As part of the evaluation of the Fifth Leadership Colloquium, Harder+Company asked participants to list three words that best described their experience. This graphic gives greater prominence to words that appeared more frequently.

All photos: Anne Carr
EXECUTIVE SUMMARY

At the Fifth Leadership Colloquium, the U.S. National Oral Health Alliance brought together more than 120 participants to examine the financing of oral health. This comes at a time when the United States continues to tackle significant economic and social challenges of many kinds throughout the country. Representing a diversity of oral health and health experiences and knowledge, the participants delved into the financing of oral health – past, present, and with a particular focus on the future.

The colloquium engaged participants in small-group and whole-group discussions. Presentations by contributors offered insights from their own experiences and raised questions for all to address. This summary booklet presents an overview of the discussions, critical messages, and potential next steps.

Financing Models for Oral Health

Unifying Messages Emerging from the Fifth Leadership Colloquium

Participants at the colloquium examined financing models for oral health. They shared their insights, knowledge, experiences, questions, and hopes for the future concerning oral health financing pathways. A set of unifying messages to support progress emerged through their discussions.

• Create a national advocacy platform for oral health policy and financing. Work across national, regional, and local arenas to coordinate a financial and social agenda that ensures optimal oral health for all. Align policymakers, payers, providers, and patients around a value-based payment system that is transparent. In a resource-constrained environment, maximize resources within the current health, education, and social services systems in order to increase the impact of those resources on oral health.

• Strengthen oral health and financial health literacy. Define “optimal oral health” as evidence-based, measurable, and cost-effective. Include community-level interventions that promote the relationship of oral health to systemic health. Enhance oral and financial health literacy by educating all people about the toll of poor oral health, including financial burden. Advance proven approaches that help individuals and families make good choices. Embrace the Triple Aim\(^1\) to help people make better, more informed choices by pursuing three dimensions simultaneously: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

\(^{1}\) For additional information about the Triple Aim, visit the Institute for Healthcare Improvement website at www.ihi.org
Examine oral health financing within the context of overall health care. Prioritize models that incentivize the collaboration of services across health interventions. When considering oral health financing, engage diverse stakeholders as partners, including dental and medical professionals, third party payers, health advocates, policymakers, community-based organizations, hospital emergency departments, the dental industry, and consumers.

Develop innovative, value-based, patient-centered reimbursement models. Promote a collaborative relationship between organized dentistry and the payer community. Move reimbursement models from volume-based to value-based as measured by improved oral health and overall health outcomes that incentivize health care providers, patients, and payers. Create a system that is patient-centered, quality-driven, widely available, affordable, and accessible for all people. Target funds to care for the most vulnerable, including young adults, seniors, and the working poor.

Gather data to measure and drive “return on investment.” To understand the cost of oral health care, utilize relevant data that is gathered consistently and collaboratively nationwide. Quantify the economic impact of poor oral health across the U.S. population, while demonstrating the societal and economic impact of good oral health care with respect to return on investment. Continually measure change over time in order to understand what strategies and level of support work together (or not) to improve optimal oral health for all.

Shift the focus from treatment to disease prevention. Underscore preventive care as an important national, regional, and local priority, where collaboration across all infrastructures is critical. Include oral health in integrated, interdisciplinary Accountable Care Organizations that address payment and service delivery, including prevention and treatment. Use education, oral health literacy, and communication to increase demand for preventive care.

Engage the local community to share educational and fiscal responsibility. Involve community leaders, oral health and other health care providers, local employers and unions, businesses, schools, and others to share educational and fiscal responsibility to change oral health

THE MISSION OF THE U.S. NATIONAL ORAL HEALTH ALLIANCE

The Alliance provides the platform for a diverse network of stakeholders to forge common ground in order to harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations across our country.
behavior in the community. Incorporate oral health into overall health education curricula, beginning with the education of young children and their families and extending to health professionals. Educate about the root causes of oral disease in order to strengthen prevention and manage the health of the individual and the community. A full set of high-level messages from the colloquium discussions is provided in Appendix I on page 44.

Envisioning Opportunities for the Alliance to Help Shape Financing for the Future of Oral Health

The facilitated discussion among all participants near the close of the colloquium explored how the Alliance can have a significant impact on the direction of the country as it relates to future financing for oral health. Participants proposed a set of objectives for the country to expand the reach of the colloquium to help strengthen financial approaches to improve oral health care for all people:

- **Envision a framework for health financing systems that can come together nationwide to improve oral health for all people.**
  Work with government leaders to organize networks of community, county, city, and state systems to strengthen the base for oral health financing. Begin by building on the connections within the more than “100 congressional districts” represented at the Fifth Leadership Colloquium to engage government leaders to work together to direct financing to support oral health for all.

- **Develop and draw upon best available information and data to engage local, state, and national legislators who can influence and drive health systems change.**
  Provide the “best available” data to legislators, the media, and the public in order to underscore the need for shared accountability when it comes to oral health.

- **Strengthen financial and oral health literacy throughout the country.**
  Develop highly effective national, state, and local education programs and campaigns to help individuals, families, and communities understand and choose the pathway to prevention, good oral health, and financial savings.

- **Support medical and oral health care providers as they work side by side to provide interdisciplinary health care for underserved people.**
  Continue to bring together talented people with a shared commitment and interest to advance the thinking about financing to improve oral health and health access for all people.

Desired Outcomes of the Fifth Leadership Colloquium

- **Increase our individual and collective knowledge about oral health financing and the complex opportunities and challenges we face as we focus on oral health for all.**

- **Understand the Affordable Care Act and other changes in the health care and oral health financing environment and their implications for care, community, and policy.**

- **Gain insight into the possibilities for change and come together on several common ground messages that can be shared with the rest of the country.**
The Alliance has begun to create a public trust for oral health. Strong connections are being established across the oral health and medical communities. Representatives of for-profit and not-for-profit organizations, government at different levels, and educators, health providers, community leaders, and other oral health stakeholders are being engaged.

Working together to forge common ground, the Alliance seeks to be broadly accountable to individuals and families who have little or no access to oral health. The Alliance has begun to build awareness about the primacy of oral health for the wellbeing of individuals, families, and their communities. As the Alliance strengthens linkages and partnerships across the country, diverse funding sources are being sought to support the core elements required to fulfill our shared mission.
Setting the Stage Together

Ralph Fuccillo
Founding Board Member
U.S. National Oral Health Alliance
Chief Mission Officer, DentaQuest
President, DentaQuest Foundation

In his welcome to the Fifth Leadership Colloquium, Ralph Fuccillo encouraged participants to bring their experiences to the dialogue. He acknowledged that some individuals in the room had participated in past leadership colloquia, while others were here for the first time. Ralph shared his perspective about the financial challenges facing the United States on a national, regional, and personal level, and about the role of the U.S. National Oral Health Alliance.

“Recently, we celebrated the second anniversary of the U.S. National Oral Health Alliance. Two years before that, many of us came together at the 2009 Access to Dental Care Summit convened by the American Dental Association. Together we tackled a serious question: What are we going to do, in the short and the long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people? We came out of the Summit with six priorities. Following the Summit, representatives of diverse oral health stakeholder groups came together in a process of cooperation that led to founding the Alliance. Over 300 people have joined the Alliance. In 2014, we will recognize the fifth anniversary of the Summit. Now we must ask ourselves: What can we achieve together in the coming year?

Across the United States, we are challenged to find agreement on our economic situation. As the national economy hangs over us, many individuals and families struggle with personal financing challenges. Oral health financing is one part of that vast range of issues. Think about the question we asked ourselves at the Summit about oral health care for vulnerable, underserved people. They are not in this room today. Individuals do not feel well because they have dental pain and are worried about how to pay for it. We come together at this colloquium to create common ground on behalf of people who need prevention and care. We represent those voices not here today. As we leave this colloquium tomorrow, we hope to have come together in areas of common ground and to have expanded our community to work together as we go forward.

In planning for this colloquium, we understood the complexities surrounding financing oral health. Clearly, we must explore the nature of financing from a range of perspectives. The beauty of this process is the opportunity for all of us to learn from each other and build knowledge together. We are not all dentists or dental experts, nor have our experiences been the same. In this room what I know and what someone else knows come together. That is the dynamic. Together, we will move ahead to explore different ideas and pathways to solve problems. We have a lot of energy in this Alliance ‘neighborhood.’ Let us build on this moment!”
We Are All Paying for Oral Health

Chester W. Douglass, DMD, PhD
Professor Emeritus of Oral Health Policy and Epidemiology
Harvard School of Dental Medicine

“Oral health does not come ‘free.’ Together we all pay for oral health. How much have we each paid? The Consumer Oral Health Dollar 2011 table shows the money we spend on dental care, over-the-counter consumer products, dental education and dental hygiene education, hospital dental care (in the emergency and operating rooms), community dental health programs, and related initiatives. These 2011 numbers are at least 10 percent lower than today’s actual numbers. Moreover, the over-the-counter (OTC) number is a low estimate in this table. For example, mouth rinse alone is a $1 billion product globally, as are denture OTC products. Then, in adding the very large toothpaste market and other OTC products, I believe that the total OTC expenditures are closer to $10 billion. In addition, the top-line products have become more expensive. Overall, more people are trying to maintain their oral health and reduce their dental care costs.

Let’s consider how to find common ground for our collective oral health. What is oral health? Oral health is the lack of disease in your mouth and the ability to speak, eat, and appear socially acceptable. Oral health is a combination of aesthetics, phonetics, mastication, and no disease. We want you to think about ways to finance initiatives so that individuals or groups of individuals might improve their oral health.

The Consumer Oral Health Dollar 2011

<table>
<thead>
<tr>
<th>Dollars ($)</th>
<th>Percent (%)</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>$108B</td>
<td>94%</td>
<td>Dental Care Expenditures</td>
</tr>
<tr>
<td>$4.5B</td>
<td>4%</td>
<td>OTC Consumer Products</td>
</tr>
<tr>
<td>$2.9B</td>
<td>2%</td>
<td>Dental Education</td>
</tr>
<tr>
<td>$16.2M</td>
<td>1.6% increase in first decade of 2000s</td>
<td>Medical Care—i.e. ER or OR</td>
</tr>
<tr>
<td>$34M</td>
<td>&lt;0.5%</td>
<td>Community Dental Health Programs</td>
</tr>
</tbody>
</table>

100%

Systems that Affect Oral Health

Financing
- Personal
- Private Insurance
- Public

Care
- Providers
- Practice Setting
- Services
- Patient

Policy
- Population Trends
  - Size
  - Aging
  - Diversity
- Local
- State
- Federal

Community
- School
- Public Safety
- Hospital
- Housing
- Business

USE THE E-COMMUNITY TO MAXIMIZE YOUR CONNECTIONS IN THE ALLIANCE

As a participant in the colloquium, you are registered to participate in the Alliance e-community: http://community.usalliancefororalhealth.org. Please engage as you contribute your ideas to conversations and launch new discussions. The e-community presents a critical opportunity for dialogue about how to achieve oral health for all – a dialogue that can stretch across the country.
The second chart provides a snapshot of four systems that affect oral health: the dental care delivery systems, social systems in the community, financing systems, and our policy systems.

1. Policy Systems: Policy occurs at the local, state, and federal levels. In today’s society, think about the demographic megatrend: aging. Consider that 10,000 baby boomers per day turn 65 years old. When we meet tomorrow, 20,000 more baby boomers will be 65. Also consider the school, housing, and business systems in our communities. Our community populations are becoming more diverse.

With respect to diversity, we have a president who nine years ago figured out ‘the role of diversity in this country.’ Consider this dynamic: by 2048, Caucasians will be the minority in this country. The current first-year dental students will be responsible to provide care to 400 million people in the United States – 90 million more people than today. This trend will strongly impact health policy.

2. Financing Systems: Consider the personal financing that we pay for out-of-pocket or through public or private insurance. All three of these funding sources come from employment earnings.

3. Community Systems: Think of systems in your community. Consider housing systems, such as assisted living for the next 20 to 30 years. Also consider future business systems and food systems. If you are striving to improve the oral health of individual people, you will need to consider junk foods and soda in public schools.

4. Care Delivery Systems: Dental care delivery systems are comprised of dental and health care providers in a variety of settings, delivering preventive, diagnostic, and treatment services to an increasingly diverse patient population.

