SUMMARY OF THE SIXTH LEADERSHIP COLLOQUIUM

STRENGTHENING THE DENTAL CARE DELIVERY SYSTEM

U.S. National Oral Health Alliance | June 17–18, 2013 Washington, DC
As part of the evaluation of the Sixth 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.
EXECUTIVE SUMMARY

The U.S. National Oral Health Alliance convened more than 160 participants at the Sixth Leadership Colloquium to share knowledge, experiences, and insights as they examined how to strengthen the U.S. dental care delivery system for all. They worked together not for their own benefit, but rather for children and adults across the country who need oral health services but cannot access them. Building on the momentum begun through the prior five colloquia, all participants are on a shared journey to improve oral health for all.

The colloquium engaged participants in small-group and whole-group discussions. Presentations by invited contributors offered personal insights and raised questions for all to address. This booklet presents a summary of the discussions, critical messages, and potential next steps.

Strengthening the Dental Care Delivery System

Unifying Messages Emerging from the Sixth Leadership Colloquium

The colloquium participants worked together to develop a shared perspective on what it will take to strengthen the dental care delivery system. They brought their breadth of experience and knowledge to envision pathways to a stronger system. A set of unifying messages to support such progress emerged through these discussions:

- **Focus Oral Health Care on Prevention and Wellness for Individuals, Families, and Communities.** Begin to transition the country’s oral health system of care from a surgical model to a comprehensive “primary care model” that emphasizes prevention. Support health management and evidence-based care by building a culture of wellness that encourages an interdisciplinary team approach and supports best practices for integrating oral health into overall health. Provide continuous learning opportunities for individuals, families, and communities.

- **Move Toward Interprofessional, Cost-Effective Workforce Models and Care Delivery Systems.** Align and incentivize oral, medical, and behavioral health systems to support an interprofessional care delivery model for the individual, family, and the whole community, which includes patient-centered care, prevention, education, and risk reduction in order to strengthen health outcomes. Encourage cost-effective workforce models that enable all segments of the population to access care. Build community expectations for high oral health literacy.

- **Transform Education for a Future Strengthened by Team-Based Oral Health and Medical Care.** Educate a diverse healthcare workforce to deliver comprehensive and team-based oral healthcare that emphasizes outcomes. Encourage oral healthcare providers to consider alternative practice settings and payment methods. Using states and communities as learning labs, share successful workforce
innovations and learn from failures. Expand current educational curricula to include oral health knowledge and information for all healthcare providers.

- **Empower Communities to Support Highly Effective Oral Health Care Systems.**
  Educate the public about the importance of oral healthcare for all. Build trust, understanding, and partnerships to support behavior change for healthy lives. Encourage grassroots efforts as the driver of health systems change. Involve and fund communities to embrace an effective, user-friendly system for oral health that all people can access readily. Assess community needs and expectations in order to dedicate adequate and appropriate resources to build such a system. Help states move beyond the status quo to expand oral healthcare options for the underserved.

- **Align Payment and Systems Approaches to Promote and Support Wellness.**
  Align sustainable funding, effective policy, and an efficient healthcare delivery infrastructure to support health wellness for all children and adults. Pay for health outcomes utilizing proven case management approaches. Move healthcare financing away from the traditional fee-for-service approach toward a value-based model that reimburses for prevention and reduced risk. Utilize private and public collaboration to fund a patient-centered, integrated, evidence-based, and data-driven system that supports sustainable economics for healthcare.

---

**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.
Sending Our Messages Across the Country about Oral Health Care for All People

Following the table discussions throughout the colloquium, each participant wrote down ideas to share across the country about how to support oral health for all. Selected messages from individual participants are grouped below by the four parts of the Systems Framework for Improving Oral Health (see graphic left): Policy, Financing, Care, and Community. Here is a sampling of representative messages from the participants:

Policy
Effective policies can be leading drivers of change within a healthcare delivery system. Policies can cut across culture, generation, and economic barriers. Even small policies can be a catalyst for major policies that can shape a national systemic approach to oral health within overall health. The future of oral health will depend on effective policies that enhance access to care, help the oral health workforce to become more efficient, and heighten the value system of the communities served. Those people who need oral healthcare the most don’t necessarily have access to policymakers. We must make that connection on their behalf.

Financing
Financing is the critical link that supports optimal oral health for all. Ongoing dependency on temporary financing and grants is a barrier when planning for long-term, effective care for underserved populations. A solid understanding of finance is fundamental to the success of operational solutions. Dentists must be educated earlier about the business dimensions of providing effective oral healthcare. Because this care has fixed costs that rise yearly, we must work toward well-conceived, sustainable financing. Develop demonstration projects to examine the effectiveness of a range of financing approaches, whether those address oral healthcare alone or combined with medical care.

Care
If we want a strong America, we need a well America. The quality of oral healthcare is excellent in this country...for those who can access it. Educate consumers to view oral health as a priority. Compassion is a critical element of care for the patient and the provider. The long lines of people awaiting care at Missions of Mercy free clinics demonstrate the breakdown in the current oral health delivery system. We must value adult care if we expect parents and caregivers to appreciate the importance of oral health for their children. In the future, prevention will focus and align oral health within overall health. Providers require the opportunity to experience hands-on training in a range of care settings. Dentists must see themselves as primary care providers. This awareness must begin when dental students work to help their patients change oral health behaviors.

Community
Support for oral health must go beyond dentists and hygienists to include parents, community health workers, medical providers, educators, and those who interact with us in the communities where we live, work, learn, and play. To prepare for the future, students must participate in cross-disciplinary, interracial oral health learning experiences in community settings. The ideal interdisciplinary curriculum will include competencies in (and a basic understanding about the importance of) oral health in the full range of community settings. From that awareness, appropriate community policies and financing decisions can impact oral healthcare delivery systems and health outcomes.
SIXTH LEADERSHIP COLLOQUIUM

Welcoming Remarks
Ralph Fuccillo
Alliance Founding Board Member
Chief Mission Officer, DentaQuest
President, DentaQuest Foundation

Opening Address
Marcia Brand, PhD
Deputy Administrator
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services

Representative Elijah E. Cummings
7th Congressional District, Maryland
U.S. House of Representatives

Speaker from the Alliance Founding Board of Directors
Douglas M. Bush
Executive Director, Indiana Dental Association
Colloquium Facilitator and Alliance Consultant

Elaine Kuttner
Principal, Cambridge Concord Associates

Individual Contributors (listed in order of contribution)
Brian Souza; Linda Niessen, DMD, MPH, MPP; Steven Kess, MBA;
Michael C. Alfano, DMD, PhD; Peter DuBois; Paul Glassman, DDS,
MA, MBA; Nicholas Mosca, DDS; Fay Donohue; Barbara Leonard;
Ruth Fisher Pollard, MS, MBA; Robert Weyant, DMD, DrPH; Jack
Dillenberg, DDS, MPH; David Krol, MD, MPH, FAAP; Richard W.
Valachovic, DMD, MPH; Ryan S. Lee, DDS, MPH; Caswell A. Evans,
DDS, MPH; Marko Vujicic, PhD

Table Facilitators
Members of the Founding Board of Directors of the U.S.
National Oral Health Alliance:
Douglas M. Bush; Caswell A. Evans, DDS, MPH; Wendy J. Frosh;
Ralph Fuccillo, MA; Leslie E. Grant, DDS; Lawrence F. Hill, DDS,
MPH; Evelyn F. Ireland, CAE; Steve Kess; Dushanka V. Kleinman,
DDS, MScD; David M. Krol, MD, MPH, FAAP; William R. Maas, DDS,
MPH; Vincent C. Mayher, DMD, MAGD; W. Ken Rich, DMD; Lindsey A.
Robinson, DDS; Cesar R. Sabates, DDS

Advisors of the U.S. National Oral Health Alliance:
Tracy E. Garland, MUP; Steven P. Geiermann, DDS;
M. Alec Parker, DMD

Past Colloquium Participants:
Jason M. Roush, DDS; Kimberlie Yineman, RDH, BA

Alliance Staff and Colloquium Organizer
Nathan Ho
Program Director, U.S. National Oral Health Alliance

Conveners: The Board of Directors and Advisors
of the U.S. National Oral Health Alliance
A list of Alliance Board of Directors and Advisors is provided in
Appendix IV.

Colloquium Participants
A full list of participants is provided in Appendix II.
On a Critical Journey to Improve Oral Health for All People in This Country

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

Ralph Fuccillo welcomed all the participants who had come together from across the United States. Some individuals were participating for the first time, while others had been part of one or more prior colloquia. Over the next two days, they would collectively explore approaches and strategies to strengthen the dental care delivery system within this country to ensure optimal oral health for all.

“As we begin this Sixth Colloquium, it is wonderful to see so many people committed to dialogue, openness, and common ground. I find it interesting that we greet each other with extended hands, providing a sense of openness as we come together to address oral health in this nation.

Some of you know the question we ask at each colloquium, which is the glue that keeps us together: What are we going to do, in the short and long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people? Keep this question in mind through our discussions over the next two days as we represent children and adults who need oral health services but cannot access them. Right now, they have no voice. This is a journey to improve oral health for all. This oral health movement requires an important element: Hope. We cannot solve all problems at once. Quoting from Jim Wallis (author and theologian), ‘Hope unbelieved is always considered nonsense. But hope believed is history in the process of being changed.’”

Marcia Brand, PhD
Deputy Administrator
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services

Introduction by Ralph Fuccillo

“We are honored to have with us today, Deputy Administrator Marcia Brand, a national champion of the oral health movement. On many occasions, I have had the occasion to work with Dr. Brand. Each time, I am reminded how important it is for people in public service to join with people across communities to express leadership, boldness, and common sense about what private-public partnerships can accomplish. Dr. Brand has been a friend to all of us in the oral health community, where she has initiated a range of programs at the Health Resources and Services Administration. She will speak about the opportunity provided by the Alliance in drawing people together for the benefit of the nation. We see that focus in the commitment of HRSA to improve access to healthcare services for people who are ‘uninsured, isolated, or medically vulnerable.’”

Marcia Brand, PhD.

“…turning the world so that it is facing the way we want things to go for millions of Americans who cannot find affordable dental care in their communities…”

Marcia Brand, PhD.
Marcia Brand

“I was thinking about the people who would be attending this colloquium, the groundwork having been set in place through prior colloquia. And so in preparation for today’s discussion, as well as for the work that goes into strengthening the dental care delivery system, it hit me. This event is perfectly captured by the group, Genesis (1976), in the line: ‘You have your own special way / Of turning the world so it’s facing / The way, that I’m going, don’t ever / Don’t ever stop.’

For many of us trying to improve oral health over the years, this is what the U.S. National Oral Health Alliance is doing. It is turning the world so that it is facing the way we want things to go for millions of Americans who cannot find affordable dental care in their communities. The Alliance is not just the best shot we have had over the past 40 years to make progress in providing access to oral healthcare. It is the only shot we have had. No other group cuts across public and private entities, sectors, education, practice, delivery sites, patient advocates and provider groups. No other group involves not only dental providers, but also nurses, physician assistants, and physicians too.

The Alliance has support from states and state-based organizations; and while we are not official members, you have support from your federal partners as well. The oral health interests of the Department of Health and Human Services (DHHS) are discussed regularly by a cross-department workgroup known as the Oral Health Coordinating Committee (OHCC), which is led by Dr. William Bailey, Assistant Surgeon General and Chief Dental Officer of the U.S. Public Health Service. Dr. Bailey is here today. You have seen committee members at your meetings, including representatives from HRSA, CDC, CMS, and NIH. The OHCC will continue to work with the Alliance to achieve shared goals: improve access, address affordability, and promote the integration of oral health into primary care.

The OHCC is working on the first HHS Strategic Framework for Oral Health. Dr. Howard Koh, Assistant Secretary for Health, announced this at the 2013 National Oral Health Conference. The strategic priorities of this plan align with your Alliance priorities. We are proposing to promote policies to integrate oral health into primary care, prevention, and health literacy; expand a primary and oral health team; and promote models (where appropriate) that incorporate new providers, expand the scope of existing providers, and use medical providers to provide evidence-based oral health services. Through this initiative, HHS is proposing to incorporate oral healthcare into primary care.

About the Health Resources and Services Administration...

The work of the Alliance aligns with our mission at HRSA. Our programs impact dental care delivery from many perspectives. With respect to workforce, about 12 percent of individuals getting their educational loans repaid are dental providers in the National Health Service Corps. HRSA spends about $20 million on dental workforce training programs and about $12 million is sent to the states to address oral health issues. Through our health centers, HRSA provided dental care to more than 4 million patients last year. We have made investments in school-based health centers. We also provide care through the Ryan White Program for people living with HIV and AIDS.
Building on our work to integrate oral health and primary care, about 75 percent of the health centers we manage offer comprehensive primary dental services. At those centers, we begin to model the integration of oral health and primary care. We also want to determine how to get electronic records to talk to each other at those centers. We have been working to expand oral health capacity through our state-based grants and will make those awards in September 2013. Clearly, HRSA has a lot of investment in enhancing oral health infrastructure.

DHHS, HRSA, and the Oral Health Coordinating Committee are enthusiastic partners of the U.S. National Oral Health Alliance in seeking to strengthen the oral healthcare delivery system. We look forward to working with you.”

**Today’s Call to Action**

**Representative Elijah E. Cummings**
7th Congressional District, Maryland
U.S. House of Representatives

**Introduction by Ralph Fuccillo**

“Throughout this colloquium, think about trust and common ground. Let no one be naive to think that seeking common ground is easy. Through these conversations, as in past colloquia, we begin to hear a unified voice. Honor that, take it in, and enjoy it. That is what these discussions are about. I am particularly pleased to introduce Congressman Elijah Cummings, who has been with us previously on other stages and [previously on other states and rooms]. Congressman Cummings has served in the House of Representatives since 1996. He has become a true friend of the Alliance, on the path that we are all taking together.”

**Representative Elijah Cummings**

“At times, I say to my fellow members of the United States Congress that we can no longer afford just to get to common ground. We must get to higher ground. When I think of oral health, three words come
immediately to mind: pain, passion, and purpose. For me, the pain did not begin with Deamonte Driver and his tragic death five years ago. The pain goes back 55 years to when I was a little boy in South Baltimore unable to get dental care. My mommy and daddy were sharecroppers who moved to Baltimore to give their children a better education. They didn’t know much about dental care; they were trying to survive. Today, we have parents not taking care of their children’s dental needs simply because they don’t know. As a result, we have yet another generation that does not understand the connection of their teeth and bodies. We have much work to do. If we do not help people understand the concept I am about to say, our effectiveness will not be all that it can be. People do things for one of two reasons (or a combination of both): to gain pleasure or avoid pain. Once we can help people take care of their bodies, they can be rid of pain and continue to have pleasure. That connection must be made.

We have much work to do. If we do not help people understand the concept I am about to say, our effectiveness will not be all that it can be. People do things for one of two reasons (or a combination of both): to gain pleasure or avoid pain. Once we can help people take care of their bodies, they can be rid of pain and continue to have pleasure. That connection must be made.

