://www.nap.edu/openbook.php?isbn=0309038308>.

<sup>12</sup> Public Health Functions Steering Committee. *Public Health in America*. Washington, DC: U.S. Public Health Services, 1994. (see essential services piece at <http://www.cdc.gov/nphpsp/essentialServices.html>).

## Comparison of the Dental Clinician and the Dental Public Health Practitioner<sup>13</sup>

Dental Clinician	Dental Public Health Practitioner
Focuses on the individual patient	Focuses on the community, which could be defined by geographic or political boundaries, socio-demographic characteristics, or health status
Conducts examination	Implements oral health surveillance systems and collects data on the community's oral health status <a href="http://www.ncbi.nlm.nih.gov/pubmed/12962467">http://www.ncbi.nlm.nih.gov/pubmed/12962467</a> and <a href="http://www.cdc.gov/pcd/issues/2009/Apr/08_0108.htm">http://www.cdc.gov/pcd/issues/2009/Apr/08_0108.htm</a>
Establishes diagnosis	Analyzes and interprets data from surveys, surveillance systems, and other data sources
Discusses findings with patient; develops treatment plan	Engages community partners and forms community oral health coalitions; develops a community oral health plan to address the findings from oral health surveillance; plans community-based prevention and treatment programs; develops policies to address identified need <a href="http://www.dentaquestfoundation.org/compendium/DQF_Compendium.pdf">http://www.dentaquestfoundation.org/compendium/DQF_Compendium.pdf</a>
Provides treatment	Implements community-based oral health programs, which requires gathering resources in an organized, systematic and rational way and preferably with broad-based community support and involvement <a href="http://www.astdd.org/best-practices/">http://www.astdd.org/best-practices/</a>
Receives payment for services	Obtains funding to operate programs, which may come from a range of sources including government, private foundations, philanthropic organizations, and commercial or private donors
Schedules periodic follow-up visits	Conducts program evaluation <a href="http://www.cdc.gov/eval/framework.htm">http://www.cdc.gov/eval/framework.htm</a>

While private practice dentists focus on the individual, public health specialists focus on the community. They are concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs, as well as the prevention and control of dental diseases on a community basis. These specialists are required to have broad knowledge and skills in public health administration, research methodology, the prevention and control of oral diseases, and the delivery and financing of oral health care.

The American Board of Dental Public Health was officially designated as the national examining and certifying agency for the specialty by the House of Delegates of the American Dental Association in October 1951 and was recertified in 1986 and 2001.<sup>14</sup>

<sup>13</sup> Adapted from: Tomar SL. Public Health Programs. In: Harris NO, García-Godoy F, Nathe CN (eds). Primary Preventive Dentistry. 7<sup>th</sup> Edition. Upper Saddle River, NJ: Pearson; 2009.

<sup>14</sup> For additional information, see <http://aaphd.org/default.asp?page=ABDPHMenu.htm>.



## Dentists working within Public Health Settings

Many dentists work within public health settings to enhance the traditional DPH infrastructure. Many do so without formal public health training. These public health settings include, but are not limited to: city, county and state health departments; correctional facilities; nursing and other long-term care facilities for the elderly and those with various disabilities; school-based health programs; and free and/or volunteer clinics.

The majority of dentists working within Federally Qualified Health Centers (FQHCs) are one such example. Less than 2% of the current dental workforce provides care within FQHCs. At the same time, it is significant that approximately 69% of health center dentists are ADA members.<sup>15</sup> Health centers provide an interdisciplinary approach to patient care emphasizing preventive and treatment options to promote and improve health outcomes, while reducing health disparities.

Federally Qualified Health Centers are either located within or serve a high need community or target population. They are governed by a community board comprised of 51% users of the facilities. They provide comprehensive primary care to all regardless of ability to pay. Federal grant dollars are intended to support sliding fee scale discounts and enabling services, such as interpretation services and transportation, for individuals living at or below 200% of the Federal Poverty Level. Federal grant dollars are competitive, finite, and comprise approximately a third of a health center's overall budget.<sup>16</sup>

In 2009, almost 19 million patients received health care services at FQHCs with about 3.5 million patients receiving dental services with over 8.4 million patient visits. The number of individuals seeking care at health centers is expected to grow due to health care reform and the current economic circumstances. Information on the demographics of patients seen and services provided at health centers is gathered annually through the Uniform Data Service.<sup>17</sup>

Under President George W. Bush's administration, over 1200 new access points were created within new or existing health centers, with the majority having onsite dental programs and the rest contracting dental services off-site. With health care reform, there is an additional 11 billion dollars authorized over five years to increase health center capacity, including oral health. There are not enough experienced dental directors to lead and provide guidance to this ever-growing number of fledgling dental programs.<sup>18</sup>

The lack of experienced leadership has resulted in a growing number of dental programs facing sustainability issues. While not the norm, some health centers allocate federal grant dollars solely to medical programs, while dental programs are expected to be self-sustaining. Having experienced dental leaders within FQHCs has the potential to mitigate inappropriate demands on the dental program.