All these systems come together in a framework that we want you to consider during our discussions at this colloquium. Think about these four systems in state, county, city, and federal government.

In thinking of financing systems, consider anything we can do to improve oral health financing that will lead to no disease, as well as teeth with which you can speak and eat. That sets forward the framework for exploring the ideas that we ask you to think about throughout this colloquium and beyond. My personal observation is that the work of the talented people who have come together in this room will lead to better oral health for more people. We hope and expect that your commitment, interest, and attention to financing alternatives will lead to ideas that somewhere and somehow move us forward in financing benefit plans so as to improve oral health for a greater number of people in our society.”

SIX ALLIANCE PRIORITY AREAS

- Prevention and public health infrastructure (Focus of the Second Leadership Colloquium)
- Oral health literacy (Focus of the Third Leadership Colloquium)
- Medical and dental collaboration (Focus of the First Leadership Colloquium)
- Metrics for improving oral health (Focus of the Fourth Leadership Colloquium)
- Financing models (Focus of Fifth Leadership Colloquium)
- Strengthening the dental care delivery system (Focus of Sixth Leadership Colloquium)
COLLOQUIUM UNDERPINNINGS

Colloquium Approach – Working Toward Common Good

Elaine Kuttner
Alliance Consultant and Facilitator
Principal, Cambridge Concord Associates

“All gathered here today bring an impressive range of perspectives to this Alliance platform. Our opportunity is to work together toward a common purpose. The comedian Lily Tomlin once commented: ‘After all, we are all in this together by ourselves.’ At the Alliance, we go about our conversations in a special way. Building on our diversity of knowledge, opinions, and values, we will work together to arrive at a place of common ground.

Consider our colloquium focus on financing models for oral health. Many people feel completely at home delving into numbers and financing, while others back away. At times, that may present a potential barrier. Yet at this colloquium, together we will work through challenges we may face.

We will use the lens of the financial and funding system to explore what must come together to effect change for oral health for all. A systems approach is in play here: policy, funding, care, and community. The four parts of the system work separately and together. While here at this colloquium, fully engage in discussion with as many people as possible who represent different points of view. Each of us will take away insights as to how we individually and together can strengthen oral health care for all people in this country. Working together, we will strengthen the outcomes of the Alliance.”

Building the Platform on Common Ground

Two Board officers shared their insights into Alliance work.

Vincent C. Mayher, DMD, MAGD
Alliance Officer and Founding Board Member
General Practitioner, Haddonfield, New Jersey

Consistent Underpinnings of All Alliance Work – Trust and Common Ground

“I will address a topic that is ‘near and dear’ to me and my colleagues on the Alliance Board. We operate from two guiding principles: trust and the pursuit of common ground. From the get-go four years ago, we were as diverse a group as we could be – with different backgrounds, ideas, and philosophies. If we were to move forward and make things happen, it was absolutely necessary to establish a set of ground rules.

As a dentist in private practice I was used to mingling with other dentists in private practice who thought like me. On the Alliance Board, I was sitting at a table with a new, very diverse cast of characters with backgrounds ranging from public health, medicine, government, industry, and philanthropy to education and more. I felt like young Luke Skywalker in the first Star Wars movie, stepping into that intergalactic pub filled with an array of strange space aliens from all over the universe. I am sure others thought the same about me. However, unlike Luke, I didn’t have Obi-Wan Kenobi watching my back.

As I was sitting at that table four years ago, wondering how I got there and what to do, somehow a voice in the back of my head made it through: ‘Use the Force, Vinny.’ What was the Force? In this case, the Force defined the parameters of how we, as a group, were to work with one another if we were to begin to address our charge and forge a united effort for oral health.
We began with the basics, a starting point: we all agreed that access to quality oral health care was rapidly waning for so many, and something needed to be done about it. What do you know! We found common ground! We also realized that if we were going to work together to address this crisis, we would need to take a leap of faith. We would need to trust one another despite our differences.

Common ground and trust became the underpinnings of the Alliance – our Force. We further developed this into our Working Norms, which I share with you so that we can apply them to how we work together over the next two days. As you sit with one another, you may not agree on certain issues. But we ask that you honor differences of perspective and seek to understand others’ points of view. Thoroughly explore an issue before assuming knowledge. Don’t be afraid to take a risk. That is, don’t hold back and suppress your opinions in order to go along with the prevailing view. Speak up. Conversely, don’t be afraid to change your opinion if that proverbial light bulb turns on. Always strive for common ground so that you can make decisions through consensus.

Over the years, utilizing these Working Norms has built an atmosphere of trust and openness. I can tell you sincerely they have served our Alliance Board well. From a personal perspective, this experience has been refreshing. Don’t get me wrong, I still have my own ideas and opinions on issues within my profession. And those ideas and opinions are probably at odds with others on the Alliance Board. I can communicate these ideas knowing full well that if there is a way to find common ground within our differences, we will make every effort to do so. At the end of the day, no matter what, we will remain friends and colleagues with a profound mutual respect for one another.

As you participate today, if you find yourself sitting next to an intergalactic space alien, use the Force. Make an effort to get to know him or her and share ideas. If you already know people, get to know them better. I promise that you will not regret it.

We have a lot on our agenda. I don’t have to tell you that within the dental profession, financial challenges play perhaps the major role in preventing access to care. This challenge does not start simply with people unable to afford dental care. It starts much earlier. It is also about that first-year dental student opening up her first tuition bill and suddenly realizing that, by the...
time she graduates, she will be a half million dollars in debt. It is about those who cannot afford to eat a healthy meal, and consequently are forced to eat junk food. This problem is pervasive. All of us have to work to solve it.

If we are going to make things happen – at this colloquium and especially after we leave each other’s company tomorrow – we have to take a leap of faith. Finding common ground and consequently speaking with one voice is the only way possible for our diverse community of stakeholders to be heard when we state our case to the powers that be. That is how we will make real progress in getting much needed help for those who depend on us.”

Caswell A. Evans, DDS, MPH
Alliance Officer and Founding Board Member
Associate Dean for Prevention and Public Health Sciences
University of Illinois at Chicago, College of Dentistry

Joining Our Journey to Increase Oral Health Access for All

“As the Alliance leadership envisioned the critical objective for access to oral health care for all, we embarked on a series of colloquia. At each colloquium, unifying messages evolve from the participants’ discussions and contributions. Working together, we are all part of a journey to increase oral health access for all.

Medical and Dental Collaboration
(November 2011, Washington, DC)
The need to stay focused on the 'overall health of the individual' was a key message sent from the first colloquium. Oral health must be an essential and routine dimension of comprehensive care for all people. As colloquium participants, we underscored the need to strengthen interprofessional and patient education, integrate delivery and financing systems, and expand the dialogue on oral health.

Prevention and Public Health
(March 2012, Chicago)
How to advance the prevention of dental and oral disease through public health efforts was at the heart of the second colloquium. Together, we underscored the need for new public-private partnerships to strengthen oral health in the United States. Shared points of view evolved to create an expectation of wellness and health, assure an equitable and just system, engage the public fully in their own and their family’s oral health, and implement a financing strategy to support prevention.

Oral Health Literacy as a Pathway to Health Equity
(June 2012, San Francisco)
A four-part systems approach – Community, Care, Funding, and Policy – framed our discussions at the third colloquium. We moved toward common ground regarding opportunities embedded in each system. In particular, who must partner to make significant progress? In shaping unifying messages, the participants underscored the objective to direct attention to prevention, shift policy and financing, educate the public, connect and partner, and advocate for all people.

Metrics for Improving Oral Health
(November 2012, New Orleans)
The objective to develop and draw attention to critical metrics for improving oral health was examined during the fourth colloquium. As the participants shared knowledge and experiences, a set of unifying messages evolved: Create a standardized approach to gather oral health data. Develop a national oral health plan. Examine oral health cost, financing, and outcomes. Use data to build a nationwide dialogue about oral health. Provide information to help people take action.

Today, we convene our Fifth Colloquium to examine Financing Models for Oral Health. The Sixth Colloquium to be held in Washington, DC in June 2013 will focus on Strengthening the Dental Care Delivery System.”
Oral Health Financing and This Leadership Colloquium (Discussion #1)

Discussion Questions

Why did you choose to attend this colloquium on financing models for oral health? What can you contribute to this platform of common ground? If you attended earlier colloquia, what about the earlier experiences led you to participate today? What would you say if someone told you they do not go to the dentist because they cannot afford it?

In their initial table conversations, the participants discussed their own experiences, the nature of their work, and what they hoped to share and learn over the two days. From that discussion, examples are provided about the impact of oral health financing programs and policies affecting the participants’ lives and those around them. Each point below reflects the thoughts of one participant. (The list of colloquium participants is provided in Appendix II on page 46.)

Personal reflections on oral health and financing

- I was fortunate that my parents appreciated the need for dental care even though they could barely afford it. We received preventive care at school.

- The GI Bill was important to my family; it helped my father get an education, and had a major impact on our family’s ability to get oral health and medical care. The military service model was different than the commercial model where there is less focus on population care.

- The dentist’s office was often a place of pain, though eventually my perceptions changed as dentists provided more preventive care.

- In past years, oral health was considered optional since you will lose your teeth anyway, and such thinking continues to have an impact today.

- The biggest event was community fluoridation, so that I wouldn’t wake up like my parents each day with toothaches.

Observations about participating in the leadership colloquium

- Because I am experienced in finding care for those who have no insurance, I bring that perspective.

- Given that my past experience required the valuable contributions of others, I recognize the need to involve many kinds of people in these conversations.

- Funding will change dramatically in the coming years, as we move to financing for value and outcomes.

- I hope to find ways to fix Medicaid financing for dental care.

- My focus is on children’s oral health and policy experience. Interdisciplinary collaboration between medical and dental providers is essential.

- My objective is to gain outside-dental perspectives.

- In my state, individuals in need of dental care go to the emergency room.
How can we address the fact that some people don’t go to the dentist because they cannot afford it?

• Health literacy is key to making a difference.

• Talk with legislators about the need for more resources to support oral health.

• Help people understand how they can afford coverage.

• Educate the public about oral health and the value of prevention. Some oral health problems are progressive and not resolving; they cost more, hurt more, and never stop on their own. Reasons, other than money, such as transportation barriers, contribute to why patients do not seek dental care.

Examples of questions raised by individual participants

• How can we make dental care affordable? How can we ensure funding for what works? How will we know what works?

• Why is provider enrollment in Medicaid decreasing?

• How can Head Start play a consistent role in addressing the needs of the underserved?

• Why are some dental professionals afraid to see children?

• We need more medical-dental collaboration; the mouth needs to be part of the body; and dentists need more training about overall health. How can we accomplish that?

• Because new dentists have significant debt when they leave dental school, they have to make money to pay off their loans. How can society address that challenge?

Oral Health Financing Timeline: 1930s to Today (Discussion #2)

Discussion Questions

Consider the timeline that was laid out. Choose one point on that timeline or one era that was particularly memorable to you because of the effect it had on your personal (or family) oral health decisions or on your work. Briefly share with the rest of the group how the programs and policies created during that era impacted your life and/or work. Engage in a table-wide discussion about the evolution of oral health financing and reimbursement over time, and the opportunities and challenges those changes have created for various people and populations. How do you feel about our current situation?

Though the table discussions began by considering the past, they quickly focused on the realities of today, as well as aspirations and expectations for the future. Individual statements by the colloquium participants and group ideas are gathered together by topic area.

Past and Present: Contrasts, Concerns, & Progress

• The impact of Medicare and Medicaid

The creation of Medicare and Medicaid shaped an environment to help address some of the inequities for those who could not access healthcare services. Issues concerning coverage vary by state. Recognizing the opportunities for a good livelihood, students chose the dental profession. One participant observed that prior to Medicaid, capitation was positive; and dentists could expect to make a
good living. Medicaid began to present obstacles for dentists, another participant observed. As coverage became more limited, some dentists had to “fight for services for patients.” Third-party management of Medicaid in the 2000s seemed to cause “more problems than good.” The decision not to include dental care in Medicare seemed to undermine the future for baby boomers accustomed to dental insurance.

