Proceedings of the November 18-20, 2013
Prevention Summit: Advancing America’s Oral Health

ADA Headquarters Building, Chicago, Illinois

Council on Access, Prevention and Interprofessional Relations
American Dental Association

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Executive Summary

OVERVIEW

Significant gains have been made over the past century in promoting dental health and wellness. At the same time, persistent oral health disparities at the population and health care delivery levels make clear that current care, prevention and policy efforts are not adequate to the task of optimizing oral health nationally for all people. We cannot drill, fill and extract our way out of this crisis without a fundamentally different approach: one that prioritizes disease prevention, promotes parity between oral health and overall health, overcomes fragmentation within the oral health field, and integrates oral health into overall health initiatives.

In response to this need, the American Dental Association’s (ADA) Council on Access, Prevention and Interprofessional Relations (CAPIR) convened the 2013 Prevention Summit: Advancing America’s Oral Health. CAPIR identified representatives from eleven key stakeholder groups including dental and non-dental health care professionals, researchers and academicians, public health professionals, patient advocates, policymakers, funders, third-party payers, industry, and organized dentistry. These representatives formed the Prevention Summit Planning Group, and took ownership for inviting participants in their respective stakeholder groups and for planning the summit.

"We cannot drill, fill and extract our way out of this crisis without a fundamentally different approach: one that accentuates disease prevention."

The Summit was held from November 18–20, 2013, in Chicago IL, and included 121 participants along with additional observers. The Summit was made possible through generous sponsorship from Colgate, the DentaQuest Foundation, the California Dental Association, the ADA Foundation, Delta Dental, the Dental Trade Alliance, the American Academy of Pediatric Dentistry, Patterson Dental and Legacy.

The goal of the 2013 Prevention Summit was to develop a national framework for action on the prevention of oral disease that leverages today’s opportunities, represents strategic choices, takes full advantage of multi-stakeholder engagement, and includes plans for sustainability and accountability. Over the course of three days, participants moved toward consensus around a national effort that would significantly strengthen oral health efforts in the United States. Participants charged the multi-stakeholder Planning Group with refining a proposed framework for action that would engage a wide array of stakeholders both within and outside the oral health field.

SUMMIT OUTCOMES

At the close of the Summit, participants reached broad agreement around a proposal for a national prevention effort. With the ultimate goal of optimum oral health for all, this proposal called for a multi-pronged strategy to ensure that individual behaviors, community systems, financing structures and policies are based on the understanding that oral health and oral disease prevention are integral aspects of promoting overall health and wellness. The effort would aim to:

1. Place prevention messages, tools and information into the hands of policymakers, the public and the professionals that serve them; and
2. Integrate oral health-related prevention into the lives of individuals, families and communities.
Implementation would entail a national, coordinated advocacy and oral health literacy campaign with targeted messages and resources for multiple audiences including policymakers, the public, and health professionals both within and outside oral health. At the same time, this national campaign would serve as an umbrella for supporting community-based initiatives and demonstration projects engaging diverse populations throughout the country.

Imagined as a multi-phase effort built on continual research, learning, and improvement, this effort would offer multiple entry points for involvement by a broad array of stakeholders, including many non-traditional partners such as schools, pharmacies, and faith-based organizations. It would be designed as a public-private partnership, and would link with existing efforts and movements related to health promotion and disease prevention.

SUMMIT ACTIVITIES BY DAY

Day 1

The first day of the Summit confirmed the goals and directions for the Summit. Participants developed a shared vision for the future of oral health and discussed key social change levers and economic realities. Dr. Roy Thompson, CAPIR Chair, and Dr. Kathleen O’Loughlin, ADA Executive Director, framed the need for a national prevention strategy and cited the tremendous opportunity afforded by this multi-stakeholder gathering. Representatives of the Planning Group described the history of the planning process and presented key decisions underlying the design of the Summit:

- Focus on four key oral conditions: caries, periodontal disease, oral cancer, and facial injuries
- Utilize a systems approach to prevention, utilizing four conceptual frameworks as planning and discussion tools
- Begin with a set of foundational commitments based on principles of prevention, oral health promotion, evidence-based practice, equity, and the preservation of tissue

The initial presentations were designed to inform strategic thinking about how to catalyze large-scale social change. Dr. Hayagreeva Rao, Atholl McBean Professor of Organizational Behavior and Human Resources at Stanford University, offered a keynote address on the processes by which organized groups can foster social movements and create behavioral change at scale. Dr. Robert Compton, Executive Director of the DentaQuest Institute, shared promising findings on the effects of financial incentives on preventive practice in oral health. Dr. Marko Vujicic, Managing Vice President of the ADA’s Health Policy Resource Center, offered a glimpse into the future of the health care field, describing substantial changes related to interprofessional care and dental compensation. He urged dentists to take on the leadership role within the “oral health care team.”

Participants shared the particular knowledge and experience each brought to the table, while expressing a strong desire that the Summit lead to broad consensus around a feasible, actionable plan. Participants developed a collaborative vision for the future, describing changes they hoped to see over the next ten years across the multiple spheres that influence an individual’s oral health, based on the Child, Family, and Community Influences on Oral Health framework (See Appendix D). Finally, participants further developed the Summit’s underlying principles and discussed ways that current financial and economic realities will affect prevention strategies.

Day 2

The second day began with a focus on the prevention of specific oral conditions: caries, periodontal disease, oral cancer, and facial injuries. Speakers offered presentations on primary causes of each condition, common prevention strategies, key challenges, and opportunities for future prevention efforts. Based on this information, participants worked in mixed-stakeholder groups to develop promising, condition-specific prevention strategies. Participants focused on efforts to prevent oral disease prior to disease manifestation, while seeking to address risk factors and social determinants of health at the level of the community and the broader environment, drawing on one of the Summit’s central frameworks, Stages of Prevention (See Appendix D). Participants
synthesized their suggestions into a set of high-level prevention strategies that would address multiple oral health conditions and begin to move the country towards the desired future.

Day 3

The final day of the Summit focused on coming to broad agreement around one proposal that could serve as the foundation for a national framework for action. The original stakeholder groups assessed the high-level prevention strategies from Day 2, bringing their particular interests and concerns to bear, while discussing roles they could play in implementing the resulting framework.

The Summit’s second keynote speaker, Dr. Terry C. Davis, Professor of Medicine and Pediatrics at Louisiana State University, shared best practices and key concepts of health literacy, a topic already emerging as central to the group’s prevention strategies. Her thoughts informed both the design and language of the evolving strategies.

Participants reached substantial agreement around a proposal for a national prevention effort. At the same time, many participants expressed a desire that the proposal include other promising ideas that had come out during the Summit. What ultimately resulted was a draft framework for action that included high-level goals, key principles, and potential strategies targeting diverse stakeholder groups. Participants charged the Planning Group to reconvene after the Summit to further develop the proposal and engage additional stakeholders in the process, as needed.

MOVING FORWARD

On December 7, 2013, the Planning Group produced a briefing paper that further clarified and fleshed out the proposal from the Summit. The briefing paper is included in Appendix A. In January 2014, the Planning Group reconvened to further develop the concepts laid out in the briefing paper and refine the draft framework for action. This revised framework includes an overarching approach, underlying values, and key areas of action, as well as initial ideas about evaluation, timeframe, governance structures, and next steps. These documents are available at http://www.ada.org/9552.aspx. The framework will be used as a springboard for further dialogue and engagement.
Introduction

Over the past century, significant gains have been made in preventing oral disease and promoting dental health and wellness. Interventions, such as community water fluoridation and sealants, along with public health campaigns promoting regular dental cleanings and daily brushing, have greatly improved oral health for many in the country. At the same time, we continue to see persistent oral health disparities at the population and health care delivery levels stratified along lines of race, ethnicity, socioeconomic status and education. It is clear that current care, prevention and policy efforts are not adequate to the task of optimizing oral health nationally for all people.

"The dental health crisis is caused by a failure to prevent disease."

These disparities cannot be fixed simply by performing more procedures. The dental health crisis is caused by a failure to prevent disease. We cannot drill, fill and extract our way out of this crisis without a fundamentally different approach: one that accentuates disease prevention, promotes parity between oral health and overall health, overcomes fragmentation within the oral health field, and integrates oral health into overall health initiatives.

In response to this crisis, the American Dental Association (ADA) convened the 2013 Prevention Summit: Advancing America’s Oral Health, which brought together individuals from multiple disciplines who have a commitment to prevention in both clinical and population-based settings to create a common vision for action. The ADA’s Council on Access, Prevention and Interprofessional Relations (CAPIR) identified eleven stakeholder groups, along with a key representative from each group to form the Prevention Summit Planning Group. These representatives met in November 2012 and took ownership for planning the Summit, including development of the agenda as well as the selection of participants and speakers. Over the course of a year, the Planning Group met regularly. The Summit was held November 18–20, 2013, in Chicago IL, and included 121 participants along with additional observers.

PLANNING GROUP MEMBERS

Academia/Research .................................................................Dr. Robert Weyant
ADA Board and Councils .................................................. Dr. Charles Norman III
Foundations ..........................................................Mr. Ralph Fuccillo
General Dentists/Dental Team/Specialties ......................Dr. Gary Davis
Health Promotion/Disease Prevention .......................... Dr. Dushanka Kleinman
Industry ...........................................................Mr. Gary Price
Non-Dental Health Care Providers ..............................David M. Krol
Patient Advocates ......................................................Ms. Beth Truett
Policymakers ..........................................................Ms. Mary Foley
Third Party Payers ...................................................... Dr. Ron Inge
ADA Tripartite (State Associations).............................. Mr. Peter DuBois

SUMMIT PURPOSE

The purpose of the 2013 Prevention Summit was to develop a framework for action that leverages current opportunities, represents strategic choices, takes full advantage of multi-stakeholder engagement, and includes plans for sustainability and accountability.
OBJECTIVES

- To catalyze and revitalize the national inter-professional, multi-stakeholder movement advancing the prevention of oral diseases, the promotion of oral health literacy and the importance of oral health risk management.

- To focus on actions that take current evidence-based knowledge to a place of broad and effective dissemination and implementation.

- To ensure a systems approach that represents well-orchestrated and integrated action by multiple stakeholders while building on best practices and leveraging what is already in place.

- To establish a culture of primary prevention based on a set of shared values that include new partnerships and decision-makers who will make a difference.

SPONSORS

The Summit was made possible through the generous support of these sponsors:

Convener ................................................................................ American Dental Association

Gold Sponsor .......................................................................................................... Colgate

Silver Sponsors ............................................................................ DentaQuest Foundation
California Dental Association

Bronze Sponsors ...................................................................................... ADA Foundation
Delta Dental
Dental Trade Alliance

Additional Support Provided by ...................... American Academy of Pediatric Dentistry
Patterson Dental
Legacy
Summit Proceedings
Day 1, November 18

OPENING REMARKS

Day 1 began with opening remarks designed to welcome participants and to frame the meeting by stressing its purpose and potential to make a significant difference in the prevention of oral disease.

Welcome from the Host

Roy Thompson, D.D.S.
Chair, Council on Access, Prevention and Interprofessional Relations, American Dental Association

“On behalf of the ADA and the Council on Access, Prevention and Interprofessional Relations, I welcome you to Chicago, and thank you in advance for your time in this important endeavor. This summit brings together leading thinkers in multiple disciplines involved in the improvement of health care, specifically related to dental disease. Don’t underestimate what we are going to accomplish here in Chicago. I refuse to settle for the status quo, and will relentlessly search for great ideas. I refuse to be discouraged by failures and bumps in the road. I want to see your passion. I want you to be fiercely curious, to be respectful and open to ideas you may not agree with, and to expect that we will make a difference. Success comes from cooperation and communication, and our celebration is improved health among all sectors of the population.”

Welcome from the Convener

Kathleen T. O’Loughlin, D.M.D., M.P.H.
Executive Director and Chief Operating Officer, American Dental Association

“We are here because, as much activity as we are all engaged in, we are not moving the needle the way we need to on oral health. We’ve made tremendous strides, but we may have plateaued; and the storm of greater health disparities, decreasing access to care, and increasing disease among at risk populations is headed our way. We are here today to talk about prevention. We know we can’t do it alone. It is going to take collective, concerted action using a strategic framework to which we can all contribute. You are some of the smartest people in this area, and collectively you know more than any other group we’ve convened. We need to transcend the little mountains we all stand on, and come to some collective wisdom about a national prevention strategy. The work is out there for us to do, and we can have an impact.”

Summit Agenda and Process Overview

Elaine Kuttner
Principal, Cambridge Concord Associates
Summit Facilitator

“This summit is the result of a multi-stakeholder collaboration. The planning group did not take lightly the charge to ‘think big’; they decided to reinvigorate the prevention movement for oral health. This Summit would not just be a chance to talk; instead we would leave having developed actionable strategies that could be put into place in an orchestrated fashion to jump-start the next phase of the prevention movement. If it wasn’t about action, they didn’t want it to happen. This summit would lay the groundwork for new partnerships and collaboration. This will be that moment in time that has a before and an after. Everyone will look back and say, ‘Yes, that is why we are doing things the way we do them now.’ The planning group is committed to working with all of you to further shape ad bring this vision to life.”
Working Norms

- Build an atmosphere of trust and openness.
- Seek to understand and honor all perspectives, however different from your own.
- Thoroughly explore an issue before assuming knowledge.
- Encourage risk taking.
- Avoid side discussions and texting; they both serve to dismiss the viewpoint of whoever is speaking.
- Strive toward “common ground” and make decisions through consensus whenever possible.