The ADA's Council on Access, Prevention and Interprofessional Relations and the Council on Government and Public Affairs are working to increase the familiarity between dentists working in private

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<sup>15</sup>[http://www.nnoha.org/goopages/pages\\_downloadgallery/download.php?filename=14689.pdf&orig\\_name=nnoha\\_salary\\_survey\\_v12\\_on-demand.pdf&cdpath=/filearchive/nnoha\\_salary\\_survey\\_v12\\_on-demand.pdf](http://www.nnoha.org/goopages/pages_downloadgallery/download.php?filename=14689.pdf&orig_name=nnoha_salary_survey_v12_on-demand.pdf&cdpath=/filearchive/nnoha_salary_survey_v12_on-demand.pdf)

<sup>16</sup> For additional information on health centers, see <http://bphc.hrsa.gov/about/index.html>.

<sup>17</sup> For additional information on the Uniform Data System summary compiled annually by HRSA, see <http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html>.

<sup>18</sup> The last official HRSA oral health guidance to health centers was issued in March 1987. In the absence of such guidance and the lack of technical assistance that formally had been provided by regional dental consultants, it has become painfully clear that FQHC executive directors and fiscal officers are the principal guides and mentors for the increasing number of new dental graduates who are desperately trying to provide leadership within their health centers. As well meaning as these administrators are, they cannot provide the expertise needed to ensure that these dental programs are sustainable and efficient.



practice and those working within FQHCs. There are more similarities than differences between these two practice models, but private practice dentists find it difficult to comprehend some health center policies, such as use of a [prospective payment system](#), [sliding fee scale discounts](#) and [scheduling practices](#).<sup>19</sup> Methods for promoting this growing familiarity include:

- Having a dentist on every health center board of directors to provide oral health guidance and insight.
- Experienced private practitioners could offer to regularly mentor inexperienced health center dental directors in clinical and management expertise.
- New graduates looking to build their own private practices could work part-time within health centers, securing loan repayment while gaining experience within an interdisciplinary approach to patient care.<sup>20</sup>

To this end, *The ABCs of FQHCs* is a free continuing education course offered by the Council on Access, Prevention and Interprofessional Relations at the 2009 - 2012 ADA Annual Sessions to encourage greater appreciation of health center dental programs. Similar education modules are being developed for use within state and local dental societies. State dental associations have been encouraged to collaborate with state primary care associations, which advocate on behalf of health centers. Acting together within the parameters of a state oral health coalition, state dental associations and state primary care associations can be more effective advocates for their constituents and the patients they serve.

Health centers are not islands unto themselves. They are a vital part of the dental public health safety net. There is a role for increased collaboration among dentists working in health centers and those working within private practice. Working together, these dentists can strengthen the dental public health infrastructure to better meet the oral health needs of the underserved within their communities.

Although quite limited, there are a variety of other dental public health settings besides FQHCs in which dentists provide clinical services. These include but are not limited to correctional facilities, local health department clinics, school based health centers, and facilities for the developmentally disabled.

### Oral and Dental Health Accomplishments

There have been countless improvements in the nation's oral health over the past 75 years. While most of these are called accomplishments of dental public health; they are all accomplishments of the oral health system, which includes the private sector and dental public health working jointly to accomplish a shared goal for the community's benefit. Examples abound, but some of the most notable include:

- [Community water fluoridation](#): The most recently released CDC statistics show that, in 2008, 195.5 million people (72.4%) on public water systems had access to optimally fluoridated water, which is a substantial increase from the 2006 figure of 184 million people (69.2%).

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<sup>19</sup> For additional information, see [http://www.insurekidsnow.gov/professionals/federal/chipra\\_fohc.pdf](http://www.insurekidsnow.gov/professionals/federal/chipra_fohc.pdf), <http://bphc.hrsa.gov/technicalassistance/taresources/slidingsscale.html>, and <http://dentalclinicmanual.com/chapt4/index.html>.

<sup>20</sup> The ADA provided additional recommendations for promoting familiarity between dentists working within the private sector and health centers as part of its testimony to the Institute of Medicine's Committee on Oral Health Access to Services addressing expertise and technical assistance needed within health centers on July 27, 2010. For more information, see, <http://www.iom.edu/Activities/HealthServices/OralHealthAccess/2010-JUL-27.aspx>.