• **The role of employers for insurance benefits**
  In the past and still today, dental benefits attract high-quality employees to a company. Most employees don’t understand that their company could have purchased a “better” dental plan. Dialogue should take place between the employer and the employee as to the suitability of a comprehensive dental plan.

• **Public health programs supporting prevention**
  Community water fluoridation and fluoride in toothpaste had a positive impact on oral health and gave hope that individuals would not end up like their parents with numerous dental cavities – for example, greater use of sealants today versus fillings in the past.

• **The vital relationship between oral health and overall health**
  An interdisciplinary approach to oral and medical health will strengthen the focus on prevention. Yet dental care is not recognized by all as primary care; rather, it is viewed as elective, which makes it subject to budget shortfalls. This country must shift from a focus on dentistry as primarily treatment to an emphasis on prevention, which supports the relationship of oral health to overall health. Create opportunities for medical and dental collaboration². Increase reimbursement for oral health when tied to overall health outcomes. Because significant challenges exist for many individuals and families to be able to afford both a standalone dental plan and a medical plan, create opportunities for integrated plans. A risk-assessment approach focuses on how all patients can become or remain healthy.

• **Incentive to strengthen oral health**
  Some plans are using provider incentives to promote behavior change, such as incentives for 75 percent of children getting sealants. Hoping to encourage greater preventive care, a range of organizations are focusing on the mouth as an access point to the body for other diseases. Diagnostic codes support risk-based care versus the current model of one-size fits all. Major companies have completed or have studies underway investigating the relationship of oral and medical health and implications for cost and funding.

• **Systems that separate oral health from the whole body health**
  Most medical care providers do not view the mouth and oral health as part of their scope of practice. Oral health and medical health often remain distinct because the systems of care that support these aspects of overall health are often separate. To not have dental care included in Medicare was viewed by some individuals as “bad public policy.” Insurance is billed differently because dental care payments are based on treatment codes, while medical care is based primarily on diagnosis codes and the severity of that diagnosis. The dental system tracks output instead of outcome – making it difficult to develop evidence-based dental practices. Data collection to support the cost/benefit analysis of dental services often misses pertinent medical information, such as information about ER visits or other associated medical interventions, which presents an opportunity for improvement or change.

• **Supporting a family-centric approach to prevention and care**
  When we emphasize preventive care, we invest in

our future. How can we move from treatment to prevention for children and families? How do we incentivize prevention? How can we utilize risk assessment and diagnostic codes to reimburse appropriately for preventive dental efforts? We must use all avenues of primary care (medical, behavioral, and dental health) as entry points for providing family-centric oral health. Consider this a direct investment in our future, which will reduce the overall cost of oral health care. Dentists need more training about care for all family members across the lifespan, including the very young, pregnant women, and the elderly. The Affordable Care Act addresses children primarily; though how it should be operationalized remains a question and an opportunity.

- **Expand understanding of the importance of health literacy**
  Significantly increase health literacy in dentistry across the country. Educate leaders within schools, communities, and the nation to focus on prevention. Get the media involved in significant ways, such as emphasizing the relationship of good oral health leading to overall health, self-esteem, and the ability to get employment. Health is less expensive than disease. Teaching people to be healthy costs money — and that is money well spent. About 20 percent of the population (high risk) presents with 80 percent of the disease. Who pays to educate the public to value and utilize health and wellness programs?

- **Rescue funds for children’s health and oral health programs**
  Reductions in state and federal budgets have had an impact on programs to support health and oral health education (e.g., Head Start) and healthy food (e.g., Meals on Wheels). As some states have cut their funding for oral health for children, they have experienced an increase in missed school days due to dental problems.

- **The critical nature of oral health coverage in Medicare**
  Medicare costs are pulling money from health systems. Accountable Care Organizations and others recognize that leaving out dental health from overall health will not allow people to meet their overall health goals. Baby Boomers who are accustomed to having dental insurance will “not know what hit them” when they enroll in Medicare. Though Medicare-covered diabetic patients receive coverage for other diabetes-related issues, they do not receive coverage for oral health preventive care or periodontal treatment.

- **Special needs for older adults and nursing homes**
  Older adult patients are buying what they believe is insurance, but it comes with long waiting periods and broad restrictions. The growing number of older adults can provide a substantial voting constituency to support new oral health initiatives. Expedite
reimbursement for dental care for nursing home patients, as it is difficult to implement even free programs in nursing homes. Expand knowledge of the incurred medical expense reimbursement mechanism for residents of long-term care facilities who are Medicaid-eligible. Consider the Mouth Care Without a Battle program to alleviate conflict over brushing the teeth of nursing home patients.

- **Community-based prevention efforts**
  Support sealant programs in schools and the use of fluoride varnish. Treat dental caries as an infectious disease. Expand the population of caregivers to prevent dental disease. Given the increasing rates of oral cancer in younger adults due to the human papillomavirus (HPV), support and explain vaccinations for boys and girls.

- **Focusing on oral health across the lifespan**
  Clarify and expand anticipatory guidance about oral health care across the span of an individual’s life. Start now to teach consumers about the oral health risks associated with various ages across the lifespan. It is “ancient history” to expect to lose your teeth by age 40. Employ new language to start the conversation. Focusing on risk management can save a lot of money and pain.

- **Envisioning the future**
  Increasingly move into a world with greater attribution and accountability. Demand greater responsibility for actions to meet individual and community needs. Health plans may convert to defined contribution plans where employees will choose, though the risk is that employees will view dental coverage as optional or a luxury.

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**Overview of the Affordable Care Act and Implications for Oral Health (Discussion #3)**

**Discussion Questions**

_Having heard this morning’s presentation on the Affordable Care Act, take a few moments at your table to identify one question that the group would like to put forward for further discussion or research. There is no need to answer the question at this time, but rather to identify an important area for future consideration._

The colloquium participants put forward a range of questions that require multidisciplinary discussion and research. They have been categorized by topic areas. Please visit the Alliance’s e-community to contribute to the discussions underway (web address below). You may also choose to initiate a discussion around a topic of particular interest to you. Following are questions that each roundtable put forth for consideration:

**Regarding the Affordable Care Act (ACA)**

- What can be done to ensure that the pediatric oral health benefit is implemented as described in the ACA?

- What will be the response to the unintended misses and consequences after full implementation of the ACA? How will this affect planning for the infrastructure necessary to ensure optimal oral health for all? How can we keep up with the various changes in the implementation of the ACA?

- What financial sustainability is needed to sustain the Medicaid Expansion?

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**Voice Your Thoughts on the Discussion Questions**

_in the Alliance e-community with colleagues across the country:_

http://community.usalliancefororalhealth.org.
Role of exchanges (Health Insurance Marketplaces)
- Now that we are on the horizon of exchange and expansion activation, how will the gaps or oversights concerning oral health play out?
- What is the status of the children’s oral health benefit in the exchanges/marketplaces? Can the rules and regulations process ensure optimal designation for children and add adults?
- How can we make sure there is equity in the application of rules and in the federal subsidy of cost sharing under medical and standalone programs?
- Should there be equity in the federal subsidy of cost sharing under medical and standalone programs?

Cost of care – value vs. volume
- What is the cost of treating oral disease over the lifespan?
- How do we move from an incentivized, volume-based dental delivery system to an outcome-based model? How can it be funded and how do we assure that individuals with severe issues get the treatment they need? As we transition, how do we fund both?
- How do we learn from the various models (e.g., federal, state, or a combination) with respect to value, cost, and quality of health care? How do we evaluate these by objective criteria developed by experts, stakeholders, and providers, using measures that are realistic, appropriate, and defensible over time?

Range of providers
- If Medicaid reimbursement is poor, how can private practice dentists be encouraged to contract with Federally Qualified Health Centers (FQHCs) to maximize revenue and access to care?
- How do dentists provide health care for their employees?
- If employees have coverage, will children get care? Are there enough providers?
- How can financing systems (under the Affordable Care Act) pay for oral health prevention by primary care providers in FQHCs and elsewhere?

Accountable Care Organizations (ACOs)
- How can oral health be included in an ACO? How can we integrate oral health into overall health and the ACOs? How does an ACO quantify and/or qualify the value of that inclusion?

Educating consumers
- How can consumers be encouraged to buy coverage for children since it is not required, but is offered?
- How can individuals get a better understanding of the ACA and gain the ability to explain it to others? How do we establish common goals? Given the need for basic information on what is covered and the consequences of choices, where can people get that information in plain language?

Large and small groups
- How does the law define small and large groups? Can individuals band together to form a small or large group? Could the local Veterans of Foreign Wars be recognized as a small group?
Coverage for adults
• What are the opportunities through health care reform to provide oral health care for adults? How will we address the needs of older adults not in long-term care facilities? Will a window of opportunity open when the number of older adults increases to a certain percentage of the population?
• What do we do about those left out or not addressed by the ACA? What can we do nationally to get states to expand dental services to adults? How can we get states to eliminate the optional status of adult dental coverage in Medicaid?
• What can the Centers for Medicare and Medicaid Services (CMS) do to inform those decisions and show what works?

Enrollment options
• How will we educate consumers as to what enrollment option is best for a given purchaser?
• What are the rules for purchasing dental insurance inside and outside the marketplace exchanges? Is it an offer requirement or required purchase?

Role of Partners in the U.S. National Oral Health Alliance
• What role can the Alliance play in reconnecting oral health benefits to medical benefits?

Financing Oral Health: A Systems Approach (Discussion #4)

Discussion Questions
The current situation and projected future of oral health financing tend to engender an array of personal, social, and political reactions. What are your reactions? What are the most important opportunities that we should leverage as we work toward our “shared vision of optimal oral health for all” in this new financing environment?

The table discussions focused on opportunities, as well as the risk of lost opportunities unless steps are taken to embrace a strong systems approach. The participants shared a range of ideas and recommendations about risks and opportunities in the evolving financing environment.

Strengthening prevention and risk-based care
• As dentistry strives to operate as a prevention-based methodology, consider how best to work toward a prevention focus that integrates oral health with overall health.
• Focus on the social determinants of health. Identify successful education opportunities to transition to assessment, prevention, and guidance for all patients across this country.
• For some, the current business model remains “drill and fill.” Examine how to implement risk-based care responsibly in a way that emphasizes disease management over surgical intervention.

Medical and dental collaboration directed at overall health
• The integration of medical and oral health is critical today. Commit to climbing out of our dental and medical silos to focus on collaboration. Can we build a system that rewards collaboration? Challengers ask whether dental health could “slip into obscurity” if the delivery systems are not kept separate. Twenty years ago, oral health was included in all health reform efforts. Can we replicate that?
• How can we move toward a true integrated system of medical and dental care? How can we create and implement provider and patient incentives to strengthen the patient’s oral health, while integrating the financing system to make it work? Can we separate funding from the delivery of care?
• Interprofessional education represents a new opportunity. Focus on moving oral health and medical health curricula closer together. Leverage the Affordable Care Act funding to promote such collaboration.
Financial management, sustainability, and cost

- To increase attention to financing for dental health, one must understand the cost of dental disease and its impact on overall health. Educate oral health stakeholders (providers, policymakers, and the public) about oral health payment, prevention, and care. Incentivize people to manage both their disease and the cost of the disease.

- Financial sustainability concerns are increasing. The system is fragmented and needs to be changed. How can we prepare for greater demands for health and oral health services? Do we need a complete rethink about funding? Do we know what “basic dental coverage” for adults is today? Do we have the right definitions for oral health and medical health in order to facilitate reimbursement strategies? We need more consistency in defining/determining medical necessity. Consider moving to national standards, including standardized definitions.

- If we were starting from scratch, how would we shape funding for the future? How can we align payment systems to drive the care cycle with greater effectiveness and efficiency? Will we move away from fee-for-service and redefine a somewhat amorphous payment methodology? Should we consider a capitated managed care model? Can we move the global payment system into private practice systems?

- At the federal level, integrate programs directed at chronic disease and dental disease. Consider integrating similar “at risk” diseases, such as cardiovascular, diabetes, and dental. How do we ensure that dental does not get pushed aside in the overall health focus? Consider that the mouth can be a portal to good health or disease. States should use this rationale when seeking federal grants in this area.

- Behavioral and environmental factors have a major role in oral health and disease. Access to oral and medical health plays a significant role, as does poor oral hygiene and diet. Risk-based care can move patients to change their behavior or seek preventive care. An example might be individualizing recall appointments based on the periodontal status and needs of the patient. Strengthen the preventative oral health system with the use of risk assessment and dental diagnostic codes.

