

# **Strategy for the Enhancement of the Dental Public Health Infrastructure at HRSA**

## **Submitted by HRSA Regional Dental Consultants January 2002**

### **Executive Summary**

From the early 1980s until the present, there has been a dramatic decrease in oral health leadership and dental presence within HRSA and its predecessors. At the HRSA central and regional office level, the number of dental public health professionals has dwindled from more than 100 to less than 20. Of these remaining dental professionals, 33% will reach the 30-year mandatory retirement level for commissioned corps officers by 2003; 78% will reach the 30-year mark by 2009. With dental school credit, the majority of this group would be eligible for full retirement by 2005. During this same time, the number of federal dentists assigned to community and migrant health centers decreased from more than 400 to 5. As HRSA's oral health leadership declines, access to oral health care has similarly decreased while the prevalence of dental disease and oral health disparities has increased for the nation's most vulnerable populations.

The Surgeon General's Report on Oral Health recommended the building of an effective health infrastructure that meets the oral health needs of all Americans.<sup>1</sup> Through the establishment of a strong dental public health infrastructure, HRSA can provide the leadership necessary to effectively implement and coordinate Oral Health programs and activities across all federal and state programs while increasing the number of health professionals available to provide dental public health expertise to vulnerable populations. HRSA can contribute an essential component within the development of a National Oral Health Plan. Currently, the HRSA Oral Health Working Group exists as an ad hoc committee composed of various HRSA bureau and central office dental personnel. This committee has no consistent support structure or broad HRSA authority regarding oral health issues.

In order to support and enhance the local and state momentum surrounding the rejuvenation of oral health as an essential component of an interdisciplinary approach to patient care, the HRSA Office of Field Operations, Associate Administrator, has assigned a regional dental consultant as lead oral health consultant for the ten HRSA regional offices. The lead consultant will coordinate the activities of the HRSA regional dental consultants as they continue to advance activities around oral health in the field. To bring this work to fruition, the following recommendations are proposed

- **Establish an active central oral health point of contact within HRSA with support staff** to coordinate oral health activities across HRSA while integrating with other agencies, including CMS, ACF, CDC, NIDCR, IHS, BOP, Coast Guard, and the USPHS Chief Dental Officer's office.
- **Recruit and sustain an effective cadre of federal oral health professionals**, who will provide leadership and dental public health expertise at regional, state, and community levels in addition to maintaining rapid response availability.

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1 U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, p.12

- **Enhance career development training for current and future staff.** Establish, fund and implement a career dental public health training plan to assure that fully trained dental professionals are available for leadership positions within clinical, dental public health and epidemiological areas. Master's level postgraduate training, i.e., MPH, MPA, etc., should be considered the minimum level of training with residency experience and board certification encouraged as appropriate. Clinical training supported by HRSA should be determined by individual program needs. Update dental billets and identify critical non-dental leadership positions as potential assignments for dental professionals.

By implementing these recommendations, HRSA will continue to contribute to the rebuilding of state and community dental public health capacity and infrastructure to better assess, plan and assure the oral health of our target populations. This infrastructure will enable a viable pipeline of experienced and adequately trained federal oral health professionals who can provide leadership from both the field and administrative positions within HRSA and other federal agencies.

## **Background**

HRSA and its predecessors have played a pivotal role in building this country's dental public health infrastructure through capacity building, leadership training, accessible service delivery and research. Through external grants to academic institutions and states as well as internal training programs, HRSA was the predominant source of long-term specialty training and dental public health residency training designed to prepare individuals for leadership and specialized clinical responsibilities within dental public health.

Up to the early 1980s, HRSA played a key role in meeting the public's oral health needs through the establishment and maintenance of a national dental public health infrastructure largely financed through Title V dollars. This was the genesis of many state and community dental public health programs. The Health Resource Administration's (a HRSA predecessor) Division of Dentistry sponsored training for state dental directors and most of the other dental public health professionals in our Nation with more than 100 individuals receiving long-term training. This Division's 250+ employees and two research centers provided much needed dental expertise to those states, which were unable to meet their own critical needs.

Through the National Health Service Corps (NHSC), HRSA was the principal federal agency striving to increase access to dental services in both urban and rural underserved areas. Hundreds of federal dentists were assigned to dental health professional shortage areas with millions of dollars provided for start up dental equipment. Extensive NHSC scholarship and loan repayment programs encouraged dentists to practice in underserved communities. Each HRSA regional office had a dental professional assigned to address NHSC and other dental issues.

