Proceedings of the March 23-25, 2009
Access to Dental Care Summit
ADA Headquarters Building, Chicago, Illinois

Council on Access, Prevention and Interprofessional Relations
American Dental Association
The Council acknowledges with great appreciation the assistance of Dr. Steven P. Geiermann, senior manager, Access, Community Oral Health Infrastructure and Capacity; Council on Access, Prevention and Interprofessional Relations, in preparing this report. The material contained in these Proceedings is for informational purposes only and is not intended to be viewed as a recommendation to become ADA Policy.
What are we going to do, in the short and the long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people?
Executive Summary

The 2007 American Dental Association (ADA) House of Delegates authorized an Access to Dental Care Summit in 2009 by adopting Resolution 17H (Trans.2007:421), which reads as follows:

17H-2007. Resolved, that the Council on Access, Prevention and Interprofessional Relations, in cooperation with other appropriate ADA agencies, convene a national access to dental care summit, with planning in 2008 and implementation in early 2009, and be it further

Resolved, that the summit will include a broad spectrum of stakeholders in order

- to consolidate information about current efforts focused on improving access to care activities
- to develop a coordinated strategy for addressing access to oral health care challenges and
- to establish metrics for activities related to the defined strategies.

On March 23, 2009, the ADA convened representatives from a variety of communities of interest to create a shared vision to improve the oral health of underserved populations. For the nation to make significant progress toward this goal, the commitment of a broad group of collaborative stakeholders is needed to promote new initiatives that all communities of interest can support. The three-day Summit affirmed the dental profession’s commitment to serve as a convener and a collaborator committed to finding common ground and shared solutions to one of the nation’s most vulnerable people.

The goals for the Summit included:

- creating a common vision for long-term improvement to access to oral health care
- engaging in participatory problem solving, where the knowledge and perspectives of different sources of expertise and interests work together, so that all aspects of the challenges to improve oral health are addressed collaboratively
- identifying and discussing new approaches and initiatives, that all stakeholders can support, to address oral health disparities and access for the underserved
- developing a draft implementation plan for improving access to care

The ADA House of Delegates provided funding for a 12-member Summit planning team, composed of ADA volunteer leaders and external stakeholders, supported by ADA staff, to plan the event. In light of the success of the Future Search method of inquiry utilized during the American Indian/Alaskan Native Oral Health Access Summit held in November 2007 and the ADA Advocacy Summit held in February 2006, the Council on Access, Prevention and Interprofessional Relations (CAPIR) supported the use of the Future Search method for finding common ground for the 2009 Access to Dental Care Summit. Howard Ross of Cook-Ross, Inc. was contracted to facilitate the Summit utilizing this model.

The following individuals served on the planning committee: Dr. John Findley, president, American Dental Association; Dr. Leslie Grant, past president, National Dental Association; Admiral Christopher Halliday, chief dental officer, U.S. Public Health Service; Ms. Shelly Gehshan, director, Advancing Children’s Dental Health Initiative, Pew Charitable Trusts; Mr. Steve Kess, vice president, Professional Relations, Henry Schein; Ms. JoAnn Volk, legislative representative, American Federation of Labor and Congress of Industrial Organizations; Dr. Richard Valachovic, executive director, American Dental Education Association; Ms. Evelyn Ireland, executive director, National Association of Dental Plans; Dr. Lawrence Hill, executive director, American Association for Community Dental Programs; Dr. David Lurie, president-elect, Colorado Dental Association; Dr. David Krol, associate professor and chair, Department of Pediatrics, University of Toledo College of Medicine; and Ms. Martha Philips, executive director, Georgia Dental Association.
The planning team identified 144 Summit participants representing ADA leadership, dental special interest groups, federal agencies, health care policymakers, dental industry, consumer advocacy groups, education and research institutions, financing organizations including third-party payers and philanthropy, safety net providers, non-dental health care providers, dental volunteer leaders, and state dental societies (For a listing of invited participants, see Appendix 1).

The planning group developed the following question to focus the discussion during the Summit:

*What are we going to do, in the short and the long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people?*

The ADA’s hope is that this Summit will serve as the starting point to engage communities of interest in a serious dialogue on how to improve the oral health of those most at risk for oral disease. It is hoped that this process will result in the development of new, dynamic communities that collaborate to develop strategic initiatives and policies, along with the political will to find common ground and shared solutions.

Through a format that collectively examined history, present issues, and future action, participants formed and joined cross-stakeholder action groups to address seven key issues. At the recommendation of a conference participant, there was general agreement to convene a separate workgroup to provide leadership in the areas of coordination and communication.

The topical areas included:

- Workforce development strategies
- Reorganization of the dental delivery system
- Financing models
- Population-based prevention strategies and strengthening the public health infrastructure
- Improving oral health literacy through social marketing
- Collaboration between the medical and dental communities
- Developing metrics for measuring and defining access
- Building a sustainable infrastructure for communication and collaboration

When possible, short-term and long-term targets were identified for each focus area, as well as possible collaborations and strategies necessary to achieve them. Lastly, the participants identified specific individual actions that could begin immediately after the Summit.

The Access to Dental Care Summit laid the foundation for a common vision to begin to improve access to oral health care for underserved people. Through participatory problem solving and sharing common and unique perspectives, collaboration among diverse stakeholders was embraced as the best means to address challenges to improving oral health access. Working within the eight topical workgroups, participants identified new approaches and initiatives that stakeholders could collectively support to reduce oral health disparities and enhance access to oral health care. The targets and strategies identified within each focus area are the building blocks for a draft implementation plan, which if realized will, *in the short and the long term, both individually and collectively, assure optimal oral health through prevention and treatment for underserved people*.

This Summit represented an important moment in ADA history, solidifying a foundation of collaboration to achieve oral health initiatives that will help underserved populations, but it was only a beginning. The long-term success of this Summit depends upon the commitment and vision of the Summit participants and their constituencies.

The Access to Dental Care Summit took place at the ADA’s national headquarters in Chicago and was underwritten primarily through the generous sponsorship from the Wm. Wrigley Jr. Co., along with the support of Procter & Gamble and the Dental Trade Alliance.
Access to Dental Care Summit
American Dental Association Chicago Headquarters
211 East Chicago Ave.
March 23-25, 2009
Agenda

Monday, March 23

Welcome and Meeting Overview
Dr. John S. Findley, president, American Dental Association
Dr. Lindsey A. Robinson, chair, Council on Access, Prevention and Interprofessional Relations
Howard J. Ross, founder and chief learning officer, Cook-Ross Inc.

Future Search
Introductions and Ground Rules
Goal: Creating a Learning Community

Presentation: “Assessing Oral Health and Access to Dental Care in the United States”
Captain Bruce Dye, dental epidemiology officer, U.S. Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics

Future Search
Exploring the Past: Highlights and Milestones
Goal: Appreciating our history, trends we have experienced and what the past means to us.

Ronald A. Chez M.D., FACOG, founding deputy director of the Samueli Institute

Tuesday, March 24

Presentation: “Oral Health: A Social Marketing Perspective”
William A. Smith, executive vice president, Academy for Educational Development

Future Search
Focus on the Present: Current Trends
Goal: Understanding the forces that have an impact on oral health access

Future Search
Focus on the Future
Goal: Imagining an ideal future for oral health access.