Education is particularly important to all that we do. In Baltimore, Dr. Elijah Saunders, a renowned cardiologist and international expert on hypertension, noticed in his research that people were going to doctors, yet their blood pressure stayed high. Why? People were listening to the doctor, getting prescriptions, but never taking their medicine. Peoples’ lives depend upon what happens in this room. I am a champion for your cause. I am the little boy who sat in the class in pain. I am the one whose self-esteem was damaged because I could not open my mouth. I am the child who over and over again watched my classmates believe that tooth decay was supposed to be a part of their lives. What follows is low self-esteem, failure to pay attention in class, and failure to live a life like normal kids do.

So what do we have to do? Make sure that people are educated about their teeth. Find a way for the dental profession to work with the medical profession to concentrate not only on children’s dental health, but also on adult dental health. Many adults are in trouble but don’t know it. Many adults go to bed every night without brushing their teeth. We need soldiers in our army who understand the connection between teeth and body.

The health and oral health of our children is our ‘number one goal.’ It is not okay to see a person like Deamonte Driver still coming into the emergency room today because he has not received the care he needs. We are a country that is better than that. I am here today because I want to speak to the soldiers. We are all interconnected in our journey. You are informed and in touch with your representatives and senators. You have to let them know what this oral health issue is all about. You must be heard.

A lot of people say: Why should I bother? How does my opinion help? A friend of mine was about to die. He said to his mother: ‘Miss Maggie, I am tired of going against the forces that seem far greater than me. I am tired of being David against Goliath.’ She held his hand and said, ‘If you want to do nothing else, be a witness.’ When Deamonte Driver can die at 12 years old because he cannot get a dentist to treat him in one of the wealthiest counties in the country, all of us must be the witnesses. If we want to have a strong America, we must have a well America. Working together, we can change the future.”

Ralph Fuccillo

“We all now stand on higher ground together. We are so grateful to Congressman Cummings for sharing his purpose and passion with us today. Many people in this room have eliminated the pain he discussed. As we go through the day, think about the passion we each bring to our work. Yet, as Congressman Cummings said, it is not about us; instead, it is about our shared mission for the people we serve. We must keep this conversation vibrant and heard far beyond this meeting today.”
“If we want to have a strong America, we must have a well America. We are all interconnected in our journey today. Working together, we can change the future.”

– Representative Elijah E. Cummings
7th Congressional District, Maryland
U.S. House of Representatives
Elaine Kuttner
Colloquium Facilitator
Principal, Cambridge Concord Associates

“The Sixth Leadership Colloquium begins the completion of six rich discussions that have brought together many people. Is there anyone in this room who has been to all six colloquia? Yes. Like me, many people have had the chance to see the evolution of these discussions, including the rationale behind the high-level messages that evolve from the colloquia. For many individuals here for the first time, I want to make a special point. We provide a platform for common ground. Each individual who comes into this space brings history, knowledge, wisdom, concerns, joys, and much more to the discussions. Together, we are the sum of all these parts. The value that each person contributes is what makes these discussions amazing. Our mission, values, and core principles reflect our shared purpose.”

Mission
The Alliance provides a 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.

Values
• Integrity and transparency
• Respectful relationships
• Creativity and innovation
• Comprehensive approaches
• Forward-looking solutions

Core Principles
• Trust-building
• Diverse and effective partnerships
• Shared leadership without expectation of ownership

Six Priority Areas
• Prevention and public health infrastructure
• Oral health literacy
• Medical and dental collaboration
• Metrics for improving oral health
• Financing models
• Strengthening the dental care delivery system

Our Diverse Network and Working Norms

Douglas M. Bush
Executive Director, Indiana Dental Association
Alliance Board Officer and Founding Board Member

“Recognizing that many of you are attending a colloquium for the first time, I will share a bit of history. The mission of the Alliance is to provide a platform for a diverse network of stakeholders to forge common ground. Together, we can harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations across our country. Place an emphasis on the phrase, diverse network. We have drawn together a wide group of people at this colloquium who share values. You just heard Elaine Kuttner underscore the Core Principles of the Alliance. Finally, our Working Norms provide the basis for how we participate with one another as we work together toward common ground. Within the Alliance, we are serious about these Working Norms. While we all have our own opinions, we honor all opinions around the tables. We listen to each other. Though it may be easy to respect the people around your table when they agree with what you say, it may be a bit more challenging when they don’t agree with a key point you share. That is true for all of us. Seek to understand the point of view of each person at your table. It is through our shared discussions that we will reach common ground to strengthen oral health for all.”
Systems Approach to Oral Health Care  
(Discussion #1)

Contributor

Brian Souza  
Managing Director  
DentaQuest Foundation

“A systems approach may be the only way to strengthen oral healthcare systems. Consider these brief excerpts from a recent report1, New Ways of Developing Leadership in a Highly Connected World: ‘We live in a world of skyrocketing complexity and filled with adaptive challenges that require solutions that lie outside the current way of doing business…Unlike technical challenges that are more easily solved with traditional models of leadership, adaptive challenges require a networked approach so that people can cooperate across traditional boundaries that exist within organizations and across issues, sectors, and social conditions…We need to work in highly connected ways.’

The world of complexity is displayed in a graphic titled, ‘Obesity Systems Influence Diagram2,’ which takes us outside our world of oral health. The graphic was produced by shiftN, an organization that helps its clients bring clarity to complexity. The diagram lays out the specific factors that influence obesity, and it begins to group those factors into key systems – showing their interconnectedness. This also is relevant for our work in oral health.


In the case of obesity, a decade ago the focus was on only two factors: food consumption and individual physical activity. If you can get people to eat less and exercise more, we can move toward solving the obesity crisis. Yet these two bubbles are only part of the story. If we focus only on those two systems, we miss the majority of the story. A systems-wide approach is important.

Recently, our DentaQuest Foundation team has been reading Clayton Christensen’s book, *The Innovator’s Prescription: A Disruptive Solution for Healthcare*. If we are going to bend the curve of cost of care, and if we are going to improve outcomes, we must think about care and care delivery beyond the patient-provider interactions. Dr. Christensen uses the example of diabetes: ‘The average person with diabetes spends 2 hours a year managing the disease with his or her healthcare provider, and spends 8,758 hours trying to manage diabetes on his/her own.’ While we don’t want to minimize the importance of those 2 hours, we also cannot ignore the other 8,758 hours as we consider how to change the care delivery system. Reversing diabetes trends requires a systems lens. That also is true for oral health.

In considering oral health today, what happens when the oral healthcare system fails? At a recent worldwide conference of foundations, a session titled ‘Fail Fest’ put forward as its premise that we can learn from those times when something doesn’t go as intended. Individuals from small and huge foundations, including the Gates Foundation, shared examples of their failures. We have all seen images of thousands of people waiting in lines to receive dental care through Mission of Mercy clinics. These are manifestations of the failure of our country’s oral healthcare systems to meet the needs of the population. Dr. Terry Dickinson, Founder of the Mission of Mercy Project, said in his presentation at the Second Leadership Colloquium: ‘As much as I love what I do, I hate to have to do it. It’s just not the answer; it’s not the solution.’

We understand the tragic and complex truth: Deamoto Driver died because the systems failed him. Our work going forward is to dive deep into the systems that impact oral health, including those that support the oral healthcare system. We must embrace the interconnectedness of this work. National and state policy shapes how care is financed, organized, and delivered. Policy can help shape and support (or not) community-based prevention and education programs. Financing drives the type and amount of care provided, and financing can open the door to new ways of providing care. Yet, without a strong network of community-based education, prevention, and avocation programs, policies, financing, and care may become ineffective or meaningless. Our work together is to envision and influence a highly effective oral healthcare system that supports the needs of all people in this country.

Discussion #1 Questions

Given your own work, with which of the four system components do you primarily identify? Say a few words about how you spend your time. Have you ever tried to improve or make changes to one part of the oral health system? Were you successful or did you encounter challenges? If you did encounter challenges, were they coming from your own part of the four-part system or from one or more of the other three parts?

Working in small groups, participants shared examples of successes and challenges in their work within the four systems. They exchanged thoughts about the value of medical-dental collaboration and how to make a better oral health pathway for the benefit of all people across the country.

---

A selection of the participants’ shared experiences and expectations for the colloquium follows –

- **Interconnectedness of the four components**
  An understanding of the interconnectedness of this oral health system is essential, given that no one sector can stand alone. For example, policy, financing, and community all have an impact on how care is delivered. In most dental schools, all sectors are presented, though their importance may be weighted differently at different times. At times, one part may seem out of alignment. For instance, though the goal is to help individuals and families move toward prevention, funding must be in place for that to occur. How can limited resources best be used given the goal to strengthen oral health for all? Some participants stressed the importance of a family-centric approach; while others stressed the need to address individual needs first, including those of their families, while also addressing community needs.

- **Value created through medical-dental collaboration**
  Build greater understanding about the potential impact of interprofessional initiatives on oral health outcomes. Encourage health services research that is informed by such collaboration. Though opportunities for oral health intervention exist across the lifespan, they are not always where you expect them. For example, one opportunity to influence oral health is in meeting expectant mothers within the medical setting. Consider what collaborative approaches could increase oral health access for the elderly (often neglected today), as people live longer and keep their teeth longer.

  At times, the priority for oral health prevention may become secondary to a medical focus. For example, dental care may prove difficult to include at school-based clinics. One participant drew attention to a foundation in Maine that makes yearly grants in general medicine, while striving always to include oral health. Another individual described an approach in West Virginia where grants have strengthened the infrastructure for oral health.

- **Explore effective ways to work together**
  We cannot do it alone; so do not let individual agendas take precedence. Network effectively. Draw non-traditional partners together to address challenges to access. Consider examining: Who is being served and how? What remains to be accomplished? With what organizations can we expand our network? Have we considered non-traditional partners?

  When collaboration works well, it drives progress. At other times, differences may get in the way. For example, funding may not always align with the most effective approaches to deliver oral healthcare in a particular setting. These are not always obstacles; they may present opportunities.

- **Bring people together to shape effective policy**
  The capacity to ensure effective policymaking requires communicating with the public, drawing like-minded people together, and collaborating. Begin the dialogue and seek common ground to keep people at the table. Trying to influence oral health policy within the framework of medical policy can be difficult. Start with a diverse mix of people with interprofessional and advocacy backgrounds.

- **Shape a better oral health future for all**
  History repeats itself. In the past, we have had failures in the oral health system. Where do we stand today? Who benefits by maintaining the current oral healthcare system? How can we make a better future? In recognizing fiscal limits, accommodation is important; and by finding common ground, we can change oral health outcomes for the benefit of all.
Considering the Future of Oral Health & Oral Health Systems in Our Country (Discussion #2)

Contributors

Linda Niessen, DMD, MPH, MPP
Dean of the College of Dental Medicine
Nova Southeastern University

“I am thrilled to be part of this expanding focus on oral health. Throughout my career, I have served as a clinician providing oral healthcare to various populations, most recently for medically complex older adults. However, I started my career in the U.S. Public Health Service, Division of Indian Health, where I worked for the Choctaw Nation of Oklahoma and provided dental care to children and their families. As a clinician in a hospital dental program, you think about individual patients and how to improve their oral health. As a public health dentist, you also think about populations and how to improve the oral health of the population you are serving. I’d like to discuss the similarities of these two perspectives.

As a public health dentist thinking about populations, I live in a world where we address widespread chronic diseases that have the potential for morbidity and methods to prevent these conditions. There is a body of knowledge in prevention that is not being applied today. Looking forward, how can we use a systemic approach to solve oral health problems?

As clinicians, we talk primarily to the patients who receive the care. However, when developing and implementing population-based oral health programs, we talk to people outside the clinical dental arena about different topics than our usual clinical issues. These population-based discussions often center around policy, financing, and care delivery. The discussions often force us outside our comfort zones, requiring us to create new networks for oral health.

The future of oral health and the need for systemic change will require us to interact with individuals and organizations outside our current networks. We will need to communicate with individuals in the policy arena who may not understand oral health, nor the extent to which lack of access to dental care is a problem.

I would like to offer an example of systemic change that was implemented by the State of Texas and its Medicaid dental program. Some years ago, the State of Texas faced a lawsuit over lack of access to dental care by the Medicaid population. The reimbursement rates were low and few dentists participated. As a result, Medicaid-eligible children could not access dental care. Eventually, the lawsuit was settled and the state of Texas took a systemic approach to the change. Texas Medicaid policies were changed; reimbursement rates to dentists were increased; and the Texas Dental Association worked diligently to get dentists to participate in the program. In addition, as part of the state Medicaid contract, Texas required those dental insurance companies bidding on the Medicaid contract to put into place a system of patient advocates in the 11 districts of the state of Texas. These community advocates, many of whom are social workers, help patients to access needed dental care by linking them with dentists in their respective communities. Progress does not come from the dental professionals alone.

What outcomes are we beginning to see in Texas? Prior to these systemic changes, 1 in 4 of Medicaid-eligible children received a dental visit. Today 72 percent of the children have at least one dental visit a year. The
improvements are ongoing and the systemic approach is moving in the right direction. In the future, we will see a commitment to Triple Aim-enhanced patient care, lower costs, and improved population health."

Steven Kess, MBA
Alliance Founding Board Member
Vice President of Global Professional Relations
Henry Schein, Inc.

“I am in the business of providing products, services, equipment, and technology to professionals in dentistry, medicine, and veterinary healthcare for use every day in providing their services. In that context, we have a very broad opportunity at Henry Schein to understand the trends, issues, and opportunities these health professionals face. From a large industry perspective, I will speak about a range of issues that we have seen addressed, and some of exciting changes. My involvement with the Alliance began in 2009, when the ADA convened the Access to Dental Care Summit that covered the spectrum of 12 different stakeholder groups. Twelve members of each group participated in two-day discussions to identify tasks and opportunities. The Alliance evolved from that summit.

Within the oral health community, there are not enough resources to solve the challenges and issues that face the oral health needs of our society. In recognizing that no one sector can do it alone, the future is in the hands of everyone in this room. Dr. Brand made reference to the public and private partnership model, which I will expand further to include government agencies, non-government organizations, academia, health professionals, the private sector, and industry working together. Networks must be outward facing to involve people with whom you may not be familiar or comfortable and, possibly, with people who may not agree with you. That is where the future is.

At Henry Schein, we believe in globalization locally implemented. Factors within the grid of community funding vary by location, state, and region in the United States. Those variances have to be understood. However, the truth is that common denominators exist across the country in varying degrees from all sectors. As the oral health community comes together with different perspectives, it is time that we all focus on the same end-point. We have to move carefully, yet quickly, to collaborate on sustainable models that work. We face so much fragmentation in oral health. Every community wants its own version of the solution. Very few people talk with each other to say: ‘Here are the results of my program, which may be applicable in other locations. Let’s talk.’

With the exception of the Alliance, the oral health community rarely collaborates, which is one reason I joined the Alliance. This is where the future lies. However, we also need to educate people in other sectors about leadership and problem-solving opportunities. We have to invest in the capacity of communities to appreciate their roles in the solution. We used to tell communities what to do. Today we ask them what to do, but they don’t necessarily know how to respond. We haven’t given them the tools to appreciate the situations in which they find themselves.

Let us look back into the pipeline of leadership across all sectors. Focus on education, collaboration, and solving problems across sectors. Together, we must champion models that are reproducible, sustainable, and have measurable outcomes. Without those components, we would be hard-pressed to get policymakers, funding agents, and others to pay attention to the scope and impact of the oral health ‘silent epidemic.’