KEYNOTE SPEAKER

The Summit’s first speaker, Dr. Hayagreeva Rao, offered a keynote address on the processes by which organized groups can create behavioral change at scale. He argued that the large-scale changes sought by the Summit’s participants require a social movement. His ideas continued to inform conversations and strategies throughout the Summit, keeping participants focused on the need for public engagement and mobilization.

Scaling Social Change: Implications for Oral Health

Hayagreeva Rao, Ph.D.
Atholl McBean Professor of Organizational Behavior and Human Resources, Stanford University

“This is an extraordinarily accomplished and diverse audience, so I approach my task with a little bit of humility. My role is not to tell you how to plan your movement, but rather to offer a few provocations.”

“You are in the business of scaling social and behavioral change. If you want anything scaled, the challenge is to create felt accountability, which is when people do the right thing even when nobody is looking over their shoulder. There are challenges to creating felt accountability. First of all, one might not have all the resources and authority. Second, your audiences already have enormous cognitive load, which decreases their willpower and ability to make responsible decisions. So, if you are in the business of scaling felt accountability, it’s not addition that matters but subtraction. Third, embarrassment is a big issue. If you don’t have resources, or your oral health is in a bad state, then you are afraid of being negatively valued — a problem that is exacerbated by status differences.”

“Oral health requires a social movement.”

“Oral health requires a social movement. When you want to organize a movement, do not think of it as an air war, think of it as ground war. When you’re thinking of an air war, you’re thinking of message bombardment. You’re thinking of something desirable, but abstractly: in terms of numbers, criteria, and incentives. When thinking of a ground war, you engage real people. Incentives may not be the issue — you want 100,000 people to go one foot.”

“A social movement has two compelling requirements: A hot cause that rouses emotion, and a cool solution that is unconventional, collective, easy to adopt, and not cognitively burdensome. What is your hot cause? What is your cool solution? Here are some provocations and examples.”

- “Mothers Against Drunk Driving (MADD) decided their enemy wasn’t the driver. Instead, they started a campaign against underage drinking. Most of the campaign was fought on the ground, though with some air war. They attacked the idea that beer is acceptable. They harnessed the power of youth with campaigns in schools engaging young children and parents. They are getting directly to the end user.”

- “The Institute for Health Improvement (IHI) spearheaded a campaign to reduce inadvertent deaths in hospitals. When they needed a story to personify what their campaign was about, founder Don Berwick went to his son, who asked, ‘How many lives are you going to save?’ Don said ‘some.’ His son asked, ‘When?’ and he said “soon.” His son said, ‘Some is not a number, soon is not a time. We need to know
exactly how many people will turn out and when.’ So they chose 100,000 lives in two years, and called it the Save 100,000 Lives Movement. Now they have upped it to a 5 million lives campaign.”

- "Doug Dietz is an acclaimed designer of MRI machines for General Electric. He visited a hospital using one of his machines, and he was reduced to tears when he saw a seven-year-old crying inconsolably. It broke his heart to see young kids sedated. He had never seen the experience from a child’s point of view. He took it to heart and is now very busy re-imagining what the MRI can be. He took team of three people and spent a week at a daycare. He said, ‘I’m not smart enough, I needed real experts. These kids are my team.’ With his new child-friendly MRI machines, sedation rates have dropped from 90% to 100%.”

“What is your analogue? What is your test bed to try out ideas? What is your 5 million lives campaign? What is the oral health movement? Who is your enemy? How will you get large numbers together? Who is your coalition? What is your target? What is your hard count?”

“Change behavior first in the hope that it changes beliefs. Take advantage of the power of habit. What we think of as habits are often examples of social norms being enforced. If you can’t get people to do something individually, get them to do it as a group.

"In summary, you need a hot cause and a cool solution. Resist the temptation to think big bang quickly. The cost of failure if you start big is too high. Start small and scale rapidly. Fail fast.”

INTRODUCTIONS

Participants began the summit within their own stakeholder group, sharing their hopes and fears for the summit, along with the assets they bring to the collective effort. These conversations began a collective understanding of shared goals, potential challenges, and an appreciation of the diversity present in the room. Below, the most common responses have been summarized (See Appendix F for the full list of responses).

1. My greatest hope for the Summit is...
   - “That it will make a difference.”
   - “That we reach consensus.”
   - “That we think outside the box.”
   - “Concrete, actionable plans.”
   - “Measurable, scalable outcomes.”
   - “Increased recognition of the value of oral health prevention.”
   - “To develop relationships and collaboration.”

2. If I have a fear, it is...
   - “No action will be taken.”
   - “A lack of collaboration.”
   - “A lack of broad stakeholder representation.”

3. What I bring to this summit is...
   - “Enthusiasm and passion.”
   - “Experience and knowledge in a range of professions, programs, and topic areas.”
   - “Multidisciplinary views and experiences.”
   - “Experience with success.”
   - “A healthy impatience with the status quo.”
   - “An open mind and a willingness to listen.”
   - “A wide array of perspectives and commitments.”
   - “Pragmatism combined with optimism.”
UNDERPINNINGS OF OUR WORK

In order to build a shared understanding of the Summit’s purpose, representatives of the Planning Group shared the values and assumptions underlying the planning process. The Planning Group chose to take a systems approach to prevention and selected four frameworks to use as tools for conceptualizing prevention strategies. In addition, the Planning Group focused on four oral conditions to ground collective strategizing in the realities of specific oral health challenges. Finally, the Planning Group developed a “foundational commitment” outlining the values that guided their design process. Participants had the opportunity to respond to the Planning Group’s proposed foundational commitment so that it could grow and evolve through the participation of all at the Summit.

Associate Dean for Research, Professor and Chair, Department of Health Services Administration
School of Public Health, University of Maryland

David M. Krol, M.D., M.P.H., F.A.A.P.
Senior Program Officer, Robert Wood Johnson Foundation

Conditions (See Appendix E)
- Caries
- Periodontal Disease
- Oral Cancer
- Facial Injuries

Frameworks (See Appendix D)
- Child, Family, and Community Influences on Oral Health (Fisher-Owens Model)
- Four Stages of Prevention (Primordial, Primary, Secondary, Tertiary)
- National Quality Measures Clearinghouse (NQMC) Domain Framework
- DentaQuest Foundation’s Systems Change Approach

Foundational Commitment
- Promote oral health as an essential component of overall health and well-being and integrate the oral health movement into the overall health movement in our country;
- Further primordial and primary disease prevention efforts; (See Appendix D, Four Stages Of Prevention)
- Build a culture that fully embraces and incentivizes prevention and oral health promotion;
- Ensure the equitable application of evidence-based knowledge and practices; reinforcing and incentivizing the use of this knowledge and practices;
- Create a culture that consistently practices conservative management of oral diseases and aims to preserve tissue.

Feedback on Foundational Commitment

Participants responded to the Foundational Commitment as presented by the Planning Group. They suggested changes, clarifications, and additions to capture the shared commitments of the diverse stakeholder groups. In their comments, participants spoke of:
- The need to emphasize public health in coordination with care;
- The important roles to be played by communities and consumers;
- The need for mobilizing and coalition building;
- The importance of health disparities and the need to consider redistribution of resources and services, including policy, financing, and promotion of innovative insurance systems;
- A vision of oral health becoming the norm;
- A recognition that oral health is a shared responsibility; and
- A vision of oral health as integrated with all health decisions and policies.
ENVISIONING OUR DESIRED FUTURE

In order to guide the process of designing prevention strategies, the facilitator led the participants through a visioning exercise in their stakeholder groups. Participants imagined that ten years had passed and the prevention strategies developed at this summit had been implemented successfully. What far-reaching changes would be seen? What results would demonstrate that the strategies had made a difference? Using the Child, Family, and Community Influences on Oral Health framework (see Appendix D), responses spanned the multiple spheres that influence oral health: the individual, the family, the community, and the broader environment. Below, the pieces of this collective vision have been organized by theme.

Improved oral health outcomes
- No child with cavities under 5.
- No recurrence of oral disease in adults.
- 100% of kids brush twice a day for two minutes with fluoridated toothpaste.

Incentives aligned with effective prevention and care
- Patients are rewarded for better oral health behavior.
- Lower insurance premiums are used as incentives for improved oral health.
- Reimbursement is for outcomes, wellness, and quality measures, not procedures.
- Payment is aligned with a patient-centered approach based on risk assessment and evidence.
- No financial disincentives — policy is aligned with desired outcomes.

A population that understands and values oral health
- Oral health is valued across the lifespan.
- Speaking out for oral health is cool, and has champions outside the dental profession.
- Heightened public awareness of the need to improve oral health.
- The public recognizes of the connection between oral health and overall health.
- The population has individual “felt accountability” for oral health.

The integration of oral health and overall health
- There is a “new normal” in which with the mouth is understood as part of the body.
- There is oral health parity in policies, benefits, education, legislation, financing, and population health measures.
- Oral care is a part of prenatal care.
- Oral health is part of all primary care visits, and primary care professionals empower patients to protect the health of their teeth and gums.
- Oral health is integrated into the health education secondary school curriculum.
- Dental care is integrated into the patient-centered medical/health home.
- Oral health benefits are integrated into 3rd party payment products across the entire lifespan.
- Electronic dental record is fully integrated with electronic medical record.

Broad-based collaboration around oral health
- There is a proliferation of school-based dental clinics.
- Health professionals from across disciplines are involved in oral health.
- The promotion of oral health literacy includes non-traditional community partners.
- All relevant partners are engaged in oral health efforts (e.g. communities, providers, payers, families).
- Community support systems are optimized.
- Health educators without walls — implementing oral health prevention.
- All professions embrace evidence-based practice, with aligned resources to support decision-making in public and private arenas.

An enhanced research agenda
- Research agenda that supports primordial prevention (i.e. efforts to minimize future hazards to health).
- Population-focused research is linked to the triple aim and a systems approach.
Established prevention measures have become universal
- 100% of high-risk populations receive sealants/fluoride treatments.
- 100% of all U.S. communities have water fluoridation.

Improved health systems
- The system is navigable.
- Interoperable electronic health records/systems data.

A new paradigm for oral health education and prevention
- Better oral health is seen as more than a smiling face.
- Oral health literacy starts early.
- We are working to achieve a tobacco-free society.
- Healthy foods for all.
- Practitioners aligned with protocols.
- Oral health messaging includes cost savings and improved health outcomes related to chronic disease.
- Initiatives address products that produce negative impacts on oral health (smoking, soft drinks).
- Culture shift from treatment to prevention.

FINANCING & ECONOMICS OF ORAL HEALTH

The final two speakers on Day 1 addressed the financing and economics of health as a key system that must be addressed in any emerging framework for action. Their presentations focused on large-scale trends that will shape any prevention effort, and on how financing can serve as a valuable social change lever.

How Financing Incentivizes and Reinforces Practice

Robert Compton, D.D.S.
Executive Director, DentaQuest Institute
President, DentaQuest Oral Health Center

“At DentaQuest, we talk about the four systems that impact health: care, finance, policy, and community. We look at the care system as having a direct impact on health, and we work to align finance and policy in order to improve our systems of care. One thing we focus on a lot is data. Often we can’t measure outcomes of care, but we can measure the process of care, along with evidence that certain types of care lead to good health outcomes.”

“We have known about the effectiveness of sealants for a long time, but we have struggled to raise the percentage of children receiving sealants. DentaQuest came up with a program for our Medicaid networks to approach this issue by working from a chronic care model. We started with baseline measurements and focus groups with dentists and office managers. For those practices interested in participating, we identified kids between the ages of 6 and 7, and 12 and 13, who had received restorations in the past. We gave dentists the list and asked them to please reach out to those kids and evaluate them for sealants. We also gave them educational material for the parents. In six months, we had an 18 to 20% increase in sealants among kids aged 6 to 7. Among kids aged 12 to 13, we saw an increase of 20 to 24%. We also saw a halo effect: not only did the dentists target the ages we were looking at, but they started putting sealants on other kids as well.”

“We are learning that it is not just about treating chronic disease…behavior might be a significantly stronger factor.”

“We ran a similar program with our commercial network focused on fluoride treatments for children, and periodontal maintenance for adults. When we added a financial incentive for the practice, we saw a 13.6% increase for fluoride treatments and a 12.7% increase for periodontal maintenance. Our CEO asked if we could do it again without changing the goals or incentives. We did it again and saw similar results. In fact, we had lifted the curve across the entire network.”
“We are learning that it is not just about treating chronic disease. Health care only contributes 10% to the factors that cause premature death. Behavior might be a significantly stronger factor: drinking, smoking, eating the wrong food, being overweight. The next thing we are looking at is the importance of changing behavior.”

“We are trying to adapt the chronic care model from medicine to dentistry. For the Early Childhood Caries initiative, we created a protocol based around chronic care management that starts with a caries risk assessment and behavioral assessment. Then we ask if they have the time and ability to make a change, and pick one goal. Maybe they’ll identify that they put their child to bed with milk in a bottle. Can we change that to water? Then we do a fluoride varnish and provide care. We might do visits monthly, then move to three months, and then six months. Using this protocol, Children’s Hospital in Boston has been able to lower the risk status of children, reduce the percentage of kids going to the operating room, reduce cavitation, and reduce pain. They showed that they could improve health outcomes, deliver a better patient experience, and reduce cost per child. For every dollar they invested they saved $10.83. The challenge comes back to system change. We can change the way we treat patients. How do we look at policy and finance to support this kind of care?”

