Re-engineering Dental Education to Improve the Public Good

John N. Williams, Dean
November 16, 2015
Welcome To Indianapolis
Indy Sights
Brief...History of IU School of Dentistry

- Dental School Founded 1879 as Indiana Dental College
- 1926 State Supported Program & affiliated with IU
- Integrated into IU Campus and Health Affairs
- Graduated 1st DDS class 1882
- History & Legacy for over 136 years!
Dr. John N. Williams

Speaker Disclosures

• Speaker to provide pertinent information regarding personal interest in any company or product related to the program to be presented.

  – Served as Volunteer: Commission on Dental Accreditation 2010-14; elected by ADEA (2010) to serve as one of four representatives
    • Chair, Commission on Dental Accreditation 2013-14
    • Chair, CODA Predoctoral Review Committee 2010-14
    • Chair, CODA Finance Committee 2013-14

  – Other Disclosures
    • *Dean, Indiana University School of Dentistry (Indianapolis, IN)
    • Board of Trustee member, Transylvania University (Lexington, KY)
    • *Board member, Delta Dental Plans of Kentucky (Louisville, KY)
    • *Consultant, P&G dentalcare.com internet strategies (Cincinnati, OH)

* indicates compensated
Re-engineering Dental Education to Improve the Public Good
NNOHA Keynote Program Objectives

• Understand the current trends in US dental education
• Know about the challenges to financial sustainability of dental education
• Understand the barriers to change in the current environment
• Explore alternative models of dental education and clinical care
• Delve into financial models to create win-win relationships between dental educational programs and public health facilities
CURRENT TRENDS IN US DENTAL EDUCATION
Source: http://www.adea.org/snapshot/
Total educational debt is the sum of college debt and dental school debt.

60% over $200K

$300 K
INDIANA UNIVERSITY SCHOOL OF DENTISTRY

2004-2013

0
6,000
5,000
4,000
3,000
2,000
1,000

DDS distribution
2,054 Employed
1,783 Specialty
140 USPHS
100 Cold Start
1,073 Various

No Standard Curriculum/Accreditation/Certification
CHALLENGES TO FINANCIAL SUSTAINABILITY OF DENTAL EDUCATION
Financial Challenges

• Loss of state financial support
• Offset by tuition increases
  – Publics look like Privates
• Need for capital re-investment in instructional, clinical and research facilities
• Alignment with Sponsoring Institutional Mission
  – Teaching, Research & Service
• Faculty Retention/Compensation
BARRIERS TO CHANGE IN THE CURRENT ENVIRONMENT
Barriers to Change

- Tradition – Solo Private Practice
- Perception of Dental Accreditation issues
- Fear of Loss
- High Demand for dental education – why change?
- Loss of control-faculty & practitioners
- Medicaid reimbursement too low
The Health Policy Institute (HPI) aims to be a thought leader and trusted source for critical policy knowledge related to the U.S. dental care system. HPI achieves this by generating, synthesizing, and disseminating innovative research on a variety of topics that are relevant to policy makers, health care advocates, and providers within the U.S. dental care system. Some of the key issues that HPI focuses on include the impact of health reform on the dental care sector, access to dental care for key populations, dental practice economics, dental care service delivery and financing, and dental education.
Cost is Major Barrier to Demand

http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx
Dental care Utilization (demand)

http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx
Flattening of Demand

http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx

NATIONAL DENTAL EXPENDITURE HAS LEVELLED OFF AFTER SEVERAL YEARS OF STEADY GROWTH. FLAT DENTAL SPENDING APPEARS TO BE THE "NEW NORMAL," AND A KEY DRIVER OF THIS SLOWDOWN IN THE DENTAL ECONOMY IS DECLINING DENTAL CARE UTILIZATION AMONG WORKING-AGE ADULTS.
DDS Earnings Decline

http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx
Supply Increase DDS Graduates

http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx
The Booming Medicaid Market

http://jada.ada.org/article/S0002-8177(14)00085-3/pdf

Healthy Indiana Plan (waiver) +350,000

Figure. The adult dental benefits expansion in select states. ACA: Affordable Care Act. Sources: The Henry J. Kaiser Family Foundation and United States Department of Health & Human Services.
Opportunities for Change

http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1015_1.ashx

Dentists have an opportunity to embrace the value agenda. While much of the shift away from old models of care to new, patient-centric value-based practice requires systems changes, providers are in particularly effective positions to influence that change. The ADA is helping to lead policy dialogue in this area.

Integrate CBDE Dental Education and FQHCs

ALTERNATIVE MODELS OF DENTAL EDUCATION AND CLINICAL CARE
Medical Schools Form Consortium to Examine Accelerated MD Programs

AAMC Reporter: September 2015

—By Robin Warshaw, special to the Reporter

In response to a looming doctor shortage and in an effort to reduce student debt, medical schools have formed a consortium to examine accelerated MD programs. The consortium includes NYU School of Medicine, the consortium is supported by the Robert and Florence Lehman Foundation and the Lewis H. and Isabel M. Kroeker Foundation.