This mission cannot be accomplished by any one person or sector, regardless of their resources and expertise. This is a community of well-intenders getting together. Always keep in mind those people we are helping, why we are doing it, and who else is helping or partnering with us.”
Michael C. Alfano, DMD, PhD  
Senior Presidential Fellow  
Executive Vice President Emeritus  
New York University

“When I was Dean of the NYU College of Dentistry, we had the opportunity to merge the College of Nursing with the College of Dentistry. Although this is counterintuitive, we believed that if we could have nurse practitioners in the dental office, then the tens of millions of people who don’t regularly access healthcare, but do access dental care, would have access to flu shots, blood pressure evaluation, and the like. Academically, we had great synergy and the relationship prospered beyond anyone’s imagination with both institutions moving up significantly in research rankings. Yet the dental community itself behaved badly when this combination of dentistry with nursing was announced.

Years later in a different job at NYU, I tried to stay out of the affairs of dentistry. However, I received a call from a good friend, the former dean of the School of Dental Medicine at Columbia University. He was involved with the Kellogg Foundation and asked me to serve on a panel that was developing a curriculum for mid-level dental practitioners. I told him that it wasn’t appropriate for me to do those things anymore, but he was having trouble getting dental deans and former deans to serve on the panel. They were afraid that their schools would be ostracized by local dental societies. Disappointed by such inappropriate political pressure by some in the dental profession, I ended up accepting the invitation to serve on the panel. These stories create a frame of reference for where we are today. While organized dentistry acknowledges that an ‘access to care’ problem exists (an acknowledgement which I applaud), it continues to maintain that it does not even want to study the potential role for mid-level practitioners in the United States. I submit that the acknowledgement of a problem coupled with strong resistance to studying solutions to this problem is an anti-intellectual position that is unworthy of a science-based profession like dentistry.

In contrast, some in the public health community think that mid-level dental providers are the perfect answer to access to care in this country and want to proceed post-haste to implement the mid-level practitioner model. Yet within the U.S. system, we don’t have a clue if this is going to work because of the tripartite payer system in place – private pay, insurance, and government programs. In almost all successful models of mid-level practitioner deployment, the payment comes from state or federal government. Thus, since it is unlikely that additional government support for dental care will be forthcoming in the United States in the near term, it is possible that we could introduce mid-level practitioners into the system without enhancing the ability for people to access care at all. Therefore, I believe that both sides in this controversy have it wrong.

I see two future pathways: the ideal pathway and the likely pathway. In the ideal pathway, we will evaluate mid-level providers within the current, complex U.S. dental care delivery system. If we are serious about how such a system might work we would consider the suggestions of such groups as the ADA, the ADHA, the California Dental Association, HRSA, the Kellogg Foundation, and Community Catalyst; and we would build the best ideas into a research demonstration program. This would need to be at least a five-year evaluation to assess not only the clinical outcomes over time, but also the economics and sustainability of such an approach.

Perhaps this study will show that we can create a system that includes mid-level providers either within the scope of dental practice or perhaps in ‘health homes’ with robust patterns of cross referrals. This ideal pathway would have the following outcomes: More people will get care delivered at a lower cost; more jobs will be created in healthcare; and the dentist will earn more income (not less) – representing win-win-win.

Alas, we seem to be on a pathway – the likely pathway – wherein two separate dental practice models will be created: the traditional model and the mid-level model.
Organized dentistry and public advocates will fight over mid-level providers. Organized dentistry will win some; and public legislative advocates will win some. In most states with mid-level providers, these providers will not be linked to the dental profession. This would potentially create enormous confusion in the public and might also lead to a reduction in the overall quality of care. For example, patients might go to a mid-level provider thinking that the person is a dentist, but the mid-level provider would not be able to offer implant dentistry even if it represents the best therapy for a given patient. Outcomes from the likely pathway will be that the confused public will have two levels of care, but not in the way that most dentists think. Esteem for the dental profession will drop. Insurance (public or private) will incentivize patients to go to the least expensive provider; dental schools will start folding again; and, most importantly, access will not be enhanced.

Surely we can do better than this.”

Peter DuBois  
Executive Director  
California Dental Association

“The great majority of our members in the California Dental Association are in private practice today. Private practice dentistry is in the midst of a sea change. In reality, private practitioners are beginning to feel enormous economic pressures. That phenomenon is underscored by the rapid development of ever-increasing, large-scale group practices and dental service organizations funded by Wall Street.

We saw a similar phenomenon in medicine in the late ‘80s and early ‘90s. Venture capital saw an opportunity in medicine similar to what it sees today in private practice dentistry. Near-term they could acquire control if not ownership of practices, force down overhead expenses, and increase profitability. They also could bring together increasing numbers of physicians, which would be valuable as systems began to agglomerate delivery capacity. Then they would sell the practices and make money.

Today that is beginning to happen in dentistry. Wall Street investors are investing in about a dozen fast-growing companies, including some in California. In medicine, it became clear that you can force down the overhead only so far until there is no more to squeeze out. Suddenly the profitability is gone. By then the venture capitalists hope to be out of the deal. They attract a less sophisticated group of second owners to come in. Or they attract a sophisticated group of second owners who fully understand that it is no longer about profitability, but rather about something related to the development of a health system. It is unclear how this will play out. Certainly, I do not believe there is significant, sustainable year-over-year profitability in dental practice cost reduction or revenue enhancement.

At some point, push will come to shove for first-generation investors. Either those groups will implode, or they will be acquired by friendly health systems. All the policy initiatives in play currently point us toward the integration of dentistry into health systems overall. Possibly, one day dentistry could be fully integrated with medicine, and dental practices fully integrated with medical practices. The rate of change may be very slow.

I talk with strategic planners in large health systems in California and ask them: Where does oral health figure in your priorities as you make plans for Accountable Care Organizations? They say it is not even on the list. They have so much work to do with integrating their medical specialists, nursing staffs, and lab people; they cannot think about dentistry. At some point they will. In the meantime, it is possible that cost pressure on private practice dentistry will have driven large numbers of dentists into large-scale practice – whether a service organization or a group practice. At that point (10 to 15 years from now), we could see a sea change where dentistry migrates into the medical hospital delivery system.

Until recently, dentists indicated they loved their profession ‘just the way it is.’ For them to cope with near- and long-term economic and system challenges
will be difficult. I see that struggle going on with our CDA members. We did an access survey about four years ago and were stunned that a majority of our members didn’t think there was an oral health access problem. They love the particular dimensions of their practices, their lives, and their families. Consequently, we continue to have tremendous educational challenges.

I think it is wonderful that this coalition has come together. In the midst of change, it is important to have friends, collaborators, and a network to help you think and cheer you up when gloomy. Having been through several significant change experiences in healthcare, I know that it is not a straight-line progression. You make progress and slide back. The important thing is to stay focused on the ultimate goal: providing service to those in need, providing adequate oral health literacy, and offering prevention to help those who will be in need.”

**Discussion #2 Questions**

The contributors talked about the future of oral health and the systems that impact oral healthcare in our country. What are your overall reactions? What themes did you hear? What excites you and what concerns you about the possibilities ahead? Based on your own work and the trends you observe, what are your own ideas about the future of oral health in this country? What are your expectations for change over the next decade?

The participants put forth a range of ideas involving change and accountability for oral health. The growing alignment of oral healthcare and medical healthcare figured prominently in their discussions, as did implications for how oral healthcare will be delivered in the future.

- **Change in an ‘Era of Accountability”**
  As accountability for oral health continues to grow, new measurement systems for care will drive change. If implemented as planned, the Affordable Care Act will draw national attention to quality, although it may take time to have an impact. Accountable Care Organizations will play a role in moving toward integration. From a dental perspective, integration may be slow. Will low-income individuals and families truly have good access to care? Will a public funding result in a two-tier system? Assuming momentum builds toward patient-centered homes, how will oral health fit in?

- **Interconnect Oral Health, Medical Health, and Funding**
  Today’s two-tiered payer system represents a missed opportunity to align oral health and medical health, while managing the cost effectiveness of care. Patient-centered, integrated oral health and medical care will come to fruition eventually, but it will be a slow process. Competing agendas impede progress. Funding remains a huge issue, notably when there is currently no dental benefit. Can we envision sustainable funding mechanisms that medical and oral health leaders can endorse collectively?

The United States has one of the best oral healthcare delivery systems in the world. Yet some individual providers (medical and dental) do not fully appreciate the impact of oral health on overall health. These attitudes continue to keep dentistry segregated from other healthcare. The future is dependent upon the ability of healthcare providers and policymakers to understand the interconnectedness of oral health and overall health. Science does not support the separation of the two areas. Maintaining one’s oral health may require a skill-set beyond that of some of today’s dental providers. The concept of “it takes a village” may be appropriate. Ultimately, we may see a holistic care model, where medical care and dental care come together in a prevention focus: a one-stop model.

Multidiscipline offices can provide a helpful option for dentists who are struggling. One key to success for large group practices – dental or medical – is to align the business side with the care side. For young dental professionals in large-model practices, concerns will remain about the pressure between providing quality care and productivity. Dentistry will benefit by taking a more monitored approach to quality-measured care.
• **Share Responsibilities with Non-Dentist Oral Health Professionals**

Knowledge about mid-level providers comes largely from positive experiences in other countries where these professionals have changed how service and care are provided. Change could happen in this country too, yet fear remains about sharing power and responsibility with non-dentists. Some perceive that mid-level providers would be separate from the current system and without supervision. Mid-level providers are not envisioned to be independent but rather would be new members of the oral health team under the supervision of a dentist.

If the current system is dysfunctional, a new team member is not the solution. Understand where these potential new members of the dental team can “bridge” care. On the medical side, examine the role of physician assistants and nurse practitioners. Is there an analogous scenario for dental mid-level providers to have a widely accepted role in the oral health community?

• **The Need for Change and Access**

Sharing knowledge and outcomes data is crucial to drive systems change quickly. The current system does not meet all dental needs. The existing gap between the current dental system capacity and the increasing dental demands of the community is challenging. We understand how to improve population oral health, but not necessarily how to incentivize good health for all people. Are there sufficient models that show successful integration? The dental profession seems fearful about partnering with other professions to integrate oral health into the healthcare delivery system. Some dental professionals do not understand the need for such change. Is organized dentistry willing to try new things? Can the profession learn from others (Canada, for example)?

The dental profession and the public’s expectations for oral health are changing. The dental community and the diverse range of oral health stakeholders must come together around a common agenda, where each provides part of the solution. If we are not responsible for such action, it will happen without us. Be progressive. Be a leader.

• **Shift the Model from Treatment to Prevention**

Across the dental environment, we see a lack of focus on primary prevention. Historically, dentistry is a surgical profession, where action is taken after dental disease presents itself. We cannot continue to rely upon old approaches for old problems and expect new results. Dentists have begun to consider the importance of health literacy and wellness. Is the message of prevention getting across to our patients? Do they see prevention as more than simply “brushing and flossing?”

How can we shift the predominant care delivery model from treatment to prevention? Incentivize dental and medical providers to promote individual and community prevention efforts! For sustainable momentum, prevention efforts must be reimbursable. What is necessary for that to happen? Where do risk assessment and diagnosis codes come into play for documentation? How can the dental community be positioned best to place greater emphasis on prevention?

With the Affordable Care Act’s provisions, an increase is anticipated in pediatric oral health demands. For children, the primary focus must be oral health prevention efforts that will be directed over a lifetime. Educate parents and caregivers to instill appropriate behavioral changes in the next generation. Maximize the role of “dental homes” within the “health home” to establish effective, ongoing relationships among the family, the oral health provider, and other primary care providers.

• **Best Solutions for the Future**

There is no single solution. We must try new approaches to chart the best paths forward for oral healthcare delivery. Engage dentists to work together, while also collaborating with other health providers to shape the future. Create opportunities
for private practice dentists to understand the greater demand for oral health services among the underserved. Envision new ways to engage private practice dentists to increase their capacity to provide access for the underserved and be reimbursed adequately for the services provided.

What can patients expect in the future? Will oral health delivery systems evolve to become more like other primary care systems? Though the future is not yet clear, it appears cooperative dentistry will expand. Collaboration with medical providers will take place within interprofessional education as well as practice models. One might expect the dental safety net to be strengthened via expansion of private-public collaboration.

New Realities, Economics, and Practice Models
Change will happen. Increasingly, dentists are accepting the reality that the dental business model will evolve. That train has already left the station and dentists want to help shape that journey. Though economics is a key driver, change also provides an opportunity to integrate oral health and community health more deeply into the objectives of Accountable Care Organizations and the Affordable Care Act.

Engage all aspects of the community by building oral health networks across neighborhoods, schools, churches, peer groups, patient advocacy groups, and local fraternal organizations. Don’t forget grocery stores, hairdressers, and local gathering places of many kinds as venues for sharing information. Promote greater oral health literacy and education for families and individuals through those networks. Start from the ground up and build momentum. Dentistry should use new branding approaches to deepen the public understanding about the importance of oral health.

What Will We Need in our Communities? (Discussion #3)

Contributors
Paul Glassman, DDS, MA, MBA
Professor and Director of Community Oral Health
University of the Pacific School of Dentistry

“The majority of underserved people in our country, and those people with the majority of the dental disease, do not take advantage of the traditional dental care system. Consequently, efforts to make the traditional system (private practice, dental clinics, and fixed dental facilities) more efficient and with higher throughput are not likely to have a significant impact on dental disease. Instead, we must think differently about how to serve those underserved people.

Consider a few facts. Only 40 percent of children on Medicaid receive any dental services. About one-third of low income children have untreated disease, representing twice the rate of children with more income. Forty percent of lower-income elderly adults have untreated tooth decay. About one-third of low-income elderly, disadvantaged, and disabled people have not had dental services in a five-year period.

Thirteen years ago, the Surgeon General’s Report on Oral Health pointed out that we have profound health disparities among groups, including racial and ethnic minorities. Moreover, because the majority of dental disease is chronic, we need to think about using the techniques developed in general health for working with chronic disease, known as chronic disease management systems. Think too about driving this change through the techniques of quality improvement, measurement, and accountability.

What is the difference between acute care and chronic disease management? The acute-care surgical intervention model is provider-centric. People go to where the provider is and receive services in a way that is convenient for providers. Treatment and payment are based on discrete episodes of care. The emphasis is on surgical intervention. Within chronic disease
management, when possible, care is delivered to where people are, and the emphasis is on maintaining health across the lifecycle of their conditions. This requires a longer view. Payment is based on the value achieved in improving health across the lifecycle of the condition. The emphasis is on risk assessment, prevention, early intervention, and using biological, medical, behavioral, and social tools.

We have an opportunity to improve the oral health of underserved populations by providing services in community locations where underserved people receive social, educational, and general health services. How can this work? Many of you have seen me use the graphic, Moving Oral Health from Volume to Value (see figure), in talking about the Era of Accountability. Payment systems that incentivize the oral health industry to improve oral health for the entire population will drive change. Accountability will be based on payment systems that shift from volume-based to value-based, which will drive profound change in the delivery system. New approaches driven by the Era of Accountability include: bringing care to non-traditional settings; considering new types of allied personnel or expanded roles for existing personnel; engaging non-dental providers, physicians, nurses, and others in the healthcare system; developing integrated health homes; using telehealth systems to enable people to communicate across distances; and emphasizing prevention and early intervention.