**Dentistry at a Crossroads**

Marko Vujicic, Ph.D.  
*Managing Vice President, Health Policy Resource Center*  
*American Dental Association*

“We have an unprecedented opportunity in the current U.S. health care environment to rethink how dentists want to position themselves. Do dentists want to be the head of the dental care team or the oral health team? A big part of the oral disease burden happens at home, in cribs, at the dinner table — we need a captain that’s going to oversee all of that, not just the delivery of dental care. Dentists need to start leading, or else others are going to make those important decisions without us.”

“Going forward, incentives will be adjusted so that health care providers are given more for outcomes and evidence-based procedures. The system is not going to change over night, but we should not underestimate how tomorrow’s environment will be different. Payment will slowly shift towards incentivizing providers for what they do for you, rather than what they do to you. Right now we are on the treadmill of financing systems that rely on clinical judgment. The system is going to move much more towards paying for providers to influence behaviors. This opens a world of possibilities. What if I was paid for each night a kid had water rather than milk in the crib? We will see new types of providers such as behavior change specialists. I have even been in countries where the provider gets money and gives some of that money to the patient for doing the right thing.”

“The health care environment is changing. Adults are going to the dentist less, kids and seniors are going more. There are three states where utilization with Medicaid is beating utilization with commercial insurance. 108 million Americans see a physician, but do not see a dentist. 60% of children aged 1 to 4 see a pediatrician and don’t see a dentist. There is an opportunity here to link up with pediatrician community through better referrals or co-locating. The converse is that 27 million Americans visit the dentist but do not visit a physician. This is an opportunity for other health care providers to leverage the dental community. We have this incredible touch point to the population, there are a lot of us, and we are skilled professionals with high level of patient trust. In tomorrow’s health care environment, there will be opportunities for dentists to team up with other health care providers. Through interdisciplinary and interprofessional collaboration, we can increase utilization.”

“There is a huge opportunity to flex your muscles and move into the primary care field. Tomorrow’s environment is about busting down silos. Incentivizing dentists to do basic hypertension, diabetes, and cholesterol screening saves dollars. This is something the dental community can explore. As the system moves towards rewarding people for oral health achievements there is an opportunity to move into that role as head of the oral health team.”
DISCUSSION: FINANCIAL AND ECONOMIC REALITIES

Building on the presentations from Drs. Compton and Vujicic, participants discussed current financial and economic realities, as well as future trends, which might shape or inform national prevention strategies. Their conversation was guided by the following questions:

- How realistic are our aspirations when we consider the current and emerging funding models for oral and overall healthcare?
- What are the most important “macro” dynamics that must be considered when launching new or building upon existing prevention strategies?

The results of these table discussions have been summarized below.

Changes to the Dental Profession
Many discussions focused on cultural, structural, and financial changes taking place in the dental profession, including the shift from dentists as solo practitioners to employees in large practices. It was argued that dentists should be at the table helping to shape these changes in the overall healthcare system. Participants spoke of the need for a shift in mindset within the profession, with dentists taking ownership over oral health prevention, while understanding prevention as a “team sport.” There is a need for “dentistry to be everywhere” including underserved areas by looking beyond conventional service models and the traditional dental team.

Dental Education
Given ongoing changes in incentives, prevention, and the broader health care system, concerns were expressed that dental students “may not have the skill sets to operate in this new world order.” Schools may need to adjust curriculum, or even reach out to different types of students. Equally challenging are the increasing costs of a dental education and the debts being incurred.

Risk Assessment
There is a need to develop and improve risk assessment tools that are evidence-based. For example, data is needed to understand the effectiveness of personal risk assessments that involve consumers taking ownership over their health.

Return on Investment
More research is needed to make the case for the use of incentives in oral health prevention. What is the value proposition for third party payers and ACOs? “What is the return on investment for prevention activities?”

Sustainability
There is the challenge of ensuring that new funding models are sustainable, especially in light of the financial challenges facing Medicaid, the lack of adult dental coverage in Medicaid and Medicare, and the many factors that impact service utilization.

Integration
There are growing opportunities for oral health to be recognized as and further integrated into overall healthcare. Will dental be a part of a healthcare ACO or will a standalone dental ACO be needed? Will dental plans be bundled with medical plans?

Challenges to Financial Incentives
Participants noted the challenges and roadblocks to creating an effective incentive structure. In addition to the difficulty of shaping or changing behaviors, the following issues were raised:

- Patients switching insurance plans
- The danger of this unintentionally increasing disparities
- The lack of diagnosis codes for dental diseases

Other Trends
- Expansion of the Medicaid population
- Increase in FQHCs
• Fee for service shrinking
• Large percentage of population underserved
• Artificial disparity created by a generation not seeking care

Engagement
To address emerging trends, other stakeholders and partners must be engaged. These include non-dental health professionals; consumers; patient and communities advocates; other advocacy groups, including biotech; and dental and related industries, such as those addressing tobacco and food.
OPENING REMARKS

Welcome

Jane Grover, D.D.S., M.P.H.
Director, Council on Access, Prevention and Interprofessional Relations
American Dental Association

"Today is D-day: dental disease prevention day. You are here because of who you are and not what you do. Designing strategies requires higher-level, environmental thinking. If we don’t think from the higher level the view on the ground never changes"

ORAL HEALTH CONDITIONS

Over the course of the morning, nine presenters spoke briefly about four key oral health conditions: oral cancer, periodontal disease, facial injuries, and caries, describing the current state of prevention related to each condition and pointing to promising avenues for future work. These talks were to ensure a common understanding of each condition, and to provoke creative strategizing among participants.

Following these presentations, participants worked at mixed-stakeholder tables to produce a set of prevention strategies that would have a significant impact on that condition, with a particular focus on primary and primordial prevention, as defined in the Four Stages of Prevention framework (See Appendix D). This process served as a “brainstorming” exercise to catalyze the process of collaborative strategizing.

Oral Cancer

Speaker 1: Current Prevention Efforts

Paul Brocklehurst, B.D.S, M.D.P.H., Ph.D., F.D.S. R.C.S.
Senior Clinical Lecturer, NIHR Clinician Scientist and Honorary Consultant in Dental Public Health
University of Manchester

"In the U.K. and the U.S., oral cancer incidence is increasing year by year, particularly with the younger age group. Late-stage disease is common, and late-stage presentation is a real killer. You can’t treat your way out of this condition. We’re not seeing any changes in survival rates. However, 98% of oral cancer incidences are attributed to known risk factors — tobacco, alcohol, HPV — and we can make a difference through primary, secondary, and tertiary prevention. Screening is key: if we can detect cancer early it will affect survival rates. The problem is that not every dentist does screening, many of the right patients don’t visit dentist offices, and physicians do not know how to detect the condition early. However, physicians and other health professionals can be trained to do screening. This is about making every contact count."

"In terms of primary prevention, we have had huge success with bans on smoking, taxation on alcohol, raising the minimum age for consumption, and national vaccination. We can also consider the use of ‘nudging,’ with strategies such as reducing cues like ashtrays and beer mats, reducing the amount of consumption, and encouraging people to switch to healthier alternatives. However, we do not have a lot of robust evidence on the impact of nudging."

Speaker 2: Opportunities

Alice M. Horowitz, Ph.D.
Research Associate Professor, Hershel S. Horowitz Center for Health Literacy
School of Public Health, University of Maryland
“Health literacy is not just about what the patient knows and practices, but also what the health provider knows and practices. In the U.S., adults do not generally understand oral cancer prevention and detection well. When they are asked where they get information, they say from their dentist or dental hygienist. But many adults, especially those with low income and education levels, do not have access to dental care providers. In terms of dentist knowledge, many have a limited understanding of oral cancer risk factors, where it occurs, the appearance of the lesions, and efficacy of the HPV vaccine. So, from a health literacy perspective, we have a ‘perfect storm.’ We have a lot of work to do. We need additional education. I would like to know if any schools require students to be able to perform oral cancer exams before they are allowed to practice. We need to get them on board about HPV vaccine, and have dentists and hygienists encouraging appropriate age groups to get the vaccine.”

**Oral Cancer Prevention Strategies**

*Screening*
Increase oral cancer screening, particularly among those at high risk due to smoking, alcohol, or HPV. Strategies include training all members of the medical team in oral cancer screening and counseling; incentivizing screenings through reimbursements; and a public media awareness raising campaign.

*Risk Behaviors*
Decrease the use of alcohol and tobacco products through collaboration with other health advocates. Strategies could include public campaigns, promotion of alternatives, or taxes on tobacco and alcohol products.

*Vaccination*
Educate the public and health professionals about HPV and its connection with oral cancer. Consider having a teenage patient as a spokesperson. Promote and/or mandate HPV vaccinations for appropriate age groups. Collaborate across medical disciplines to create multiple opportunities to learn about and receive the vaccine.

*Patient Education*
Raise public awareness about oral cancer and its risk factors, the need to ask for screening, and techniques for self-screening.

*Finance*
Develop financial incentives considering reimbursement for patient education, screening, and follow-ups from patient referrals.

*Training*
Ensure that all health professionals demonstrate competency in oral cancer, including how to screen for cancer and how to recognize and address risk factors, such as tobacco, HPV, and alcohol.

*Collaboration*
Engage in interprofessional collaboration with partners such as nurse midwives, gynecologists, physician assistants, nurse practitioners, primary care physicians, and organizations such as the National Association of School Nurses, WIC, Head Start, and Early Head Start. Encourage buy-in from government.

*Research*
Develop research studies to look at the effect of prevention strategies and early detection, emphasizing potential outcomes and cost savings.

**Periodontal Disease**

**Speaker 1: Current Prevention Efforts**

*Kenneth Kornman, D.D.S., Ph.D.*

*Chief Executive Officer and Chief Scientific Officer, Interleukin Genetics*
“Periodontitis is a bacterially-induced chronic inflammatory disease that destroys bone and connective tissues that support the teeth. There are three mistaken assumptions about periodontitis: that everyone is equally susceptible, that disease severity is a function of magnitude and time of bacterial exposure, and that prevention and treatment are uniformly predictable with adequate bacterial control. In fact, moderate periodontitis is predictably prevented with minimal burden on patient and delivery system. But if the patient has certain risk factors, including smoking, diabetes, and certain genetic markers, this individual could develop moderate to severe periodontitis, which is the primary dental condition associated with systemic diseases. Even if severe periodontal disease is properly treated, many patients continue to show disease progression, or to lose teeth, especially if they demonstrate these risk factors. We must improve diagnosis and identify those substantially at risk. We need an approach to prevention that is not one-size-fits-all.”

**Speaker 2: Opportunities**

George W. Taylor, D.M.D., M.P.H., Dr.P.H.
Professor and Chair, Department of Preventive and Restorative Dental Sciences
University of California San Francisco School of Dentistry

“Periodontal disease shares four risk factors with several other non-communicable diseases. These risk factors are tobacco use, physical inactivity, harmful use of alcohol, and unhealthy diets. In addition, both periodontitis and type-2 diabetes — common lifestyle-related chronic diseases — share many risk factors including age, education, finances, stress, social isolation, and more. There are bi-directional interrelationships between periodontal infection and type-2 diabetes, and both have been linked to obesity. These connections open up the door for interprofessional prevention and care.”

“There are several analyses showing the benefit of periodontal therapy on diabetes. A study that my group conducted at the University of Michigan, with Delta Dental, found significant cost savings from treatment for periodontal disease for people with diabetes and cardiovascular disease. With regards to opportunities, I am looking at how to incorporate risk assessment and the development of quality improvement measures into continuing education. If we’re thinking about primordial to tertiary prevention, we can also think about bi-directional relationships in the prevention scheme, and linking periodontitis prevention strategies to current prevention movements (e.g. diabetes) relating to common risk factors.”

**Periodontal Disease Prevention Strategies**

*Education*
Develop an education campaign with consumer-oriented messaging to empower action and behavioral change. The campaign could include a “know your numbers” program that puts risk information and recommended actions in the hands of individuals, similar to what currently exists with hypertension and cholesterol.

*Medication*
Develop and promote medications to reduce bacterial load and control plaque (the bio-film).

*Finance*
Increase dental care for chronic disease patients through specially-structured health plans, financial rewards for follow-ups, payment for genetic testing, provider liability coverage savings for taking continuing education courses on the topic, or other financial incentives. Educate payors on the return on investment for periodontal screening and care.

*Interprofessional Integration*
Incentivize increased interprofessional education promoting the connection between oral health and systemic health, including periodontal disease and other chronic conditions, such as diabetes. Increase bi-directional referrals by training physicians to screen for periodontitis and dentists to screen for diabetes and other conditions. Develop coordinated care systems that incorporate oral health and include integrated outcome measures.
Collaboration
Collaborate with advocacy groups who are addressing diabetes, obesity, cardiovascular diseases and other conditions potentially linked to periodontal disease. Foster dialogue across families, consumers, public health advocates, school systems, payors, and providers.

Community
“Take education and assessments to where people are.” Promote awareness and assessment at the community level through community health workers, health promoters/navigators, primary care physicians, and/or virtual dental homes. Have dentists play a role as community leaders.