The number of dentists participating in the NHSC Loan Repayment program, employed directly by the health delivery site, has fallen to less than 200. Although these dentists have broadened accessible service delivery, their presence is still insufficient to meet the growing demand for primary oral health services across the Nation. Adequate leadership at the central and regional office level would greatly enhance the efficiency and effectiveness of these new oral health professionals.

Through interagency agreements, HRSA provided dental public health expertise to other federal agencies, such as the Administration for Children and Family's Head Start program, while

collaboratively developing oral health standards, guidelines and educational training modules. State and local technical assistance networks were established and local dentists solicited to provide care to Head Start children. HRSA was delegated authority and reimbursed to develop dental service components in other Office of Economic Opportunity programs including: VISTA, Job Corps Community Action agencies and neighborhood health centers. Through an interagency personnel detail, HRSA provides dental technical assistance to CMS (formerly HCFA) to encourage and sustain oral health policy development.

Currently, the Nation is witnessing a steady attrition of the ability of HRSA and state health departments to assure an adequate level of trained dental public health professionals to meet the need for oral health services as both state and local dental public health infrastructures steadily erode in parallel with the decrease in the federal presence. The number of trained public health dentists has decreased. In 1979, approximately 1,600 dentists and 800 hygienists were engaged in public health activities in this country. Of these health professionals, no more than 450 dentists and fewer hygienists had received graduate training in public health. In *Health Personnel in the United States: Eighth Report to Congress*,<sup>2</sup> the Department of Health and Human Services noted a shortage of public health personnel, especially citing a declining dentist population by the year 2000.

This loss of capacity poses questions about the ability of the Federal government and states to effect positive change as states assume increasing responsibility in public health and the operation of new systems of health delivery, including managed care. According to a 1999 report of 51 state and territorial health agencies, 35 have full-time dental directors, five have part-time dental directors, and 11 have no dental director.<sup>3</sup>

HRSA has just signed a Memorandum of Agreement with the Administration of Children and Families to assess the dental consultation needs for the Head Start program nationwide. The present HHS/HRSA administration plans to double the number of dental patients seen in community health centers over the next 5 years, in addition to adding 1,200 new access points nationwide. The Robert Wood Johnson Foundation, with HRSA's participation and expertise, plans to invest \$19 million in establishing community-based dental education programs within our nation's dental schools.

It is essential that HRSA enhance its dental public health infrastructure to provide the leadership necessary to take advantage of these opportunities and to meet the ever-growing oral health challenges.

## **Central Point of Contact within HRSA**

Strong dedicated leadership is fundamental if HRSA is to rejuvenate the dental public health infrastructure within this nation. To provide such leadership, it is essential that HRSA establish a Central Point of Contact (POC) for oral health. This POC must have input into policy-making decisions, budgetary overview of all of HRSA's programs concerning oral health, and the authority to coordinate activities within HRSA's bureaus and other agencies.

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2 Bureau of Health Professions, *Health Personnel in the United States, Eighth report to Congress*, Rockville, MD: Health Resources and Services Administration, 1991, DHHS, n. HRS-P-OD-92-1

3 J.D. Shulman, L.C. Neissen, G.C. Kress, B. DeSpain, and R. Duffy, "Dental Public Health for the 21<sup>st</sup> Century: Implications for Specialty Education and Practice," *Journal of Public Health Dentistry* 58 (1999): 75-83.

## **Rebuilding the Dental Public Health Infrastructure**

From 1979 to the present, HRSA's field strength has steadily diminished from more than 400 federal oral health professionals to 5. In order to regain this strength, it is recommended that HRSA add ten federal dental officers annually until a sustainable cadre of 40-50 oral health professionals is available to provide leadership at the federal, state and community levels. Dental hygienists with public health skills and experience should be recruited to complement the work of the public health dentists and to build better partnerships with the dental hygiene profession. Until this cadre can be realized, consider retaining experienced personnel by extending the careers of select Commissioned Corps dental officers in key leadership positions beyond 30 years or offer such officers the option of converting to Civil Service.