Consider one example we have been testing in California. The ‘virtual dental home’ is a system to enable allied personnel to be situated in community sites. For example, a dental hygienist in a school takes x-rays and photographs, and creates an electronic health record that lives in a cloud-based server. The dentist at a remote location becomes involved in the care and provides instructions to help keep people healthy in their communities. We call this approach a ‘geographically distributed, telehealth-enabled, oral health team.’ This expanded team provides the opportunity for dentists to re-conceptualize their practices as not ending at the four walls of their offices. In addition, allied personnel can have an expanded role in taking care
of people who do not visit the traditional dental care system. [Access the University of the Pacific School of Dentistry website.]

We have come a long way in understanding the scientific basis of chronic disease management, modern caries management, and partial caries removal. We have greater understanding about how to keep people healthy in their communities. This revolution in science, delivery and finance systems provides a real way for us to develop integrated, community-based, oral health systems based on chronic disease management and oral health outcomes.

Nicholas Mosca, DDS
Director, Office of STD/HIV
Mississippi Department of Health
Immediate Past President, American Association of Public Health Dentistry

“Most of us see ‘community’ geographically. However, it is not only the locale where we live, but also the norms of behaviors and values that we expect within that group. Community is not static. It shifts and evolves. As Dr. Glassman said, in considering telehealth, we have to look at the mobilization of society in how homogeneous people are now dispersed. As the groups become heterogeneous, there are pockets of vested interest. Within community, people have shared interests. They bond because they look out for themselves. Yet as society becomes increasingly complex, our system must address that. If we look at politics from the ‘30s, ‘40s, and ‘50s, we can see an exponential explosion of organized associations and public interest groups. According to David Truman’s theory, that had to do with the evolution of the complexity of society.

Also, we tend to categorize communities based on shared interests. We place at the bottom of communities those people we tend to marginalize. They are labeled as dependents and deviants (based on the work of Helen Ingram and Anne Schneider). We tend to put the poor, drug users, single mothers, and welfare mothers in a category we stigmatize as ‘being worthless.’ In categorizing children and pregnant women, we tend to see them at the same strata and vulnerable. The elite class (the advantaged) is at the top. That means classism is a strong driver in community.

Today I work in the HIV/STD world. HIV was a severely marginalized community. In Mississippi, the disease began to spread from gay white males to the black community. Thirty percent of our HIV cases in Mississippi occur among black women. Today, homogeneous communities are beginning to work collaboratively to figure it out. That is how community fosters itself. We look at our own underlying values and deeply held beliefs, and we grapple with how we can relate to those who differ from us. A philosophical term for this is ‘communitarianism,’ which is the responsibility of the individual to the community. Having gone through Hurricane Katrina, we went from ‘me’ to ‘we.’

What do we learn from this? From work by Ronald Burt in 2004: ‘People who stand near the (structural) holes in the social structure are at higher risk of having good ideas.’ As a dentist working at a hospital, I provided care to HIV patients. Before others, Dr. Saul Silverman started to see disease in the mouth of individuals who had HIV disease. He was standing next to those structural holes. He was in a relationship with this homogeneous community.

4. The Virtual Dental Home: Improving the Oral Health of Vulnerable and Underserved Populations using Geographically Distributed Telehealth-Enabled Teams; Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry, May 2013. Visit www.dental.pacific.edu


To be effective in working through community to solve problems, we have to step outside our homogeneous group. The community of health has three structural groups. The health elites have unique knowledge because their education differentiates them and makes them ‘go-to’ people. The rationalizers are also elite, but they are not trained as health professionals. They operate the business of health, and they tend to rationalize and equalize the power of the profession. The bottom group includes the disenfranchised people—the unheard voices who are powerless and without care. If we could work with those three communities at different levels of strategy, maybe we could have a maximal gain. We have to change the trajectory.

The book, Whatever It Takes by Paul Tough, is about the life of Geoffrey Canada. Geoffrey asked the question: What would it take to change lives, not one by one, but in a programmatic standardized way that could be applied broadly and replicated? He changed the magnification. Let’s not look at the individual. Let’s look at the block in Harlem. Let’s look at a community group and determine what that group needs collectively. Then that model can be replicated across the country. The goal for all of us here today is to recognize that we have to change our focus. If we do, we will see people where none were seen before.”

Discussion #3 Questions

Building on our contributors’ comments and given our collective goal of providing “optimal oral health for all,” what are the most important things we must keep “front and center” as we shape the future of oral health in our communities? What will need to be strengthened, changed, or newly implemented at the community level? What do you believe the ideal community oral health system should look like? What difference will these changes make for the people who make up our communities?

At the core of these table discussions was the value in educating, motivating, and providing care to communities to strengthen oral health and the quality of life for individuals and families.

Strengthen the Quality of Life Through Oral Health Care

- Improving the quality of life for individuals and families is paramount. Listen to the community. The right community-based approaches will engage people to take responsibility for their own oral health and that of their families and friends. What do they need to do to strengthen their commitment to better oral health? Make the connection of good oral health to overall health for both providers and communities.

- Seek out those who are most affected by lack of oral healthcare, whether they are in communities without healthcare, out of touch with existing healthcare resources, or in survival mode. Encourage non-traditional delivery locations that can strengthen access to care, such as schools, public housing neighborhoods, and other isolated areas that can be served by mobile healthcare units. Eliminate barriers to providing oral healthcare in long-term care facilities.

- Strengthen the patient experience, including the quality of treatment and care received. Put measurement tools in place to better understand which approaches to care are most effective and introduce changes as needed.

Invest in and Expedite Prevention

- Help individuals, families, and communities comprehend that dental disease is preventable. Use highly integrated communication and outreach channels that build upon one another to educate the public to adopt the most effective approaches to prevention. Allocate funding to support these prevention educational programs. Build on grassroots and drive from the top as well. Invest in science and research.

to support valuable data collection and analysis in order to build a research-based position about disease management.

- Invest in oral health literacy programs that change behavior. Dedicated coordination will be required to integrate a prevention mindset in communities across the country. Involve interdisciplinary health professionals, educators, researchers, and businesses at local, regional, and national levels. Seek local and state governmental support of innovative prevention outreach and education programs.

- Invest in leading-edge science and research that demonstrates the impact of prevention on oral health disease burden. Educate oral health and medical care providers to embrace these best practices to prevention.

- Instill prevention into the community through education. Educate mothers about the oral disease process and the impact of fluoridation and other prevention efforts. Learn from previous local, state, and national prevention programs that urged people to stop smoking. Extrapolate that learning to change behavior to support good oral health and prevention.

**Encourage Interprofessional Collaboration**

- Align dental and medical educational curricula in all schools to integrate oral health into overall healthcare. Promote collaboration among interdisciplinary providers as they strive to meet the needs of their patients. Some communities have already begun to take action across the country. Encourage other community members to envision a future of collaborative oral and medical healthcare and join this team. Help them engage quickly, effectively, and collaboratively in the changing oral health environment.

- Recognize dental care and medical providers as co-drivers of change to support patient health. Encourage collaboration to support patient health in ways patients cannot do alone. Shift the focus from disease treatment to health management and prevention across the lifespan. Underscore the urgency. Bridge the public and private sectors of health care to better address the significant hurdles ahead as the landscape changes. For those dentists leaving private practice for cooperative settings, help them make that change. Note the importance of patient navigators within the community as a foundational element of this integrated system of care.

**Strive for a Highly Effective Community Oral Health System**

- Assess the oral health needs within the community. Involve community leaders in education, decision-making, and change efforts. Build trust among oral health stakeholders. Philanthropy can be helpful to support transitions to become healthy communities; the community must be prepared to drive change.

- Culturally competent providers strengthen communication within a community. Some classically trained dental practitioners may be challenged in shifting their focus from the individual to the community. This awareness can be learned over time by meeting people where they are and seeking to understand what motivates them. Treat communities as individuals. One size does not fit all. Assess and focus on what works best for each community. What's critical is an honest “cultural humility” combined with efforts to build trust and understanding.

- Community leaders can provide insight to instill the appreciation of cultural competency within oral health-care providers. Share resources and experiences among these leaders. Learn from those who have gone before. Build upon the diversity within your state oral health coalition to strengthen community health systems at the grassroots level. Pay attention to the cultural norms of different communities. Get to know who the community “gatekeepers” and “enablers” are and utilize their ability to open doors!
Provide Care to Individuals and Families within their Communities

- Identify new access points to overcome barriers to care. Empower individuals and families to take responsibility for their oral health and to advocate for greater oral health access. Develop family-centered models as it is not enough solely to “treat the child.” Educate the whole family about oral health. Provide a sustainable oral health delivery system that supports a lifespan of care for the entire family from pregnancy through eldercare.

- Balance preventive care and treatment, while recognizing that approaches may differ for children and adults. Preventive care can be delivered and taught in many effective settings throughout the community (separate from surgical care).

- Ideal healthcare within the community focuses on prevention, enables an integrated approach to dental and medical systems, supports population education, builds oral health awareness, and provides care access to marginalized populations.

Learn from Community Health Educators, Care Providers, and Outreach Workers

- A community-based delivery system has dual benefits: vulnerable populations can access care more readily and providers will gain understanding about the community culture. Cultivate relationships between healthcare providers and others who work within these communities. Educate all health caregivers about the value of health educators, patient navigators, and social workers in building an effective community-based care delivery system.

- Put oral health in the “toolbox” of community outreach workers and health educators. Train community workers about best approaches and expected outcomes around prevention and oral health. Use their expertise to break down resistance of some care providers to changing the current delivery of care. Help them better understand the value in integrating oral health care to address other systemic conditions and disease.

Attend to the Business of Oral Health

- Develop a business model for community-based oral health that is sustainable, supported by metrics, improves health outcomes for patients, rewards providers for their work and experience, and influences a willingness to explore non-traditional systems for providing dental care.

- Create localized networks of stakeholders representing dental, medical, business, social systems, and insurance to drive “health change” within and across communities.

- A highly effective payment model will attract and sustain adequate providers. Public funding is lacking today. Develop funding systems that are responsible to providers and patients alike. Consider reimbursement for patient education, reimbursing physicians for dental referrals, reciprocity of licensure, implementing dental risk assessment and diagnostic codes, and formulating policies to facilitate changes that allow dentists to practice more efficiently and effectively.
What We Will Need in our Financing Systems (Discussion #4)

Contributors

Fay Donohue  
President & CEO  
DentaQuest

“If we are to strengthen the oral health delivery system, we must remind everyone that all money and funds spent on healthcare and oral healthcare come from one source: wages. Our income. We contribute by paying taxes, paying directly to a provider, or paying through an insurance plan or third-party payer; or our employer gives us less wages because they pay out funds to help subsidize us. This is not a mythical money tree. Instead, these funds come out of everyone’s pockets. Consider that $108 billion goes to fund oral healthcare delivery in this country. Is that a lot or a little? Without context, numbers are meaningless. Think about all the diseases we fund, including money that goes to heart, asthma, cancers, and essentially two diseases in oral health. Rank them. We spend more money on dental care than any disease except heart disease. Dental care is #2. Money spent on dental care is in a neck-and-neck race with all cancers combined. That is more money than asthma, diabetes, accidents, or mental health.

In terms of all of the money we spend on children’s care in this country (from well-baby care to children’s hospitals), 23-26 percent of that spending goes to dental care. When people say that oral health is a rounding error, that drives me insane. This is not a rounding error. Funding does matter.

Do we spend too much money, too little, or the right amount on oral healthcare? Are we getting the right outcomes from the money spent? Probably not, given all the data we have seen. Maybe the problem is how we distribute those funds. We have distributed those funds the same way forever. Whether your grandmother went to a dentist who provided a service and she paid out of her pocket, or today you receive some financial help from an insurance company or the government: for 99 percent of the population, it is a fee-for-service system. People do what you pay them to do. They are rewarded for what they do. Consequently, dentists provide a range of services. Perhaps the funding challenge is to examine: How do we pay? How do we think about outcomes in a different way? How do we pay for value?

All money spent on dental care comes out of wages. Half of the $108 billion is paid by credit cards and checks. The consumer expectation is that ‘someone does something and I pay.’ Changing systems isn’t just changing a reimbursement from a Medicaid program or an insurance program, or even changing provider behavior. We must change how people think. The economist in me says: maybe the right amount is being spent, or maybe it is too much. However, maybe the system is inefficient. If within a system, 70 percent of the providers are solo practitioners who don’t have a hygienist, but they do have between $700,000 and $1 million worth of capital used for about 33 hours, that is not the most efficient system. Perhaps we are paying much too much for checking and cleaning the teeth of low-risk children. Maybe the problem is distribution. Are we spending money on the wrong things? We spend a great deal of time talking about care and relatively less time talking about health. Moreover, in considering factors toward a goal for optimal oral health, we may have to do more thinking about nutrition and other factors beyond care alone.

The right funding question is not: What will we need in the funding system if we are to strengthen the care delivery system? Instead ask: How do we use funds to innovate, change, create, and ultimately strengthen the care delivery system? How do we fund a different system?”
Barbara Leonard  
Vice President of Programs  
Maine Health Access Foundation

“In Maine, dental pain is the most common reason for young adults (in their 20s to 40s) to go to the emergency room. A recent story in our local newspaper, the Kennebunk Journal, quoted two dental hygienists about pending legislation related to a new mid-level dental provider. As an independent practice hygienist (a licensing category in Maine), one of the hygienists supported the idea of mid-level practitioners. In remembering when he was a kid, whenever his tooth hurt, he would put a paperclip in that tooth to kill the pain. He is now a hygienist and, if that mid-level provider law were to pass, he would like additional training so he could serve kids who are like he was.

Common knowledge in the state capitol is that more money was spent on lobbying related to the mid-level dental provider bill in Maine in 2013 (proposed in the Maine House and subsequently defeated in June) than was spent on gun control legislation. Maine, a rural state, believes strongly that everyone should be able to own a gun and hunt, thereby carrying on traditions that family members have had for generations. Dental provider legislation is a tough, tough issue. The vote on this bill has been delayed until the bitter end of the legislative session, which is slated for today. The other things up for vote today are Medicaid expansion and the state budget. Perhaps this gives you a sense of how tough the discussion of dental providers has been in our state.

I work for a private foundation. Many foundations exist today at local, state, and national levels. When we do our very best, we provide the ‘boost.’ It is not about us. It is about what those organizations we fund can do with our support. However, it is about us a little bit. One of the benefits that we provide is that we are a bit removed at times; and from this place of higher ground, we can see what is happening more broadly. We can provide perspectives and help make connections for those we fund. When you seek support from private foundations for your work, look to them as partners. We don’t know as much as you do on the ground. However, sometimes we can pull back and provide a very valuable perspective. We are your partners. We can support innovation in the work you are doing and give you a boost. At the same time, we are never the long-term solution to funding. Moreover, we want to learn with you about what you’re doing. When you undertake innovative work, we want to know how things are going – both the good and bad.

If we consider Robert Frost’s poem about ‘two roads diverging in the woods,’ he extols taking the path ‘less traveled by.’ At this colloquium, we are seeing that less traveled path, and we need to take it.”