- The [National Oral Health Surveillance System](#) (NOHSS) is a collaborative effort between CDC's Division of Oral Health and the Association of State and Territorial Dental Directors (ASTDD). NOHSS is designed to monitor the burden of oral disease, use of the oral health care delivery system, and the status of community water fluoridation on both a national and state level.
- Increased use of dental sealants based upon the ADA Council on Scientific Affairs' evidence and the Centers for Disease Control and Prevention (CDC) [recommendations for sealant use in school-based sealant programs](#)
- Advances in dental research within the ADA's [Paffenbarger Institute](#) and the [National Institute of Dental and Craniofacial Research](#)
- [Application of Standard Precautions in Dental Practices](#) ensuring the safety of both patients and dental staff members.
- [Decrease in dental caries rates](#)
- [Decreases in oral cancer rates](#)
- Decreases in the prevalence of periodontitis.<sup>21</sup>
- ADA advocacy efforts on behalf of increased appropriations for Indian Health Service dental program through reauthorization of the [Indian Health Care Improvement Act](#) and [maintaining a strong oral health presence within the CDC](#).

### Dental Public Health Challenges

Dental public health challenges are not exclusive to the DPH community. These challenges often impact the oral health of the nation and the ADA plays a primary role in overcoming them. Although these challenges are numerous and complex, they tend to circle around one theme: oral health is essential for a healthy America and not all Americans have good oral health.

Clearly, improving access to oral care is one of the major challenges facing dentistry. Some feel this is primarily a reflection of the maldistribution of oral health care workers and others believe it represents a shortage of skilled oral health care workers. For some, it is not simply a problem of the number of dental professionals and where they are located; it is a reflection of the failure to prevent and control oral diseases to the greatest extent possible. Regardless of how one interprets the data, it is difficult to deny that many in the nation cannot access needed dental services.

ADA policy states that: "No law, regulation or mandate will improve the oral health of the public unless policymakers, patients and dentists work together with a shared understanding of the importance of oral health and its relationships to overall health."<sup>22</sup> Implementation of this policy necessitates that all dentists work together: public and private, administrative and clinical, and academic and governmental. It will demand a strong public health infrastructure in those federal, state and local agencies and organizations that develop policies impacting and affecting dentistry.

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<sup>21</sup> Latest For further information, see the NHANES data: [http://www.cdc.gov/nchs/data/series/sr\\_11/sr11\\_248.pdf](http://www.cdc.gov/nchs/data/series/sr_11/sr11_248.pdf) , table 55 (p. 63), as well as: Hujuel PP, del Aguila MA, DeRouen TA, Bergström J. A hidden periodontitis epidemic during the 20th century? Community Dent Oral Epidemiol. 2003 Feb, 31(1):1-6. Available at: <http://onlinelibrary.wiley.com/doi/10.1034/j.1600-0528.2003.00061.x/pdf>.

<sup>22</sup> <http://www.ada.org/news/1801.aspx>

There is a need for dental leaders within federal, state and local governmental structures who are trained public health professionals. When these individuals are strategically placed within governmental entities and have time to develop both credibility and trust within a particular agency, they serve as sentinels and champions for oral health. They see the *big picture* and ensure that oral health is integrated within the context of a larger agency agenda and programming. When absent, through no fault of the agency itself, that prism is simply missing. Opportunities for addressing oral health issues are simply lost.

Examples of the importance of having a vibrant dental public health infrastructure in federal and state health departments abound:

- Strong DPH leadership at CDC has helped the profession develop appropriate guidelines for water fluoridation, use of dental sealants and infection control measures, and helped in the establishment of a National Oral Health Surveillance System. Yet, in 2011, the chief dental officer positions at HRSA, CDC and CMS were vacant. *Who is providing expert oral health advice and guidance to the leadership within these federal agencies when these positions are vacant? Who is encouraging collaboration with diverse oral health stakeholders?*
- If dentists with strong public health credentials are not overseeing the assessment of community needs, developing and implementing health policies to meet those demands, and assuring that proper evaluation is ongoing; the door is left open for well-meaning, but less qualified, advocacy and philanthropic organizations to become the primary guidance for governmental entities.
- Oral health is becoming more accepted as an integral component of an interdisciplinary approach to patient care within HRSA funded health centers. *How does one best integrate dental and medical expertise within the confines of a medical home, a dental home and/or a health home?*
- At the state level, competent state oral health programs assist health agency officials and public health administrators to develop and operate strong oral health programs and implement the core dental public health functions for the state. The same is true for local health programs that provide oral health services or develop oral health policies. *How are these strong, competent oral health programs maintained in the light of severe state budget cuts?*
- 23.4 percent of States (including the District of Columbia) and local health agencies that serve jurisdictions of 250,000 or more persons had a dental public health program directed by a dental professional with public health training in 2009. A Healthy People 2020 objective in this area seeks a 10% improvement by 2020.<sup>23</sup>

Other challenges facing the nation's oral health status include the future makeup of the dental profession. There is almost universal agreement that new dental team members will be introduced into the profession sometime in the future. One may ask how a new dental team member would affect community health. In one instance, if the addition of expanded function dental assistants increases a private practitioner's efficiency, effectiveness, productivity and profitability, this enhanced practice viability may allow this dentist to increase the number of Medicaid eligible patients seen within the practice.