Future Search
Common Ground for the Future
Goal: Discovering our common future and direction.

Wednesday, March 25

Future Search
- Creating Change Strategies
- Building Action Plans
- Next Steps

Adjourn
Methods

Participants from a variety of stakeholder groups gathered to consider the following question:

*What are we going to do, in the short and the long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people?*

The Summit used a unique planning method known as *Future Search* to establish an environment in which to:

- create a common vision for long term improvement to access to oral health care
- engage in participatory problem solving, where the knowledge and perspectives of different sources of expertise and interests work together, so that all aspects of the challenges to improve oral health are addressed collaboratively
- identify and discuss new approaches and initiatives, that all stakeholders can support, to address oral health disparities and access for the underserved
- develop a draft implementation plan for improving access to care

The following characteristics distinguish *Future Search* conferences from other participatory strategy meetings:

- The WHOLE SYSTEM participates – a cross-section of as many interested parties as practical. That means more diversity and less hierarchy than is usual in a working meeting and a chance for each person to be heard and to learn alternative ways of looking at the task at hand.
- Future scenarios are put into HISTORICAL and GLOBAL perspectives. That means thinking globally before acting locally. This feature enhances shared understanding and a greater commitment to act. It also increases the range of potential actions.
- People SELF-MANAGE their work and use DIALOGUE – not "problem-solving" -- as the main tool. That means helping each other do the tasks and taking responsibility for personal perceptions and actions.
- COMMON GROUND, rather than conflict management, is the frame of reference. That means honoring our differences rather than having to reconcile them.

Stakeholder Groups

The 12 stakeholder groups and their planning representatives included:

- State dental societies                     Martha Philips (Georgia Dental Association)
- Volunteer dental leaders                  Dr. David Lurye (Colorado Dental Association)
- ADA leadership                            Dr. John Findley (ADA)
- Dental special interest groups            Dr. Leslie Grant (National Dental Association)
- Dental education and research institutions Dr. Richard Valachovic (ADEA)
- Finance organizations                     Evelyn Ireland (National Assn of Dental Plans)
- Consumer advocacy groups                  JoAnn Volk (AFL-CIO)
- Health care policymakers                 Shelly Gehshan (Pew Trusts)
- Dental industry/business community        Steve Kess (Henry-Schein)
- Non-dental health workers                 Dr. David Krol (AAP)
- Federal program stakeholders             Admiral Christopher Halliday (USPHS)
- Safety net dental providers               Dr. Lawrence Hill (AACDP)
Outcomes

At the conclusion of the Summit, the participants identified seven areas within which to focus future efforts. When possible, short-term and long-term targets were identified for each focus area, as well as possible collaborations and strategies necessary to achieve these targets. Lastly, the participants identified specific individual actions that could begin immediately upon concluding the Summit. These targets, strategies and individual actions were identified within a particular moment in time. They were not proposed as the only goals and outcomes possible. They are evolving, dynamic and envisioned as a starting point for discussion and action.

At the recommendation of a conference participant, there was general agreement to convene a separate workgroup to provide leadership in the areas of coordination and communication among all of the topical areas.

The topical areas included:

- Workforce development strategies
- Reorganization of the dental delivery system
- Financing models
- Population-based prevention strategies and strengthening the public health infrastructure
- Improving oral health literacy through social marketing
- Collaboration between the medical and dental communities
- Developing metrics for measuring and defining access
- Building a sustainable infrastructure for communication and collaboration

Long-term targets included:

- Expansion and distribution of a well-trained, diverse dental workforce with nationwide evaluation standards and regulation.
- An integrated dental delivery system with a financing model that incorporates incentives to keep the treated population healthy.
- Defining universal coverage and access as including a government program, an employer-based program, and self pay, which differentiates universal coverage from a single-payer program.
- Achieve Healthy People 2010 oral health objectives for fluoridation and sealants.
- Enhance the dental public health infrastructure at the national, state and local levels, especially through increased funding support.
- Implement a social marketing campaign regarding oral health literacy.
- Develop a cross-disciplinary, high-level educational program, including professional curriculum development with appropriate content and demonstrable competencies.
- Develop and utilize a fully integrated electronic medical/dental (health) record.
- Define what the measure of optimal oral health is.
- Develop a sustainable infrastructure for coordination and communication of Summit long-term and short-term action items.

Long-term strategies included:

- Establish a renewed National Call to Action to Promote Oral Health in order to accomplish its five principal actions and implementation strategies through public-private partnerships.
- Secure sustainable funding for dental loan repayment programs.
- Create a new reimbursement model as the current one does not deliver what is needed. This new system, supported by public-private partnerships, should address the needs of both low-income and self-pay patients.
- Equitable sharing of costs by all stakeholders, including federal, state, individuals, employers, insurers, providers, and contributing industries.
Stratify and prioritize target populations based on risk assessment in order to focus limited resources upon those most in need.

Develop focus groups of those who are not proactively engaged in oral health activities. Use the information gathered to more effectively develop oral health literacy messages.

Coordinate oral health educational content across medical, dental, nursing, and other related health professional programs utilizing a myriad of collaborating multi-disciplinary professional, educational and academic organizations.

Collect appropriate access data routinely and regularly, once definitions have been determined.

Seek "common ground" among all Summit participants and other interested stakeholders in order to provide an administrative base with adequate budget and staffing to support communication and coordination among all Summit workgroups.

Short-term strategies included:

- Maximize capacity and efficiency within the current dental office environment.
- Utilize more effective continuing dental education to enable general dentists to be more comfortable treating children.
- Identify examples of systems redesign that have worked and develop champions to promote these models.
- Seek parity in levels of minimum coverage equivalent to medical coverage.
- Support oral health inclusion within healthcare reform, including increasing federal support of Medicaid.
- Request that President Obama make his personal dental visit a public event to emphasize the importance of oral health.
- Conduct an inventory analysis of existing dental public health programs to determine what is currently being addressed and where the gaps are.
- Identify the current oral health literacy stakeholders and their efforts, so that an effective national coalition in support of oral health literacy can be formed.
- Investigate current integrated electronic health record models and work towards agreement on what an ideal model should be able to provide.
- Determine what is optimal, functional, and essential to defining oral health access from a public policy perspective.

The Access to Dental Care Summit drew together diverse oral health stakeholder groups in a forum that examined relevant issues of the past, present, and future, clarifying common ground and empowering each member to take responsibility for collective action through focused initiatives. It laid the foundation for a common vision to begin to improve access to oral health care for underserved people. Through participatory problem solving and sharing common and unique perspectives, collaboration among diverse stakeholders was embraced as the best means to address challenges to improving oral health access. Working within the eight topical workgroups, participants identified new approaches and initiatives that stakeholders could collectively support to reduce oral health disparities and enhance access to oral health care. The targets and strategies identified within each focus area are the building blocks for a draft implementation plan, which if realized will, in the short and the long term, both individually and collectively, assure optimal oral health through prevention and treatment for underserved people. For more details, see Appendix 2.