- Align the incentives. Improve the outcomes. Examine more cost-effective ways to deliver care. Reduce the costs. The current system is wasting money. Promote transparency by sharing statewide cost and service data. If we don’t have “accountable metrics,” we cannot measure progress. If we don’t know how to measure oral health, who will? “What gets measured gets managed.” (Peter Drucker)
• What is the role of evidence-based dentistry? Is it to educate the patient? Is it to educate the professional? From the American Dental Association: “Evidence-based dentistry is based on: the best available scientific evidence, a dentist’s clinical skill and judgment, and each individual patient’s needs and preferences.” All three must be balanced in providing quality patient care.

The Affordable Care Act (ACA)
• The prominence of oral health in the world of public policy has increased over the past 20 years. Further educate policymakers about the cost of the burden of disease. What is the actual economic impact?

• The ACA came about to change the system by focusing on cost savings as the result of prevention. We can see a dramatic difference by state in how the ACA affects Medicaid oral health. How can we best educate the public about the ACA? Is the ACA losing its potential to be effective?

• Most people in this country are employed by small employers defined as 50 employees or fewer currently and will be 100 employees or fewer in 2016 according to the ACA. Though many policymakers think health is “all taken care of,” the majority of people will find themselves in the public medical and dental health programs.

Oral health education and community support
• Given a lack of understanding about oral health, we have an opportunity to educate and promote oral health literacy. Lack of outreach to the public is a serious barrier for patients in some states. Define oral health for all to understand. Engage communities to educate and build cultural competence around oral health. Educate all medical and oral health providers to consider good oral health as a critically important lifelong continuity that requires family and community support. Educate consumers to take responsibility for their own oral health expectations, behavior, and results; they are the decision-makers. Bring the best minds together to understand how to change behavior positively.

• Expand prevention efforts for children and families. Encourage the oral health industry to become an ally to schools. Improve Medicaid for children; add oral health education into the prevention payment scheme. Educate parents about oral health care, along with their children.

• Be proactive. At the community level, engage in discussion about the welfare of all individuals and families. Be attentive to the needs of the working poor. Now emerging is oral health integration in the patient-centered medical home (PCMH) environment within community health centers.

• Develop a set of principles to establish and guide the framework for preferred oral health outcomes. Reward people for good health. Good oral health can prevent dental issues and reduce expenses. Today, some companies participate in group dental plans that reward good dental health.

Involving the states
• Uncertainty on the part of states represents a problem. How can we engage states to focus on dental benefits? With federal money available, we have an opportunity to add “adult dental” back into state benefits. The federal government needs to provide incentives to states to expand Medicaid and other humanitarian efforts.

• Pilot a financing arrangement in different parts of the country for a few years. Just adding dollars will not work. Address variability across states. How can we work with states as they design the Capability Maturity Model Integration (CMMI) grants?

• Set up benchmarks for oral health improvement in order to get additional funds from grants and foundations. Explore funding opportunities from private foundations to build a healthier approach to oral health.
Opportunities for innovation

- Look at innovation in the states. Identify promising approaches to strengthen care and lower costs, and learn from those innovations for use in other parts of the country.

- Focus on opportunities for innovation in care delivery, e.g., school-based programs, teledentistry, affiliation with FQHCs, and outside-the-walls dentistry. Health centers are addressing dental with different approaches and levels of funding.

- Diagnostic coding for dental health represents an opportunity to link procedure codes for services provided to the underlying condition that is being addressed by the treatment. That link will increase our understanding about the oral health of the community.

Implications for Care (Discussion #5)

Discussion Questions

It is clear that our approach to financing and reimbursement for dental care in this country is based on complex business models. Moreover, it requires that individualized patients and providers continually make very difficult choices that have long-lasting effects on health and well-being. Keeping in mind the opportunities and challenges we identified in previous table discussions: What are your ideas for addressing the ongoing struggle between what level of care is available and what is affordable?

The participants discussed dental care from a wide range of perspectives. Such concepts as availability and affordability, strengthening the patient focus, and oral health cost and affordability were discussed. Examples of their shared ideas are provided below.

Availability and affordability of care

Examples: Make affordable dental care available to all individuals and families – with adequate networks and workforce. What level of care do people want? Is it the same as what they need or what they receive? Who defines appropriate care? Some people view oral health as a privilege, rather than an expectation, necessity, or aspiration. Dental care must be individualized to address the needs of each patient. Basic levels of services/care should include prevention, disease control, eliminating infection, and urgent care.

Considering prevention and related ideas

Examples: Shift people away from expecting treatment toward anticipating prevention. We need data and evidence about good oral health care and prevention. We need a change of philosophy in treating patients. The surgical model of care is obsolete. Consider Early Childhood Caries projects and early intervention. Encourage Federally Qualified Health Centers (FQHCs) to focus more on prevention in order to enhance greater access to care. Some dental insurers are beginning to incentivize prevention (such as sealants); and some insurers send out notices to patients and reward the dentists for providing the sealants. DentaQuest’s prevention-based incentive program3 represents an incentive model built on prevention and early diagnosis. Given that you get what you measure, measure the right things.

Cost of care, benefits, and options

Examples: Dentists should offer options in their treatment plans for patients. Options are always available for low-cost-interventions, but they are not always offered. The best option is not always the most expensive. Make effective treatment affordable. Expect dentists to explain treatment options. Education helps patients have more realistic expectations and make fact-based decisions. Move away from trying to protect patients’ pocketbooks and focus on what patients need. Approach the Federal Office of Personnel Management for examples of datasets for evidence-based decisions.

Patient and family focus

*Examples:* Address what the patient needs. In the past, not all patients felt comfortable asking questions of their health care providers; today patients are becoming more involved in their health and treatment – feeling empowered. Provide patients with all the information they need to make informed decisions. Build accountability for patient-centered health results, e.g., transparency, data availability. Patients should provide feedback to the dentist.

Communication and messages

*Examples:* Identify advocates to provide a public presence, such as the mayor of a major city or a similarly prominent voice. Build oral health literacy across the country. Collaborate on identifying and promulgating unifying messages to advance the importance of oral health (e.g., the advances made in oral health literacy outreach to Native Americans in Arizona⁴). Launch a public oral health promotion. Teach people to value oral health. Some people do not access oral health although they have access. It is not a priority for them.

Dental and medical collaboration and integrated care

*Examples:* Connect medical and dental on the academic and institutional level in order to more fully address patient needs. What becomes of care for vulnerable populations? Consider the value of integrated care. Do current worksite wellness programs include incentives for improved oral health? Education is an integral part of the picture, but it is not a standalone. Oral health care is available in many settings, such as schools, primary care, WIC (special supplemental nutrition program for Women, Infants and Children), and Head Start. A patient’s “health home” should include oral health.

Cost, affordability, and reimbursement

*Examples:* Often people make choices based on how their personal reimbursement works. Focus payments on keeping people well, not on procedures. Risk-based models of care and payment can free up resources by eliminating unnecessary care and focusing resources for those with the highest risk and need. Should patients be given a basic level of care that is affordable, and be provided with options for additional services as a choice, such as implants? Is what is affordable what is available? If people cannot pay, should they be provided services from private or public systems? Who makes that determination?

Dental care professionals as health professionals

*Examples:* Dentists need to see themselves as health professionals in the fullest sense. Dental education must change to meet the needs of the changing environment. Dentists today need good business training. Patients want “the right care at the right time” and with reasonable right cost. Is provider turnover resulting from lack of trust? Should dental teams expand to include new members, such as dental therapists or community dental health coordinators? Does a gap exist in oral health services today with respect to access and affordability? Some difficulties exist in how to place mid-level providers in the work environment.

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The value of good oral health
Examples: We must do a better job of marketing the value of good oral health. Prevention is more affordable than dental treatment. DentaQuest’s Early Childhood Caries Collaborative is an example of improving outcomes while reducing cost. Focus on managed care. Start testing different modules or variables to see what works best.

Volume versus quality…and cost
Examples: The rise of corporate dentistry suggests that volume pays, though quality can be an issue. Dentists might ask: What do we do that is unnecessary? Is there something that dentistry does too much of that does not strengthen the standard of care? As in many fields, new technology increases cost, rather than reducing cost. Yet low-technology approaches to good treatment options are being used less and less.

Implications for Community (Discussion #6)

Discussion Questions
In considering the financial constraints that communities are experiencing, the difficult choices that they need to make, and the need for equitable solutions: What opportunities may exist to generate or redirect resources to address essential prevention programs, oral health surveillance, oral health literacy, and education? Keep in mind such things as partnerships, linkages with state budgets, and federal support.

The colloquium participants shared ideas about organizations and communities receiving regional support and assistance from local philanthropies, regional government, and local organizations to strengthen oral health in their communities. Examples follow:

Local community investment in oral health
• Prevention focus: Prevention saves money. Society pays for disease when it does not invest in prevention. Build prevention pathways to oral health in children and adults in ways that eliminate pain, reduce missed school and work days, and lessen emergency care costs. Engage oral health and medical professionals to establish a foundation for prevention initiatives by building a broad base of partners and diverse financial support. Work with the Prevention Research Centers5 to explore how communities can work with families, schools, community groups, faith-based groups, and industry to promote healthy lifestyles.

• Partnerships: In resource-poor areas, nonprofit organizations working together often provide seed money for oral health. Build public-private partnerships, such as Dental OPTIONS in Ohio6. Engage multiple stakeholders to provide financial and other resources to oral health and health partnerships.

• Community champions: When people come together, problems get solved. Nurture community champions who are willing to advocate for oral health on an ongoing basis so that individuals and families can access care at costs they can afford. Ask these community leaders what they need to support their work. Increase pro bono oral health care as a critical resource, among a wide range of important resources.

5. Centers for Disease Control and Prevention; Prevention Research Centers. http://www.cdc.gov/prc
• **Local and state organizations**: To support oral health access, leverage the strengths and reach of local service organizations, such as the Lions Clubs, church communities, local and state organizations directed to seniors, school-based groups, HIV organizations, AARP (formerly American Association of Retired Persons), and more. Develop community-based linkages, volunteer champions, and models of oral health literacy. Work together across organizations to involve local and state legislators. In Minnesota, 1,500 members of a nonprofit state-based oral health coalition helped develop a state oral health plan to increase oral health education and prevention.

• **Technology and communication**: Link community health voices by using technology, such as the internet, blogs, school- and church-based emails and websites promoting good oral and medical health for individuals and communities. Promote the value of early intervention and prevention. School-based telemedicine in Georgia and teledentistry in Arizona focus on educating and increasing access to oral health care for more people in rural communities to strengthen oral health outcomes.

• **Multi-pronged campaigns**: Develop an oral health literacy interprofessional campaign involving national, state, and local public leaders and media to educate the public about the value of prevention and good oral health. To increase awareness to the public, partner with related campaigns, such as those addressing obesity and diabetes.

Children, education, and prevention
• **Well-child visits**: Specify the need for an oral health check-up within well-child visits. In some states, FQHCs have hired hygienists to see children at their well-child visits. Work with parents to ensure follow-up care for children who have received dental care in a hospital operating room.

• **School curriculum**: Develop an oral health curriculum (local and state) for elementary schools. Educate local community influencers about oral health objectives. Require oral health assessments for each school year. Involve the school nurse and the local oral health providers. Fund the process to include oral health information in public health textbooks as well as textbooks for allied health professors and social workers.

• **Fluoride varnish**: Explore opportunities to apply fluoride varnish to children’s teeth. The Ohio Association of Community Health Centers has a grant to add varnish at well-child visits and could pay FQHCs an additional fee. When the dental funding was cut in California, a local coalition procured funding elsewhere to keep the sealant program going. In Minnesota, local coalitions provided support for school-based sealant and fluoride varnish programs.

Safe water and fluoridation
• **Public health**: Provide information to national, state, and community leaders about the preventive benefits of community water fluoridation as a public health intervention. The ADA website is a useful resource about fluoridation.

• **Shared support**: States, communities, and organizations come together to provide safe fluoridated water. Build advocacy. Gain support from local foundations and dental plans to support water fluoridation.