Discussion #4 Questions

As we conceive of a system designed to provide “optimal oral health for all,” what will we need to change about how we finance oral healthcare? How might a re-envisioned funding system work? What will our financing and reimbursement system look like as we incentivize the kinds of communities we discussed earlier?

The participants explored the realities of funding today, with a focus on what changes are needed to build the optimal funding system of the future.

Pathways Forward for Financing and Risk Models

- Available funding is decreasing. Self-pay funding represents about 50 percent of total oral healthcare. Given the finite resources, how can available dollars be redistributed to maximize outcomes? Envision a different finance system that incentivizes people to expect greater outcomes for what they pay for. Identify structural changes that will create pathways to greater effectiveness and efficiencies. What barriers impede federal and state funding of oral health? Blend government funding streams to eliminate duplication and maximize results. What can raise oral health as a priority for governmental entities?

- Spread risk and responsibility among payers, patients, and providers. Consider a risk assessment model for oral health that does not necessarily rely
upon the medical model. However, what can be learned from existing medical models? Must medical and oral health models align? If so, how and why? From a risk perspective, what are the comparative benefits for practicing as solo practitioners or within group models?

- The system cannot afford to keep medical and dental insurance separate. Develop an effective mechanism to pay for healthcare that includes medical, dental, and behavioral health. If dental insurance were merged with medical insurance, providers and patients would benefit. Medical dollars can be saved when medically-compromised patients receive dental benefits. Another example of savings is through the integration of medical and dental records.

- Over the near- and mid-term, what is the most effective role for philanthropy in supporting prevention within oral health? Fund scientific research, new business models, and creative initiatives that will help drive prevention. An apparent disconnect exists between a philanthropic interest in funding innovation and the public/private payer focus on maintaining the status quo restorative focus (drill and bill). Encourage philanthropic leaders to support research and pilot programs in order to determine how oral health financing can support the most effective approaches.

Incentives and Funding for Prevention

- Incentivize the prevention of oral disease. Understand how various payment models impact consumer behavior. Move away from the current approach of funding treatment and procedures. Direct funding to incentivize the patient and the provider to embrace prevention. Invest dollars where the need is greatest and where effective change will actualize prevention. Start with evidence-based payments (such as dental sealants) that support better health outcomes and prevention.

- An oral health prevention focus can include seeing patients on a regular basis (year after year) for continuity of care, which is a hallmark of private dental practice. Fund chronic disease management, along with surgical intervention, in order to make the business case for cross-cutting interventions.

- Incentivize the efforts of dental care providers to drive prevention and promote behavioral change. Incentivize patients to maintain good oral health, including educating adults who do not appreciate the value of prevention. Involve behavior change specialists to share insights into why individuals make the choices they do. Invest preventive resources in areas of high need in order to transition high-risk populations to low-risk status.

- Establishing and maintaining medical and dental homes requires funding. What are the standards and/or protocols, such as risk assessments and diagnostic codes? How important is tracing patient care and oral health over the lifespan? What is the incentive for a provider to keep the patient in good oral health “for life”? Determine ways to measure health and quality of care, while paying incentives based on outcomes derived from these measures.

- Build a value-versus procedure-based system that educates and incentivizes providers to support healthy behavioral change. Pay for outcomes. Pay for education. Incentivize patients and reward prevention efforts throughout an individual’s lifetime. Seek community support to sustain these behavioral changes.
Aligning Medical and Dental Funding

• Acknowledge oral health as part of primary care and develop a comprehensive funding rationale as such. Explore ways to integrate payments for medical and dental treatment. Full appreciation of the cost of oral health must include an overall healthcare perspective. View oral health as a commodity rather than a right or privilege. Create medical and dental partnerships. Could physician assistants or nurse practitioners play roles within a dental office? Could hygienists be situated in medical practices?

• Examine how new or proposed members of the dental team could be utilized to create a more efficient and effective dental care delivery system. How can we finance these additional players? Can this be done under the Affordable Care Act? How can independent practice hygienists or hygienists practicing within public health settings be better utilized? Examine the impact of dental therapists, advanced dental hygiene practitioners, and community dental health coordinators upon a revitalized dental care delivery system.

• As health systems evaluate and potentially merge medical and dental services, should other health professionals be incorporated into this system of care – e.g. various medical and allied health professionals? What is the role of the various medical and allied health professionals with respect to the oral health team? Should we engage pharmacists? What role does teledentistry play in merging the dental home and the medical home?

• Within Accountable Care Organizations, how do we incorporate dental into the financing stream? Dental care can be included in ACOs as a potential model. Fund dental pilot projects to lay a foundation for “buy in” to ACOs. To make the case, use the language surrounding evidence-based interventions versus “promising practices.” Provide ACOs with global budgets to address oral health-related conditions in order to incentivize coordinated interdisciplinary healthcare.

Approaches for Community-Based Intervention, Care, and Funding

• Investigate the ramification of moving from a principally private practice infrastructure to a more corporate or community-shared practice of oral health prevention and care. A public health model moves away from customized and turnkey care in the community. Build diverse partnerships within the public and private sectors while introducing community-based prevention measures.

• Partner with community leaders to educate, provide care, build prevention, and bring oral health literacy to their community. Consider incentivizing oral health literacy outside the walls of dentistry. What can be learned from AmeriCorps educators who were most effective within their communities? Get care to people where they are, such as schools and nursing homes. In rural areas, use teledentistry as an adjunct to the oral health needs of people who cannot access care readily.

• Provide funding for patient navigators to help patients access the dental care delivery system. Include insurance companies in the conversation to better understand the future role of accountability and health outcomes. Implement dental diagnosis codes to initiate a pathway for greater prevention reimbursement. What additional support can third-party insurers provide in the future?

• Identify best solutions for moving away from emergency visits. Develop innovative ways to move oral health patients into appropriate primary care settings and away from the emergency room.
At the federal and state government levels, baseline surveillance is used to identify the burden of dental disease. This surveillance is done at oral health screenings at school, health fairs, and WIC programs. Continue this surveillance and ensure early conversations about the importance of oral health and intervention with high-risk populations.

Dental Care Providers – Future Expectations

- How should we chart the future in ways that will benefit providers and patients alike? Is organized dentistry’s defense of the current dental care delivery system a barrier to change? Do care delivery models exist in other countries from which we can learn? Can we envision potentially effective pathways to pilot these models in the United States?

- If a new healthcare delivery model for oral health providers is considered, is there an educational model to support it? The traditional model has not yielded optimal oral health for all. Let the market decide the future. Direct more money to examine, test, and promote successful innovative models. Consider funding such approaches through, as with taxation on soda, cigarettes, and/or candy.

- Recognize the cost of dental education and maintaining a practice. Will overwhelming debt drive new practitioners away from incorporating care of the underserved into their practices? How will we support the dental workforce as they work in communities across the country in ways that assume changing roles?

- Demystify the dental community on managed care and related funding mechanisms. Will managed care improve the quality of care? Reduce the cost of care? In some cases, has managed care been used to reduce costs rather than improve health? Educate providers about how the system works and about their own role as part of the solution.

- Support new members of the dental team with an aim to increase efficiency, effectiveness, productivity, quality of care, patient safety, and profitability. Develop data to analyze how utilizing a multiplicity of people with different knowledge and skill-sets can enhance access.

- Diversify the dental team to include researchers, people who counsel patients, and people who provide patient care. Examine models for salaried dentists that utilize performance measures for compensation, such as measuring reduction in disease-related appointments.

What Policies Will We Need in Place? (Discussion #5)

Contributors

Ruth Fisher Pollard, MS, MBA
Executive Director, Advocacy and Community Affairs
Children’s National Medical Center

“As we hold this colloquium in our nation’s capital, we are in the back yard of the federal government – the iconic symbol of policy. The federal government sets public policy for us as a nation and often defines resources (insufficient many would say). If we have learned anything from the federal government, it is that all policy is local!

Mahatma Gandhi stated that: ‘A policy is a temporary creed liable to be changed, but while it holds good it has got to be pursued with apostolic zeal.’ His definition suggests that policy should be fluid while passionately pursued. A general and acceptable definition of policy is a ‘course of action adopted and pursued by government or another respective entity.’ What is important is that both definitions mandate ACTION. I posit that the apostolic zeal Gandhi calls for is not only in the senators, congressmen, and congresswomen on Capitol Hill. It is also in this room, in your state, municipality, and city, where the course of action is taken through community mobilizing, patient advocacy, and network weaving reflective of your population’s needs.

In the District of Columbia, we have had several successes in informing and directing policy to benefit an improved system of oral health for children, especially...
children most in need of care. Through our coalition’s network, advocacy efforts, and community mobilizing, we engaged with the DC Health Care Finance Department (our Medicaid agency) to change the policy of fluoride varnish application — undergirded by financing (reimbursement) for dentists and primary care providers. The coalition pursued that policy change with the apostolic zeal that Gandhi had in mind. I heard yesterday how Colorado moved mountains through policy work. That’s apostolic zeal.

During our recent quarterly meeting of the DC Pediatric Oral Health Coalition, one of our members, Dr. Maria Marquez, a pediatrician, said: ‘We need a revolution in medical school … the system we are using was recommended in the early 1900s.’ Dr. Marquez was referring to training that often produces medical doctors with a mindset that doesn’t necessarily support a ‘systems approach’ to health and healthcare. In borrowing Dr. Marquez’s statement, I would extend that revolution to include dental, nursing, physician assistants, law, public health, and pharmacy schools — essentially any institution that trains our health providers and stakeholders.

We must pursue with apostolic zeal those polices that support: a true systems approach, medical and dental collaboration and overall health collaboration, reimbursements to pediatric dentists that align with reimbursements to pediatricians, and loan forgiveness. That is a systems approach! We need polices that are supported by the science of political science rather than subjectivity, that is, policies using credible data and best practices so that funding clearly follows. We must eliminate unnecessary barriers to the process of policymaking. And, we cannot limit our policy work to health or healthcare alone. This work requires us to step out of our comfort zones, expand our networks, and passionately pursue policies in other sectors (such as education) that can support our vision.

I am reminded of another quote, this one from The Leadership Challenge: ‘Leaders must challenge the process because systems will unconsciously conspire to maintain the status quo and prevent change.’ In paraphrasing the words of one colloquium participant: ‘Old thinking will not do. We must all continue to challenge old policies. If they are relevant, we keep them. If not, we revise or eliminate them.’ Those of us represented here must keep moving so that we don’t become ‘status quo.’ We must work to ensure that the systems’ approach described by Brian Souza doesn’t further compartmentalize oral health in our country. We need apostolic zeal as we pursue our strategy of the ‘systems lens’ as the only way to think about oral health delivery. In this system, all of us — everyone — value oral health as part of health. No exceptions. We need a revolution! We need mavericks with apostolic zeal to realize our vision."

Robert Weyant, DMD, DrPH
Associate Dean
University of Pittsburgh School of Dental Medicine

“Don Berwick has helped change our thinking about healthcare systems with this simple statement: ‘Every system is perfectly designed to achieve exactly the results it gets.’ We are working in systems that produce outcomes.

First: When we think about optimizing healthcare outcomes, think in terms of systems. However, understanding systems is difficult. The logical conclusion to Don Berwick’s statement is: If we want to change the results, we have to change the system.

Second: Making changes in systems is required to improve outcomes. Yet how or where to make those changes in the system is not always obvious. Many places in that system exert pressure for change. Intuitively, however, we know that is almost impossible given the complex systems. We have a systems change in the works. The Affordable Care Act was designed to address specific problems, particularly the high cost of care, low access of care, and inadequate outcomes of care. The ACA was built on three pillars: improved universal access, mandated coverage, and subsidized premiums. Though not an optimal solution, it is achievable.
Third: Policy fixes are the necessary drivers for system change. But policy does not occur in a vacuum. The result and outcomes may not always be what is optimal or even desired.

Is dentistry in the ACA? Not really. Has the ACA had value and benefits for dentistry? I think it has.

Benefit #1: The ACA focuses attention on the fact that we are part of a system now. Heretofore, dentistry kept itself financially and conceptually separated from the healthcare system. Health care financing is separate and unequal for dentistry, and the practice of dentistry occurs in relative isolation. (Typically, the dental school is the most isolated school on the healthcare campus.)

Benefit #2: We are starting to refocus on effective systems for patients. I use the word ‘patients’ advisedly, because it tends to imply someone sitting in a dental office, when in fact the people we may be concerned with never get into dental offices. We are starting to understand that problem.

We still talk about the financing of care, workforce issues, insurance coverage, and so on. These terms describe a system of care. In reality, we need to talk about a system of health.

A case in point: My grandson recently turned two years old. He enjoys excellent health and has unfettered access to the best medical and dental care. At the same time, we are all too familiar with Deamonte Driver and others who are the tip of a tragic iceberg of a system that has produced many who live with lifetimes of disease, pain, and reduced quality of life. Yet, my grandson and Deamonte are in the same system of care. Those with the least disease get the most care; and those with the most disease get the least care. Economists and public health professionals call this the ‘inverse care law.’

The system of care that serves my grandson is great, but that is not the whole story. In the first two years of his life, Lukas has spent two hours inside a dental health professional environment. In that time, he has received very little benefit that has created the health he enjoys and the trajectory he is on for a lifetime. In reality, the elements of this health system are broader. They include parents who are knowledgeable about what it takes to maintain good oral health, and who have access to health resources. Their community provides access to high-quality, affordable, healthy foods. Friends and families value good oral health and impart those attitudes to their children. Schools offer healthy food choices, physical activity, and health messages. An accessible healthcare system focuses on prevention and early disease management. Health policy empowers individuals to maintain healthy lifestyles.

We must focus on the health system, rather than the care system. When we go upstream, we will find our natural partners. They are working in obesity, diabetes, tobacco control, cancer, heart disease, and more. Collectively, we can work to achieve an overall improvement in health.”

Discussion #5 Questions

For the future oral healthcare system to be most effective, what national, state, and/or community policies will be needed? What kind of public and private partnerships will make a difference in bringing these policies to reality?

The colloquium participants discussed the need to further engage legislators in the oral health conversation, including helping them understand the critical value of oral health to all their constituencies, and the potential influence of the Affordable Care Act in drawing oral and medical health financing closer together.

Role of Government for Policy and Action

• The federal government should be a leader in promoting the importance of oral health. How can healthcare be shaped effectively if government enti-
ties do not have a full awareness of the essential role of oral health within overall health? Educate legislators about oral health issues. Educate the public to become effective advocates for their own oral health. Does oral health have a consistent policy presence in Washington? Who are its champions? Opportunities are being missed. Today’s legislators want evidence-based policies. What are the unintended consequences of remaining on the current course? What policy changes are needed?

- Supported by the standard of care, identify policies that support the most efficient, effective model of care to meet the oral health needs of communities. Utilize fiscal resources wisely as costs and spending increase. The public pays regardless, but we must seek viable solutions that make public health and economic decisions work together. Collaboration is essential: develop approaches for the federal government to partner with oral health and medical providers, public and private insurers, philanthropy, and patients.