### **Staff Development**

Adequate training opportunities for dental professionals will assure that viable pipelines of experienced well-trained professionals are available to transition into roles of increasing leadership. Training opportunities should enhance leadership in both dental public health and clinical arenas. Utilizing clearly defined career tracks and individual development plans, it is recommended that two to four federal dental professionals be sponsored for Masters degrees and two to four additional federal dental professionals be based half-time in residencies working toward appropriate board certification. These training opportunities should be offered on a continual basis to build and maintain HRSA's dental public health expertise. Based on a program's specific needs assessment, it is recommended that federal dental professionals be sponsored in appropriate clinical residences, such as general and pediatric dentistry.

This plan places great emphasis upon the importance of dental public health education. Essential to the support, implementation, and maintenance of the dental public health infrastructure across this nation is the development of dental public health residency programs, including:

#### **X *HRSA Headquarters-based residency program***

Currently, the Chief Dental Officer of the U.S. Public Health Service maintains and directs an American Dental Association accredited residency training program in dental public health. This residency is available to dentists who have completed a postdoctoral master's degree program in public health. Completion of the residency enables eligibility for certification in the specialty of dental public health.

Residencies are on-site training experiences with specified academic requirements. Since accreditation status is difficult to establish initially, the HRSA residency could technically be located under the auspices of the PHS Chief Dental Officer's residency program, but will be housed and managed by HRSA. This residency program could eventually be replicated at select field sites with board certified dental public health specialists from area universities.

#### **X *Joint State/HRSA Residency Programs***

This long-term training program will be modeled upon the Louisiana Demonstration Project. Working with the dental affiliate of the Association of State and Territorial Health Officers,

HRSA annually will identify a State Health Agency with high unmet oral health needs and a declining dental public health infrastructure. An experienced mid-career PHS dentist will be assigned to that state, where an individualized training plan, linked with schools of public health, dentistry and/or other entities as appropriate, will be devised for the assignee. Each assignment is expected to last from two to four years, depending upon the timeframe required for reestablishing the State Health Agency's dental public health capacity. The State Health Agency must make a commitment to continue to support a substantial dental public health program and presence after completion of the residency program.

X ***Competitive grant programs to assist dental public health specialty training programs***

Schools of public health are encouraged to partner with community dentistry departments within dental schools, state dental directors, and HRSA's regional dental consultants to assure that their curriculum reflects a strong dental public health influence. A competitive grant program will assure that graduates of these public health institutions are well versed in core dental public health competencies with diverse practical experiences assessing and promoting primary oral health among populations represented within community and migrant health, maternal and child health, HIV/AIDS, elderly, and homeless programs.

Collaboration between schools of public health and dental schools would assure that students and residents in training are exposed to the fundamentals of dental public health and are provided rotational opportunities within primary care settings. Joint DDS-MPH programs could be logical outgrowths of this collaboration.

All HRSA leadership positions should require a MPH or equivalent postgraduate training. If an individual occupying such a billet does not have this training, it is recommended that time and support be made available to pursue this degree. An assistant regional dental consultant position could be utilized as a training billet for professionals, including dental hygienists, in the dental public health career track.

### **Innovative Models**

To be effective in improving access to oral health care for underserved populations, additional HRSA dental public health professionals need to be assigned to collaborating federal agencies, state health departments, academic institutions, and community and migrant health centers. The successful assignments of CAPT Don Schneider to CMS, CAPT Jim Sutherland to the Louisiana Department of Health and CDR Steve Geiermann to the City of Chicago's Department of Public Health are examples of the importance and impact of these collaborative relationships. While such assignments provide valuable experience for HRSA dental professionals and builds HRSA's dental public health infrastructure, they also assure a cooperative and enhanced approach to improving oral health at all levels. HRSA must continue to explore and support other innovative proposals and partnerships such as the one being developed with a dental school in Region VI and another with the Indian Health Service and the NHSC being facilitated by Regions V and VIII.

### **Conclusion**

Establishing a strong dental public health infrastructure within HRSA is a prerequisite to addressing and meeting the oral health access needs of the underserved of this Nation. HRSA has focused the attention of both public and private sectors on the lack of access to oral health care and has laid the

groundwork for needed capacity building, leadership training, accessible service delivery and research. As the *Access Agency*, HRSA is well positioned to assume this critical leadership role in the confluence between oral health and public health. Establishing a focus for oral health within HRSA and building and sustaining a cadre of 40-50 federal dental professionals while establishing career development training opportunities for current and future oral health staff. This will be a catalyst for the development and enhancement of a national dental public health infrastructure poised to achieve HRSA's goal of moving toward 100% access and zero oral health disparities for Americans everywhere and being responsive to the National Oral Health Plan currently in development.

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