The ADA is pilot testing the Community Dental Health Coordinator (CDHC), while other models include the Advance Dental Hygiene Practitioner and the Dental Health Aide Therapist. Ultimately all of these models will be evaluated on the strength of the evidence as to whether they can improve access to quality care for various communities. DPH principles of assessment, policy development and assurance

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<sup>23</sup> For more information about Healthy People 2020, see <http://www.healthypeople.gov/2020/default.aspx>.

hopefully will provide the basis upon which these models will be evaluated and in which situations they might add value. It is unlikely that any one model will fit the needs of all communities or be acceptable to all groups.

Maximizing access to current community-based prevention programs remains a challenge and identifying new prevention strategies to address problems, such as Early Childhood Caries (ECC), remains elusive and will require expanded research and evaluation efforts.

### **Summary**

Too often the principal role of Dental Public Health is thought of as “taking care of the poor.” While assuring that necessary dental services are provided to meet the oral health demands of the underserved is part of the core functions of assessment, policy development and assurance; this is only a part of the role that dental public health plays. Unfortunately, this most visible expectation of the profession fails to meet the needs of those who must rely on the dental safety net to receive basic dental care. The public has given our profession the right and the obligation to be the provider of oral health services for all persons. If we fail to live up to that obligation as a profession, we may well lose the trust of the public and open up the door for others with less knowledge and interest to make decisions affecting the profession and the public.

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## Self-Assessment

1. **True or False: ADA policy states that “Improving oral health in America requires a strong public health infrastructure to overcome obstacles to care.”**

**True.** In 2008, the ADA House of Delegates adopted Association healthcare reform policy (*Trans.2008:429*) that emphasized the importance of a strong public health infrastructure.

2. **While the dental clinician focuses on the individual patient, the dental public health practitioner focuses upon:**

- A. the Federal Government
- B. the Community
- C. External stakeholders
- D. Advocacy organizations

**B. The Community.** The dental public health practitioner focuses on the community, which could be defined by geographic or political boundaries, socio-demographic characteristics, or health status.

3. **True or False: Approximately 69% of dentists working within health centers are members of the ADA.**

**True.** A 2010 survey conducted by the National Network for Oral Health Access indicated that 69% of dentists working within health centers are members of the ADA.

4. **Community-based preventive initiatives, which are proven and cost-effective measures, include:**

- A. Community water fluoridation
- B. School-based screening and sealant programs
- C. None of the above
- D. Both of the above

**D. Both.** Community-based preventive initiatives include all of the above.

5. **True or False: The core public health functions are assessment, policy development and assurance.**

**True.** The core public health functions were identified by the Institute of Medicine in its 1988 study entitled *The Future of Public Health*.

6. **True or False: Since every dentist contributes in his or her way to the dental public health infrastructure; therefore, every dentist is a public health dentist.**

**False.** Public health specialists focus on the community and are concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs, as well as the prevention and control of dental diseases on a community basis. They have broad knowledge and skills in public health administration, research methodology, the prevention and control of oral diseases, and the delivery and financing of oral health care.

7. **True or False: While a private practitioner conducts a patient examination in order to establish a diagnosis; the dental public health professional conducts an assessment by analyzing and interpreting data from surveys, surveillance systems, and other data sources.**

**True.** Regular surveillance of a community and/or demographic population provides the basis for accurate assessment of the needs of the community.

8. **The ADA is working to increase the familiarity of dentists working in private practice with those working within Federally Qualified Health Centers. Methods for promoting this growing familiarity include:**

- A. There should be a dentist on every health center board of directors to provide guidance.
- B. Experienced private practitioners could mentor inexperienced health center dentists.
- C. New graduates could work part-time in health centers to secure loan repayment and gain experience within an interdisciplinary approach to patient care, while building their own practice.
- D. All of the above.

**D. All of the above.** Each of these recommendations would increase familiarity among dentists within a community.

9. **True or False: Efforts to improve access to dental care require investment in the nation's currently insufficient public health infrastructure.**

**True.** The ADA recognizes that community-based disease prevention and treatment programs must be expanded and barriers to personal oral health care eliminated, if we are to meet the needs of the population.

10. **True or False: Dental Public Health provides the ADA Board of Trustees with the capacity to communicate and collaborate with the full span of public health and health care delivery systems.**

**True.** Collaboration between the Board of Trustees and Dental Public Health will help the ADA achieve its goal of assuring optional oral health for all.