This Summit represented an important moment in ADA history, solidifying a foundation of collaboration to achieve oral health initiatives that will help underserved populations, but it was only a beginning. The long-term success of this Summit depends upon the commitment and vision of the Summit participants and their constituencies.
Appendix 1: Invited Stakeholder Group members

State Dental Societies

C. Jay Brown  District of Columbia Dental Society
Dan Bucker  Florida Dental Association
Doug Bush  Indiana Dental Association
Terry Dickinson  Virginia Dental Association
Dick Diercks  Minnesota Dental Association
Peter DuBois  California Dental Association
Mary Kay Linn  Texas Dental Association
David Owsianny  Ohio Dental Association
Martha Phillips  Georgia Dental Association
Kevin Robertson  Kansas Dental Association
Robert H. Talley  Nevada Dental Association
Peter Taylor  Vermont State Dental Society

Dental Industry

Stuart Beecher  GlaxoSmithKline
Cindy Hearn  Care Credit/GE Capitol
Pam Hemmen  Patterson Dental
Steve Higgins  Sybron Dental Specialties
Steve Kess  Henry Schein, Inc., Global Professional Relations
Linda Niessen  Dentsply
Foti Panagakos  Colgate-Palmolive
Bob Savage  Drake Labs
Kevin Thomas  Omnicare, a 3M Company
J. Leslie Winston  Procter & Gamble
Steve Zibell  Wm. Wrigley Jr. Co.
Bill Zulauf  Midmark

Dental Specialty Interest Groups

Diann Bomkamp  American Dental Hygienists’ Association
Ngoc Chu  Association of Vietnamese American Dentists
Bill MacDonnell  American Society of Dentist Anesthesiologists
Leslie E. Grant  National Dental Association
Sandra Harris  Private Practice Orthodontist
Paula Jones  Academy of General Dentistry
Beverly Largent  American Academy of Pediatric Dentists
Steven L. Myles  Student National Dental Association
Victor Rodriguez  Hispanic Dental Association
David Smith  Society of American Indian Dentists
Scott Tomar  American Association of Public Health Dentistry
Christine Wood  Association of State and Territorial Dental Directors

Federal Program Stakeholders

Jay Anderson  Health Resources and Services Administration chief dental officer
David Bingaman  HRSA/Office of Performance Review/Chicago Regional Division
Stacey Bohlen  National Indian Health Board
Conan Davis  Centers for Medicare and Medicaid Services
Chris Iafolla  U.S. Public Health Service and Indian Health Service
Timothy Iafolla  National Institute of Dental and Craniofacial Research
William R. Maas  Centers for Disease Control and Prevention
Gary C. Martin  United State Air Force  
Steve Matis  United States Navy  
Dee Robertson  Pediatrician within the Indian Health Service  
Arthur Scott  United States Army  
Tim Ward  Department of Veterans Affairs  

Healthcare Policymakers  
Meg Booth  Children's Dental Health Project  
Amy Cober  Florida Governor health policy advisor  
Pat Finnerty  Virginia Medicaid  
Wendy Frosh  New Hampshire Oral Health Coalition  
Shelly Gehshan  Apple Tree Dental  
Wynne Grossman  Dental Health Foundation  
Michael Helgeson  Florida Governor health policy advisor  
Bob Isman  Medicaid/SCHIP Dental Association  
Tricia Leddy  Rhode Island Governor health policy advisor  
Pat Thibaudeau  retired state senator from Washington State  
Maggie Tinsman  retired Iowa state senator and policy consultant  
Susan Tucker  Maryland Department of Health and Mental Hygiene  

Non-dental Representatives  
Ruth Ballweg  MEDEX Northwest University of Washington School of Medicine  
Marguerite Dimarco  College of Nursing, University of Akron  
Sara Frato  Stark County Educational Service Center  
Elaine T. Jurkowski  School of Social Work, Southern Illinois University  
Elizabeth Kinion  Montana State University, College of Nursing  
Dushanka Kleinman  University of Maryland School of Public Health  
David M. Krol  American Academy of Pediatrics/University of Toledo  
Connie Mobley  University of Nevada, Las Vegas School of Medicine  
Wendy Mouradian  University of Washington School of Dentistry  
Renee Samelson  Albany Medical College  
Jacqueline R. Scott  Harrison Institute for Public Law, Georgetown University Law Center  
Hugh Silk  University of Massachusetts Medical School  

Dental Education and Research Institutions  
Bryan Cook  American Council on Education, Center for Policy Analysis  
Susan I. Duley  Clayton State University  
Caswell Evans  University of Illinois at Chicago, College of Dentistry  
Cecile A. Feldman  University of Medicine and Dentistry of New Jersey  
Donna D. Grant-Mills  Howard University College of Dentistry  
Jack Bresch  American Dental Education Association  
Patrick M. Lloyd  University of Minnesota School of Dentistry  
M. Elaine Neenan  University of Texas Health Science Center at San Antonio Dental School  
Adriana Segura Donly  University of Texas Health Science Center at San Antonio Dental School  
Huw Thomas  University of Alabama at Birmingham School of Dentistry  
Eugene Anderson  American Dental Education Association  
John N. Williams  University of North Carolina at Chapel Hill School of Dentistry  

Consumer Advocacy Groups  
Betsy Anderson  Family Voices  
Jamey Bell  Connecticut Voices for Children  
Lisa Codispoti  National Women's Law Center
Jaime Corliss   Health Care for All Massachusetts
Sally Hart     Center for Medicare Advocacy
Ed Martinez    San Ysidro Health Center
Laurie Norris  Public Justice Center
Jane Perkins   National Health Law Program
Michael Scandrett Minnesota Safety Net Coalition
Janice Kupiec   American Dental Association
Beth Truett    Oral Health America
JoAnn Volk     American Federation of Labor and Congress of Industrial Organizations

Finance Organizations

Gary W. Allen  Willamette Dental Insurance, Inc.
Craig W. Amundson HealthPartners, Inc.
Tim Brown     National Association of Dental Plans
Paul Chaitkin  First Commonwealth/Guardian
Ralph Fuccillo Oral Health Foundation (now DentaQuest Foundation)
Mary Johnson   Principal Financial Group
Kevin Klein    Doral, Market Development & Client Services
Richard Klich  United Concordia Companies, Inc.
Julia Paradise Kaiser Commission on Medicaid and the Uninsured
Barkley Payne  American Dental Association Foundation
Laura Smith    Washington Dental Service Foundation
Charles Stewart Aetna Dental

ADA Leadership

O. Andy Elliott American Dental Association
Edward Vigna   American Dental Association
Raymond Gist   American Dental Association
Jane Grover    American Dental Association
Dustin Janssen American Student Dental Association
Lewis Lampiris American Dental Association
Samuel Low     American Dental Association
Vincent Mayher Academy of General Dentistry
William Prentice American Dental Association
W. Ken Rich    American Dental Association
Mary Smith     American Dental Association
Ronald Tankersley American Dental Association

