Can New Collaborations Decrease Costs and Increase the Value of Clinical Education in Dentistry?

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The distinctive characteristics of parent institutions, class sizes, community partnerships, and available financial resources are just some of the variables that influence clinical education programs in U.S. dental schools. As faculty and administrators, we share the common goal across all dental schools to produce competent new dentists in an environment that must balance teaching new care providers essential skills with providing patient-centered care in the most cost-effective manner possible. Schools collect data that define educational, quality, and business management outcomes in order to comply with the Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Education Programs and to report annual revenue and expenditures associated with these programs in the American Dental Association (ADA) Survey of Dental Education: Group III, Financial Management. However, given the confidential nature of the accreditation process and the protection of institutional identity in the financial reports, it is difficult for schools to compare their individual clinical operations to comparable institutions.

In this issue of the Journal of Dental Education, we are reminded of the value of sharing information between peer institutions about essential clinical enterprises. In his Perspectives article, Dr. John W. Reinhardt describes how a group of nine U.S. dental schools conducted a detailed financial survey of their clinical operations and shared the confidential results among themselves to define benchmarks of financial productivity and expenses. The nine dental schools were at the University of Illinois at Chicago, Indiana University, University of Iowa, University of Maryland, University of Michigan, University of Minnesota, University of Nebraska, The Ohio State University, and Rutgers University. These universities are in the Big Ten Conference, where the Committee on Institutional Cooperation was established decades ago as the athletic league’s academic counterpart. Reinhardt reports that the trusting relationship enjoyed among the administrators of these nine dental schools allowed for discussions about clinical productivity and expenses, business strengths and weaknesses, and best practices to determine how each school could improve its clinical fiscal sustainability.

In addition to this critical focus on financial management of dental education clinics, this issue includes Badger et al.’s call for attention to how dental schools prepare students to make decisions about their future clinical practice environments. Using data from the annual American Dental Education Association (ADEA) Survey of Dental School Seniors, these authors point to the increasing number of graduates choosing to enter a corporate dental practice environment, whether as an owner, employee, or independent contractor. Badger et al. question whether our current curricula prepare these students for future employment, suggesting that practice management education must reflect trends in practice model changes to include an emphasis on group practice models and interprofessional practice. Their recommendations for curricular enhancements focus on shifts in the business of dental practice; the legal structure of the corporate practice of dentistry and the dentist’s rights and responsibilities in this and other practice models; appropriate questions for students to ask about practice models they are considering; and the potential for interactive opportunities for students to experience various types of practice models to include interprofessional educational experiences.

While these articles highlight different aspects of dental education programs, they both recommend change at a time when dental faculty and administrators are acutely aware of the rising costs of dental education and their impact on student debt. The
ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing made several recommendations for lowering educational costs and reducing student borrowing. Those focused on both student and institutional roles including the following: promoting financial literacy and ensuring that the highest quality financial aid services and counseling are available to prospective and current students, residents, and fellows; continuing to pursue funding for scholarships from stakeholder communities; exploring alternative dental education models; enhancing advocacy partnerships with other dental organizations; and continuing to take a leadership role on issues related to the cost of dental education and student borrowing. In a recent survey of U.S. dental schools designed to examine their perceptions regarding the rising cost of dental education and its impact on student borrowing, the responding deans suggested that a number of actions could be taken to help lower the cost of providing dental education to students, especially regarding partnerships and collaborations, clinics, and institutional costs.

Reinhardt suggests that, like the Big Ten dental schools, other schools could benefit from sharing clinical information within small groups of peer schools selected on the basis of location, mission, or other factors. A new opportunity for sharing confidential financial information between schools with the express purpose of improving fiscal sustainability of their clinical operations is available with the recent ADEA Survey of Dental School Clinic Finances. Badger et al. suggest additions to the dental curriculum to prepare students to enter a changing landscape of dental practice. With intention, let’s explore best practices for using our clinical environments to teach students about principles of practice management. These changes seem particularly needed since, according to the 2014 ADEA Survey of Dental School Seniors, approximately 30% of the graduating students perceived the time spent on practice administration in their dental education to be inadequate.

The Reinhardt and Badger et al. articles can be viewed as a call for action or, better yet, a “call for collaboration” during transformational times in dental education and practice. A dental school’s clinical operations are increasingly viewed as valuable sources of revenue in the school’s total revenue; on average, they represent a higher percentage of total revenue than the support of state and local governments. The opportunity to learn best practices from other institutions related to reducing costs and increasing revenue is important to maximizing a school’s financial management. And, while we are sharing information about each other’s clinical operations in a new collaboration, let’s share with the same schools our clinically based enhancements to our practice management curricula.

Resources are available to inspire and guide change in the clinical education programs at U.S. dental schools. These include the white papers from the work of the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI), the ongoing efforts of ADEA CCI liaisons, additional articles published in the Journal of Dental Education, and educational tools published on MedEdPORTAL. It is time to view strong collaborations between dental schools as an important resource for best practices that can enhance our clinical education programs.

REFERENCES


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