- Consider a marriage of policies with minimum standards. In the best interest of the long-term health of the patient, dentists should develop treatment plan options that can be supported by the funder. Incremental policy adjustments (stepwise) are the building blocks to major change. We need “apostolic zeal” because policy changes are not easy to effect. Authorization without allocation of resources (policy without funding) is wasteful. Consider universal funding for oral health prevention and care.

Role of the Alliance in Drawing Attention to Oral Health

- Build upon the work of the U.S. National Oral Health Alliance as a unifying voice to involve other stakeholder groups in building momentum, awareness, and impact. The Alliance represents “all of us.” The oral health community needs to establish a broader base to get the attention of legislators. Three thousand emails with the same headline will get their attention. Who are our champions?

- Significantly increase awareness about oral health within the national, state, and local arenas. Educate the public about the future of oral healthcare. The Alliance provides a forum for dialogue; expand that dialogue to engage the public. Consider the Peace Corps model to increase awareness on a national level, while incentivizing new dental graduates to serve in underserved areas. Deploy proven, direct approaches to communicate effective messages.

- Consider a seventh colloquium that focuses on shaping unifying messages to take to legislators. Develop a framework for action, including a five-point interprofessional unifying message, and take it to Capitol Hill. Coordinate this initiative with the Tenth Anniversary of the Surgeon General’s Call to Action on Oral Health in America. Remember Ryan White as an example of how people can come together to make a difference.

- Create partnerships that work effectively across the public health system. Support an overarching health issue that will benefit oral health as well. For example, legislation proposed by the Healthy Kids & Families Coalition was not going to pass until the Church Women United launched a campaign of postcards from its members to legislators. The legislation passed; and the governor drew attention to the health of children. Find common ground and align your efforts.

Affordable Care Act as a Driver for Change

- The Affordable Care Act is a motivating factor for integrated payment systems. As written, the ACA does not value oral health to the same extent it does medical health. Dentistry is undervalued and is often seen as “elective” rather than “essential.” Has the dental community brought that upon itself? What can be learned from the Connecticut Medicaid model with respect to the importance of maintaining adequate reimbursement for services rendered?
The Need for Oral Health Policy Change

- Recognize the need for policy change. Policy is more than legislation. The existence of policy does not guarantee compliance and reinforcement. Appropriations are necessary to move policies forward. Ensure that new policies will not create unintended barriers within the system, as some have done in the past. Create policies that support positive, innovative, and cost-reducing outcomes that incentivize dental and medical providers to align their delivery of highly effective services.

- Given that one size does not fit all, experiment with different approaches. For example, consider paying more for providing care outside of regular work times (8-5). Demonstrate practice sustainability when delivering care within non-traditional settings and incentivize accordingly.

- Pay for outcomes. For example, can reduced care rates be used to reward individuals and families for staying healthy? Can we reward companies who have higher percentages of healthy employees? What are the baselines and standards for such “healthy performance?” What type of benefits would reward communities to strive for healthy residents?

Involve Pediatricians and Other Providers

- Implement oral health policy around school admissions and mandatory requirements, similar to immunization requirements. A number of states are moving in this direction; however, there are problems with follow-up, as some children may get a cleaning, but not return to complete the restorative portion of their treatment plan. Can case management help patients navigate the dental care delivery system?

- Oral health literacy is important. Support policies that introduce parents and children to a good oral health curriculum starting at an early age. Help them understand the value of good oral health habits. For example, mandate that Head Start kids brush after meals.

- Does the average pediatrician “buy into” the importance of oral health? Recent medical graduates may be more open to oral health collaboration, than older physicians (and more likely to refer children to dentists). Even primary care doctors who are willing to make dental referrals for children by age one find it difficult to identify general dentists who are comfortable treating small children.

How Would Our System of Care be Shaped? (Discussion #6)

Contributors

Jack Dillenberg, DDS, MPH
Dean, Arizona School of Dentistry & Oral Health
A.T. Still University

“To ensure a successful system of care, we have to make sure that everybody cares – well beyond this room. We have to work together. What I have learned as a former state health officer, and now as the dean of a dental school, is that an interprofessional approach is important. Dentists cannot do it alone. To make the system better, oral health has to be
adopted by, believed in, and practiced by a lot of people. We know what should be done, but knowing is not enough. Knowing has to translate into action. For example, hopefully, we all flossed today because we know that is the right thing to do. It is that translation into action that is important. I also have learned that dentists alone do not make an oral health system.

We need to develop opportunities for others within the dental profession to help us succeed. Whether you call them mid-level providers or clinical extenders, it doesn’t matter. Within the dental system, we need a physician assistant similar to that role in the medical profession. The physician assistant with a certificate in oral health can work on the medical side and make referrals to the dental side. Some of us may get upset with health professionals that are social entrepreneurs. Yet some of those professionals learn about and understand the needs of the communities; and then they develop innovative solutions to create a system of care that works to improve health at reduced costs. For example, medical care has succeeded in involving nurse practitioners and physician assistants. Similarly, we need people within the dental profession who will help us succeed: mid-level providers or clinical extenders.

In this business, if you get paid for something, you will do it. That is a simple principle. Dentists need to be paid to do nutrition counseling, tobacco cessation, and similar health-improving approaches. Why aren’t we talking about this? Why aren’t we spending time with our patients to deal with broader health issues? It is not about teeth alone. Oral health is about health. It is about the person attached to the tooth, the family attached to the person, and ultimately the community attached to the person. To improve the health of the people in this nation, we need to build that system. We have a vital role to play in this change. We have an opportunity to begin with all of us here today. Let’s not be afraid. Remember: for the turtle to go forward, he has to stick his neck out!

David Krol, MD, MPH, FAAP
Alliance Founding Board Member
Fellow, American Academy of Pediatrics

“How should this care system be shaped? First and foremost, the system needs to be capable and competent to serve both patient and population. It is not just about the individual, but it is about community. It keeps both patient and population at the center. The essence really starts with the needs of the patient and the population. The system is either built around or adapts to those needs.

Second, the system truly delivers care. It is an active verb: to bring care. So we have to deliver care; it is not just waiting for someone to come to the service. Through the system, we take care and service to the individual and the population.

Third, prevention and treatment need to be in the same conversation. Essentially, there is some sort of parity or, depending on the need of the population, some sort of ratio of prevention and treatment that is ideal for the population. To truly deliver care, we need multiple access points to the system in different settings where people can enter that health system to receive care. In these settings, that care needs to be evidence-based and of high quality. Having said that, I know that sometimes that can be a crutch or a powerful force for inertia. So it is extremely important that the system of care embraces innovation, testing, and change when appropriate.

Fourth, the care system requires (or needs to require) those who deliver the care to be part of a high-functioning team. Jack mentioned interprofessionalism. I will add that we not confine it to professionals, as some of us might define them. We must include those individuals whom we might refer to as ‘other-than professionals’ as part of that high-functioning team.

What is a high-functioning team? First and foremost, the team members share the same goal. We all work toward the same goal as a part of this system of care. We value diversity by all definitions, including
professional diversity and many other definitions that we know well. All members of that high-functioning team need to engage in shared, participative, and adaptive leadership – and leadership shifts. Not just one individual on that team is the leader. The team shares leadership. Finally, no individual in the care system, and part of that care team, is greater than the team itself.”

**Discussion #6 Questions**

*Building on all the discussions we have had thus far, come to agreement at your table on 5 to 10 characteristics of the ideal future system of care. Consider that future system from the patient’s point of view. How will the patient or other beneficiaries of that system experience care and the outcomes of that care? What will remain the same and what will be different?*

The participants examined characteristics for the “ideal system of care” for oral health in the future. The animated conversations were driven by the range of professional experiences, areas of expertise, and expectations among the participants.

**Essential Characteristics of the Future System of Care**

Envisioning the ideal future system of patient-centered care, the participants provided a range of characteristics, grouped by quality of care, community approach, and care delivery.

- **Quality of care**: An accessible, affordable “whole health” system utilizes an interdisciplinary team-based approach to care for the patient, which is culturally-sensitive, quality-based, quality-delivered, and provides equivalent care for all. It is built upon best practices and outcome-based standards that are cost-effective, evidence-based, prevention-focused, sustainable, and use the best-available science.

- **Community approach**: Care centers on the patient, family, and community across the lifespan and builds upon improving health literacy within communities across the country. It is a system of care with multiple access points, such as schools, Head Start, WIC, assisted living and nursing homes – and focused on creating health homes and healthy neighborhoods within the community. These may include non-traditional stakeholders and models, such as pharmacists, teledentistry to address rural communities, faith-based organizations, parish nurses, school educators, beauty salons, taverns, and grocery stores.

- **Care delivery**: Create an efficient system that is responsive to the patient’s needs and health status with an interdisciplinary and interprofessional team-based approach, and which is ideally co-located for accessing medical and dental care. It offers multiple access points, utilizes a health home model that is patient-centered and supported by case management and patient navigation services. It emphasizes value over volume, while providing value-based needs assessments and interpretive analysis. It creates a system that is sustainable, affordable, and decentralized, while empowering networks and ensuring sustainability.

- **Funding**: Considering supply and demand, provide affordable care that is service and cost appropriate. Focus on value over volume by emphasizing data-driven performance measures and payment based upon outcomes. Provide information so patients and providers can evaluate the price and quality of services rendered. Offer portable and affordable health plans. Require baselines and assessments to understand return on care investment. Fund innovation. Reward patients for maintaining good oral health.
Integrated and Lifelong System of Care

- Care must be timely. Provide the earliest-possible intervention for children, which should continue throughout their lives. Have adolescents buy into their own health and oral healthcare so they can grow up as adults responsible for their own care across the lifespan.

- Define essential oral health benefits that integrate oral health with overall health. Strengthen multidisciplinary teams that provide a consistent quality of care through the lifespan to support changing needs. Interprofessional collaboration will become the norm.

Community-Based System of Care

- Support patient navigation and case management at the community level to connect individuals to an integrated healthcare system. Whenever possible, enable individuals and families to receive care in their own communities and build relationships between patients and health providers. Identify and strengthen multiple access points within the community system and incentivize collaboration. Envision a system that is adaptive, nimble, and able to react in a timely manner to the demands of the community.

Strong Provider / Patient Connection

- Focus on the patient as a customer. Educate patients and their families about their oral health and the responsibility associated with maintaining that health. Build patient / provider trust that is based on a shared point of view and mutually desired outcomes for oral health. Provide care in culturally appropriate settings, using simple direct language understood by the patient. Encourage the patient to ask questions.

- What does “patient-centered” mean? People feel welcome, receive appropriate treatment, and do not feel under-treated or over-treated. Care is individualized, accessible, and affordable. The patient and provider share responsibility for oral health. The patient’s point of view is honored along with the team perspective of providers. These points of view are participatory, equitable, efficient, effective, outcome-based, and community-matched, with an aim toward reducing disease burden. Care is reasonably accessible, including prompt appointments, time-of-day, finance, and location. Patient-centered health records are the norm. Patients document their experiences and symptoms as they occur. Copies of records stay with the patients.

- Provide information to patients in clearly understood language that recognizes each patient’s knowledge and context. Train oral healthcare providers to be health literate. As needed, use community-based translators to assist patients in navigating the system.

Payment and Reimbursement Structure

- In the ideal system, everyone gets care regardless of payer source or ability to pay. Focus payment on health rather than on services rendered. The reimbursement structure must encompass prevention as well as treatment. Include oral health in collaborative funding opportunities wherever possible.

- Simplify and integrate oral health and overall health coverage into a single insurance system for all services. Continue to ask the question: What involvement do individuals and families want and need in the financing of their oral health?

Role of Education in a Culture of Prevention

- By focusing on health and wellness, prevention and treatment will find equilibrium in the oral health community. Support early intervention models built upon prevention objectives. The system becomes far more than simple care delivery when prevention becomes the norm. Ensure that the patient and provider share a “preventive care” mindset. Educate the patient to take responsibility for his or her oral
health. Ensure that adequate compensation is provided for preventive measures and for a widening range of oral health team members, including community health workers, physicians, school nurses, and nutritionists.

- Dentists and medical doctors share a focus (and a reputation) as caring health providers. To support mutual learning, they must share experiences as peers. Provide common health education for both medical and dental personnel to ensure a systemic oral health focus.

**Interprofessional Care Providers – Traditional and New Additions**

- Interprofessional education will translate eventually into appropriate interprofessional care and communication. Look to the dentist as the primary decision-maker of the dental team. In the future, fewer numbers of highly specialized dentists will be responsible for more layers of specialty-trained oral health professionals comprising the system. Involve traditional and new members to function as a team, who will engage the patient in multiple, interdisciplinary venues.

- Define the oral health “scope of practice” from a national perspective. Utilize the existing workforce in the most effective and efficient ways possible.

**Integrated Data Systems – Electronic Records / Information / Data**

- Maintain an evidence-based system to document outcomes, treatment options, and dental economics, which include diagnostic codes, surveillance, and inclusion of medical as well as dental costs in cost-benefit analysis. Create a system based on appropriate risk assessment protocols, while acknowledging that risk assessment can be imprecise.

- Use integrated data systems that produce actionable data. Track the oral health status of the patient and support oral health in all medical/dental clinical decision-support systems for the patient.

- Develop personal health records that include oral health, which are portable and stay with the patients. Patients can document their experiences and symptoms as they occur. Mandate electronic integrated health records across the healthcare system, including appropriate evaluation and actionable data. Electronic integrated health information should be available at the point of decision-making. Use the best-available science to create evidence-based care protocols. The rapid advancement of technology and materials will continue to improve dentistry.

**Preparing for the Future Oral Health Care System (Discussion #7)**

**Contributors**

**Richard W. Valachovic, D.M.D., M.P.H.**  
President and CEO, American Dental Education Association

“What kind of education and training will we use to prepare our young professionals effectively for the future? We are at a moment in time similar to that faced by the healthcare professions in the early 1900s. Abraham Flexner wrote his report on medical education and William Gies wrote his report on dental education. What were the features of those times that required those reports? First, changes in demographics were brought on by immigration and other factors in the United States. Second, changes in the pedagogy and educational method of instruction were introduced. Third, changes took place in the healthcare marketplace, and academic health centers were introduced. If we are at that place of transformation again, what do we face in dentistry, including all the dental professions: dentistry, dental hygiene, dental therapy, dental assisting, and dental laboratory technology?”
We have a very new appreciation of the value of dental care in the United States. That is true for the public in general, individual patients, applicants to dental programs, policymakers, and university presidents. Consider some of the changes occurring now. *U.S. News & World Report* recently ranked dentistry as #1 of the 500 ranked occupations in the United States. Dental hygiene is ranked #10.

From the university perspective, we have seen dramatic change. Seven dental institutions closed between 1986 and 2000. Those were all private schools: three were Jesuit-related, and one was Oral Roberts. That change has had an impact. We were graduating 6,300 dentists in 1980, dropping to 3,900 in 1990. Today, we are back up to about 5,500 dentists. Since 2000, we have opened 13 dental schools; and 7 universities plan to open dental schools before 2020.

At the same time, the higher education landscape is changing. For example, in preparing for new learning experiences across all higher education (not just the dental and other health professions), we will see much more web-facilitated learning. It will be blended or flipped. That is, students will see the lecture at home and do homework in the classroom in a facilitated way. Moreover, if anything is going to change higher education dramatically, it will be MOOCs (massive open online courses). Already, we see dramatic change using simulation technology; health professional education is becoming more inter-professional and team-based; and enhanced communication and leadership skills are important.