Volunteer Dental Leaders

Bruce Burton   Oregon Dental Association
Tom Floyd      Florida Dental Association
Mike Flynn     Minnesota Dental Association
Lisa Howard    Maine Dental Association
Mark Kilcollin West Virginia Dental Association
David Lurye   Colorado Dental Association
Sal Manriquez Fellow, American Academy of Oro-Facial Pain
Carol Morrow   Colorado Dental Association
David Neumeister Vermont Dental Association
Cesar Sabates  Florida Dental Association
Ted Sherwin    Virginia Dental Association
Darrell Teruya Hawaii Dental Association
Safety Net Dental Providers

Myron Allukian    Retired City of Boston dental director
Teri Chafin      Jefferson City/Birmingham Alabama Health Department
Neal Demby       Lutheran Medical Center, Dept of Dental Medicine
Mark Doherty     Safety Net Solutions – The Catalyst Institute
Jared Fine       Oakland/Alameda County Health Department
Kathy Geurink    University of Texas Health Sciences at San Antonio Dental School
Paul Glassman    Dugoni School of Dentistry
Lawrence Hill    CincySmiles Foundation
Irene Hilton     San Francisco Department of Public Health, Silver Avenue Health Center
Frank Mazzeo     Family Health Centers of S.W. Florida
Ron Nagle        Indian Health Service
Janet Yellowitz  Special Care Dentistry
Appendix 2: Summit Notes

IMPORTANT NOTE: These are “raw” notes taken from the flipcharts of the various segments of the Summit. Some of these notes may be difficult to fully comprehend in light of lack of explanatory or contextual statements provided. The purpose of the notes is to preserve and share the raw data with Summit participants, ADA leadership and other interested parties.

Monday, March 23, 2009

What are we going to do in the short and long term, both collectively and individually, to assure optimal oral health, through the protection and treatment of underserved people?

Presentation

Captain Bruce Dye, dental officer, U.S. Public Health Service, spoke to the topic: “Assessing Oral Health and Access to Dental Care in the United States.” Dr. Dye explained that there is a lack of purpose-driven data to motivate people to address oral health issues. To correct this, a measurable definition of adequate access to dental care, definitions based on life stages, on-going relevant data collection, and an effective national oral health surveillance system are needed. To view Dr. Dye’s slide presentation, see Appendix 5.

Exploring the Past: Highlights and Milestones

How did we get to where we are?

The goal of this session was to create an appreciation of the participants’ common history and set the Summit context with a joint picture of the world, participant values and hopes for the future, and to develop a community picture of collective values and histories. Participants identified individual personal and professional events and placed them on a time line. Groups then assessed the time line, examining select eras and noting broad themes and key events within three categories: societal, dental care, and personal.

It was noted that many things change over time regarding oral health and within the practice of dentistry:

- Much of early dentistry was practiced in barbershops. In the 1850s, dentistry became separated from medicine and the first dental schools were founded. There are many efforts today to integrate oral health back into overall health.

- Over the late 19th century and into the next, dental care was viewed primarily as a personal responsibility. There was little social pressure to keep one’s teeth. Questions have now arisen over sharing that responsibility among various individuals with collaborative roles for achieving good oral health, including personal home care and professional care with support of health literacy efforts.

- The growing globalization of America has increased social consciousness about diversity and its effect on best practices. The caries index is escalating as societies become increasingly industrialized.

- Policy decisions regarding oral health from the ADA, the government, and among various stakeholders continue to slowly evolve.

- Responding to perceived shortages of dental care providers over 40 years ago, the federal government funded new dental schools and expanded class size. Today, private educational systems have replaced the government as the primary drivers for expanding dental educational opportunities.
It was noted that other issues remain constant over time regarding oral health and within the practice of dentistry:

- The economic impact of dental education remains important. Increasing levels of educational debt force graduating dentists to make career choices based on personal finances rather than on where the need for providing oral health services is great.

- The lack of diversity in the dental workforce over the years has had residual effects and may limit the collective understanding of access to care issues and health disparities.

- With the establishment of dentistry as a profession, states passed dental practice acts establishing a broad scope of authority, which created a social compact between the profession, the public, and policymakers. Currently many health professions, including dentistry, advocate for policies that appear to protect “turf.” Organized dentistry is challenged to consciously address access and consider collaboration with non-dentists.

- Not many oral drug options have changed. The burden of proof to provide evidence in support of anti-caries drugs is so high that its pursuit is not cost-effective. Oral health professionals are forced to utilize products such as fluoride varnish off label.

- Impact of oral health on readiness for deployment into the armed services remains a constant. Individuals were excluded from service due to poor oral health during the two World Wars and the same holds true for young people looking to serve in the armed services today. At the same time, due to advances in dental technology and materials, our ability to improve oral health has never been greater.

- The economy remains a significant issue as the current oral health delivery system is primarily based on an entrepreneurial model, which is not designed to create the most health for the most people for the least amount of money.

**Presentation**

Ronald Chez, M.D. FACOG, spoke to the topic: “Optimal Oral Health: Access, Professionalism and Ethics of the Social Contract.” He asserted that health care inequality is a moral issue and there should be zero tolerance for health care disparities. Dr. Chez emphasized the importance of recognizing the humanity of patients and approaching them as allies with individual cultural and personal experiences. To view Dr. Chez’ slide presentation, see Appendix 5.

**Tuesday, March 24, 2009**

**Presentation**

William A. Smith, executive vice president, Academy for Educational Development, spoke to the topic: “Oral Health: A Social Marketing Perspective.” Social marketing is an organizational process creating a program that is easy to say yes to. Smith asserted that an appreciation of social marketing is critical in understanding who people are and finding out what they feel they need. To view Mr. Smith’s slide presentation, see Appendix 5.

**Focus on the Present: Current Trends**

*What are the main drivers behind the current situation in oral health for underserved people?*

The goal of this session was to clarify common areas for collaboration. The focus was upon the guiding question: **What are we going to do in the short and long term, both collectively and individually, to assure optimal oral health, through the protection and treatment of underserved people?**
concepts and issues offered by the participants created a visual “map” of the external trends shaping the current situation in oral health for underserved people.

After reviewing the mind map, attendees were invited to vote to prioritize the numerous concepts and issues with the following results:

- Workforce development [131]
- Reorganization of the dental delivery system [84]
- Financing models [77]
- Oral health literacy [69]
- Social marketing [58]
- Reintegrating dental and medicine [53]
- Population-based prevention [51]
- Dental reimbursement [47]
- Defining the target [47]
- Strengthen dental/academic/public health [38]
- Education program [31]
- Defining target [29]
- Cultural competence [17]
- Patients with special needs [16]
- Measuring progress [16]
- Ethical and moral issues [14]
- Dental practice reform financing [10]
- Fear, anxiety and pain [9]
- Scientific advancement [7]
- Appropriate role of government [6]
- Process development [4]
- Innovation [2]
- Individual accountability [2]

A “mind map” created by Summit participants to illustrate current issues shaping access to dental care.

**Stakeholder Group Reflections: Accomplishments and Regrets**

Each of the 12 original stakeholder groups developed a short list of accomplishments and regrets related to their efforts to improve access to oral health care for underserved people. The goal of the session was to build trust and demonstrate a willingness to take responsibility for past actions, which could pave the
Focus on the Future: Imagining an ideal future for oral health access.