Themes:
- MD Shortage/distribution
- Cost of student debt
- Acceleration/efficient education
Re-engineering Premise (CBDE Program)

(3) + (2) = 5 years

Dental Education (3) +
- 3 year DDS/DMD
- Highly Competency Based
  - Advanced Placement Biomedical Sciences
  - Online self paced learning
- Reduce cost to dental student [3yrs instead of 4]
- Use of dental team members to full scope of certification/license

Community/Public Sector (2)
- 2 year residency hybrid
- Blend DPH & AEGD/GPR elements (policy & practice)
- Loan forgiveness
- Use of dental team members to full scope of certification/license
3 + 2 Model (CBDE Program)

**Dental School**
- Biomedical Sciences
- Behavioral Sciences
- Pre-clinical
- Part 1 & 2 NBDE
- 40% clinical care (1,000 hrs)
- Qualifying Comprehensive Clinical Assessment

**FQHC**
- Interprofessional Education and Practice
- OH-Systemic Health
- Mission Driven - Societal
- 3,000+ hrs Clinical Care
- Dental Team Work
- Loan Forgiveness
- Population Health
- Accredited by CODA

Accredited by CODA
Rationale for 3 + 2

• Increases clinical experiences
• IPE & IPP
• Reduces student debt
  – 75% dental school
  – Loan forgiveness (FQHC)
• Satisfies Mission to Treat Underserved
• Expands Access
• Creates steady pipeline
**Need to Expand Access 2012**

http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf

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**KEY FINDINGS**

- More than 47 million people live in places where it is difficult to access dental care.¹
- About 17 million low-income children received no dental care in 2009.²
- One fourth of adults in the U.S. ages 65 and older have lost all of their teeth.³
- Low-income adults are almost twice as likely as higher-income adults to have gone without a dental check up in the previous year.⁴
- Bad dental health impacts overall health and increases the risk for diabetes, heart disease, and poor birth outcomes.⁵
Virtual Dental Education-FQHC Network Integration
Distribution of Dental Schools in North America

- Private State-related - 4
- Canada - 10
22.9 million patients
4.8 million dental patients (20.9%)
Health Professional Shortage Areas (HPSA) - Dental Health

HPSA Clinician Priority Scores

HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians.

Scores range from 1 to 26.

Higher scores equal greater priority.

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; July 9, 2012.

Note: Alaska and Hawaii not shown to scale.
Medically Underserved Areas - MUAs and Medically Underserved Populations - MUPs Designated Type

MUA/MUP Type
- Governor
- Medically Underserved Area
- Medically Underserved Population

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; July 9, 2012.

Note: Alaska and Hawaii not shown to scale.
Highlights:

- The majority of Health Center oral health providers are satisfied with their careers. Eighty-four percent of dentists and 94% of dental hygienists indicated intent to remain employed at Health Centers.
- The number one reason for choosing Health Center careers indicated among dentists and dental hygienists was that they “felt a mission to the dentally underserved population.”
- The majority of respondents indicated a high degree of satisfaction with their benefits and work environments, such as the quality of support staff.
- Twenty-nine percent of executive directors reported having at least one dentist vacancy, and of those vacancies, only 35.6% were longer than 6 months in duration.
- A large group of dental directors (39.8%) and dentists (26.3%) indicated that their salaries were greater than $140,000 per year (excluding benefits). While the most common salary range for dental hygienists was within the $50,001–$60,000 range, 24% indicated that their salaries were greater than $70,000 per year (excluding benefits).
- Many oral health providers rotated through a Health Center oral health program before working at a Health Center, including 40.6% of dental directors, 51.7% of dentists, and 60.1% of dental hygienists.
- Almost half of the respondents worked in private practices before working at Health Centers. In addition, a high percentage of respondents came to Health Centers immediately after graduating from school.
- Providers with more years of experience or who had been employed by Health Centers longer were more likely to indicate intent to remain employed at Health Centers.
- Providers who came to Health Centers because they felt a sense of mission; who perceived adequate interaction with Health Center medical colleagues; and who felt they had adequate administrative support, clerical support, and facilities and equipment were more likely to indicate intent to remain employed at Health Centers.
Access to Care

FINANCIAL MODELS TO CREATE WIN-WIN RELATIONSHIPS BETWEEN DENTAL EDUCATIONAL PROGRAMS AND PUBLIC HEALTH FACILITIES
Re-engineering Premise (CBDE Program) 

(3) + (2) = 5 years

Dental Education (3) + 
• 3 year DDS/DMD
• Highly Competency Based  
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• Reduce cost to dental student  [3yrs instead of 4] 
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Community/Public Sector (2) 
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• Loan forgiveness 
• Use of dental team members to full scope of certification/license
Win-Win Opportunities

**Dental Education**
- Lower cost to student
- Competency based
- Enhanced clinical experience/greater confidence
- Quality Measures
- Value Driven Care
- Integrate OH-Systemic Health

**FQHC**
- Co-op Program
- Experience with future DDS
- More dental personnel/ FTE added
- IP Education & Practice
- Offset growing Medicaid demand/ACA network expansions
“The results showed that the alumni with well-structured experiences rated the quality of their CBDE more positively and its impact on their professional lives as stronger than those with less well-structured experiences. They also had more positive attitudes concerning treating underserved patients and were more likely to treat underserved patients than their peers with less well-structured experiences.”
Existing CBDE Models

http://www.jdentaled.org/content/76/1/98.full.pdf+html

- ASDOH
- Kirksville
- Univ of Michigan
- Colorado

Let's Expand and formalize CBDE: 3 + 2 model
£
KEEP DREAMING AND STAY SCHEMING
Enjoy your trip through America!
Thank You!

Questions?

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