Smoking
Address smoking by monitoring pollutants in nicotine, limiting places for people to smoke, offering behavioral incentives, and developing champions for tobacco cessation. This would require partnering with the tobacco cessation movement, and other medical professionals such as smoking cessation specialists.

Risk Assessment
Implement risk assessments and genetic testing for periodontal disease, and the use of CMS risk codes.

Facial Injuries

Speaker 1: Current Prevention Efforts
Alexis B. Olsson, D.D.S.
Chief, Oral & Maxillofacial Surgery
Professor, Clinical Otolaryngology-Head & Neck Surgery Northwestern University Feinberg School of Medicine Northwestern Memorial Hospital

“Facial surgery is an integral part of addressing injuries to the head and neck region, and the dentition sets the framework for surgery. State of the art treatment is not trying to mask injuries from the past. We are reconstructing puzzle pieces back to the way they looked prior to the accident. Dentistry is an integral part of that reconstruction.”

“There is a spectrum of causes of facial injuries, including interpersonal violence and domestic abuse. The causes have changed over time — 100 years ago, it was primarily farm injuries. It was a different picture in rural areas than in suburban and urban areas. In urban areas, we see gunshot wounds. In rural areas, we see ATV injuries. Sports injuries are most prevalent in suburban and urban areas. Despite preventive efforts with facemasks and other safety devices, sports injuries still happen frequently. As bicycle use increases, falls will increase. Automobile accidents still cause 12 to 15% of all facial injuries. The one prevention effort that has helped has been the use of the air bag. Mouth guards have also made a significant difference when used properly.”

Speaker 2: Opportunities
Past President, Academy for Sports Dentistry
Faculty-Team Dentist, Course-Academy for Sports Dentistry

“I am going to use a sports analogy, which will give us ideas about prevention in other areas. Some states have mandated mouth guards in various sports, but the strategy has failed. Why? What are the impediments to successful prevention? How do we motivate people?”

“Collaboration and education will lead the way. We must work from the top and from the grassroots. We will need to infiltrate other organizations; for example, we should have dental health professionals on sports governing bodies. We have to work at the grassroots level with communities — teachers, coaches, school
health professionals. We need to encourage our own colleagues to do prevention of injury in our dental offices. We need to cooperate with physician friends, plastic surgeons, and those who treat trauma. We need more education in our schools, and to take advantage of public service announcements, ads on cell phones, and better use of social media. We need better injury-reporting measures that are simple for all providers to use."

**Facial Injury Prevention Strategies**

**Safety Device Promotion**
Promote the use of sports safety devices, such as mouth guards, through public campaigns, mandates, and community-based education. This would likely require partnerships with sports organizations, equipment companies, advertisers and coaching associations. Engage champions including sports stars, mothers, and youth. Redesign safety devices, such as helmets, for better protection and to be more attractive to encourage great usage.

**Education**
Develop population-, school-, and community-based education campaigns focused on parents, students, and other potential patients. Educate about the dangers of risky behaviors (e.g. texting and driving, ATVs), and help people learn conflict resolution skills. Discourage media glorification of violence. Leverage social media and develop replicable curriculum.

**Policy**
Shift contexts to discourage dangerous behaviors. Raise the price of alcohol, change state laws regarding impaired driving, ban glasses and bottles on bars, and promote other safety policies.

**Collaboration**
Look for partners among retailers, educators, policymakers, police, transportation, insurance companies, and other health professions. Partner with advocacy groups, who are addressing the reduction of alcohol consumption and violence.

**Reporting**
Improve injury reporting by creating reporting mechanisms for dentists and other providers, developing diagnostic coding to collect injury information, and creating an injury registry.

**Screening**
Have dentists screen for interpersonal violence, abuse, and bullying.

**Dental Leadership**
Promote dental leadership on facial injury issues by placing dentists on boards of health safety, sporting organizations, ACOs, and school decision-making bodies.

**Finance**
Make the case for a return on investment for prevention activities, based on the costs related to personal injuries.

**Caries**

**Speaker 1: Current Prevention Efforts**
Yasmi Crystal, D.M.D., F.A.A.P.D. (Fluoride Modalities)
Clinical Associate Professor of Pediatric Dentistry Department of Pediatric Dentistry
New York University, College of Dentistry

“The outer surface of our teeth is the hardest tissue in our body. When conditions of the oral environment are acidic, the minerals from inside the tooth get leached out in demineralization. When conditions return to neutral, the teeth remineralize. This is a continual process, a balance between pathological and protective factors. When pathogenic factors prevail over a long period of time, the result is tissue destruction or cavities.”
“In terms of caries prevention, we have seen incredible reductions of caries rates since water fluoridation and the use of fluoride toothpaste. We know that fluoride prevents caries by inhibiting demineralization, enhancing remineralization, and interfering with bacterial functions. Water fluoridation is the best community health method, because it offers a slow exposure over a period of time and works for all ages. The only group for which caries rates are increasing is in two to five year olds, possibly because fluoride recommendations were leaving this age group without protection. Caries in primary teeth leads to increased potential of caries in permanent teeth. We know fluorides and sealants are our best weapons, but the figures are still too high. When the acid challenge is too great, fluoride protection is not enough. We need other modalities in addition, in order to fulfill the preventive needs of a changing population.”

**Speaker 2: Current Prevention Efforts**

*Julie Frantsve-Hawley, R.D.H., Ph.D. (Non-Fluoride Modalities)*

*Senior Director, ADA Center for Evidence-Based Dentistry*

“Caries is multi-factorial, and each of these factors is a potential target for prevention. What works? Behavior modification works and can be targeted at many levels, including the patient, the caregiver, the school, and the public. We know sealants work and fluoride is a home run. We also have ideas about non-fluoride agents that might work to address caries through managing bacterial activity or remineralization. We’re not getting home runs. We’re getting some foul balls, but a few have made it to first base. For some, including sugar-free chewing gums, xylitol lozenges/hard candy, and chlorhexidine + thymol varnish, there is clinical evidence of their potential effectiveness on caries prevention when used in conjunction with other practices. For others, there are laboratory studies to indicate that they might work, but clinical evidence to demonstrate their effectiveness is lacking.”

“When we think about evidence for agents that work, the interest doesn’t match the evidence. We’re not doing what works. Community fluoridation works, and it is not at 100%, so there is room for growth. We don’t have enough people doing sealants. The bottom line for caries prevention is to do what works, target those who would benefit most, and investigate and invent new things that work. Caries can be the next smallpox.”

**Speaker 3: Opportunities**

*Amid Ismail, B.D.S., M.P.H., M.B.A., Dr.P.H.*

*Dean, Maurice H. Kornberg School of Dentistry, Temple University*

“Our goals for caries are 1) sound teeth, 2) protection of healthy enamel and dentin when restorative care is indicated, and 3) no untreated “cavitated and dentinal” caries and infection. Apart from water fluoridation, we spend most of our money on clinical interventions, with variable success. Our disease levels have not changed in primary teeth for long time. Even in Nova Scotia and New Zealand, where there is coverage for all children, there are still disparities. We have to make a heavy investment in prevention and make sure that money is used wisely. We should take the socioeconomic factors of oral health seriously. What about joining the movement to eliminate poverty? If we reduce poverty, we improve dental health, which is better for our health and for business.”

“Humans are not single organisms. If you look at the mouth, we have about 3,600 species of bacteria in saliva and about 7,000 in plaque. We cannot attack just a few bacterial species. It is time for local, national, and global programs to manage caries with a focus on health, rather than restorative care. This will require integrated health/oral health care models, implemented by an oral health care team. This will require reframing dentistry with a focus on promoting oral health and overall health, and providing evidence-based primordial, primary, secondary, and tertiary care and prevention for individuals and populations. How will we educate oral health professionals? The future will be different. Treatment will remain a cornerstone of our profession, but we will move out of mouth to the human body, the community, and the world. There will be a focus on reducing poverty and inequities. We will work for a healthy, diverse microbiome, while creating integrated systems that pay for and incentivize health.”

**Caries Prevention Strategies**
Social Determinants
Partner with others to address the social determinants of health (e.g. poverty, education, employment).

Exams
Increase oral exams for caries. Consider mandatory oral exams prior to entering kindergarten, and financial incentives for schools that comply. Disseminate standardized messages about the “year one visit” and collaborate with other medical professionals to develop protocols and expedite referrals.

Education
Encourage healthy behaviors through population- and community-based campaigns related to brushing, fluoride, and other preventative measures. Use multiple messages designed for targeted populations (e.g. mothers, expectant women, and other caregivers). Leverage media tools, such as social media, blogs, and smartphone apps, as well as in-person methods, such as motivational interviewing. Encourage people, through places of employment, to take advantage of dental benefits. Hire allied health professionals in dental offices to educate patients about diet, obesity, and the impact on health including oral health. Distribute best practices for education and programs on the prevention of dental caries. Educate all, not only those with low SES. Expand the AD Council campaign to include products (e.g. toothbrush and toothpaste).

Interprofessional Integration
Work with medical homes/health homes to conduct risk assessments, promote more effective protective treatment, and support behavior modification. For example, dentists could hire and place hygienists in medical homes. Partner with primary care providers. Integrate oral health into ACOs and global payments. Leverage the FQHC model of medical/dental integration. Promote interprofessional diagnostic codes.

Water Fluoridation
Work for 100% fluoridated communities by talking about water fluoridation with patients, disproving anti-fluoride “junk science,” increasing funding for crumbling infrastructure, and establish “early warning systems” for rollbacks in fluoridated water.

Risk Behaviors
Encourage healthy nutrition and avoidance of risky consumption patterns. Possible strategies include labeling sugar-rich or anti-cariogenic foods, subsidizing healthy food choices, working with WIC to promote anti-cariogenic foods, taxing sugar and alcohol, increasing access to healthy foods, running public referenda of cariogenic foods, suing the sugar industry over deceptive practices, and making toothbrushes purchasable through WIC. Communicate evidence to policymakers regarding the reduction of sugars and cariogenic foods and the benefits of community-water fluoridation on the oral health of the community.

Community Outreach
Engage and raise the oral health awareness of those unable to access dental care by moving beyond the walls of dental offices and having dentists act as leaders in the community. Opportunities to practice community-based prevention include senior centers, Head Start, and WIC. Teledentistry offers another option that could incorporate oral health into an overall disease management model.

Sealants
Increase sealant application by dentists in their offices. Remove the state-specific prior exam requirement for placing sealants to allow for greater usage in school-based programs.

Research
Conduct more research on non-fluoride products to address caries, and on the full range of risk factors for caries.
HIGH-LEVEL PREVENTION STRATEGIES

Using their lists of condition-based strategies as a starting point, participants at each table were asked to agree on one “high-level prevention strategy” that could impact several of the four conditions presented and leverage the unique, multi-stakeholder capacity of the Summit. Each group presented its proposed approach to prevent oral disease and promote oral health. In their presentations, participants began to address key strategic issues, including leveraging current efforts and what stakeholders would need to be engaged. A list of potential stakeholders to be engaged, developed during this exercise, is included in Appendix G. (Note: Groups differed somewhat in terms of how narrowly they focused, how many “parts” or “prongs” their strategy had, and how they used the terms “goal” and “strategy.” This flexibility allowed each group to approach the exercise in the way they felt would be most effective.)

Group 1: Moving communities toward health through comprehensive assessment of risk and coordinated preventive interventions

“We are looking at families as our unit of analysis. Families touch any number of community institutions, but these interactions remain fragmented. We see a benefit in integrating these family-institution interactions in a comprehensive way using a risk assessment tool. This tool would connect institutions so that risk factors noted by one institution are communicated to all other institutions, initiating a series of referrals and interactions across the community. For example, if an adult applies for food stamps and shows signs of food insecurity, this would be flagged. The entire family would get referrals or have other institutional interactions in order to screen for needs and conditions related to that risk factor, such as dental decay. This becomes a comprehensive system that moves communities toward increased health sustaining capacity.”

Group 2: Provide a road map to better oral health with an emphasis on oral health promotion for all citizens

“This big-picture goal would be carried out through a set of systemic strategies, including 1) integrated health systems across the health spectrum; 2) an increase in interprofessional, collaborative efforts; and 3) the discovery and increased utilization of alternative access points for patients to receive health information and participate in oral health promotion. These strategies respond to the need for health information in the wake of the ACA, the increased national focus on health, and the interprofessional opportunity created by the 28 million individuals who are accessing the dental system and not the health system, as well as the 100 million accessing the health system, but not the dental system. These strategies would leverage existing health prevention and care efforts (e.g. WIC, diabetes prevention efforts, school-based clinics), with a particular focus on activating the public health system and its educational capacities. We would see school-based initiatives to develop health curricula and engage parents, teachers, coaches, etc.; mass media efforts providing information to patients about their roles and rights in the health system; and interprofessional education for health professionals.”

Group 3: Transition the oral health system into a chronic disease model framework

“This strategy emphasizes broad-based partnerships aimed at promoting both oral and overall health. It involves identifying and assessing promising integrated practice models; bringing oral health activities into education, social networks, and general health systems; and integrating the dental profession into the primary care medico-dental home. The strategy allows consumers to fuel the oral health movement, while also working with a broad spectrum of state and national level stakeholders (e.g. industry, payors, educators, legislators). At the legislative level, this strategy would push for parity, access, and oral health integration. At the grassroots level it would fund oral health coalitions with achievable strategies. It would capitalize on the ACA launch, as well as on emerging technologies to identify and implement innovative and integrated practice models for care delivery.