At this point in the Summit, the 12 original stakeholder groups were disbanded and new groups were formed; each included a member from each of the former stakeholder groups to nurture cross-stakeholder dialogue and to clarify shared priorities from a systemic point of view. Each new group was asked to create a vision of oral health access five years in the future, which emphasized common ground and collaboration. It should be a future that the participants are willing to commit to bring to reality.

Wednesday, March 25, 2009

Identifying Common Ground for the Future

From the futuristic visioning exercise, participants identified seven key issues they agreed to pursue. In addition, cultural competency, elimination of disparities, and collaboration were promoted as overarching frameworks for inclusion within each of the focus areas. At the recommendation of a conference participant, there was general agreement to convene a separate workgroup to provide leadership in the areas of coordination and communication.

The topical areas included:

- Workforce development strategies
- Reorganization of the dental delivery system
- Financing models
- Population-based prevention strategies and strengthening the public health infrastructure
- Improving oral health literacy through social marketing
- Collaboration between the medical and dental communities
- Developing metrics for measuring and defining access
- Building a sustainable infrastructure for communication and collaboration

Workgroups were formed to develop both short and long term targets and strategies within each particular focus area, as well as suggested activities and individual actions for achieving dramatic outcomes. It was understood that participants would be free to devote their time and energy to any of the workgroups, not simply the one to which they initially were assigned. The goal of this session was to build momentum and move participants into engaged, focused action. For details regarding each of the eight focus areas, see Appendix 4.
Appendix 3: Accomplishments and Regrets

**IMPORTANT NOTE:** These are “raw” notes taken from the flipcharts of the various segments of the Summit. Some of these notes may be difficult to fully comprehend in light of lack of explanatory or contextual statements provided. The purpose of the notes is to preserve and share the raw data with Summit participants, ADA leadership and other interested parties.

### ADA Leadership

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
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<tbody>
<tr>
<td>• Advocate for both the profession and the patient. [SCHIP]</td>
<td>• Being closed minded and not effective listeners.</td>
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<tr>
<td>• Promoting science and evidence-based dentistry. [prevention and treatment]</td>
<td>• Being reactive rather than proactive.</td>
</tr>
<tr>
<td>• That the ADA is a credible organization that sets the standards for quality.</td>
<td>• Being insular and not recognizing non-dental groups.</td>
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### State Dental Societies

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<thead>
<tr>
<th>What Are We Proud of?</th>
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<tbody>
<tr>
<td>• Promoted high standard of dentistry within their states.</td>
<td>• Not being successful in stopping the gutting of public health programs</td>
</tr>
<tr>
<td>• Efforts to improve and increase Medicaid provider networks to provide more access to care, while reducing administrative burdens.</td>
<td>• Not able to support existing adult Medicaid programs with greater funding and being unable to stop the elimination of such programs.</td>
</tr>
<tr>
<td>• Charity care has increased.</td>
<td>• Not always recognizing that access issues do exist in certain areas.</td>
</tr>
</tbody>
</table>

### Dental Industry/Business Community

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collective support of various outreach programs, such as GKAS and Special Olympics, Special Smiles.</td>
<td>• Pace at which industry has been brought into the access to care discussions.</td>
</tr>
<tr>
<td>• Quality and innovative products researched and provided to the dental community.</td>
<td>• Inability to implement business processes and best practices models.</td>
</tr>
<tr>
<td>• Cooperation among highly competitive companies.</td>
<td>• Lack of participation as industry leaders in organized oral health initiatives.</td>
</tr>
</tbody>
</table>

### Dental Specialty Interest Groups

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organized dentistry for investing in this opportunity to collaborate.</td>
<td>• Unable to define the target populations that need treatment the most.</td>
</tr>
<tr>
<td>• Diversity among and within the stakeholder groups.</td>
<td>• Turf issues we have dealt with in dentistry for some time, especially abusive language and name calling.</td>
</tr>
<tr>
<td>• Preventive aspects of dentistry.</td>
<td>• The historical separation of medicine and dentistry and the time it is taking to bring the two entities together.</td>
</tr>
</tbody>
</table>
### Federal Program Stakeholders

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
</table>
| • Excellent usage of workforce multipliers.  
  • Use of the standard dental readiness classification system, which is a very effective way to “tell our story.”  
  • Population-based and community-based programs. | • Not done an adequate job measuring and publishing work done, especially within military and Indian Health Service.  
  • Too politically correct as there are things that cannot be voiced while in uniform.  
  • Being slow in updating DOD policy on fluoridation. |

### Healthcare Policymakers

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
</table>
| • SCHIP and improvements in various state Medicaid programs, especially with regard to fluoride varnish.  
  • Effectiveness of state oral health coalitions and advocacy groups.  
  • Raising the importance and visibility of oral health among policymakers and philanthropies. | • Still have not solved access problem and it took a child’s death to spark interest.  
  • Adult dental benefits are still optional within Medicaid and there are none within Medicare. Too few firms and states include dental within their benefit packages.  
  • Not enough movement towards action among legislators; not enough evidence-based data upon which to base decisions. |

### Non-Dental Health Workers

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
</table>
| • Good use of mid-level medical providers.  
  • Numerous position papers from medical groups supporting oral health.  
  • Progress towards promoting oral health in medical education. | • Have not used available resources as well as we should.  
  • Not enough oral health champions in our various interdisciplinary realms.  
  • Self-righteous attitude and not acknowledging the dental professions enough for the work that they are doing. |

### Dental Education and Research Institutions

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
</table>
| • Supporting access proposals at the federal level and beginning to be more involved in health care reform.  
  • Clinical preparation and competency for entry-level professionals.  
  • The role that dental schools play as safety net providers. | • Lack of a diverse workforce.  
  • Values, attitudes and ethics of dental students are not always what they should be.  
  • Financing of dental school and the clinical enterprise has been a challenge in terms of viability.  
  • Faculty shortages due to a major disparity in the economic differential between the private practice of dentistry, both in general practice and specialty areas, compared to academic compensation. |
### Consumer Advocacy Groups

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give voice to underserved populations.</td>
<td>• Waited too long to collaborate broadly.</td>
</tr>
<tr>
<td>• Raising awareness of oral health within the patient, family and advocacy community.</td>
<td>• Took too long to accept the fact of limited resources. Advocacy changes when the fiscal pie is not as big as one would like.</td>
</tr>
<tr>
<td>• Advocacy efforts at all levels, including administratively, legislatively, and judicially.</td>
<td></td>
</tr>
</tbody>
</table>

### Finance Organizations

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proven corollary between insurance coverage and access to care.</td>
<td>• Many more people without access to dental health insurance.</td>
</tr>
<tr>
<td>• Insurance premiums have remained relatively stable over the years.</td>
<td>• Having no real measurement of quality with regard to accessing oral health care.</td>
</tr>
<tr>
<td>• Preventing fraud and abuse, while prosecuting those who take advantage of the underserved.</td>
<td>• Allocation of available resources is disproportionate.</td>
</tr>
</tbody>
</table>