Partnerships for prevention
• **Working together**: Incentivize and link oral health and primary care providers to work together to support oral health prevention (e.g., sealants and fluoride varnish). Involve more local private practitioners with state-based oral health programs within their communities.

• **Shared educational curriculum**: Engage dental and medical schools to co-develop a curriculum for physical assessments (including oral health) in underserved communities. The National Interprofessional
Initiative on Oral Health (NIIOH) has a web-based curriculum, Smiles for Life\(^7\), that illustrates how to incorporate oral health into medical practices. For example, collaborative approaches to promote oral health can be valuable in Health Professional Shortage Areas\(^8\), such as inner-city neighborhoods and rural communities. Many farm workers rely upon family nurse practitioners and physicians to identify their need for prevention.

**Senior citizens:** Work with senior advocacy organizations to promote “wellness programs” for older adults. Secure funding for preventative oral health and health programs in nursing homes. Investigate the “incurred medical expense” reimbursement mechanism that has been utilized successfully to provide vision and hearing aids for Medicaid-eligible residents within long-term care facilities. Involve a dental hygienist involved in promoting oral health prevention efforts within every nursing home. Educate staff to provide oral health care to the elderly, while teaching residents to better care for their own oral health.

**Pharmacists:** Partner with community pharmacists for oral health education. For example, link into commercial Minute Clinics\(^9\) to support oral health education and make dental referrals for patients, such as those with diabetes. (About 300 million people visit community pharmacies each week across the United States.)

**Funding approaches:** Support funding mechanisms that cross dental and medical services. As an example, physicians can be paid from dental funds for promoting fluoride varnish. Are there similar cross-discipline funding mechanisms for dentists? Some physicians may not fully understand the potential cost savings of keeping people’s mouths healthy.

**Data matters to secure and support funding**

**Data to support funding:** Though necessary to justify and secure funding, the oral health community struggles with data collection. Develop approaches to gather data to establish baselines and evaluate programs on a continuing basis. Use data to strengthen access to oral health for individuals, families, and communities. Electronic health records can facilitate efficiency and be used to promote prevention.

**Data examples:** Oregon local supporters secured funding for data collection to support an application for resources from a local organization. Another organization gained a “grassroots funding commitment” to support the development of good data about prenatal health care.

**Centralized data:** Link data systems to help data have wider impact. Develop an approach to centralize oral health data and knowledge. Create an opportunity for the Alliance to convene public health agencies to discuss centralized data.

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7. [www.smilesforlifeoralhealth.org](http://www.smilesforlifeoralhealth.org)
9. [www.minuteclinic.com](http://www.minuteclinic.com)
Implications for Policy (Discussion #7)

Discussion Questions

To whom and for what are we accountable as we shape the future direction of financing for oral health? What role might our common ground discussions play in ongoing decision-making, action, and accountability related to the financing of oral health moving forward? What other stakeholders need to be involved in shaping the future of financing?

The colloquium participants examined the role of policy in building a sustainable financing approach to support the oral health needs of all people. A shared objective began to take shape: Design effective policy approaches to deliver better oral health outcomes at lower cost for all people in the future. Examples of ideas shared and questions raised are clustered below.

A focus on accountabilities and outcomes

• A focus on outcomes can help consider who is responsible for good oral health. In reality, that responsibility is shared: patients are responsible to learn about and manage their own oral health, as well as that of their families. Oral health providers are accountable for the care provided to their patients, including the right care, at the right time, and at the right cost. Oral health payers are responsible for adequate reimbursement, administrative simplification, and standardization of reporting. Government and payers have a responsibility to address the needs of the underserved (and those who cannot afford insurance) as do major corporations. Government has a role as educators, policymakers, and investors. Community ensures the availability of and access to oral health care providers.

• An approach that pays for performance and outcome is not always supported by the current “pay for procedures” financing approach; we need to change that. Align financial incentives, improve patient outcomes, and control the costs.

• To support better outcomes for the patient, the payer, and society, oral health and other providers should be accountable to identify patients requiring behavioral change to improve their oral health and reduce expenditures.

• Put pressure on the system to change. Looking ahead, build alternative models, demonstrate their effectiveness, and implement them to deliver better health outcomes at lower cost. Provide incentives to providers and payers.

Sharing knowledge, experience, and objectives

• Create opportunities for sharing knowledge and best practices among all involved, including: providers, payers, patients, educators and their schools, government representatives, health insurers, and the wider community. Engage representatives from all parties to work together to develop near- and long-term objectives for financing oral health for all.

• To understand what states may need, learn from the successful approaches of other organizations, such as the Centers for Disease Control and Prevention. Enlist experienced mentors to assist states that lack the infrastructure to submit effective grant applications.

• Engage in a dialogue the American Dental Association, the American Association of Pediatric Dentists, and representatives for patients’ voices. Begin these conversations in areas of common ground. Together, develop mid- and long-term pilot programs under the Affordable Care Act, and share outcomes and identify gaps. For example, examine the impact of training programs for alternative dental health care providers to increase access to dental health care services in underserved communities.

• Deploy high-quality measures and evaluative methods to gain and share insight into what works or not.
Role of government in oral health financing and incentives
- Working together, federal, state, and local governments have the capacity to drive change for oral health funding. Federal government incentives can direct significant attention to oral health at the state and local levels. At the same time, identify best approaches for local and state representatives to engage federal representatives.

- Medicaid administration can present a burden. Though the payer community and government can work together to design an approach to support oral health, each state’s Medicaid program is different.

- Medicaid benefits for adults should not be optional. Establish a financing model that includes dental care for adults.

- Government and payers need to be mindful of the cost of education for providers.

Understanding and representing all points of view
- Build wide-based advocacy in support of optimal oral health for all. Engage in dialogue with representative voices from across oral health, medical health, public health, education, government as payer and investor, insurance companies, unions, group investors, research, and other aspects of society to explore, question, and work together to envision the future.

- Engage public and private payers at local, state, and national levels in the conversation. Several tables of colloquium participants discussed the role of dentists, doctors, and hospitals as they are called on to assume the costs for oral or medical treatments for individuals or families who cannot pay.

Draw attention to “prevention” as the future of oral health
- Determine how to build prevention over time. What are the immediate first steps? Identify opportunities for early intervention, problem-solving, and ultimately prevention.

- Build a shared understanding that oral health and health care providers, educators, funders, and government – working together – are accountable for prevention. Provide patients with an understanding of and access to tools for prevention and a solid understanding about appropriate, evidence-based treatment and care.

- Develop payment systems that look beyond services to reimbursing individualized prevention.

- Put before policymakers at state and national levels a “platform for oral health for all” with prevention at its core. Across the country, communicate messages that draw attention to prevention.

Build broad-based community involvement – for the long term
- Put forward a definition of “oral health” that all people in this country can accept as their own – from provider to patient, across dental and medical, including funders for oral health, and involving all manner of educators, service providers, government officials, and community organizations.

- Work with local community organizations, individual service providers, and funding organizations to come together as a continuing supportive network and safety net when needed. Involve local dentists and doctors, nearby hospitals and emergency rooms, pharmacy services, homeless coalitions, churches, other local organizations, and a range of funders.

- Build on existing links between schools and families. In addition to providing education, teachers and school staff provide emotional support, continuity, and links to community resources and funders.

- Understand how the role of advocacy groups makes the difference in consumer movements. Shape a “consumer action” approach for oral health education, access, and financial support.
Perspectives on Financing Models for Oral Health (Individual Contributors)

Oral Health Financing Timeline 1930s to Today

Linda C. Niessen, DMD, MPH, MPP
Vice President and Chief Clinical Officer, Dentsply International

Development of the Reimbursement Industry and Dental Benefits

“If we can understand the numbers and how money flows within an organization, we can better understand the organization. Looking back, in 1929 the United States spent $0.48 billion on dental expenditures. Though expenditures decreased by 1940, over the following decades they grew to $4.75 billion in 1970. By 2010, dental expenditures had increased to $105 billion.

In considering dental expenses as a percent of medical expenses, however, the trends are completely different. Dentistry represented 13 percent of medical care in 1929, but that percent began to decrease as medical expenses increased. This trend decreased, not because people were spending less on dental care, but rather because the denominator (the amount spent on medical care in the United States) increased at a faster rate.

If we examine how Americans pay for dental care, in the United States today, an estimated 175 million people have dental insurance – essentially 100 times greater than in 1970. In 1970 people paid for dental care primarily out of pocket, with 90 percent by out-of-pocket expenses, 5 percent public insurance, and 5 percent dental insurance. In 1970, about 1.5 million people had dental insurance, which then declined and leveled off. In 2010, dental insurance has become the primary source of dental funding, accounting for 48 percent of the $105 billion spent on dental care. Out-of-pocket costs account for 41 percent and government expenditures increased to 9 percent. Of note, government expenditures for dental care doubled between 2000 and 2010, from 4.6 percent in 2000 to 9 percent in 2010.

Having examined the origins of health insurance, I want to share this story. Justin Kimball, as vice president of Baylor Hospital, developed a plan in 1929. In the interest of stabilizing the financial situation of the hospital, he decided that for $6 per year, Dallas teachers could receive 21 days of hospital care (which took effect after one week at the hospital). That was the origin of Blue Cross.

In 1954, the International Longshoremen’s and Warehousemen’s Union/Pacific Maritime Association asked the Seattle District Dental Society to submit a proposal for a dental program that would provide coverage for children under 14 years old. The resulting Dental Service Corporation was the beginning of the Delta Dental plan. All the Delta Dental plans were started by the dentists in their respective states as nonprofit organizations to provide dental insurance.”

E. Joseph Alderman, Jr., DDS, MPH
Executive Director, American Board of Dental Public Health
Former Director, Oral Health Section, Georgia Department of Human Resources

Evolution of State and Federal Investments in Oral Health

“Hold on to your seats while I take you through a fast trip of ‘Oral Health Investments from the Great
Depression through the Great Recession.’ These are my opinions based upon life experiences, successes, challenges, conversations with colleagues, and Google.

1929: The Great Depression, the New Deal and Black Tuesday.

1932: The United States experienced one of its bleakest years; 25 percent of the American workforce was unemployed.

1933: President Franklin Roosevelt instituted a series of experimental programs collectively known as the New Deal. One of these was the Social Security Act (1935) comprising several social welfare and social insurance programs.

1941: World War II; the veterans return.

1944: President Roosevelt signed the GI Bill on June 22, 1944, and about 7.8 million of the 16 million World War II veterans opted for a college education, rather than flooding the job market. In the peak year of 1947, veterans accounted for 49 percent of college admissions.

1944–1952: GI Bill home loan warrantees for nearly 2.4 million veterans.

1965: The Great Society, Medicare Title XVIII and Medicaid Title XIX.

1966: Medicare implemented and served more than 19 million individuals; coverage of oral health services for people 65 years and older was not supported by private dentists or professional associations.

(That is one reason why oral health generally is not included today.)

1967: Early and periodic screening, diagnosis and treatment (EPSDT) expanded for comprehensive health services (including oral health) for Medicaid children under age 21.

1989: Medicaid coverage mandated for pregnant women and children under age 6 (133% FPL).

1997: The Balanced Budget Act created the State Children's Health Insurance Program (SCHIP) for working families, including oral health for children.

2001: Health Care Financing Administration name changed to the Centers for Medicare and Medicaid Services (CMS).

2003: Medicare Prescription Drugs Improvement and Modernization Act, representing the most significant change in Medicare since the program began.


2008: A liquidity crisis evolved and the housing bubble burst; global recession was affected across the world economy. (Still today, the economic side effects of the European Debt Crisis and limited prospects for global growth in 2013–2014 continue to pose obstacles to full recovery from the Great Recession.)

2010: Affordable Care Act included oral health services for children; requiring state exchanges to include oral health services as part of the essential health benefits package.

State Investment

1918: North Carolina’s Oral Health Section was the first dental public health program in the nation. Many of the oral health service programs were in the south, designed for children, and supported with limited state money and the support of dental societies and associations.
Federal Investment

1935: As part of the New Deal, a Maternal and Child Health grant (Title V) was developed, which is the nation’s oldest federal-state partnership. (Today, most state oral health programs are funded in large part by the Maternal and Child Health Block Grant Program.) In 1981, Title V converted to the Block Grant Program.