Group 4: Launch a campaign to re-imagine prevention

“This strategy seeks to re-imagine and reinvent the delivery systems for prevention throughout the lifespan. It would engage diverse professions and foster crosstalk between disciplines. It would identify multiple points of entry into prevention — schools, nursing homes, retail centers, PTAs, and other places where people at risk go to receive care. Social marketing experts with the dental and high-tech industries could develop messages that
would truly motivate positive oral health behaviors. Other health delivery systems are changing, so prevention needs to change as well. If we are successful, we will see an increase in oral health literacy and consumers would be empowered to do more for themselves. This strategy will explore how other providers can contribute to oral health prevention as exemplified by the extension of fluoride varnish application to include physicians and nurses.”

Group 5: Create an integrated, culturally competent health system built on multidirectional, evidence-based, preventive and comprehensive care model.

“This strategy would begin with a health home demonstration project based on public-private partnerships. The project could begin by leveraging existing FQHC programs and sharing health care workers across silos, with the eventual goal of co-location. The demonstration project would include activities around education, prevention, behavior modification, and community health worker outreach. It would involve the development of collective goals and shared systems, including training and education, IT, revenue, rewards and incentives, and regulations. This approach would save both money and time, with the outcome of better health and better care at a lower per capita cost. This strategy builds directly off of the ACA and the community health care worker movement, and requires involvement from a wide range of stakeholders including consumers, health workers, social workers, researchers, industry, policymakers, third party payers, etc. Success would be measured through cost savings, comparative effectiveness research, reductions in disparities, quality of life measures, number of patients served, and overall health outcomes.”

Group 6: Develop a community-based network to support health and well being across the lifespan

“Oral health conditions vary by community and by location, and it is important for communities to take ownership of disease prevention. Given that these conditions disproportionately affect people in low-income communities, the intent is to increase social capital in low-income communities and to empower communities to attack poverty. This will involve breaking down silos and aligning efforts more thoughtfully. It will also require education across various groups, including providers, community members, and patients who are at the greatest risk for dental disease. Community development is key — if residents in a community are healthy, they are more likely to contribute to society. There is an opportunity right now with health reform to obtain funding to test the model and enhance alignment.”

Group 7: Focus on early childhood caries: A winnable battle. Preventing a lifetime of disease

“The eradication of early childhood caries was considered a reachable goal. The goal would be achieved through community engagement, delivery preventive care across the lifespan and by addressing protective factors. In addition, there would be need to engage all relevant stakeholders in the integration of oral health into all health policies. The goal of eradicating early childhood caries can leverage on the current focus on holistic health, the fact that children’s health resonates with most stakeholders, as well as on the fact that evidence already exists that the battle is winnable. Reaching this goal will necessitate basic scientific research, community research, risk assessment, implementation of the science and community outreach. The oral health community will need to be present when policy decision are made at the community, state, and federal levels. Provider incentives will need to be closely aligned with existing programs. For example, home visits could be an effective strategy, based on the nursing family model for visitation. This strategy would require collaboration with public health where appropriate, and success could be measured by assessing changes in preventable ER and OR visits.”

Group 8: Aim to raise a generation of caries-free children, starting now

“In order to create felt accountability, the group tried to come up with a theme that everyone in the community could sign on to as they leave the theater: *raise a generation of caries-free children, starting now*. One of the most important components of this strategy is collaboration — not just among themselves, but also with community health people, educators, policymakers, industry, physicians, etc. Another critical aspect is education, not just of the public but also of providers. There is need to create a new climate and to bring more people into the system. It is important to start with providers who see patients that dentists don’t necessarily see. To have a generation of healthy kids, it is important to start with the mothers. There is need to build on
Participants noted the following:

Following the presentations, participants discussed similarities, trends, and strategies that resonated with them. Participants noted the following:

**Group 9: Leverage knowledge for action and behavioral change**

“This strategy is about engaging and empowering the public — including consumers, non-dental professionals, etc. — to drive the conversation around oral health, take action, and instigate behavioral changes. This will involve dentistry taking a more active role in oral health education. A key tool would be an app called “Know Your Numbers” — a risk assessment tool for patients, consumers, and non-dental providers. It would offer a way to easily understand one’s risk for oral health conditions, moving beyond dentistry to include hemoglobin, body mass index, and other risk factors. This strategy leverages existing IT technology, a changing legislative environment, and the current trend in empowering consumers through technology. In developing this interactive public health campaign, we could learn from existing apps related to health, as well as existing risk assessment tools. We would work with payers and providers to tie the campaign to diverse financial incentives. The campaign could also benefit from working with celebrities, youth, and patients — not just experts. We would start small, assess how the app is being used, and scale up or fail fast.”

**Group 10: Focus on eradicating dental caries**

“This strategy will require a community-based demonstration project that brings together many different prevention strategies in one high-risk community — a modern-day Grand Rapids. This strategy would address all four systems in the DentaQuest Systems Change model. In terms of policy, it would address multiple policy communities including professional policy, educational policy, fluoride policy, etc. In terms of the community, our goal would be to increase oral health literacy, build the cultural competence of providers, and leverage women (particularly mothers) as change agents. In terms of financing, we would incentivize prevention for a variety of professionals and non-professionals, including money for health education. And in terms of care, we would utilize quality measures and provider engagement. These strategies would necessitate engaging “unusual suspects” such as economists, community psychologists, anthropologists, etc., and would be evaluated through both quantitative outcomes and a qualitative approach to understand the community’s experience.”

**Group 11: Help people everywhere to understand that oral health matters**

“To reach our goal, we propose a six-year oral health literacy initiative with multiple stages. This will be an integrated strategy to create multidimensional, consumer-valued messaging to reinvent prevention. Phases would include prenatal to age 3, adolescents, adults, and seniors, with layered risk assessments. It will be a public-private collaboration dedicated to integrated care strategies, using nontraditional partners. There will be multiple roles for partners, (e.g. initiators, syndicators, distributors) with clearly laid out roles for each, and utilizing resources available within communities. One nontraditional role, for example, is that of the community pharmacy — a huge point of access for screening and referrals, with about 301 million visits to community pharmacies each week. We would utilize available guidelines, and create templates that are patient-centered. We recognize that challenges are different in different communities, so our role will be to set the goal lines and out-of-bounds areas, offer resources and tools so communities can call their own plays, and then collect quantitative and qualitative evidence to understand what’s going on. We will start with a concept, bringing people together, pilot the campaign, improve the campaign, and then scale to the regional and national levels, through an iterative quality improvement cycle.”

**Discussion**

*Following the presentations, participants discussed similarities, trends, and strategies that resonated with them.*

Participants noted the following:

- A common focus on consumer empowerment and systems change
- The value of comprehensive approaches that incorporates national trends
- A number of groups focused on dental caries, particularly in children, as a winnable battle
- The need to discuss intra-dental collaboration, and how to leverage the diverse dental workforce through the creation of an effective dental team that can address collaboration.
• The importance of cultural competency as an aspect of any strategy
• The promise of a “know your numbers” app or other technological/social media tools
• An opportunity to leverage existing public health infrastructure
• A heavy focus on engaging non-traditional partners

MERGING HIGH-LEVEL PREVENTION STRATEGIES

Following the presentation of the eleven strategies, participants were charged with the task of selecting, merging, and refining their ideas in order to move towards a smaller set of prevention approaches that would 1) leverage the multi-stakeholder and national nature of the summit, 2) be implementable and effective at this moment in time, and 3) achieve the greatest effect on prevention. The initial eleven groups moved around the room, combined their ideas with those of others, and ultimately translated their eleven strategies to five distinct approaches, each with multiple parts. Below, the five approaches are listed according to the names given them at the Summit, along with the strategies that merged to form them. The final step — moving to consensus around one multi-pronged prevention strategy — would take place on the third day of the summit.

1. Create an integrated, culturally competent health system built on multidirectional, evidence based, community-centered, preventive comprehensive care
   • Group 5: Create an integrated, culturally competent health system built on multidirectional, evidence-based prevention and comprehensive care.
   • Group 6: Develop a community-facing network to support health and wellbeing across the lifespan.

2. Eradicate Childhood Caries: A Winnable Battle
   • Group 8: Raise a generation of caries-free children, starting now.
   • Group 10: Eradicate dental caries.

3. Transition the oral health system to a chronic disease model framework
   • Group 3: Transition the oral health system to a chronic disease model framework.

4. Achieve oral health equity. Eliminate oral health disparities
   • Group 2: Provide a road map to better oral health with an emphasis on oral health promotion for all citizens.

5. Oral Health Matters: A Campaign to Re-imagine Prevention
   • Group 1: Moving communities toward health through comprehensive assessment of risk and coordinated preventive interventions.
   • Group 4: Campaign to re-imagine prevention.
   • Group 9: Leverage knowledge for action and behavioral change.
   • Group 11: Help people everywhere to understand that oral health matters.
Summit Proceedings
Day 3, November 20

OPENING REMARKS

Welcome
Charles H. Norman III, D.D.S.
President, American Dental Association

Agenda and Process Overview
Elaine Kuttner
Principal, Cambridge Concord Associates
Summit Facilitator

KEYNOTE SPEAKER

Day 3 began with a presentation by the Summit’s second keynote speaker. Dr. Terry Davis shared best practices and key concepts from the field of health literacy, a topic already emerging as central to some of the proposed prevention strategies. Her talk informed both the design and language of the framework that ultimately emerged from the Summit.

Putting Health Literacy into Oral Health Practice and Public Health Initiatives

Terry C. Davis, Ph.D.
Professor of Medicine and Pediatrics
Louisiana State University

“The majority of US adults struggle with health literacy, and literacy levels are getting worse. The Department of Health and Human Services defines oral health literacy as ‘The degree to which individuals have the capacity to obtain, process, and understand basic oral and craniofacial health information and services needed to make appropriate health decisions.’ In today’s talk we will address the following questions:

- Is there an imbalance in the public’s (or your patients’) basic oral health literacy and the knowledge needed to prevent oral disease?
- Can we make oral health information and services easier to understand and use?
- What are promising public health and patient education strategies to improve oral healthcare?”

“What are promising public health and patient education strategies to improve oral healthcare?”

“When we started looking at health literacy, we were focused on the lack of skills and abilities among patients. What we have to do now is address the unnecessary complexity of health information and the health system. We assume patients understand what we are talking about, that we are good communicators. But the first national survey of dental communication reported that routine use of effective communication techniques is low. Two thirds of dentists said they would be open to more training on communication.”

“Oral health requires health literacy: to schedule an appointment, to determine how much toothpaste to use on a toddler's tooth brush, to understand when to stop using baby bottles, to recognize potential complications of a root canal, to complete a Medicaid application, or to understand media campaigns promoting fluoridation. Low oral health literacy is linked to inaccurate knowledge about water fluoridation, less knowledge about the severity of dental carries, fewer dental visits, and worse perceived oral health quality of life. Numeracy is a problem as well. Reading prescription labels is an everyday health math task, but who teaches people to read a prescription label? I began working with team from Emory and Northwestern, looking at Rx bottles. We created a patient-
centered label that improves understanding and coherence. We have a bigger pill bottle with a larger font, and a label that makes clear what information the patient needs.”

“There are three main tests to screen people for literacy in health care: REALM (Rapid Estimate of Literacy Medicine), TOFHLA (Test of Functional Health Literacy), and NVS (Newest Vital Sign.) There is also a qualitative test about the confidence of filling out medical forms. Dentists have picked this up and developed tests specific to dental care. These tests are useful for research, but there is no evidence that they are helpful to use in clinics. To get accurate measures of a patient’s specific health literacy clinically, you need to do a teach-back: ask them to confirm what you want them to know and do. Use plain language on all materials, for everyone.”

“Customer surveys reveal that the first source of dental information is the dentist. Patients believe what you say — you’re knowledgeable, and they know that. You just need to figure out how to communicate your message. How can dentists do a better job with patient education? I teach the seven steps to improve patient education.

1. Slow down
2. Avoid dental jargon, use living room language
3. Use pictures, teaching tools (pamphlets, teeth)
4. Limit information – write brief take home information
5. Focus on ‘need to know’ and ‘do’
6. Repeat and summarize info
7. ‘Teach back’/’show back’ to confirm understanding

“As dentists, ask yourself what it is like to be a patient in your setting. Are signs easy to follow? Are check-in personnel calm and friendly? Are forms easy to read and answer? Are they in the right languages? Is the environment welcoming?”

Written health information is organized from a medical model rather than being patient-centered. It is long, with too much information; it lacks cultural diversity; there is a lack of attention to tone and emotion, a lack of patient input and evaluation, a lack of a well-thought-out distribution and sustainability plan, and a lack of awareness about what is available on the Internet. I suggest you ask these seven questions about your materials:

1. Is the title patient centered?
2. Is the layout user friendly?
3. Do illustrations convey the message?
4. Is the message clear and easy to pick out?
5. What is the behavioral objective?
6. Is the information manageable?
7. Is the information culturally appropriate — does it look and sound like it is “meant for me”?
8. Good model: American college of physicians patient self-management guides

“Finally, what is our bridge to action? How does this talk stimulate your thinking and practice? What research ideas does it spark? What could we do to make health information and services more user-friendly?”