### Volunteer Dental Leaders

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focusing on prevention, especially fluoride usage.</td>
<td>• 20% of the population that we are not reaching, particularly for not being cognizant of oral health literacy issues.</td>
</tr>
<tr>
<td>• Volunteerism, especially within Give Kids A Smile and Mission of Mercy programs.</td>
<td>• Not having communicated well with other health care providers.</td>
</tr>
<tr>
<td>• Reduced the burden of dental infections and disease seen in previous generations.</td>
<td>• Not educate students enough about access</td>
</tr>
<tr>
<td></td>
<td>• Failing to communicate effectively with legislators about the importance of oral health.</td>
</tr>
<tr>
<td></td>
<td>• That we cannot agree on what good oral health is within this Summit.</td>
</tr>
</tbody>
</table>

### Safety Net Dental Providers

<table>
<thead>
<tr>
<th>What Are We Proud of?</th>
<th>What Do We Regret?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being the provider of last resort.</td>
<td>• Having not accomplished enough to date.</td>
</tr>
<tr>
<td>• Early adopters of community oriented innovations and population-based preventative programs.</td>
<td>• Not effectively communicating what we are doing, why we are doing what we do, and what we need to do in the future.</td>
</tr>
<tr>
<td>• Bridge builders with organized dentistry.</td>
<td>• Not sharing our best practices.</td>
</tr>
</tbody>
</table>
Appendix 4: Individual Focus Area Workgroup Notes

IMPORTANT NOTE: These are “raw” notes taken from the flipcharts of the various segments of the Summit. Some of these notes may be difficult to fully comprehend in light of lack of explanatory or contextual statements provided. The purpose of the notes is to preserve and share the raw data with Summit participants, ADA leadership and other interested parties.

During this final session, the Summit participants were asked to work within the topical area of their choice with a maximum of 20 individuals working in any one specific group. Not everyone was able to get their first choice. Some moved among workgroups and contributed to several topical areas. Other participants were specifically requested to join the Coordination and Communication Workgroup due to their particular expertise and/or affiliations. These participants had originally expressed interest in other topical areas. Some names appear in multiple workgroups. There may be some discrepancies in workgroup membership.

Workforce Development Strategies:

Long-Term Targets (2014):

- Expansion and distribution of a well-trained, diverse dental workforce with nationwide evaluation standards and regulation.
- Legal tort reform
- National licensure examination

Long-Term Strategies (2014):

- Establish a renewed National Call to Action to Promote Oral Health in order to accomplish its five principal actions and implementation strategies through public-private partnerships.
- Secure sustainable funding for loan repayment programs.
- Define an inclusive workforce for individuals, communities, systems of care, and environments

Short-Term Strategies:

- Address the underlying issues surrounding workforce
- Maximize capacity and efficiency within the current dental office environment
- Utilize more effective continuing dental education to enable general dentists to be more comfortable treating children.
- Begin social marketing strategies to address demand for dental services
- Market dental professionals to participate in Medicaid and other social programs
- Create additional general practice residency programs
- Change the Council on Dental Accreditation (CODA) standards to better prepare dental students to treat children

Individual Activities:

- Work together to increase student diversity
- Increase student awareness of the needs of the underserved through greater community-based training experiences
- Advocate state legislators
- Communication with other health professionals about the importance of oral health

Collaboration:

- All organized dentistry organizations
- Public health organizations
Medical and dental collaborations
Federal agencies
State boards of dentistry
Academia
National education associations

Workgroup members:
1. Adriana Segura
2. Ngoc Chu
3. Beverly Largent
4. Elaine Neenan
5. Leslie Winston
6. Kevin Robertson
7. Huw Thomas
8. Ted Sherwin
9. Chris Halliday
10. Arlene Lester (observer)
11. Steven Myles
12. Jane Grover
13. Ed Vigna
14. Mike Flynn
15. Ray Gist
16. Darrell Teruya
17. Maggie Tinsman
18. Victor Rodriguez
19. Scott Tomar
20. David Bingaman

Reorganization of the dental delivery system:

Long-Term Targets:
- An integrated dental delivery system with a financing model that incorporates incentives to keep the treated population healthy.
- Care provided should be patient and family centric.
- Utilization of a diverse dental team to deliver care with members practicing to the full extent of their training.
- Care should be located within the local community with multiple access points.
- Organize and orient professionals outside of dentistry, such as social workers and school nurses, who can contribute to the coordination of oral health access within an integrated system of care.

Long-term Strategies:
- Create a new reimbursement model as the current one does not deliver what is needed. The new system should address the needs of both low-income and self-pay patients.
- Develop public-private partnerships to support such a new financing model.
- Reach consensus as to which dental services can be delivered where.
- Develop an electronic health record to link all the pieces of the delivery system together.
- Get buy-in from the state and local dental, medical and dental hygiene associations.
- Seek collaboration with dental academia, Head Start, WIC, and social service organizations.

Short-Term Strategies:
- Identify different ways to discuss the concepts envisioned.
- Utilize presentations, issue briefs, and town hall meetings to educate and spread awareness.
- Identify examples of systems redesign that have worked and develop champions to promote these models.
- Develop communication and outreach strategies for organized dentistry and dental hygiene.
- Engage communities and communicate how redesign will benefit them.
- Define what is meant by patient-centered care.

Immediate Activities:
- Coordinate a reorganization of the dental delivery system meeting within a few months of the Summit.
• Investigate funding to support these activities.

Workgroup members:
1. Diann Bomkamp
2. David Neumeister
3. Hugh Silk
4. Steve Higgins
5. Mark Doherty
6. Meg Booth
7. Wynne Grossman
8. Ed Martinez
9. Paul Glassman
10. Shelly Gehshan
11. David Owsiany
12. Andy Elliott

Financing Models:

Long-Term Target: Defining universal coverage and access as including a government program, an employer-based program, and self pay, which differentiates this as not being a single-payer program.

Long-Term Strategies:
• Equitable sharing of costs by all stakeholders, including federal, state, individuals, employers, insurers, providers, and contributing industries.
• Examine federal requirements and identify potential funding sources.
• Identify partners, including government and dental industry.
• Everyone should be paying something, which adds “value” in the eyes of the consumer.
• No one is excluded from participating.

Short-Term Strategies:
• Seek parity in levels of minimum coverage equivalent to medical coverage.
• People must buy into the system along with funding support.
• Support oral health inclusion within healthcare reform, including increasing federal support of Medicaid.
• Track the financial benefit of enhancing prevention within Medicaid/SCHIP populations.

Individual Activities:
• Seek grassroots support from colleagues within local professional organizations.
• Seek support from leadership within affiliated professional organizations.
• Think globally; act locally.

Themes:
• Importance of cultural competency
• Promoting equity and reducing disparities
• Collaboration and care coordination
• Ethics and professionalism
• Evidence-based best practices

Workgroup members:
1. Elaine Neenan
2. Susan Duley
3. Terry Dickinson
4. Sally Hart
5. Jared Fine
6. Peter DuBois
7. Cecile Feldman
8. Conan Davis [expressed interest]
9. Richard Klich
10. Charles Stewart
11. Robert Isman
12. Patrick Finnerty
13. David Lurie
14. Julia Paradise
15. Janice Kupiec
16. Mark Kilcollin
Population-based prevention strategies and strengthening the public health infrastructure:

Long-Term Targets:
- Achieve Healthy People 2010 oral health objectives for fluoridation and sealants.
- All schools should participate fully in an oral health prevention program.
- All high-risk populations should enjoy the benefits of fluoride varnish based upon an evidenced-based determination of need.
- Enhance the dental public health infrastructure at the national, state and local levels, especially through increased funding support.