Examples of areas where the federal government helped significantly include: community water fluoridation (2010 73.9%, 204.3 million have fluoridated water), school-based sealant programs, safety net programs, and Healthy People 2020 (oral health is one of the leading health indicators).


We are benefactors from what others have done in the past. Looking to the future, it will be important to rededicate ourselves through meetings such as this to strengthen our partnerships and advocacy for oral health so we can carry out our mission of ‘optimal oral health for all.’

Burton Edelstein, DDS, MPH
Professor of Dentistry and Health Policy & Management, Columbia University
President Emeritus, Children’s Dental Health Project

Today’s Complex Financing and Reimbursement Environment

“My charge today is nothing less than the impossible. In less than 5 minutes to provide an overview about what we have in place for dental care financing; to discuss what is working and not working – in both public and private financing; and to explore the intended and unintended consequences of the way we pay for dental care. What follows are 10 verses of ‘Dental Coverage Doggerel,’ starting with the most problematic.

The Dental Coverage Doggerel

1. The nature of dental insurance

Starting at the top,
Insurance it’s not.
Dental insurance is not like auto, medical, or home insurance because it is not truly insurance. It is not based on a shared-risk for uncommon events where everyone pitches in a bit to help pay for the unfortunate person who has an accident.

2. Affordability

Key I must say,
It hardly does pay.
Nearly 40 million people (1 in 8 Americans) report needing dental care but not seeking it because of cost. Out-of-pocket costs remain about 40 percent. Unlike medical insurance where you may have some significant upfront costs but catastrophic costs are covered, with dental coverage you are without coverage as soon as you hit the big dollars.

3. Boomers

For people like me it’s a scare,
Having no part of Medicare.
Consider that 10,000 baby boomers turn 65 every day and become eligible for Medicare – federal universal insurance that has no dental benefit. Total life savings for half these boomers is $250,000 or less. They will have to figure out how to live their extended lives as they retire with little income or savings, and whatever Social Security they receive. Elective dental services may not be prime for those people.

4. The Poor

Leaving many poor with bills unpaid,
It’s only an option in Medicaid.
Medicaid lists dental care as an ‘optional service’ for adults. At least 7 states do not cover even the emergency relief of pain and infection; and in 16 states, only pain relief is covered. When an adolescent turns 19 in these states, his or her mouth no longer exists as far as Medicaid is concerned.
5. Dentists' participation
Finding a dentist who will say ‘yes,’
Is a terrifying game and anyone’s guess.
According to the American Dental Association, only 38 percent of dentists have at least one Medicaid patient in their practice. Imagine being a Medicaid beneficiary and trying to find a dentist.

6. Benefits
Covered services are rarely needs-based,
Just selected by bosses according to taste.
While dental plans can advise HR executives about coverage, it is the market and costs that significantly play into coverage decisions. Dental plans offer employers a laundry list of coverage options. To achieve a price point that works for them, coverage is adjusted and co-pays, caps, and limits are negotiated. The result is a kind of dental pre-payment plan that doesn’t look like true insurance.

7. Volume versus value
Progressive it’s not or even scientific,
Treating each like all others, not individualistic.
Coverage is not typically individualized or risk-based. Often, prevention visits are payable only every 181 days regardless of the patients’ needs. For example, the periodontal patient requiring maintenance therapy every two or three months has to wait six months before his or her insurance kicks in for the next visit and the child with high risk for cavities gets the same visit frequency as the child at low risk.

8. Incentives
Pain and incentives reward doing more…and more…and more…and more.
It’s volume not value that makes dentists score.
The incentive is clear to dentists: the more you do, the more you get paid by the insurer until the patient’s coverage runs out. Then you have to negotiate payment directly with the patient.

9. The Uninsured
And even with all of its types for small niches,
It leaves out too many and has too many hitches.
About 40 percent of the population (100 million people) has no type of dental insurance.

10. Its isolation
Standing alone by the side as it does,
Its answer to change is ‘no’ just because.
The way that it is, is the way it will be
As change is too scary and risky for me.
Dental insurance exists almost exclusively as stand-alone plans that are not integrated or coordinated with health plans. The growing body of knowledge that links oral and systemic health is creating a movement toward ‘putting the mouth back into the body.’ The challenge is to develop creative ways to integrate coverage between dental and medical plans in ways that best reflect biology and meet the needs of the patient.

Our charge is to rethink our basic assumptions about both private and public coverage. Ralph Fuccillo asked us to consider those people who are truly in need of services, but are unable to access them because of cost.”

Patrick Finnerty
Senior Advisor, State Oral Health Programs
DentaQuest Foundation
Former Virginia Medicaid Director
Overview of the Affordable Care Act and Implications for Oral Health
“Having worked in state government for 32 years, including eight years in legislative health policy and eight years as Virginia’s Medicaid Director, health care financing has been a significant part of my professional work. In examining the Affordable Care Act, it’s important to start with a good understanding of the basics:

- **Individual mandate:** Most Americans are required to obtain qualified health insurance in 2014.
- **Coverage expansion:** 29 million Americans are eligible for new coverage options via health insurance marketplaces, including subsidies in place for the low-moderate income population, and via optional Medicaid expansion.
• **Insurance market reforms:** New rules in place since the law was enacted in 2010 specify how health insurers are allowed to offer coverage. One popular rule enables dependents to remain on their parents’ policy until age 26.

• **Essential health benefits:** In 2014, all health plans in the individual and small group markets must offer an Essential Health Benefits package that includes 10 mandatory categories of coverage, including pediatric dental services. Unfortunately, the dental benefits do not extend to adults.

The State Marketplace Decisions map provides an overview of how states are implementing the ACA: state operated (18 states), partnership of state and federal government (7), and federally facilitated (26). There will be two types, an ‘individual’ marketplace for those people without access to group insurance, and a SHOP marketplace where small groups can get insurance.

The Medicaid Expansion map illustrates which states currently plan to expand Medicaid to cover low-income uninsured persons. A number of states have not made final decisions yet, so changes may follow. The process was fascinating to observe as states made their policy decisions – and arrived at fundamentally different positions. Today, Medicaid participants have to be categorically eligible and meet income eligibility. The ACA will eliminate the categorical requirements and base eligibility only on persons being below a
certain income level (e.g. about $31,300 for a family of four). Most newly eligible participants will be adults. The expansion will be 100 percent funded by the federal government from 2014–2016; decreasing to 90 percent by 2020.

How will children access dental coverage? Depending on the family’s income and other variables, children will access dental benefits through Medicaid/CHIP, employer-sponsored coverage or through one of the Marketplaces. In the Marketplace, a child’s coverage, may be obtained through a Qualified Health Plan that includes pediatric dental, or the family can purchase dental coverage through a Qualified Standalone Dental Program.

With respect to other care delivery and financing provisions within the ACA, delivery and financing reform is reflected in integrated care, quality, and innovation.

For example, within integrated care, much attention is directed at persons enrolled in both Medicare and Medicaid (dual-eligibles), which is a priority for CMS. Within the quality focus, financial incentives to hospitals and others are provided. Efforts to combat fraud and abuse are always in focus. Areas of innovation include the work of the Center for Medicare & Medicaid Innovation, prevention funds, pricing reforms, and funding for federally qualified health centers.”
Financing Oral Health:  
A Systems Approach

Evelyn F. Ireland, CAE  
Alliance Officer and Founding Board Member  
Executive Director, National Association of Dental Plans

Dental Coverage Today under Dental Benefits

“Dental benefits are changing, and how coverage works under private dental benefits. Here are the basics: 57 percent of Americans have dental benefits (little change over the past ten years). Eighty-seven percent of dental benefits are provided by private policies, roughly divided between the large group market (101 or more full-time employees) under the Affordable Care Act (ACA), and the small group market (100 or fewer FTEs) impacted by the ACA. Most dental benefits, about 97 percent, are obtained through an employer as group coverage. Fewer (90–95 percent) large employers offer dental benefits. The largest opportunity to increase dental benefits is through small employers or the individual market.

The small employer and individual market is where the ACA requires pediatric dental benefits through the Essential Health Benefits Package (EHB). In 2014 the requirement for pediatric dental coverage affects employers of 50 or fewer; and in 2016, ‘small employer’ is defined as 100 or fewer employees.

The top reason that people do not go to the dentist is cost or lack of dental coverage. The financing that dental benefits provide meets that concern, particularly for lower-income consumers. Forty-four percent of consumers with dental benefits today have annual incomes of $50,000 or less, so they find the coverage that is available today affordable. That affordability is partly the result of annual maximums that average about $1500 a year. Because only 3–5 percent of consumers hit their annual maximum, annual maximums have not increased substantially over the years.

Dental preferred provider organizations (PPO) represent more than 75 percent of the policies sold in America. A dental PPO, the largest dental PPO sold to federal employees (the MetLife High Option Plan), is one of two default benchmarks set by federal regulation for pediatric dental coverage as an essential benefit. A PPO is financed based on procedures performed or a fee-for-service with three categories of payment (100/70/50): 100 percent for prevention (office visits, cleanings, sealants, topical fluoride, x-rays), 70 percent for basic procedures like fillings and extractions, and 50 percent for major procedures like crowns.

The states have selected between this dental PPO, and the state Children’s Health Insurance Program (CHIP). Most states running their own exchanges have selected the CHIP program, while states using the federal exchange have defaulted to the FEDVIP (Federal Employees Dental and Vision Insurance Program) MetLife DPPO.

Under the ACA, there are two ways to get pediatric dental coverage: through a medical plan or through a separate dental plan. Neither will have annual or lifetime limits. However, under the medical plan, the annual deductible and out-of-pocket limit are much higher. Medical plans are allowed to apply the higher deductible ($2,000 per person or $4,000 per family) and the higher out-of-pocket level ($6,350 per person or $12,700 per family) to the dental benefit. By contrast, most standalone dental plans have an annual deductible of $50 and the OOP10 limit is lower ($700 in federally run exchanges and $1,000 in some state exchanges). This is important given that 98 percent of children have less than $900 in dental costs per year, so first dollar coverage is critical toward helping with expenses.

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10. An OOP limit is a new concept for dental which should not be confused with a deductible. The OOP is the maximum amount that a consumer will pay in a year in cost-sharing. After that point the insurance carrier pays 100 percent of all procedures. For dental the OOP limit will impact about 2 percent of consumers – usually those that receive medically necessary ortho.
Here is a simple way to look at it. Generally today, standalone dental policies pay two-thirds and the consumer pays one-third of annual costs. That is the other way around if you put dental under medical and apply the higher deductible and out-of-pocket expense limit, i.e., the consumer pays two-thirds and the medical plan pays one-third. We must look at all pieces of the puzzle to understand different approaches to financing.

What changes come under the ACA? Pediatric dental and vision benefits are part of the Essential Health Benefit Packages (EHBPs). These benefits are required to be offered to individuals and small employers. There are no annual or lifetime limits. There is an actuarial value applied that assures the patient gets value for the dollar paid. These actuarial values are either 70 percent or 85 percent with the latter being similar to the MetLife FEDVIP DPPO (Federal Employees Dental and Vision Insurance Program Dental Preferred Provider Organization) I described.

Ronald E. Inge, DDS  
Vice President, Professional Services  
Executive Director, Institute for Oral Health  
Washington Dental Service

**Going Out on a Limb to Change Reimbursement**

“The Affordable Care Act has brought dental to the forefront. Most people agree that the fee-for-service model is not working because it does not address the disease. We must transition toward a more risk-based approach to reimburse for dental services.

Five years ago, I took a leap of faith. We built a new plan in our organization. We revamped our system to provide benefits on an individual level within a group benefit plan. We were a bit ahead of our time.

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Dental Offering by Size of Employers

**Where Pediatric Dental Will be Included in 2014**

- 6-24: 40% 2005, 41% 2008, 45% 2011
- 51-100: 68% 2005, 70% 2008, 74% 2011

**In 2016**

- 101-249: 89% 2005, 87% 2008, 93% 2011
- 500-999: 87% 2005, 85% 2008, 89% 2011
- 1000+: 93% 2005, 92% 2008, 97% 2011

**Source:** NADP 2005/2008/2011 Purchaser Surveys
Everyone here today may be comfortable with the concept of risk-based determination. Dentists everywhere probably believe they do a risk assessment on each patient. As we developed our plan, the challenge was that the system incentivizes dentists to do services. When dentists were given the opportunity to determine what those services and the payment for those services might be in our new plan, they stepped back. We were too early.