STAKEHOLDER GROUP PERSPECTIVES

During the morning of Day 3, participants worked with their stakeholder groups to assess the five proposals from the previous day, and to begin imagining what roles each stakeholder group might play. The initial stakeholder conversations were guided by the following questions.

• Which proposals do you think your stakeholder group would be most able to embrace and support? What would you not be able to support? What roles do you see yourselves playing in bringing these approaches to life? What changes might you suggest?

This process, and the full-group discussions it catalyzed, made clear that while there was not yet consensus on one approach, there was significant agreement at a high level, and much potential for synergy among the various proposals. Below, the themes that emerged from these discussions have been summarized.
Emerging Agreement
Across stakeholder groups, the most commonly selected of the five proposals outlined at the end of Day 2 was #5, at the time titled *Oral Health Matters: A Campaign to Re-imagine Prevention*. This approach combined:

- A national advocacy and health literacy campaign promoting the importance of oral health;
- Community-based efforts to integrate prevention services; and
- Public engagement in risk assessment and behavior change through innovative technology.

However, most did not see this choice as necessarily precluding the other approaches. Participants described various ways that other ideas could be integrated into this broader umbrella. For example, a focus on childhood caries could be one stage in a series of staged initiatives.

Community-Centered Approach
The second most commonly selected proposal, often chosen in conjunction with #5, was #1: *Create an integrated, culturally competent health system built on multidirectional, evidence based, community-centered, preventive comprehensive care*. Participants who spoke of this approach stressed the need to address systems at a community level, particularly given the increased interest in the country around community-centered approaches. They also pointed to the importance of cultural and linguistic competency in whatever approach is ultimately chosen.

Ground War & Air War
Participants agreed that the final framework for action should include some mix of a “ground war” (mobilizing people at the community level) and an “air war” (running large-scale advocacy and media campaigns). There was some disagreement about which aspect should come first. For example, one group argued that “an ‘air war’ is designed to prepare the battlefield for a ‘ground war.’ The initial effort needs to be strong advocacy for parity at the state and federal level. That way, we can get the needed resources to accomplish what we want to accomplish.” There was also some initial discussion about whether the ground war should be coordinated in a centralized or decentralized manner.

Equity
A number of stakeholder groups reinforced the idea of including an explicit goal related to achieving oral health equity and eliminating oral health disparities.

Lifespan Focus
Many stakeholder groups expressed interest in the specific goal of eradicating childhood caries, arguing that it would be both bold and actionable, and would appeal to the public. At the same time, participants stressed that it would need to be one piece of a larger focus across the lifespan, and across conditions.

Language
There was some discussion about how to talk about and frame these ideas for a broad audience, suggesting that phrases like “re-imagining prevention” and “oral health matters” would not resonate with the public. Participants pointed to the need for multiple messages targeted at different audiences. One suggestion, taking a lesson from Dr. Davis’s talk on health literacy, was to speak of “mouths” rather than “oral health.”

Chronic Disease
Some stakeholders reinforced the value of the chronic disease model, which could help expand prevention beyond traditional oral health sites and link dentistry with a broader network of care delivery and prevention.

Poverty
Stakeholders raised the issue of poverty as a root cause of health disparities, arguing that addressing poverty should be included in the final framework.

Expanding Participation
Many participants noted that important stakeholder groups, such as patients, were not present in the room. Therefore, the goal and strategies emerging from this meeting should be designed to draw new stakeholders into the planning and implementation processes, and to offer multiple entry points for involvement.
Funding and Capacity
Participants discussed how best to leverage resources to support these emerging strategies. Funding, it was suggested, will need to come from both private and public sources, including industry and private practice. Given difficulties in finding new money for oral health prevention, there may have to be some prioritizing and reallocation of resources. Suggestions for how to attract funds included research demonstrating the economic benefits of investment in prevention and cost sharing between the oral health and overall health fields. It was also suggested that raising funds would require clarity and focus around outcomes.

Next Steps
In order to carry this approach further, participants called for a multi-stakeholder group that could facilitate continuing, collaborative planning towards a full, implementable framework for action.

Stakeholder Roles
Stakeholder groups began to imagine roles for themselves in terms of the emerging prevention approaches. For example, it was suggested that foundations could help draw in additional stakeholder groups; policymakers could enable the effort by addressing outcomes, financing, and incentives; dentists and the dental team could provide community leadership; third party payers could contribute to the creation of a new, integrated health system focused on prevention and risk, and the ADA could play a national leadership and advocacy role.

Evaluation/Improvement
Participants noted the importance of having strong systems in place for evaluation and continual improvement, so that “when programs are successful or not successful they can be discarded or scaled.”

Connecting with Movements
A number of stakeholders reinforced the idea of linking with other social movements and health-related efforts in order to collaborate around shared risk factors and social determinants of health.

PROPOSING AN INTEGRATED APPROACH
Seeing that the room was moving towards agreement on a high-level prevention approach, participants Benjamin Bluml, Dushanka Kleinman and Ralph Fuccillo volunteered a new proposal to the full group. This proposal was based on an updated version of proposal #5, which had gained the most interest from across stakeholder groups. At the same time, this new proposal merged several aspects of other proposed approaches, and addressed some of the issues raised in discussion. While recognizing that the proposal would continue to evolve and change in the coming months, and that more would be needed in order to translate these broad ideas into a full framework for action, the speakers asked the assembled group if this approach resonated enough for participants to commit to further engagement.

Benjamin M. Bluml, R.Ph.
Senior Vice President for Research and Innovation, American Pharmacists Association Foundation

“We suggest a renaming of this integrated proposal: Your Mouth Matters: Empowering and Engaging the Public, a Movement to Redesign Prevention. This initiative is imagined as a multi-phase activity, with a focus on helping people everywhere understand that oral health and a healthy mouth matters. It would require a long-term investment over the course of at least six years. The initiative would be operationalized across the lifespan, beginning with setting the goal, “caries-free by age 3,” then moving to children, adolescents, adults, and seniors. We would look at risk across the spectrum, identifying critical points of entry and making sure we engage the right populations in the right ways.”

“We see this as a public-private partnership, focusing on integrated oral health care with traditional and non-traditional providers. We
would work with faith-based organizations, schools, physician assistants, nurses, social workers, community health workers, community pharmacies, and more. The initiative has four layers or dimensions, based in the four models: the Fisher-Owens model, the NQMC Domain Framework, the Four Stages of Prevention, and the DentaQuest Systems Framework. Progress moves along a continuum that starts with engaging key stakeholders in all sectors to implement pilot efforts, and moves forward through repeating cycle of continuous quality improvement, and expansion outward to a national platform.”

“We would have a deliberate approach to engaging stakeholders, in which each group identifies roles they will play. The public will be a critical driver and communities will be engaged with resources, information about ‘goal lines’ and ‘out of bounds’ markers, best practices, templates, and tools. This will ultimately help them decide how to make initiatives on their own, and to achieve goals that make difference in their community.”

**Dushanka Kleinman, D.D.S., M.Sc.D.**
**Associate Dean for Research, Professor and Chair, Department of Health Services Administration**
**School of Public Health, University of Maryland**

“This initiative is the big umbrella. Under it, there have to be actionable, teachable, short-term initiatives that people can touch and hold as their own. It is a learning organizational movement that benefits not only from good thinking here, but also from the overall prevention movement. There will be campaigns of the traditional kind, as well as population-based efforts around the integration of services, and invitations to consumers to be part and parcel of the thinking. We want to ‘empower and engage’ the public through efforts like the ‘Know Your Numbers’ app — things that are tangible and well disseminated, that speak to age groups beyond those represented here, that get messages out, and that reinforce patient compliance with treatment as well as community and social network-based movements.”

**Ralph Fuccillo**
**Chief Mission Officer, DentaQuest**
**President, DentaQuest Foundation**

“We have come to this place where we all seem to agree on an umbrella, high-level approach. I have been in prevention for 30 years. I’ve been with groups in moments just like this, where we understand what the problems are and we have identified the crisis. But we can’t make change by telling other people what to do. We have to decide what we want to do.”

“We still have many divisions. People are struggling with questions about whether we are going to be general or specific, formal or informal, an organization or a loose affiliation, and whether we are going to get anything done. We all want to leave here with something. We don’t yet have everything right. But I’m asking us, does this resonate? Are we at a place now where we can say, ‘We have to do this’? Are we close enough to say, ‘Your Mouth Matters’?”

“Does this resonate? Are we at a place now where we can say, ‘We have to do this’?”

“I am a part of the planning committee, and if I get invited to come back I will come back. We have spent these three days reimagining prevention. Now we have to redesign. We’ve made progress. Hopefully everybody got heard, and if not, bring it back to the next conversation. It doesn’t have to take a big tragedy for us to say that we, as Americans, are going to commit to something great. I have been reading that our economy is a *connection economy*, that we are a *connection society*. If we come out of here connected, with a goal to move towards, I’ll bet we’ll do it.”

**DISCUSSION OF PROPOSAL**

*Following the presentations, participants were asked to discuss at their stakeholder tables if the proposal resonated with them, if it were doable, and if so, what it would take to implement it successfully. In response to the first and second questions, all agreed that, at a high level, the proposal resonated with their*
stakeholder group and they did feel that it was doable. In response to the third question, participants shared an array of suggestions related to improving, implementing, and assuring success.

Reaching this high-level goal would take...

An organizational and communications structure
We need to make sure we have a structure, whether centralized or diffuse, that allows for planning, coordination, and guidance. This will require communications infrastructure, and could include a centralized online space for disseminating information, as well as facilitating the sharing of diverse activities from around the country.

Clear and consistent messaging
The language and key messages will need to be further developed. Dissemination will have to be wide and consistent. Messages should be vetted with the people the effort is seeking to engage. The campaign could include a logo or other way for organizations and companies to communicate their involvement.

Broad stakeholder engagement
We need to support summit participants as they engage others in their stakeholder groups, and reach out to new stakeholders such as consumers (youth, adults, seniors) and younger professionals. There will need to be multiple entry points for involvement, and stakeholders will need to clearly understand the roles they can play.

Leveraging current activities
We now should take what we have developed here and make it more comprehensive. We need to link with the broader prevention movement. Rather than just asking them to join us, we will have to go to them, putting ourselves at the table with those leading other prevention efforts.

Clear metrics
We need clear metrics to determine effectiveness so that we know what we are accomplishing what we want to accomplish. These metrics should address all four diseases focused on at the summit.

A paradigm shift
If we are ‘redesigning’ prevention, then we are changing the way we do business. Current prevention efforts are working for certain parts of population, but we need to think about the other parts of the population who are not benefiting.

Piloting
We should begin with small-scale interventions and demonstration projects, then fail fast or scale up. When we can demonstrate success, people will be able to better engage because we will have something concrete. The strategy should be seen not as implementing what we already know, but rather determining what works and finding new ways to implement.

Funding
This effort will require resources. When there are no new dollars, we will need to shift costs and identify where dollars will come from.

An action plan
We will need an action plan with a defined core that can lead us forward. But it must also be fluid and flexible, recognizing that we are in transition now. If what we have tomorrow doesn’t work, we have to discard it and move on. A logic model would be helpful in laying out the plan clearly for ourselves and others.

NEXT STEPS
The summit conversations concluded with a discussion about next steps. Where do we go from here? What are the important next steps? What are the assumptions everyone is making? How do we make sure it doesn’t fall through the cracks? What needs to happen starting from the time we walk out door? Participants charged the
Planning Group with taking the emerging agreement from the Summit and further developing it into a draft framework for action, as well as reaching out to additional stakeholder groups. The ADA offered short-term support for the initiative until it can stand on its own.

Charles H. Norman III, D.D.S.  
President, American Dental Association

"In the last three days we’ve delivered a child. The ADA is willing to nurture it for the short term, to house it within ADA. But it is going to require bringing the family together to make some decisions about how to raise this child. We need to reconvene a small group of stakeholders to address action plans and metrics."

Ideas for Next Steps

- Produce a brief outlining the emerging agreement at the end of the Summit, as a basis for further development and dialogue. (Completed December 7, 2013 — See Appendix A)
- Reconvene the Prevention Summit Planning Group to take the next step in developing a framework for action on the prevention of oral disease. (Completed January 12, 2014)
- Support participants in creating buy-in within their own organizations and institutions and across stakeholder groups.
- Create an online space where stakeholders can share information about what actions they and their organizations are taking.

CLOSING COMMENTS

Elaine Kuttner  
Principal, Cambridge Concord Associates  
Summit Facilitator

"It is time to step back and appreciate the work we have done in partnership with one another. Over the past three days everyone in this room has brought to these deliberations a high level of commitment to the prevention mission. An initial proposal has been put forward, and at this moment there exists a great level of synergy among stakeholder groups. Everyone does not agree about everything, and of course that is to be expected. In fact that is good. If we pay attention to those dynamic tensions as we move forward, they will only serve to make the outcome richer. Let us end this meeting with a commitment to embrace the intent of the summit outcomes and continue to strengthen and refine them over the next several weeks. Then we can begin the challenging work of implementation. Congratulations and safe travels."
On November 18–20, 2013, an unprecedented interdisciplinary and multi-sector Prevention Summit on oral health was held in Chicago, IL. The summit was called in response to persistent oral health disparities across the United States and the recognition that we cannot drill, fill and extract our way out of this crisis without a fundamentally different approach; one that accentuates disease prevention.