Long-term Strategies:
- Stratify and prioritize target populations based on risk assessment in order to focus limited resources upon those most in need.
- Develop new evidenced-based tools to prevent caries, such as low fluoride toothpaste for children.

Short-Term Activities and Targets:
- Request that President Obama make his personal dental visit a public event to emphasize the importance of oral health.
- Conduct an inventory analysis of existing dental public health programs to determine what is currently being addressed and where the gaps are.
- Develop a simple caries risk assessment tool that is culturally appropriate and recognizes differences between target populations.
- Every American should have access to toothbrushes and fluoridated toothpaste.
- Promote the use of mouth guards for all organized contact sports.
- Promote oral cancer examinations as more than 20% of reported cases are not within traditional high-risk categories.
- Encourage the ADA to increase the number of staff dedicated to fluoride efforts.
- Encourage the CDC to increase the number of staff within the Division of Oral Health.

Individual Action: Begin to use “mouth health” rather than oral health and “mouth disease” rather than oral disease.

Collaboration with:
- Chronic disease prevention programs
- Dental manufacturers
- Philanthropic organizations
- Educators
- Policymakers
- Consumer groups
- Unions
- Health and human service organizations, specifically the Oral Health Action Partnership

Workgroup members:
1. Dee Robertson
2. Kathy Geurink
3. Myron Allukian
4. Amy Cober
5. Lew Lampiris
6. Lisa Howard
7. Ken Rich
8. Jared Fine
9. JoAnn Volk
10. Cindy Hearn
11. Craig Amundson
12. Pat Thibaudeau
13. Kevin Thomas
14. Bob Savage
15. Janet Yellowitz
16. Teri Chafin
17. Connie Mobley
18. Chris Wood
19. Gary C. Martin
Improving oral health literacy through social marketing:

Long-Term Targets:
- Develop evidenced-based effective oral health literacy materials, which are tailored and culturally competent.
- Implement a social marketing campaign or initiative regarding oral health literacy.

Long-Term Strategies:
- Utilize a community-based participatory research project.
- Develop focus groups of those who are not proactively engaged in oral health activities. Use the information gathered to more effectively develop oral health literacy messages.

Short-Term Activities and Targets:
- Identify the current oral health literacy stakeholders and their efforts, so that an effective national coalition in support of oral health literacy can be formed.
- Get appropriate oral health messages in WIC materials.
- Explore and develop social marketing messages to promote better oral health.
- Identify and secure financial and human resources to support social marketing endeavors.

Individual Action: Identify the various oral health literacy stakeholders who should be at the table.

Collaboration: Form a national coalition of all stakeholders who are working within oral health literacy programs. Seek to understand what is being accomplished thru their current roles and formulate a comprehensive unified message.

Workgroup members:
1. Laurie Norris
2. Terry Dickinson
3. Bruce Burton
4. Barkley Payne
5. Beth Truett
6. Betsy Anderson
7. Doug Bush
8. Sara Frato
9. Gary Podschun [observer]

Collaboration between the medical and dental communities:

Long-Term Targets:
- Develop a cross-disciplinary high-level educational program, including professional curriculum development with appropriate content and supporting demonstrable competencies.
- Develop and utilize a fully integrated electronic medical/dental (health) record.

Long-Term Strategies:
- Coordinate oral health educational content across medical, dental, nursing, and other related health professional programs utilizing a myriad of collaborating multi-disciplinary professional, educational and academic organizations.
- Develop greater participation and a coordinated strategy for action within schools of public health.
- Seek assistance from the Financing Models workgroup as to how these strategies could be supported.

Short-Term Activities:
- Determine what has already been accomplished within existing health professional curriculum emphasizing an interdisciplinary approach to oral health, evaluate them, and share them as appropriate.
- Investigate current integrated electronic health record models and work towards agreement on what an ideal model should be able to provide.
• Share the models that are currently being utilized within the Department of Veterans Affairs and the Department of Defense.

Collaboration: Involve a broad “alphabet soup” of organizations and stakeholders representing a variety of health professions, academia, public health organizations, health record manufacturers, and multiple federal groups, including the Department of Veterans Affairs and the various branches of the uniformed services.

Workgroup members:
1. Renee Samelson
2. Irene Hilton
3. Timothy Brown
4. Lew Lampiris
5. Dustin Janssen
6. David Krol
7. Bill Zulauf
8. Frank Mazzeo
9. Mary Smith
10. Gary Allen
11. Michael Helgeson
12. Susan Tucker
13. Elizabeth Kinion [expressed interest]

Developing metrics for measuring and defining access:

Long-Term Targets:
• Define what the measure of optimal oral health is.
• Define how this measure relates to underserved populations.
• Share this information across the country.

Long-Term Strategy: Collect appropriate access data routinely and regularly, once definitions have been determined.

Short-Term Targets:
• Define what optimal oral health is. It is not perfect oral health. Where does esthetics fit into the equation? It is not about whitening an individual’s teeth. It is more about what is optimal oral health within society…so that individuals can fully function within society. Why is it more important to prevent a problem rather than merely treating it?
• Are individuals free of pain, fear and anxiety related to their oral health as these concerns can be significant barriers to access? Are they able to eat and obtain nourishment to maintain basic biological function?
• Are individuals able to perform in school and remain employed in a job? Are senior citizens able to function well in social settings by being able to eat and speak well?
• What is access to oral health care? What are desirable health outcomes associated with accessing oral health care?

Short-Term Activities:
• Determine what is optimal, functional, and essential to defining oral health access from a public policy perspective. Federal government attempts to provide definition, but the majority of oral health information is gathered at the state level. Where is the consistency? Tribal information is not generally captured at the state level. Such data must be solicited directly from the tribal governments. The focus should be on the local community for gathering accurate, reliable data.
• Determine what data is currently available.
• Use an evidence-based decision-making algorithm to apply research into clinical care when addressing the needs of the underserved. Consider the intersection of:
  o Best evidence of clinically relevant research
  o The clinician’s skills and experience to diagnose and treat relevant conditions
  o The patient’s clinical condition, values and preferences
• Determine what an adequate patient to clinician ratio is. What is an adequate workforce level?
• Set national standards on study design.
• Establish national standard on dental access study design.
• Establish a “mouth health index” similar to the Body Mass Index, which could be calculated quickly and serve as an easily understood shorthand for an individual’s oral health status.

Collaboration: Develop a mixture similar to the original 12 stakeholder groups utilized for this Summit. The goal is to have enough diversity to adequately advocate to health care policymakers.