Under preventive services, we have our best opportunity to define quality. I am a disciple of Dr. Rob Compton and acknowledge what he has worked to accomplish. We have to address disease and understand how to reduce the disease burden and to change the compensation level to match that. We must transition toward a new model. Fee-for-service will always have a place, but that cannot be the dominant approach. We must talk about outcome studies. By measuring over time, we will know whether or not we can reduce the disease burden of the population. We must start there.

This morning I went for a run with a friend for the first time in 15 years. It brought to mind what I am doing now within our industry. For a long time, I was running this race by myself and trying to do things in a vacuum. Now I see people in this room moving in the same direction. I hope we can come together in areas of common ground to agree about what works and to identify how to move the system in that direction. Today’s financial system is not about health. That is the change we must make.

Triple Aim provides the opportunity. We have to move in the direction of patient-centered care. What is best care for each patient? Cost is a factor that must be dealt with. Affordability and access must be accomplished together. How can we improve the entire population one patient at a time? Start now with what we have. In our own model, we can begin to reimburse services based on risk assessment codes. The goal should be to provide the appropriate service to the appropriate patient at the appropriate time.”

Mary E. Foley, MPH
Executive Director
Medicaid CHIP State Dental Association

Financing Oral Health: A Health Systems Approach

“When I think of the overarching U.S. health system today, my mind defaults to the infrastructure of the U.S. Department of Health and Human Services (HHS). Within the HHS framework, some agencies focus on public health infrastructure and capacity, others on the health care delivery system, and still others on research, quality of care, safety, and population-based disease prevention. For example, public health programs such as Head Start sit within the Administration for Children and Families, Maternal and Child Health programs within the Health Resources and Services Administration, and community prevention programs within the Centers for Disease Control and Prevention. Public health care delivery programs such as Medicaid and the Children’s Health Insurance Program (CHIP) are housed within the Centers for Medicare and Medicaid Services (CMS), and health research rests primarily within the National Institutes of Health.

While each agency has unique responsibilities, the overarching infrastructure is designed so that all agencies support each other in their capacity to assure health and wellness for all Americans. However, federal funding mechanisms and budget restrictions create

IHI Triple Aim Initiative
We must help states understand how to use their dollars most effectively, and provide evidence-based, quality-driven oral health care services.

When looking at the spending of Medicaid funds by enrollment age, it is clear that elders and disabled adults account for the largest proportion of expenditures. Children account for a much smaller proportion, but a significant amount of the pediatric expenditure is directed toward dental care. Here lies another opportunity for policymakers. We know how to prevent dental disease. The scientific evidence is grounded. Now we must create health care payment policies that support preventive dental care protocols, and redirect funding toward preventive services. Eligibility, benefits, cost-sharing (in CHIP), and provider payments are the primary levers for managing health care delivery costs. It is time to adjust these levers with innovative strategies to deliver and fund quality services that promote preventive services, improve health, and lower costs.

Today's public health systems function as a safety net for the health care delivery system. People fall into the safety net and, unfortunately, stay there. This is costly. It is time to restructure our public health programs so that those who enter this system receive the immediate care they need, and then get re-grounded in the health care delivery system. Programs are only as strong as the policies and financing mechanisms that support them. Health care reform provides an opportunity to improve our global health infrastructure and capacity by rebuilding and strengthening the public health and health care delivery systems we have.”
Implications for Care

Francisco Ramos-Gomez, DDS, MS, MPH
Professor, Section of Pediatric Dentistry,
UCLA School of Dentistry
UCSF/UCLA Center to Address Disparities in Children’s Oral Health

Implications of Diversity for the Future of Oral Health Care

“Our dental profession is undergoing a paradigm shift. Begin with the premise that finance (particularly reimbursement) should focus on health, not on disease. We need to reinvent and reposition oral health care in this country. In order to be less reactive about disease and invasive surgical dental care, and to become more proactive to focus on health and keep and maintain healthier teeth –

1. Expand the diversity of the oral health workforce in America. Impressive demographic changes are underway in this country. A strategically diversified and culturally competent workforce will help us reach different populations more effectively – particularly Hispanic, African American, and Native American people. Among these populations, large numbers of individuals and families have been the hardest-hit with respect to lack of access to overall health, oral health care, and overall wellbeing.

2. Use evidence-based bio-behavioral interventions and prevention. The effectiveness of early intervention and prevention initiatives has become clear, such as bio-behavioral, evidence-based interventions, and self-management goals. Focus on what can change patient behavior, particularly through perinatal and infant oral health care programs. We have seen highly effective collaboration with the American Academy of Pediatrics and the American Academy of OB/GYN. Bring more combined multidisciplinary, comprehensive efforts to bio-behavioral interventions that work and can be highly successful in dentistry.

3. Develop insurance plans focused on incentives for consumers and families. Incentive-based plans can trigger effective behavioral changes year over year. In the United States, we can learn from consumer-focused experiences in medicine – specifically in Latin America, Africa, and Mexico. Through the Mexico Oportunidades program, the government provided a $3 to $5 cash incentive card for participants to use at the grocery store in exchange for completing immunization regimens for their infants and toddlers. A valuable survey finding showed the immunization progress had grown from 58 percent to 99 percent. Even minimal interventions can provide helpful incentives for patients and families. For example, insurance programs have developed consumer wellness initiatives: individuals can receive rebates or reductions in their premiums based on behavioral changes (e.g., exercising or reducing cholesterol levels as well as obesity).

4. Personalize individual and family-centered care based on ‘disease assessment and management.’ The future is doing the right thing for the right person at the right time. The pregnant mother who is healthy with a clean mouth will have infants and children who follow the same pathway. Incentivize such behavior to ‘keep healthy teeth healthier.’ Help mothers step away from the fatalistic point of view: ‘If I have ten cavities,
maybe my child will have seven or fewer cavities… an improvement.’ No. Dental caries are not normal to have. This is a chronic infectious disease that we can prevent. Communicate that message.

The work of our UCLA Center to Address Disparities in Children’s Oral Health, in combination with the applied work of the DentaQuest ECC collaborative, provides an exciting opportunity for early intervention in applied health services. We can demonstrate a huge improvement when using measures of performance and quality outcomes. For example, change the numerator and the denominator by moving away from the number of filings and toward incentives for wellness to improve a child’s oral health by early intervention.”

Kevin B. Earle, MBA, MPH
Executive Director
Arizona Dental Association

The Arizona Indian Oral Health Project
“I am happy to share our experiences from the world of grantees under the DentaQuest Oral Health 2014 project. Specifically, the Arizona Indian Oral Health Project is an effort to engage the Arizona tribal community with interested stakeholders in forming local and statewide oral health coalitions to work and advocate for improved oral health. Arizona is the home to 21 federally recognized tribes, the largest of which is the Navajo – the largest land-based tribe in the United States with the highest population. The Navajo Nation is situated in four states (parts of Arizona, New Mexico, Utah, and Colorado), representing a land mass about the size of Pennsylvania. Because of treaty arrangements, the U.S. government provides health care for the American Indians through the Indian Health Service, or provides funding through ‘self-determination grants’ to tribes to run their own health care facilities called 638 clinics.

Because of these vast distances, it is difficult for Indian people to access health services. Health care disparities are enormous. Even within the Indian Health Service, health care faces competing funding demands. Making the dollars stretch is difficult. The primary focus is on high-cost health care areas. The Tohono O’odham Nation, for example, has the highest level of diabetes in the country. Diabetes management is a priority among tribal leaders, but oral health falls further down the list.

Decay rates among American Indian children are 400 percent higher than comparable populations. This was validated recently when the Indian Health Service conducted an Early Childhood Caries Project to collect data on decay rates in community centers, WIC centers, and other places where the 0–5 age child population has touch-points. In 2010–2011, the data revealed that the mean number of decayed, missing, and filled teeth (DMFT) among children between the ages of 0–5, was as high as 4.5 in the Phoenix IHS area – more than four times the mean number for white children (1.1 DMFT) in the United States. The Navajo area data is even more alarming at 6.5 teeth. In one particular service on the Hopi reservation at Keams Canyon, the DMFT was 7.23 teeth, and 60 percent of the children have untreated decay.

With the passage of the Affordable Care Act, the Indian Health Care Improvement Act was reauthorized. We identified opportunities to improve oral health. Navajo was authorized (a two-and-a-half-year project) to explore the feasibility of developing its own Medicaid
system and a robust dental benefit. Every morning, the Phoenix Indian Medical Center has 65 or 70 people presenting with emergencies, though it has the capacity to treat only 35 or 40 of them. The challenges are enormous. The large-scale demand of a delivery system such as the Indian Health Service presents challenges to innovation focused on prevention.

The preamble to our recent grant application proposes to develop an oral health coalition among five different Arizona regions, as well as a statewide oral health coalition. We want to change the thinking about oral health among tribal communities. It is starting to work. As tribal leaders meet to discuss their health care priorities, we are making headway toward a culture of prevention and an effort to devote more financial resources to oral health. When they began discussions a year ago, oral health was number eight on their priority list. Today it is number four. Tribes operate with health representatives who engage people in their communities to provide education. Moms and grandmoms generally are the caregivers. As we look for opportunities under the Affordable Care Act, we want to bring the tribal community together to improve oral health care.”

W. Ken Rich, DMD
Founding Board Member, U.S. National Oral Health Alliance
General Practitioner, Dry Ridge, Kentucky

Implications of Care through Private Practice
About 37 years ago I started a private practice. Today, the complicated part is defining ‘private practice.’ It used to mean that you came into my office, I provided that care, and you paid me for it. The changes that we have seen in private practice are immense. That older model still exists and works for a certain percent of the population, but it does not work for all.

The root canals I do today take less time by half (at least) and are less problematic and less traumatic than 37 years ago. Materials I use are much better today. Digital x-rays, and a digital record of sorts, make my life much easier. Yet the fact remains that I am still paid for ‘procedures.’ I am paid for doing work on teeth. I am paid for taking diseased portions of a tooth away and replacing it with something artificial.

The opportunities we see ahead include the ability to focus on improving overall health in our patients. The puzzle that is this evolving system seems to be under construction. The question I have is: When will those puzzle pieces be put together? When that time comes, we have the potential to do a lot of good. Private practice will have to change more than any other segment of the dental delivery system because of what and where we have been. That is not a bad thing. The ability we have to improve the health of our patients and to measure that improvement is significant.

We talk about disease management. In the past, disease management took place in our offices. A patient came in to see the hygienist, who talked about how well you cleaned your teeth, and what might be missing in that process. We had one appointment to do that. From that point, we started talking about reconstruction. That will remain important. Yet today we also are moving toward measuring outcomes, disease management, and risk assessment. Adding those tools to our practices gives us new abilities we have not had before. These tools present an opportunity to make a difference like never before. It is a brave new world we are looking at, and I don’t know how it will evolve. It certainly will be interesting to be around as it changes."
Implications for Community

Mark E. Nehring, MEd, DMD, MPH
Professor and Chair, Department of Public Health and Community Service
Tufts University School of Dental Medicine

The Necessary Role of Collaboration and Community Connections

“In my prior role within the U.S. Public Health Service administering a national discretionary grant program, we depended on community-level responses to implement programs. Financing brought with it complexity, internal to the Maternal and Child Health Bureau and its processes. Financing was also an issue for individual applicants to grant funding opportunities: there was never enough money, implementing a national program in every state was impossible, the means to spend money presented constraints, and there was risk involved in taking concrete steps forward.

Expertise for financing is often held by others outside one’s program area. Within my bureau, we had our own accounting, but we adhered to constraints from offices above us. Collaboration was necessary across agencies and programs to leverage limited resources and help lessen risk. Financial vulnerability felt by an individual partner within the group was diffused when spread out among all partners or those possessing particular expertise.

Over recent years, we were involved in collaborating across federal agencies to leverage resources to provide oral health services to Head Start children. Doing so allowed seeding the start-up of sealant programs, developing consistent oral health messaging to providers and families, and ensuring follow-up care for restorative treatment. The broader group of collaborating stakeholders was needed to comprehensively address the needs to be met. Collaboration offered opportunities to pose the ‘what if’ questions – bringing innovation and original thinking that might never have been considered by one person alone.