Convened by the American Dental Association’s Council on Access, Prevention and Interprofessional Relations (CAPIR) and planned by representatives of eleven key stakeholder groups, the 2013 Prevention Summit brought together dental and non-dental health care professionals along with researchers, academicians, public health professionals, patient advocates, policymakers, and leaders from foundations, third-party payers, and industry. These individuals were joined by leaders of organized dentistry representing the national, state and local levels.

In the context of a rapidly transitioning national health system and a growing overall prevention movement, Summit participants sought to develop a framework for action that leverages today’s opportunities, represents strategic choices, takes full advantage of multi-stakeholder engagement, and includes plans for sustainability and accountability.

The Summit focused on prevention of oral health conditions, with an emphasis on health promotion and disease prevention, including risk factors that compromise overall health and wellness. Over the course of three days, participants identified clusters of initiatives that began to align around a broad-based, multi-pronged strategy to “redesign prevention” in the United States. This strategy will be further developed through ongoing, multi-stakeholder collaboration and will include a variety of population and community prevention efforts. It will offer multiple entry points for involvement, incorporate the unique contributions of diverse stakeholders, and create a revitalized prevention movement while remaining flexible to allow for learning, adaptation and ongoing improvement.

Overarching Goal

With the ultimate goal of optimum oral health for all, this emerging strategy aims to place prevention information and tools in the hands of the public and the professionals that serve them, while integrating oral health-related prevention into the lives of individuals, families and communities.

This strategy focuses on the basic assumption that “mouths matter,” while acknowledging that engaging the public is critical to reimagining and redesigning prevention in oral health. It calls for a national, coordinated campaign to promote oral health literacy and prevention – not just a media campaign, but a multi-pronged effort that can serve as an umbrella for demonstration projects engaging diverse populations and communities throughout the country.

This effort will be:

- **Targeted:** Identifying critical risk factors and points of entry to reach individuals and families where they are, including non-traditional settings.
- **Multi-phase:** Orchestrated to address oral health across the lifespan.
- **Multi-stakeholder:** Engaging a wide range of public and private, traditional and non-traditional partners who integrate their efforts to promote oral and overall health and wellness.
- **Evidence-based:** Leveraging existing evidence and successful programs, while building new evidence through assessment and research.
- **Systems-focused:** Addressing the multiple, interconnected systems that shape oral health outcomes.
• **About more than a healthy smile**: Based on an understanding that preserving oral health is best served by a conservative approach that preserves oral tissues; that oral diseases can be chronic diseases; and that oral health is an integral piece of overall health and wellness.

• **Linked to existing movements**: Building on existing efforts in prevention, interprofessional education and practice. In addition, linking with efforts to curb or eradicate related systemic health issues, such as diabetes and cancer, and supporting movements that address social determinants, such as poverty and lack of education.

• **A learning system**: Engaged in an ongoing process of innovation including local pilot or demonstration projects, research and assessment, and continuous quality improvement.

In order to achieve its goal of reimagining and redesigning prevention, this effort will require:

• **A broad-based network**: An overarching entity/network that can foster linkages across partners and projects allowing for communication, collaboration, coherent messaging, learning and infrastructure building. Such a network would coordinate national media efforts, while offering tools, resources, and best practices to be adapted by local initiatives.

• **A long-term investment**: A significant long-term commitment of resources based on multi-stakeholder and interprofessional strategic planning, while including short-term, targeted initiatives. Funding is likely to come from a variety of sources both public and private.

• **Digital technology**: Leveraging electronic and social media, such as a digital "hub" to facilitate networking, knowledge sharing, and the documentation of efforts supporting the outcomes of this Summit.

• **Education capacity**: The ability to ensure health care providers, policy makers, and the public have the knowledge and tools to contribute to the oral health and health and wellness movement.

• **Research capacity**: The ability to measure success and progress of prevention efforts including determining baseline data and ongoing surveillance and assessment.

**Potential Initiatives:**

Within the proposed overarching strategy, multiple initiatives will be launched and orchestrated, each following a process of piloting, assessment, revision and implementation. Some efforts may be community-centered, working with community-level partners to support integrated, interdisciplinary processes of education, risk-assessment, and prevention. Others will be population-focused, such as a broad-based media campaign aimed at jump-starting mobilization efforts and behavior change, which will be carried out in collaboration with community-based partners. Potential initiatives include:

• **Know Your Numbers**: An interactive public health initiative that puts risk assessment tools in the hands of the public through a smart-phone app.

• **Community-facing prevention systems**: A pilot for a community-based, integrated prevention system that links all relevant entities together in a culturally-competent, multi-directional, comprehensive system of risk assessment, prevention, and care.

• **Caries-Free by Age 3**: An initiative incorporating all health, social service and educational entities that touch a child and their caregivers from prenatal through age 3. This age-focused initiative could serve as a first phase for a series of initiatives focused on each stage of the lifecycle.

• **Chronic Disease Management**: An initiative that strives to contribute to primary prevention, as well as novel approaches to secondary and tertiary prevention, by extending the integration of oral health management within existing and evolving coordinated care and population health management models.

**Moving Forward:**

As conveners of the Prevention Summit, the American Dental Association has offered to provide interim infrastructure for moving forward, including staff time and information gathering, in order to nurture this effort as it develops sustainable underpinnings. Initial action steps include:

1. **Reconvene the Prevention Summit Planning Group** in order to further develop and implement the overarching strategy and make decisions about next steps.
2. **Broaden engagement** in the implementation process, with a particular focus on young professionals and consumers.

3. **Broaden the implementation team** to include all stakeholder groups, which will begin to develop a logic model with metrics for success, create a strategic plan with milestones, and initiate the process of seeking funding.

4. **Develop a method of ongoing communication** linking diverse stakeholders across the country, through which information and potential resources can be shared.
Appendix B:
Participant List
## Participant List

*Key Stakeholder Representative

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<thead>
<tr>
<th><strong>DENTAL TEAM</strong></th>
<th><strong>THIRD PARTY PAYERS</strong></th>
<th><strong>INDUSTRY</strong></th>
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<td>Davis, Gary*</td>
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Appendix C: Sponsors
We would like to thank our generous sponsors for their support of the Prevention Summit:

**Gold Sponsor**

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Chicago, IL  November 18-20, 2013
Appendix D: Frameworks
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The triad was adapted from Keyes PH. Int Dent J. 1962;12:443–464; and the concentric oval design was adapted from the National Committee on Vital and Health Statistics. Shaping a Health Statistics Vision for the 21st Century. Washington, D.C.: Department of Health and Human Services Data Council, Centers for Disease Control and Prevention, National Center for Health Statistics; 2002:viii.
Four Stages of Prevention

**Primordial Prevention** consists of actions to minimize future hazards to health. It addresses broad health determinants (environmental, economic, social, behavioural, cultural) rather than preventing personal exposure to risk factors.

**Primary Prevention** seeks to prevent the onset of specific diseases via risk reduction: by altering behaviours or exposures that can lead to disease, or by enhancing resistance to the effects of exposure to a disease agent.

**Secondary Prevention** aims to reduce progression of a disease through early detection and early intervention.

**Tertiary Prevention** takes place once a disease has developed. It seeks to soften the impact caused by the disease on the patient's function, longevity, and quality of life.

NQMC Domain Framework

Health Care Delivery Measures
Measures of care delivered to individuals and populations defined by their relationship to clinicians, clinical delivery teams, delivery organizations, or health insurance plans. Denominators for these measures are defined by some form of affiliation with a clinical care delivery organization, e.g., recipients of health care, health plan enrollees, clinical episodes, clinicians, or clinical delivery organizations.

Clinical Quality Measures
- Process
- Outcome
- Structure
- Patient Experience

Related Health Care Delivery Measures
- User-Enrollee Health State
- Management
- Use of Services
- Cost
- Efficiency

Clinical Efficiency Measures
- Population Process
- Population Access
- Population Outcome
- Population Structure
- Population Experience

Population Health Quality Measures
- Population Health State
- Population Management
- Population Use of Services
- Population Cost
- Population Health Knowledge

Population Efficiency Measures
- Social Determinants of Health
- Environment
- Population Efficiency
DentaQuest Foundation Systems Change Approach

**POLICY**
- Oral health is a key component of health policy
- Oral health policy consistent at local, state and federal levels
- Oral health measurement systems in place
- Policy to allow expanded workforce

**FINANCING**
- Sufficient funding to support care, prevention and training
- Alignment of payment with evidence, prevention, disease management and outcomes

**CARE**
- Dental workforce sufficient to meet needs efficiently & effectively
- Care based on evidence, prevention, disease management and outcomes
- Oral health integrated into all aspects of health care
- Consumer focused care delivery

**COMMUNITY**
- Oral health integrated into education and social services
- Optimal oral health literacy
- Strong community prevention and care infrastructure
- Provider base representative of community

Improving the oral health of ALL
Appendix E:
Primer on Four Dental Conditions
Four Dental Conditions — Prevention Summit Primer

This document is an overview of four common dental conditions that will be discussed during the Prevention Summit in November 2013. This document can assist non-dental providers in understanding the basic tenets of these dental conditions, how oral health is an important component of overall health and how prevention practices can help patients manage their disease.

**Dental Decay:** Dental “caries” (or cavities) happens when certain bacteria in plaque (material that is present in the mouth) utilize dietary sugars to produce acid, which gradually erodes the tooth enamel and produces a hole or cavity. Efforts to prevent caries include minimizing dietary sugars, placing sealants on the chewing surfaces of permanent teeth, frequent brushing and appropriate use of fluoride.

Decay on a single tooth can eventually erode into the pulp (or nerve) of the tooth. Because of the infective nature of tooth decay, bacteria can spread from the tooth pulp to the rest of the body producing serious facial infections leading to swelling, toxicity and sometimes death. Chronic dental infections can compromise the treatment of patients with comprehensive medical conditions, including diabetes, hypertension, renal issues or cancer treatments.

**Periodontal Disease:** Also known as “gum disease,” periodontal disease occurs when plaque film missed during home hygiene practices calcifies and begins to weaken the bony structures supporting teeth. Teeth loosen as inflammation progresses (due to certain bacteria in the plaque), especially in smokers. Gums may become painful and bleed easily, which eventually leads to a chronic, long term infection, which increases systemic inflammatory markers. Untreated periodontal disease can complicate otherwise healthy pregnancies, diabetic treatment, and cardiac surgery, to name a few examples. Periodontal disease can be prevented with appropriate dental cleanings, antimicrobial strategies and effective home care practices.

**Facial Trauma Injuries:** This category includes sports injuries, such as concussions during football. Some studies show that custom fitted mouthguards can reduce concussions by significant percentages. Other sports injuries, such as tooth breakage and avulsion, can be prevented by the appropriate use of mouthguards. Facial injuries an also result from accidents and abuse.

**Oral Cancer:** Oral cancer remains one of the most understood and poorly treated conditions. Five year survival rates for oral cancer have not improved in the last 40 years and the human papilloma virus is now strongly linked. The current case of actor Michael Douglas is one example of oral cancer with a link to HPV. Smoking and use of smokeless tobacco continues to be strong predicators of oral cancer risk development.
Appendix F: Hopes & Fears

On the first day of the 2013 Prevention Summit, participants were asked to share their hopes and fears for the Summit. Below, their answers are sorted by topic.

1. My greatest hope for the Summit is…

“That it will make a difference.”
- That it is truly impactful
- Insight into a national agenda that can make a difference
- To move the needle nationally
- To accomplish something important.
- The opportunity to create big change in primary prevention
- To make a difference to dental/oral health
- To improve oral health outcomes for children
- To increase utilization and accessibility for all populations

“That we reach consensus.”
- That new ideas and/or new approaches to existing ideas can be agreed upon
- A shared understanding of prevention and a coordinated effort
- Consensus on what prevention will look like moving forward — in a form different from today
- A shared understanding that we need new social norms around the power of individuals and communities to protect the health of teeth and gums
- Unity and actionable ideas
- That a unified strategy/direction evolves
- To find common ground
- That we reach a valid consensus on a national strategy on oral health prevention that is compelling and implementable

“That we think outside the box.”
- To think outside the box
- To throw out everything, start fresh, recognizing that the old way doesn’t work
- A new model/paradigm for oral health care
- A paradigm shift
- New ideas for a global oral health promotion and prevention agenda

“Concrete, actionable plans.”
- An action plan that has significant impact on advancing oral health and driving effective prevention strategies, especially those that individuals can practice at home
- Meaningful engagement focused on practical and implementable outcomes
- Something actionable is accomplished
- To get to actionable items
- A practical, replicable plan for action that increases access
- Something tangible that each of us can do within an action plan
- To achieve implementation
- To create actionable plans
- One or two tangible, workable collaborations that actually gets results
- To develop a real actionable plan
- A concrete plan
- One action that DIA puts in place and gets done
- To develop a plan to improve people’s lives
- That we develop a short list of national initiatives that address prevention
- Actionable results
• To develop outcomes that are applicable and financially viable
• That ideas will move to action
• Something actionable and implemented that makes a difference in preventing oral disease
• A few concrete suggestions

“Measurable, scalable outcomes.”
• Sustainable efforts with measurable outcomes
• Scalable outcomes
• Demonstrable outcome
• Meaningful outcomes