In dental education, we will see: community-based experiences focused on evidence-based dentistry; preparing life-long learners to find information and use it; changes in required competency, including national boards, licensure examinations, and a variety of testing mechanisms. The ADEA Commission on Change in Dental Education brings together all of our oral health communities.

We need to prepare our students for the changing delivery system. The traditional model will be subject to market forces, large-group practices, and learning to practice in an employee environment and not just in a small business-owner environment. This year, we are seeing graduates go into residency programs, the military, contracted employment of Indian Health Service, or other dental service organizations (DSO) in ways much different than in the past. We will see more change in the years ahead.”

**Ryan S. Lee, DDS, MPH**
*Clinical Assistant Professor*
*New York University College of Dentistry*

“I am a Clinical Assistant Professor. On the side, I have a private practice working with oncology patients linked to cancer hospitals in New York City; I am doing a part-time doctorate in health policy; and I am a weekend warrior with the U.S. military. All of this has relevance only because I am a recent graduate of dental school (four years ago). As a young dentist, I hope to bring three perspectives to this discussion: (1) millennial needs, (2) money matters, and (3) mentorship.

**1. Millennial Needs:** Though students today may rely on Wikipedia over dental text books and may have a short attention span, they embrace the opportunity to multi-task. They are not steeped in tradition nor will they adopt their uncle’s dental practice in the community where they were raised. In contrast, today’s dental student has the potential to become a social media leader with hundreds if not thousands of followers on Facebook or Twitter. So we see opportunity there. Because today’s students are more likely to engage in technical platforms and interprofessional education, some of the more established dentistry leaders will want to engage us in that way. We embrace innovation. For example, I am often asked to give talks to oncologists, nurses, and even acupuncture doctors regarding dental oncology. They are very interested in my area of specialty, dental oncology, such as implant treatment in radiation patients. While I am not often paid for such talks, I truly value these opportunities. I am passionate...
about combining clinical, research, and policy perspectives in dental oncology, regardless of financial compensation. It is a way for a young dentist like me to carve out my niche area of innovation and leadership.

**2. Money Matters:** I have somewhere between $100,000 and $500,000 in loans. I stopped counting. It is important for the millennials to be informed about existing opportunities and risks. In dental school, on Day 1, please remind students how much their loan debt will be once they graduate, the literal amount of dollars per month, and the fact that they may have to think outside the box (like move to a new geographic area) to achieve financial freedom. (New York City is expensive!) Knowing early helps. Consider my colleagues, for instance, who joined corporate dentistry chains largely because they had few options. These were international students, with good moral and ethical standards, who were forced to work for corporations simply because of their loan debt and the need to have a visa sponsored. They work hard, sometimes seeing 25-30 patients a day, and they risk losing their visas if they fail to produce enough dollars for the dental chain. It is not a one-sided thing where the millennials just “follow the money.” It’s multifactorial.

**3. Mentorship:** When looking for cheaper rental housing in my first year in dental school, one thing led to another and I got involved with community activities in Harlem, ran a free SAT mentoring program, wrote an article about it on the ADA News, and then had one-on-one mentorship conversations with the dean. This incredible experience taught me that it is okay to think that I have a voice to add about the changes in oral health delivery. Now I’m back at NYU, as a near full-time professor, thankful for the mentorship that brought me here. Students who are engaged by mentors often return to academic careers and engage a new generation of future dentists.

Perhaps I have provided you with some insights into what dental students and young dentists are willing to do to go beyond the realm of traditional practices, despite the challenges.”

---

**Caswell A. Evans, DDS, MPH**

Alliance Board Officer and Founding Board Member
Associate Dean for Prevention and Public Health Sciences
University of Illinois at Chicago, College of Dentistry

“Consider the value of dental education to the future systems we are trying to envision. As a society, what do we want from dental education? What is the purpose? Legislators are asking those exact questions in some states where support for dental education, and higher education in general, is declining rapidly. At the same time, we recognize important issues about access to care, health disparities, and unwelcoming health systems that lend themselves to tragic circumstances such as those regarding Deamonte Driver. State legislatures are asking: What societal value are we getting from these schools? I believe we should ask that same question about dental schools in our own communities.

It is difficult to change a dental curriculum. Woodrow Wilson is attributed with saying: ‘*It is easier to change the location of a cemetery, than to change the school curriculum.*’ There is some real truth to that regarding dental school curriculum. We have done some marvelous things with our curriculum at the University of Illinois, though I won’t go into those details. Moreover, I know that faculty and deans at this colloquium represent schools that are exceptions from what I am about to say.

My concern is that we have too many technically-based dental schools that do not provide a foundation for many matters we are discussing here today. If we consider the systems approach, for example, dental education provides the workforce for this care element. Yet those same educational processes result in too many dentists with distrust of community engagement and processes, including the Federally Qualified Health Center or other form of community clinic on the nearby corner, or the local health department expanding its oral health programming.
Consider policy: Some people fear (perhaps distrust) that future policymakers will recommend policy changes that affect their own empires. As far back as the mid-1960s, our profession has worked to hold in abeyance policy that would have provided access to care. When the Medicaid and Medicare programs were developed, the profession took a position against the inclusion of dental coverage in both. This position was not sustained in Medicaid. Today, few oral healthcare providers treat Medicaid patients; access to care for people covered by Medicaid continues to be challenging. This position held forth for Medicare, resulting today in no dental coverage in that program. For the next dozen years, 10,000 people will turn 65 each day. The age cohort of people 65 and older is the fastest growing age cohort in the U.S. That group will not have the benefits of oral health coverage under Medicare.

Consider funding: Some people are not interested in third-party intermediaries. (‘Lord, save me from federal intervention.’) Another funding issue: ‘I need the money upfront.’ (‘Lord, save me from federal intervention and funding.’)

In my mind, to be responsive to the types of systems change we need, oral health providers must be better informed and recognize that the other three aspects of the four-piece puzzle (see page 2) are not enemies. Instead, they are potential colleagues with opportunities to partner and venture forth showing promise. It’s the four pieces working together that comprise the whole; no one piece acting alone could possibly be considered ‘whole.’

Yet, I continue to be concerned about our inability in too many dental schools to produce dentists who can function within these four sectors. We must, and can, do a better job.”

**Discussion #7 Questions**

If we are to effectively prepare young professionals for the emerging health and oral healthcare environment, while also aiming toward optimal oral health for all, we will need to rethink aspects of our current system of professional education. Describe what your table believes to be an ideal approach.

The colloquium participants examined the future of the oral healthcare system, with a focus on examining the educational requirements and characteristics needed to help shape the future of oral health.

**Aligning Oral Health and Medical Education**

- For the benefit of students and the oral health profession, build interprofessional relationships between dental and medical schools, and dentists and physicians. Unfortunately, for schools where the medical and dental schools are in separate buildings, there is less chance of co-education opportunities. All dental students need a broad medical education as a foundation, with dentistry as essentially a specialty focus. Should co-location become a requirement for accreditation? Does this matter in this era of online educational opportunities? Do some medical schools consider dentistry outside of mainstream health? Will the current dental school curriculum deliver the quality of health professional desired to function in this newly envisioned dental care delivery system?

- Who is educating the dental students? From a clinical perspective, the students’ education varies depending on the supervising dentists in the clinic. Is too much focus being placed on “teaching to the dental boards?” Should more outside-the-institution dentists and other healthcare providers provide tutorials and other educational support? The National Board exam system needs to be re-examined. California is developing a “portfolio plan” versus a board exam for a dental student to become licensed.

- The high cost of dental education raises issues about debt repayment, tuition reimbursement, and opportunities to “pay off” educational loans by working as a public health dentist or similar. Dental students are an important part of the revenue stream for dental schools, though this is not the case for students in medical schools. Students
should be prepared to understand the decisions and opportunities they will face at graduation. They need a realistic understanding of the financial choices they will make in deciding their post-graduation pathway.

- Mentorship while in school is an important aspect of preparation. Mentors can serve as role models to help students appreciate oral healthcare that goes beyond the traditional scope of dentistry. Change the culture to provide service. The younger generations may be more open to public service. All dental students should provide support within community-based healthcare delivery settings. Customize the curriculum to address these interests. At the same time, the younger generation wants to design its own approaches to service. The new model should be integrated with other allied professions as part of the overall health system. Introduce oral health in all oral health and medical curriculum, including for dentists, hygienists, doctors, nurses, patient assistants, and so on.

- The accreditation process drives how curricula and teaching approaches are structured. Dental schools do not necessarily demonstrate an understanding of systems of health. The oral health system may be headed for a split: oral physicians (those engaged in hospital rotations and trained extensively in internal medicine) versus traditionally-trained dentists.

- Train oral health providers to be competent business people (or allow business people to run that part of the business). Take courses outside of the dental school to gain greater exposure to public health, public policy, business decision-making, and more. Gain business training, such as that from the Independent Practice Association. Get formal training in communication.

- Partner with area hygienists to participate in on-campus “shared workshops” with a range of oral health providers – to learn from each other. Develop a formalized system to expose dental/oral health students to professionals in oral health in order to strengthen cultural training and so on.

Dental School Admissions: Approach, Diversity, and Cost

- What is the ideal approach to professional dental education? Will our current system meet tomorrow’s changing environment and new perspectives? Do today’s dental educators reflect the quality, values, diversity, and skill-sets needed for educating tomorrow’s oral healthcare providers? The dental profession needs new leadership models. Entry into dental school should be based not only on college course grades, but also on demonstrable personal ethics, social justice, and service.

- Promote diversity in the pipeline. Examine the admissions process for dental schools (and programs for other oral health providers) to ensure diversity among students, and ultimately among oral health providers to reflect the diversity of the country. Foster enrollment of minorities in dental education. Look for students with strong leadership talents.

- If dental students are exposed to underserved populations while in school, there is a good chance that this increased familiarity will continue once in private practice. Some students believe that addressing the oral health needs of the underserved will become increasingly difficult since governmental assistance programs are underfunded today. The conviction and attitudes of the faculty highly influence students.

- Students who face excessive educational debt as they leave dental school are increasingly “scared” due to the U.S. economic forecast. Analyze the cost of dental education with the objective to ensure that a highly diverse student population can manage the costs. Consider opportunities for students to pay off the cost of education through community health service. Shorten the length and cost of dental school by incorporating simulation and hands-on learning opportunities.

- Build awareness about employment opportunities. During training, provide opportunities for students to explore career alternatives and gain exposure to
a variety of oral health jobs in multiple settings. Learn from those who have gone before. Partner newer students with older students to shadow and discuss job opportunities; options for loan repayment; and rewarding career choices in private practice, research, academia, the military and/or public service.

Focus on Continuing Training Options

- Is there a lack of focus in dental education to help practicing dentists keep up with changes in clinical and community-based best practices? Emphasize the need to understand and implement these changes as part of lifelong learning. Consider mandatory interdisciplinary internships for dental, medical, and other allied health students as a means of promoting a greater appreciation of oral health in systemic health.

- Maximize training opportunities that expose students to low-income individuals and families with little access to oral healthcare. Align the work of community colleges and other educational consortiums to promote greater oral health exposure and understanding while addressing challenges and opportunities. Strive to influence the oral health provider makeup to reflect community population demographics.

Moving Toward Fundamental Structural Change in the Dental Care Sector

Contributor

Marko Vujicic, PhD  
*Managing Vice President, Health Policy Resources Center  
American Dental Association*

“I am a health economist. For two years, I have been with the American Dental Association, leading policy research to help guide decision-making. I will share some areas of focus in our research today.

1. Fundamental structural changes in the dental care sector have taken place over the past decade, which have nothing to do with the economic cycle.

In adding up all U.S. dental spending and deflating that by inflation and population, somewhere in the early 2000s, the growth rate for dental spending shifted from about 4 percent to 2 percent per year. That was a fundamental change. In 2008, there was no growth in dental spending. More importantly, over the past two years (where data is available), we have seen no rebound. Trends in the utilization of dental care have been driving that change.

Over the past decade…

- The percent of U.S. children who visit a dentist in a year has gone up substantially. We have seen tremendous progress in lifting utilization among poor and near-poor children.

- In a completely different story, the percent of adults who see a dentist in a year has been declining since 2003 (preceding the economic downturn). Though utilization is falling faster for poor adults than non-poor adults, both groups are seeing a decline.

- Over the past decade we closed the rich-poor gap in dental utilization and access to care for kids. That is progress.

For adults, why would they suddenly stop using dental care in the early 2000s at a time of fairly robust economic growth? Various hypotheses include: healthier adults, barriers to care, and so on. However, trends in dental benefits were major drivers. The percent of adults with no form of dental benefits has gone up substantially over the past decade. Fewer adults have private dental insurance. Moreover, Medicaid on average has eroded for adults.
For children, the opposite is true. The percent of children with no form of benefit has declined substantially. Many more kids are covered by Medicaid and fewer kids by private dental plans.

For young adults, almost 1 in 5 says they cannot get dental care because of cost. That number reflects a substantial increase compared to a decade ago. Moreover, emergency room utilization for dental care has doubled for young adults.

2. The healthcare system will go through some transformational change. We are on the cusp of significant change and reform, which has clear implications for dental care in some areas.

Fundamental environmental factors are changing –

(A) The question is whether or not dental spending will bounce back. Under all scenarios we modeled, we are in a fundamentally new normal. The trajectory of dental spending will not rebound to the 4 percent rates seen prior to the early 2000s. Now we are modeling between 0 percent and 1.2 percent growth per year per capita. The past years of growth are done. We will see a new normal of very slow growth in dental spending.

(B) Let me raise two points about the Affordable Care Act: On the beneficiary side, our research shows that an estimated 8.7 million more kids will have some form of dental benefits by 2018. Two-thirds of that growth will come through private dental benefits and one-third through Medicaid. This will reduce the number of kids with no dental benefits by 55 percent – a remarkable achievement.

While the financial barriers to care go up, the trend in utilization is going down. That is particularly true among younger adults, as is an increased reliance on emergency rooms. Young adults have less likelihood of having private dental benefits. As a policy person, I do not see anything that will shift that in the near term.

(C) In considering payment reform, payment will move away from fee-for-service, procedure-based payment to some type of value-based or outcome-based payment. Though there is a big debate about what this means for dental, we see people around the country reforming payment.

Here to stay is the pressure to do more with less. We spend twice as much on healthcare in the United States as other equivalent countries without any gain in outcome. The fundamental premise of U.S. healthcare reform is that we have a lot of inefficiency in the system from various sources. I cannot overemphasize the need to move toward efficiency – to do more with less.

Through all three financing channels – public money, private insurance, and out-of-pocket money – we will see fundamental change in how purchasers, consumers, and patients interact with dentists. A wave of consumerism will change the conversations that patients have with providers. In particular, young folks want to be involved in their own planning. They will come into dental offices with more information (and will not focus on staying with the same provider for 30 years).

We see extreme cost constraints and a push toward more efficiency. If that plays out through consolidation on the provider side, a move toward multi-site practices will push people to explore alternative provider models. That will represent a very different, challenging world.

In concluding, we see tremendous opportunities for the profession, but only if we have the courage to think about bold options."

The Sixth Leadership Colloquium
APPENDIX I

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

Working in small groups, the 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 in our collective mission for nationwide access to oral health.