Another initiative involved targeting existing school-based health centers to seed integration of oral health services. First, we engaged in discussion with stakeholders already involved in school-based programs to understand leverage points for funding and the risks to success. We determined it was better to add oral health to existing primary care services rather than invent a standalone program. Though we were unsure about a projected 3–4 year funding stream, we placed trust in others knowledge and experience to address sustainability issues and identify models of success. Collaboration was an opportunity to leverage funds both nationally and at local levels, and diminish risk to the stakeholders. Now, in my current work, similarities exist in financing academic programs. There, too, we find collaboration is critical to attain success and achieve sustainability over time.”
Dionne J. Richardson, DDS, MPH  
State Dental Director, Office of Oral Health  
Mississippi State Department of Health

What Community Means to a State Dental Director

“I bring the voice of the Mississippi and formerly the Louisiana community, where our needs shifted direction post-Katrina. Because the students were no longer in school, our school-based sealant programs moved into trailer camps to follow the students. Having the ability to leverage support and shift focus ‘on a dime’ is the new reality—something that state health, community-based, and school-based programs have to consider.

In reflecting about implications for the community, I am encouraged yet deeply concerned about what will happen as the Affordable Care Act is implemented fully. A few years ago, a conversation about the Prevention Fund began at the National Oral Health Conference. We were filled with hope about how we could utilize Prevention Fund money to promote oral health in innovative ways to increase prevention efforts. As time goes by and appropriations remain uncertain, my concerns about ACA continue.

To leverage support for our oral health programs, we begin to involve the communities, including key stakeholders from outside dentistry. We encourage medical providers to look at the teeth and do an oral exam. Certainly do an oral exam. Working together, we examine how we can improve oral health in vulnerable people. In considering patient-centered care models, we focus on the family. We have made strides. The increased utilization of dental Medicaid beneficiaries, for example, has been encouraging. As we develop these finance models, they must focus on the patient’s overall wellbeing. Moreover, consider social determinants of health that may prevent or increase individuals’ chances for attaining care.

Encourage, empower, and educate the community at large about ACA implementation and its implications on individual health insurance needs and how to navigate through this new system of care. Similarly to the planning and implementation of the Oral Health 2014 Initiative in Mississippi, we started by asking individuals throughout the state: What must we do first to get people ‘pumped up’ about oral health? Educate. Educate. That priority has been reiterated in every region of the state. We educate parents and sometimes medical providers about aspects of care for vulnerable populations. We include teachers and others with a vested interest in the wellbeing of the individuals we serve. From there we developed a plan based on regional priorities. It is imperative to involve the community in implementing a new system of care.

I remain hopeful about what the ACA will bring. We have so many unknowns. We struggle to arrive at the best potential research questions. What should we consider? Almost always, change brings a level of angst, much decision-making, and questions. Yet when change comes, we will know intuitively what to do. We are resourceful people. As long as we listen to the voices of the people, we can help address their needs. Don’t give them what we think they should have. Instead, ask them what they need and how we can help them attain that.”
Eileen Espejo  
Director of Media and Health Policy  
Children Now, California

**Implications of Financing on the Community**

“In California, much attention has focused on the managed care dental plans in the Los Angeles and Sacramento Counties and their delivery of care to the child population. Contract implementation has begun in 2013. Within those contracts, new performance measures borrow from the S-CHIP dental program (that was eliminated for lack of funds). For example, measures include a preventive services-to-fillings ratio, sealant-to-restoration ratio, and the use of sealants-and-treatment-to-caries-prevention ratios. Though these measures may have existed already, now they are broken down by age range within benchmarks – such as a benchmark to be met to treat the 0-to-3 years population. This competitive RFP process helped elevate the ‘best of the best’ to serve children who already should be getting this care.

Because of the role that advocates played in bringing issues to light, the state convened county-specific stakeholder processes in Sacramento and Los Angeles counties. Stakeholders include not only the consumers, but also the managed care dental programs that deliver care, as well as advocacy organizations, children’s health advocates, those serving the pregnant women community, WIC, Head Start, and school-based health programs. They are all at the table to address ongoing barriers to care. Despite the new contracts in process, we expect to have continuing access issues to address.

In a state as large as California with limited resources, we have considered how to stretch the dollar and make it meaningful. We drive toward prevention. As a result of the stakeholder process, in Los Angeles County a focus on pregnant women has become a priority area for invested resources, as had medical/dental integration. Recent statistics show that the managed care dental programs had a no-show rate of about 40 percent of children in the Medicaid population. We need to address that issue.

The Centers for Medicare and Medicaid Services (CMS) have asked states to develop their pediatric oral health action plan to address goals for sealants and preventive services. That is a challenge for California, because CMS recently approved a 10 percent reduction rate to DentaCal providers. While we have great goals, they do not come with money. From the perspective of a community advocate, we must ‘walk the talk’ when trying to achieve these laudable goals for our communities.

In California, we don’t have state-sponsored programs to address oral health delivery. Instead, we look to the counties and localities to deliver the care innovatively, based on the unique needs of their populations. The challenge is to understand who is financing what and where. Progress is driven by localities that are innovative in delivery and finance. To spread successful practices throughout the state, one immediate objective is to share success stories from across the state as examples of where to invest limited resources.”

**Implications for Policy**

Colin Reusch, MPA  
Senior Policy Analyst  
Children’s Dental Health Project

“I will address the relationship between policy and financing as it relates to oral health. Policy is like sausage-making: painfully incremental, an iterative process, and focused on balancing competing interests. Policy is programs. Policy is not always legislation, yet often changes existing rules. Policy is the way we administer benefits, and the guidelines by which we deliver care. Policy is not always public policy. Oral health policy requires a broad spectrum.

Financing has many connotations, such as establishing new programs and policies, financing care itself, developing new payment methods for better health outcomes, or designing comprehensive benefits for providers and patients. Public policy is the allocation of scarce resources. Today, the will to change policy in the oral health community is growing. The fact that
resources for policy change are limited should be a catalyst for innovation. Policies like the Affordable Care Act present a framework for changing the paradigm of health care delivery in general, as well as oral health policy. Yet unintended consequences can arise as a result of the sausage-making process.

Evelyn Ireland posted a slide of a Whack-a-Mole game—a great analogy. I started to list all the ‘moles’ I encountered in implementing the oral health provisions of the Affordable Care Act. That law includes perhaps two dozen provisions that deal with the oral health system in a comprehensive way. This is not a simple problem. Instead, it requires a multifaceted solution. Yet the ‘mole’ that pops up is: There is only so much money to go around, so we will fund only a few provisions. We may say: Great, the comprehensive health benefit for children includes oral health. Yet given how the law is written, families are not required to purchase the benefit, and there are no benefits for adults. The essential health benefit represents an opportunity for changing care. Well, not so fast; disrupting the system might be expensive. Let’s keep the current system in place, including products and financing mechanisms.

The implementation of policies like the Affordable Care Act reflects not only scarce resources becoming scarcer, but also our reluctance to change the segregation of systems. The longer we stick with segregated systems of care and financing, the longer we will play this game. We can change how dental insurance is delivered somewhat by removing lifetime caps and making it look like medical insurance. Yet to recover those costs, we use deductibles and similar mechanisms. Dental care is subject to the out-of-pocket limits established by the law—essentially consumer protection for families. However, because we have two separate systems, some other consumer protections don’t apply. We might try to integrate these two systems.

The difference between public policy and a Whack-a-Mole game is that in the game, there is no prioritizing. In thinking about implementing policies like the Affordable Care Act, we must identify true priorities. As Ralph Fuccillo pointed out, we are trying to address a problem for a specific population of people. We cannot knock down all the moles. However, we must knock down those that matter most for the people we are trying to help.”
Appendix I

High-Level Messages to Communicate from this Colloquium to the Rest of the Country

Working in small groups, participants developed a list of the “most important messages” they wanted to communicate from the colloquium to the rest of the country in moving forward on our collective mission for nationwide access to oral health.

Group One
- Identify and/or develop innovative reimbursement models that move from volume (# of procedures) to value as measured by improved oral health outcomes.
- Incentivize health care providers, patients, and payers for improved oral health outcomes.
- Develop the standardized definition of optimum oral health that is evidence-based and measurable.

Group Two
- Innovative financing is necessary to achieve an oral health care system that is widely available, affordable, and effective.
- Medicare and Medicaid must fund oral health for all beneficiaries.
- Financing incentives are necessary to ensure that underserved populations receive adequate/needed/appropriate care.

Group Three
- Oral Health Education.
- Reimbursement.
- Focus on Disease Management.

Group Four
- PATIENT-focused, consumer-based systems with community level input are critical to really improving oral health.
- Work with providers, employers, and unions to create incentives to change behavior and construct evaluation tools to measure change.
- Explore opportunities to drive cost out of providing care, e.g., medical-dental HIT systems “talk” to one another to free up dollars for caring for the most vulnerable – seniors, working poor, young adults.

Group Five
- Realign payment systems. Experiment and innovate.
- Promote oral and financial health literacy.

Group Six
- Create a competing system, rather than try to change the existing one.
- Educate stakeholders (there are many) about the COST of poor oral health and the TRUTH about our currently inadequate system.
- Reimbursement must be based on contribution to health.

Group Seven
- Collect data and use it to demonstrate a high return on investment of good oral health with respect to its societal and economic impact (Mass. Medicaid).
- Promote the sense of urgency. Address this problem now, through collaboration.
- Reimbursement should be focused on optimal outcomes with the overall health of the individual as THE priority. It should not be “procedure-based.”

Group Eight
- Establish interprofessional and consumer collaboration by identifying win/win opportunities.
- Engage community stakeholders to advocate for promotion of the important link of oral health to systemic health.
• Define oral health in terms of the prevention or management of disease and functionality to include eating, speaking, and reasonable appearance.

**Group Nine**

• The financing of Oral Health Care should be customizable based upon an individual's level of risk.
• Align incentives around value-based, patient-centered care.
• Engage broad-based stakeholders as partners with the profession and insurers to advance population-based oral health with open, transparent, and accountable systems.

**Group Ten**

• There is an opportunity for oral disease prevention (like we have never had before) by including Oral Health in Accountable Care Organizations (ACOs).
• Incorporate oral health into health education curriculum – beginning with young children (require collaboration) and extend to the health professions.
• To address access issues for all, the U.S. National Oral Health Alliance must continue to diversify the community of interest groups.

**Group Eleven**

• Establish truly integrated, interdisciplinary Accountable Care Organizations that address payment and service delivery, including prevention and treatment.
• Location-independent, secured, authenticated access to relevant patient care records by qualified health care professionals on a need-to-know basis.
• Develop a closer collaborative relationship between organized dentistry and the payer community to advocate for mutually beneficial financing models to ensure optimal oral health for all.

**Group Twelve**

• Assure financing mechanisms are in place to support coordinated, quality-driven oral health services provided by a broad array of health care providers.
• Establish a core set of oral health care and oral health program measures.
• Optimize community/population-based oral health preventive strategies; and transform public health/school-based oral health programs into comprehensive oral health delivery system ACCESS sites (dental homes).

**Group Thirteen**

• Quantify the economic impact of poor oral health.
• National health platform to advocate for oral health policy and financing.
• Use education to create/increase demand for preventative care.

**Group Fourteen**

• Align policymakers, payers, providers, and patients with value (value = risk-adjusted patient-centered health outcomes/dollars spent).
• Investment in oral health will require elevating the importance of oral health among policymakers, payers and patients.
• In a resource-constrained environment, resources must be maximized within the current health, education and social services systems to increase the impact on oral health.

**Group Fifteen**

• Seize the day! Finance adult dental benefits.
• Prioritize prevention over treatment through financing.
• Prioritize funding models that incentivize collaboration.

**Group Sixteen**

• Optimal health is not possible if oral health is not included in the financing of health care.
• Financing models for oral health must include community-level interventions.
• There needs to be pervasive integration of appropriate services across all health interventions.
Participants at the Fifth Leadership Colloquium represented a wide range of backgrounds, professions, and experience. Together, they sought to learn from each other, seek common ground, and envision shared solutions.

Blue = Founding Board Member – U.S. National Oral Health Alliance

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