“Increased recognition of the value of oral health prevention.”
• For people to recognize the value of prevention
• To raise oral health awareness with the public, policy makers, and health professionals
• That prevention and oral health are framed so that both are elevated and valued

“To develop relationships and collaboration.”
• To develop and grow relationships that focus on prevention
• That a network of individuals committed to oral disease promotion establishes a stronger, more meaningful connection
• To initiate change through strong coalitions
• True collaboration to successfully implement goals, breaking down perceived barriers and biases

Other Hopes
• Messaging for proven modalities and programs
• A focus on consumers, tied to prevention
• A balanced view, considering both individuals and communities
• More effective public health and delivery systems
• Social mobilization
• To look at systemic prevention efforts
• To increase our network and see how health plans can incorporate oral health
• To not let perfection get in the way of doing something better
• That the “non-oral-health professionals” table continues to grow
• To identify ways that interdisciplinary articulation can work, particularly for pharmacists
• Cultural change within the profession
• Hot ideas and cool solutions
• I receive a new, doable idea and can give someone else the same
• To leverage oral, vision, and mental health and issues of obesity
• That knowledge is disseminated to others

2. If I have a fear, it is…

“No action is taken.”
• That I go home enthused but not engaged into doing something new
• A lack of follow-through — stakeholder creep
• The report sits on a shelf
• The summit will not be impactful
• Another whitepaper
• No shared approach
• Just more talk
• Recycling of ideas by some key individuals, then we go back to our usual jobs no action is taken
• The plan is not implemented
• A lack of dissemination
• The status quo
• How to implement strategies
• That this becomes an academic or theoretical session, without a strong focus on actionable plans
• A program just to discuss prevention with no actions and goals
• To rehash problems
• Only discussion, no actionable plan
• We miss this opportunity
• Implementation will be too slow to demonstrate a change
• We leave with nothing new
• No action will be taken
• No solid action plan
• We leave with nothing new said
• We generate good thinking that doesn’t go forward
• People wonder why they were here for 3 days
• We do not achieve practical deliverable outcomes
• We’ll talk, reach consensus, congratulate ourselves, and nothing will change
• Nothing gets done
• We do a lot of work that gets pushed into the status-quo dental paradigm
• A lot of talk with little real action
• Results will sit on a shelf
• We return to jobs and nothing will happen
• Nothing happens

“A lack of collaboration.”
• Dogma and dead horses
• Some will not be able to forget preconceived ideas
• A lack of collaboration
• The task is insurmountable due to various barriers and biases
• Traditional thinking
• Fragmented perspectives/discussion
• We will not agree on any items
• People stay in silos
• Noncooperation
• Fragmentation
• The promotion of continued fragmentation
• That we will fail to reach common ground to drive access and prevention
• That we leave with a fragmented message

“Broad stakeholder representation.”
• A lack of young ideas
• Representation of key stakeholders is missing
• The wrong people are here
• Thinking is too narrow and dental-centric
• We are missing important stakeholders (patients, diverse racial profile)

Other Fears
• We will have a strategy that is not supported by evidence
• That there are no easy answers, and too much to accomplish in the four areas
• Change is so hard that we give up
• Economic sustainability is not possible, and we cannot find the right funding mechanism
• The final plan will not be transferrable to private practice
• We do not get attention for oral health in light of the challenges of implementing ACA
• We fail to focus on patient need
• It is too self serving
• We say we can’t get it done because we need others
• Reestablishing the problem
• I don’t know enough
• The same old roadblocks are not hurdled
• We miss the opportunity to intervene as early as possible
A lack of clarity
I make no new friends
Being viewed as financier of change without other stakeholders’ realizing that our customers affect us

What We Bring
- It’s importance
- Enthusiasm, advocacy, experience
- Experience in a state oral health program and my partnerships with disparate organizations and individuals
- Multidisciplinary view and experience
- Fluoride knowledge, applied research for carries/bone health
- Experience with success
- Enthusiasm and experience in most successful and proven strategy for preventing dental caries
- Optimism
- Prevention experience and testing of what works and how it could work better
- Building consensus and moving to action
- Energy interest and healthy impatience with the status quo
- Passion for oral health for all
- Willingness to listen
- Perspective
- Diverse oral health experience with public health, health promotion, philanthropy
- Background in public health and passion for oral health for all
- Boots on the ground experience
- Opportunities for prevention outside dental office
- Passion, scientific knowledge, commitment to prevention
- Passion for interprofessional care
- Private practice, org. dentistry perspective
- Experience building partnerships
- Passion for impact and systems change
- Years of work on access for underserved
- Knowledge of dental industry
- Prevention, education, enthusiasm for PCMH
- Passion and experience in oral health and public/private partnerships
- Perspective that status quo cannot be future status quo
- Understanding importance of education
- Overall backgrounds include academia, foundations, implementation of community health programs an private practice and ADA PARTICIPATION, variety of dental backgrounds, general dentists pediatric dentists, periodontics, hygienists, community health dentists
- Experience straddling oral health and overall health
- Passion for topic
- Pragmatic problem solving
- Open mind
- Ability to connect people in meaningful ways
- Experience in dental health guidelines
- Advocate for children with emphasis on prevention
- Dental/medical connected company background
- Interest in prevention and patient education, particularly PCMH
- Family Physician and geriatric focus
- Experience in HIV AIDS and systems change in population health
- Understanding of what it will take to engage pharmacists in the movement
- Persistence
- Broad experience in multiple sectors, historical perspective, passion for science of public health
- Broad experience, academia, payer, and pragmatic spirit
- Perspective of mayor community and what’s going on with purchasers
- Enthusiasm
- Perspectives and experiences
• Eagerness to contribute
• Knowledge of what is really possible given the constraints
• Practical knowledge and an open mind
• Policy knowledge and practical experience changing the model of dental benefits related to prevention
• Understanding that prevention has to be good business as well as good practice to succeed
• A diverse background in practice and benefits
• Experience an knowledge of local state and national policy
• Optimism
Appendix G:
List of potential stakeholders to engage

Stakeholders

- Pharmacist
- Consumers
- Clinics
- Home health workers
- Community health workers
- National associations
- Faith-based organizations
- American Diabetes Association
- American Cancer Society
- Accountable Care Organizations
- Other NGOs
- Educators
- Grocery Stores
- Libraries
- Pharmacies
- Industry
- Oral health manufacturers
- Food producers
- Banks
- Internet industry
- Government/Legislators
- Grassroots oral health coalitions
- Academia/Researchers
- Regulators
- IT professionals
- Mental health
- Risk assessment developers
- Nurses

- Physician’s assistants
- Provider groups
- Schools
- Philanthropy/Foundations
- Public health
- Dental hygienists
- Third-party payers
- Academia
- Behavioral economists
- Sociologists
- Anthropologists
- Sports
- Medical Professionals
- Community health
- Physicians
- Patient and consumer advocacy groups (e.g. AARP)
- Health providers
- Education providers
- Celebrities
- Social services
- Community psychologists
- Data scientists
- Consumer Federation of America
- Parent Teacher Associations
- Sports groups
Appendix H: Agenda
7:30 - 8:30 a.m.  Breakfast

8:30 - 9:30 a.m.  Opening Remarks & Introductions

Welcome from the Host
Roy Thompson, D.D.S.
Chair, Council on Access, Prevention and Interprofessional Relations
American Dental Association

Welcome from the Convener
Kathleen T. O’Loughlin, D.M.D., M.P.H.
Executive Director and Chief Operating Officer, American Dental Association

Summit Agenda and Process Overview (Followed by Working Session)
Elaine Kuttner
Principal, Cambridge Concord Associates
Summit Facilitator

9:30 - 10:30 a.m.  Keynote Speaker (Followed by Q&A)

Hayagreeva Rao, Ph.D.
Atholl McBean Professor of Organizational Behavior and Human Resources,
Stanford University

10:30 - 10:45 a.m.  Break

10:45 - 11:15 a.m.  Our Current Environment: Opportunities and Challenges

11:15 a.m. - Noon  Underpinnings of Our Work (Followed by Working Session)

Associate Dean for Research, Professor and Chair,
Department of Health Services Administration
School of Public Health, University of Maryland

David M. Krol, M.D., M.P.H., F.A.A.P.
Senior Program Officer, Robert Wood Johnson Foundation

Noon - 1:00 p.m.  Lunch

1:00 - 2:30 p.m.  Reimagining Oral Health Prevention — Shared Vision

2:30 - 3:00 p.m.  Break: “Vision Walk”

3:00 - 4:50 p.m.  Financing & Economics of Oral Health (Followed by Working Session)

How Financing Incentivizes and Reinforces Practice
Robert Compton, D.D.S.
Executive Director, DentaQuest Institute
President, DentaQuest Oral Health Center

Dentistry at a Crossroads
Marko Vujicic, Ph.D.
Managing Vice President, Health Policy Resource Center
American Dental Association

4:50 - 5:00 p.m.  Wrap-up of Day 1 and Preparation for Day 2

Day 1 November 18, 2013
7:30 - 8:30 a.m.  Breakfast

8:30 - 8:45 a.m.  Opening Remarks

Welcome
Jane Grover, D.D.S., M.P.H.
Director, Council on Access, Prevention and Interprofessional Relations
American Dental Association

Agenda and Process for Day 2
Elaine Kuttner
Principal, Cambridge Concord Associates
Summit Facilitator

8:45 - 9:15 a.m.  Topic 1: Oral Cancer (Followed by Table Discussion)

Speaker 1: Current Prevention Efforts
Paul Brocklehurst, BDS, MDPH, PhD, FDS RCS
Senior Clinical Lecturer, NIHR Clinician Scientist and Honorary Consultant
in Dental Public Health
University of Manchester

Speaker 2: Opportunities
Alice M. Horowitz, Ph.D.
Research Associate Professor, Hershel S. Horowitz Center for Health Literacy
School of Public Health, University of Maryland

9:15 - 9:45 a.m.  Topic 2: Periodontal Disease (Followed by Table Discussion)

Speaker 1: Current Prevention Efforts
Kenneth Kornman, D.D.S., Ph.D.
Chief Executive Officer and Chief Scientific Officer, Interleukin Genetics
Waltham, MA

Speaker 2: Opportunities
George W. Taylor, D.M.D., M.P.H., Dr.P.H.
Professor and Chair, Department of Preventive and Restorative Dental Sciences
University of California San Francisco School of Dentistry

9:45 - 10:15 a.m.  Topic 3: Facial Injuries (Followed by Table Discussion)

Speaker 1: Current Prevention Efforts
Alexis B. Olsson, D.D.S.
Chief, Oral & Maxillofacial Surgery
Professor, Clinical Otolaryngology-Head & Neck Surgery
Northwestern University Feinberg School of Medicine
Northwestern Memorial Hospital

Speaker 2: Opportunities
Past President, Academy for Sports Dentistry
Faculty-Team Dentist, Course-Academy for Sports Dentistry

10:15 - 10:30 a.m.  Break
10:30 - 11:00 a.m. **Topic 4: Caries** *(Followed by Table Discussion)*

**Speaker 1: Current Prevention Efforts**
Yasmi Crystal, D.M.D., F.A.A.P.D. (Fluoride Modalities)
*Clinical Associate Professor of Pediatric Dentistry*
*Department of Pediatric Dentistry*
*New York University, College of Dentistry*

**Speaker 2: Current Prevention Efforts**
Julie Frantsve-Hawley, R.D.H., Ph.D. (Non-Fluoride Modalities)
*Senior Director, ADA Center for Evidence-Based Dentistry*

**Speaker 3: Opportunities**
Amid Ismail, B.D.S., M.P.H., M.B.A., Dr.P.H.
*Dean, Maurice H. Kornberg School of Dentistry*
*Temple University*

11:00 a.m. - Noon **Strategy Development**

Noon - 1:00 p.m. **Lunch**

1:00 - 2:15 p.m. **Strategy Presentations**

2:15 - 3:00 p.m. **Strategy Development (Continued)**

3:00 - 3:30 p.m. **Break: “Strategy Walk”**

3:30 - 4:45 p.m. **Full Summit Discussion and Coalescence of Emerging Strategies**

4:50 - 5:00 p.m. **Closing and Preparation for Day 3**
Agenda

Wednesday, November 20, 2013

7:30 - 8:10 a.m.  Breakfast

8:10 - 8:15 a.m.  Opening Remarks
Charles H. Norman III, D.D.S.
President, American Dental Association

8:15 - 9:15 a.m.  Keynote Speaker (Followed by Q&A)
Terry C. Davis, Ph.D.
Professor of Medicine and Pediatrics
Louisiana State University

9:15 - 9:30 a.m.  Agenda and Process for Day 3
Elaine Kuttner
Principal, Cambridge Concord Associates
Summit Facilitator

High-Level Strategy Recommendations (Based on Day 2 Outcomes)

9:30 - 10:45 a.m.  Considering Stakeholder Group Perspectives
and Finalizing Strategies

10:45 - 11:00 a.m.  Break

11:00 a.m. - Noon  Deeper Work on Each Strategy: Implementation

Noon - 1:00 p.m.  Lunch

1:00 - 2:00 p.m.  Reports and Full Summit Discussion on Implementation

2:00 - 2:50 p.m.  Where Do We Go From Here?

2:50 - 3:00 p.m.  Closing Remarks
Charles H. Norman III, D.D.S.
President, American Dental Association

3:00 p.m.  Adjourn