Group One

• Shift reimbursement model to one that is value-based, and emphasizes wellness and evidence-based care.
• The system must have cultural competence to foster trust, community, and individual participation in care and improved access for all residents.
• An education system that develops interprofessional skills and prepares future healthcare workforce to deliver comprehensive team-based care.

Group Two

• Reform education to prepare future providers for outcome/evidence-based care system.
• Create demonstration models for patient-centered care delivery systems and evaluate them.
• Unless the community participates, change will not be successful.

Group Three

• There is a need for a comprehensive integrated health system (including oral health, primary care, and behavioral health) that is prevention-focused.
• Health care must be accessible across the life span.
• Grassroots community efforts must be a driver of health systems change.

Group Four

• Cultural humility in engaging, understanding, and responding to community needs and expectations.
• Interprofessional collaboration in education and practice.
• Paying for healthy outcomes.

Group Five

• Incentivize interdisciplinary collaboration in service delivery and education.
• Include all adults in dental reimbursement systems in the U.S.
• Fill key knowledge gaps.

Group Six

• Change emphasis from surgical model to integrated health management and outcomes with matching funding sources.
• Dental professionals and communitywide education that support and enhance the above statement.
• Develop, implement, and evaluate cost-effective workforce models that reach the broadest segments of the population.

Group Seven

• Move to integrated interprofessional delivery models.
• Address workforce and delivery system issues that impact care, education, and prevention where people are.
• Move from FFS (fee-for-service) financing to an outcomes/value base.
**Group Eight**
- Sustainable economics for ALL is built on effective interprofessional education and care models.
- Working together by sense-making of actionable data, a solution is possible: we can create our own “health destiny.”
- Increased capacity for participant engagement requires comprehensive oral health literacy for all players/actors.

**Group Nine**
- Integrate interprofessional collaboration.
- Revise reimbursement systems.
- Education changes in dental schools.

**Group Ten**
- Bi-directional best practices across systems (oral health ≡ overall health).
- Need to balance incentives for future practice with educating the future professional.
- Patient/population needs should drive system development and change.

**Group Eleven**
- Engage and empower the underserved communities to create a system for oral health that will be effective and that they will (will be able to) use.
- The status quo is leaving too many underserved in every state; each state needs to expand options for oral care and oral health.
- We should use states as learning labs and share successful innovations and not repeat failures.
Group Twelve
- Community-based delivery.
- Collaborative interprofessional relationships.
- Educate providers about upcoming changes.
  (Alternative practice settings / payment methods)

Group Thirteen
- Culturally competent community outreach for oral health literacy and self-care across the lifespan.
- Collaboration among healthcare providers to ensure comprehensive care for patients.
- Oral health education for all healthcare providers.

Group Fourteen
- We need a community-based, integrated, value, evidence, and data-driven system that is well funded.
- We need to align payment mechanisms to promote wellness.
- We need to create a culture of wellness that includes oral health with an integrated team approach.

Group Fifteen
- Evidence and data should drive policy.
- Moving from dental care to oral health will require education of a wider array of stakeholders (policy-makers, health professionals, education, and community outreach advocates).
- Greater integration of dentistry (oral health) into healthcare.

Group Sixteen
- Multidisciplinary approach – integrate (create patient-centered care) education (IP); care delivery; payment for outcomes, risk reduction; and IT (EMR+EDR=EHR)
- Meet consumer where they’re at: build trust, understanding; and partner for behavior change.
- Pay for health (including oral health) outcomes and reducing risk.

Group Seventeen
- Oral health is primary care and prevention is reimbursable (such as case management and diagnosis screenings). Therefore, we need to find our place in patient-centered integrated care!
- Use marketing and public relations professionals to tell and position our story.
- Readiness: “Skate to where the puck will be!”

Group Eighteen
- Bridging private and public (Policy / Practitioners / Payers) sectors to provide safe, quality care to patients – getting the care correct the first time.
- Sustainable funding and policy congruency with an economic and infrastructure focus.
- “Practitioner to the Patient” – both within the community and on a knowledge awareness basis.
Participants at the Sixth 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 = Alliance Founding Board Member

Dr. Stephen Abel  
Associate Dean  
University at Buffalo School of Dental Medicine

Michael C. Alfano,  
DMD, PhD  
Senior Presidential Fellow  
Executive Vice President Emeritus  
New York University

Penny Anderson, MSW  
Executive Director  
Maryland Dental Action Coalition

Burt Arthur  
CFO  
Sarrell Dental Center

James Bader, DDS, MPH  
Research Professor  
University of North Carolina

RADM William Bailey,  
DDS, MPH  
Chief Dental Officer, USPHS  
Centers for Disease Control and Prevention

Lydia Barad,  
RDH, MPH, PAHM  
Director, Dental Management  
EmblemHealth

Benjamin Bluml, RPh  
Senior Vice President, Research and Innovation  
American Pharmacists Association

Garth Bobrowski, DMD  
General Practitioner  
Greensburg, Kentucky

Matthew Bond  
Grants and Programs Associate  
DentaQuest Foundation

Marcia Brand, PhD  
Deputy Administrator  
Health Resources & Services Administration

Jackson Brown, PhD  
Academy of General Dentistry

Jennifer Brown, JD  
Director of State Relations  
American Dental Education Association

Gail T. Brown, Esq., MSW  
Policy Director  
New Hampshire Oral Health Coalition

Douglas M. Bush  
Executive Director  
Indiana Dental Association

David P. Cappelli,  
DMD, MPH, PhD  
Associate Professor, Director, Research Division  
University of Texas Health Science Center at San Antonio

Wenzell E. Carter, DDS  
Contract Dentist  
Montgomery County Department of Health and Human Services

Paul S. Casamassimo,  
DDS, MS  
Professor  
American Academy of Pediatric Dentistry

Frank Catalanotto, DMD  
Professor and Chair  
Department of Community Dentistry and Behavioral Sciences  
University of Florida, College of Dentistry

Jim Cecil, DMD, MPH  
Retired Public Health Dentist

Anne Clancy, RDH, MBA  
Project Director  
Chicago Community Oral Health Forum

Rep. Elijah E. Cummings  
7th Congressional District, Maryland  
U.S. House of Representatives

Brian Cutler  
Senior Vice President  
OneMind Health

Jack Dillenberg, DDS, MPH  
Dean, Arizona School of Dentistry & Oral Health  
A.T. Still University, ASDOH

Maria C. Dolce, PhD, RN  
Associate Professor  
Northeastern University

Fay Donohue  
President & CEO  
DentaQuest

Tanya Dorf Brunner  
Executive Director  
Oral Health Kansas

Laura Fleming Doyle, CAE  
Executive Director  
Dental Trade Alliance Foundation

Peter A. DuBois  
Executive Director  
California Dental Association

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

Dr. Allen Finkelstein  
CEO  
Bedford HealthCare Solutions

Sarah Finne, DMD, MPH  
Oral Health Consultant  
New Hampshire Dental Society

Patrick W. Finnerty  
Senior Advisor  
DentaQuest

Andrea Forsht, EdM  
Grants and Programs Associate  
DentaQuest Foundation

David Fray, DDS  
Chief  
Hawaii Department of Health

Paula K. Friedman,  
DDS, MSD, MPH  
Associate Dean  
Boston University

Marcy Frosh  
Director of Programs  
Children's Dental Health Project

Wendy J. Frosh  
Principal  
Healthcare Management Strategies
Dr. Catherine Hayes
President
AAPHD

Monica M. Hebl, DDS
Dentist, Burleigh Dental SC
American Dental Association

Andrea Henry
Grants and Programs
Associate
DentaQuest Foundation

Lawrence F. Hill, DDS, MPH
Executive Director
American Association for Community Dental Programs

Jaime Hirschfeld, MEd
Director, Health Center Growth & Development
National Association of Community Health Centers

Nathan P. Ho
Program Director
U.S. National Oral Health Alliance

Sarah Holland
Executive Director
Virginia Oral Health Coalition

Alice M. Horowitz, PhD
Research Associate Professor
School of Public Health, University of Maryland

Mitsuko Ikeda
Project Director
National Network for Oral Health Access

Fern K. Ingber, MEd
President & CEO
National Children’s Oral Health Foundation

Evelyn F. Ireland, CAE
Executive Director
National Association of Dental Plans

Robert Johns
Executive Director
National Dental Association

Joshua Jones
VP of Governmental Affairs
Sarrell Dental

Sherelda D. Jones, MBA
Division Director I
MS State Department of Health

David J. Jordan
Dental Access Project Director
Community Catalyst

Dr. Renee Joskow
Senior Dental Advisor
Health Resources and Services Administration

Mahak Kalra, MPH
Policy Analyst
Kentucky Oral Health Coalition

Steven W. Kess, MBA
VP of Global Professional Relations
Henry Schein, Inc.

Karlene Ketola
Executive Director
Michigan Oral Health Coalition

Joseph Kilston, AuD, MS
Division Administrator
Marshfield Clinic

Amy L. Kinnamon, RDH, EFDA, BS
Dental Hygienist
Dr. Roger Winland DDS, Inc.

Dushanka V. Kleinman, DDS, MScD
Associate Dean for Research and Professor
University of Maryland School of Public Health

David Krol, MD, MPH, FAAP
Fellow
American Academy of Pediatrics

Janice Kupiec
Manager, Legislative and Regulatory Policy
American Dental Association
Colin Reusch, MPA
Senior Policy Analyst
Children's Dental Health Project

Dr. David Alan Reznik
Director of Oral Health
Grady Health System

W. Ken Rich, DMD
General Practitioner
Dry Ridge, Kentucky

Verna B. Richardson, RDH, MS
Dental Hygienist
Montgomery County Department of Health and Human Services

Lindsey A. Robinson, DDS
President
California Dental Association

Catherine Rodriguez
Regional Manager
Adventure Dental

Susan Rostov
Executive Director
KY Society of Oral & Maxillofacial Surgeons

Jason M. Roush, DDS
West Virginia State Dental Director
WVDHHR / Oral Health Program

Cesar R. Sabates, DDS
General Practitioner, Coral Gables, Florida
Past President, Florida Dental Association

Margaret I. Scarlett, DMD
Health Consultant
SCI

Lisa S. Schildhorn, DH, BS, MS
Organizational Development Consultant
Healthy Teeth, Healthy Children PA Chapter of the Academy of Pediatricians

Eli Schwarz, DDS, MPH, PhD
Professor & Chair
Oregon Health & Science University

Gina Sharps
Regional Oral Health Coordinator
Marshall University

Jan Silverman
POHRPC Assistant Director
American Academy of Pediatric Dentistry

Liz Snow
Chief Operating Officer
California Dental Association

Brian Souza
Managing Director
DentaQuest Foundation

Julie Stitzel
Campaign Manager
The Pew Charitable Trusts

Howell I. Strauss, DMD
Executive Director
AIDS Care Group

Carol Gomez Summerhayes, DDS
Private Practice
American Dental Association

Julie Terreson
Executive Assistant
GLO Science

Dr. George P. Thomas
Professor & Chair
Howard University

Roy Thompson, DDS
Private Practitioner
American Dental Association
CAPIR Council

Dr. Melanie Thwaites
Program Director, Pediatric Dentistry
Howard University College of Dentistry

Dr. Norman Tinanoff
Professor
University of Maryland School of Dentistry

Beth Truett
President & CEO
Oral Health America

Richard Valachovic, DMD, MPH
Executive Director
American Dental Education Association

Alejandra Valencia, DDS, MPH, MS
Research Director
Chicago Community Oral Health Forum

Lynn C. Van Pelt, DMD
Health Resources and Services Administration

CMDR Pamela Vodicka, MS, RD
Program Director, MCHB
Oral Health
Health Resources and Services Administration

Marko Vujicic, PhD
Managing Vice President, Health Policy Resources Center
American Dental Association

Mary Young, RDH, MHA
Director
Institute for Oral Health

Michal A. Young, MD
Neonatologist
Howard University College of Medicine

Annette Zacharias
Executive Director
National Network for Oral Health Access

Mary Young, RDH, MHA
Director
Institute for Oral Health

Robert J. Weyant, DMD, DrPH
Associate Dean
University of Pittsburgh, School of Dental Medicine

Morgan Wolf
Student
Northwestern University

Mary E. Worrall, MPH
Senior Advisor
Office on Women's Health

Brittany Wright
E-communication Coordinator
Oral Health America

Kimberlie Yineman, RDH, BA
Oral Health Program Director
North Dakota Department of Health
APPENDIX III
Unifying Messages on the Six Alliance Priority Areas

First Leadership Colloquium
Medical and Dental Collaboration
Washington, DC, November 7-8, 2011
• Stay focused on the overall health of the individual
• Strengthen interprofessional and patient education
• Integrate delivery and financing systems
• Examine the role for medical and dental records in patient-centered care
• Expand the dialogue on oral health

Second Leadership Colloquium
Prevention and Public Health Infrastructure
Chicago, IL, March 13-14, 2012
• Create an expectation for wellness and health
• Assure a system that is equitable and just
• Engage the public and increase awareness about oral health
• Implement a financing strategy to support prevention

Third Leadership Colloquium
Oral Health Literacy as a Pathway to Health Equity
San Francisco, CA, June 6-7, 2012
• Develop trust together
• Direct attention to prevention
• Shift policy and financing
• Educate the public
• Connect, partner, and collaborate
• Advocate for all people

Fourth Leadership Colloquium
Metrics for Improving Oral Health
New Orleans, LA, November 15-16, 2012
• 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 that helps people take action

Fifth Leadership Colloquium
Financing Models
Atlanta, GA, April 2-3, 2013
• Envision a framework for health financing systems that can come together nationwide to improve oral health for all people
• Develop and draw upon best available information and data to engage local, state, and national legislators who can influence and drive health systems change
• Strengthen financial and oral health literacy throughout the country
• Support medical and oral healthcare providers as they work side by side to provide interdisciplinary healthcare 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

Sixth Leadership Colloquium
Strengthening the Dental Care Delivery System
Washington, DC, June 17-18, 2013
• Focus oral health care on prevention and wellness for individuals, families, and communities
• Move toward interprofessional, cost-effective workforce models and care delivery systems
• Transform education for a future strengthened by team-based oral health and medical care
• Empower communities to support highly effective oral healthcare systems
• Align payment and systems approaches to promote and support wellness
APPENDIX IV

Board of Directors and Advisors U.S. National Oral Health Alliance

Founding Board of Directors

Douglas M. Bush
Caswell A. Evans, DDS, MPH
Wendy J. Frosh
Ralph Fuccillo, MA
Leslie E. Grant, DDS
Lawrence F. Hill, DDS, MPH
Evelyn F. Ireland, CAE
Steven W. Kess, MBA

Dushanka V. Kleinman, DDS, MScD
David M. Krol, MD, MPH, FAAP
William R. Maas, DDS, MPH
Vincent C. Mayher, DMD, MAGD
W. Ken Rich, DMD
Lindsey A. Robinson, DDS
Cesar R. Sabates, DDS

Advisors

Tracy Garland, MUP
Steven P. Geiermann, DDS
Lewis N. Lampiris, DDS, MPH

Michael Monopoli, DMD, MPH, MS
M. Alec Parker, DMD