Workgroup members:
1. Mary Johnson
2. Martha Phillips
3. Pam Hemmen
4. Mary Kay Linn
5. Susan Duley
6. Paul Chaitkin
7. Tricia Leddy
8. Art Scott
9. Sal Manrriquez
10. Stacy Bohlen
11. Elizabeth Roberts [observer]
12. Bryan Cook
13. Bill Maas
14. Nick Barone [observer]
15. Lisa Howard
16. Peter Taylor
17. Jane Perkins
18. Jamey Bell
19. Steve Matis
20. Dave Smith

Building a sustainable infrastructure for communication and collaboration:

Importance of overall coordination of Summit outcomes

• Provide a sustainable infrastructure for action: coordination and communication
  o Seek “common ground” among all participants
    ▪ Provide an administrative base with adequate budget and staffing
    ▪ Develop/adopt principles of operation
      • Emphasis of public/private partnering to build rapport and support
        o Building upon “common ground”
        o Strive for consolidation, not fragmentation, by involving non-governmental organizations and dental industry
      • Consider New Hampshire principles as a starting point
        o Function at level of core themes (macro perspective)
        o Serve as a neutral convener and/or spokesperson giving the overall effort a “face”
        o Seek linkages with other groups, both specific and general

With consensus of the Summit participants, explore an existing entity as an initial “home base”

• Consideration of Oral Health Action Partnership
  o Arose out of Surgeon General’s Call to Action
  o There is an existing infrastructure with dues paying members
    ▪ AAPHD is the current fiscal agent
    ▪ Currently, there is one staff person with Dr. Caswell Evans overseeing
  o Other options?

Potential for diverse funding support:

• 12 member oral health foundation group (Ralph Fuccillo, current president) focusing on policy and systems change
• Interest of dental industry
• Importance of sweat equity
• There must be strong accountability with measurable outcomes
• Important to remember that process is a product/outcome

Estimated budget needed to develop and implement action plan(s):

• $1 million over 5 years, plus in-kind support
- Full-time administrative staff person
- Part-time rotating facilitator
- Travel, media and presentations

Workgroup members:
1. Leslie Grant
2. Jay Anderson
3. Bill MacDonnell
4. Steve Kess
5. Donna Grant-Mills
6. Cesar Sabates
7. Ralph Fuccillo
8. Wendy Frosh
9. Caswell Evans
10. Larry Hill
11. Steven Zibell
12. Dushanka Kleinman
13. Vince Mayher
14. Lindsey Robinson
15. Tim Iafolla
16. Steve Geiermann
Appendix 5
Assessing Oral Health and Access to Dental Care in the United States

Bruce Dye, DDS, MPH

Access to Health Care

Health care reform
↓
Improves access to health care
↓
Improves health outcomes

Access to Health Care and Statistics

Effective health care system
↓
Sufficient access to care
↓
Adequate Health and Quality of Life

Access to Health Care

Surrogate measures are used to assess adequate access to health care

- Having health insurance
- Having a usual place of care

Access to Health Care

Health care reform
↓
Improves access to health care
↓
Improves health outcomes

Access to Health Care

Health care reform
↓
Improves access to health care
↓
Improves health outcomes

Access to Health Care

Effective health care system
↓
Sufficient access to care
↓
Adequate Health and Quality of Life

Access to Health Care

Surrogate measures are used to assess adequate access to health care

- Having health insurance
- Having a usual place of care

Access to Health Care

Health care reform
↓
Improves access to health care
↓
Improves health outcomes

Access to Health Care

Effective health care system
↓
Sufficient access to care
↓
Adequate Health and Quality of Life

Access to Health Care

Surrogate measures are used to assess adequate access to health care

- Having health insurance
- Having a usual place of care
Access to Dental Care

• Oral Health Surrogate measures include:
  – Unmet dental treatment needs—mostly untreated caries
  – No annual dental visits
  – Reasons for not seeking dental care—affordability

Access to Dental Care

– Having dental insurance
– Types of dental expenditures and related utilization measures

Access to Dental Care

– Dental manpower issues and adjusting the supply-demand relationship

Access to Dental Care

• What does it mean to have adequate access to dental care?
  – There is no consensus

Access to Dental Care

• Why do we need a consensus definition of what it means to have adequate access to dental care?
  – EBD
  – Best practices / models
  – Effective surveillance system
Access to Dental Care + Surveillance

• Why is surveillance important?
  – CDC: “an ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, as well as to the timely dissemination of these data to those who need to know.”
  – It’s essential for a “healthy” health-policy making process.

Access to Dental Care—Children

Untreated Caries for Children age 2-5 years

Children’s Dental Visits
Children’s Access to Dental Care

- Access to dental care has not improved because caries has not changed

Children’s Access to Dental Care

- What should the population-based definition for having adequate access to dental care for children be?
  - <10% with untreated caries,
  - or, 80% with an annual dental visit
  - or, 60% with public/private dental insurance having a dental visit in the past year
  - or, maybe we should monitor the primary caregiver’s access to dental care

Access to Dental Care—Adults

Adults age 20-64 years

- Unplanned Decay
- Annual Dental Visit

Adults age 20-64 years

- Dental Coverage
- Annual Dental Visit
Adults age 18-44 years

Adults’ Access to Dental Care

- What should the population-based definition for having adequate access to dental care for adults be?
  - Should we have a threshold for untreated caries or insurance coverage and visits similar to children,
  - or, maybe we should have a minimally acceptable threshold of people responding that affordability and other barrier problems prevented them from having a dental visit in the past year.

Access to Dental Care—Seniors

Seniors age 65 years and older

Untreated Coronal Decay

Untreated Root Caries

Dental Coverage

Annual Dental Visit

Seniors age 65 years and older

Adults 65 years and older
Seniors’ Access to Dental Care

• What should the population-based definition for having adequate access to dental care for seniors be?
  – ≤15% with untreated caries (coronal/root),
  – or, 60% with public/private dental insurance having a dental visit in the past year,

Seniors’ Access to Dental Care

• Defining adequate access to dental care for institutionalized and special needs populations will be more difficult
  – Poor surveillance

Challenges

• A measurable definition of adequate access to dental care, and ongoing, relevant data collection is key to improving access to dental care

Challenges

• Drive or be driven
• Failure to define adequate access to dental care permits others to define appropriate access to dental care:
  – dental sealants for children

Conclusions

• What do we need:
  – Workable ADEQUATE access to dental care definition
  – Definition should be life stage-specific
  – Effective national OH surveillance system
Optimal Oral Health
Access, Professionalism, Ethics and the Social Contract
Ronald A Chez MD, FACOG

Take Away Message
To encourage a purposeful and consistent professionalism in our everyday interactions with those who honor us by giving us the privilege of helping them obtain and maintain optimal health.

Its’ all about the PATIENT!!

Goals of Health Care
- The prevention of disease and injury
- The promotion and maintenance of health
- The relief of pain and suffering caused by maladies
- To be affordable and economically sustainable
- To be just and equitable
- To respect human choice and dignity
- To improve care through continuously expanding the evidence base

Hastings Center 1996

Definitions
- Disease: the diagnosis that derives from the patient's presenting signs, symptoms and lab tests.
- Illness: the human experience of the disease: • the manifestation of the patient's beliefs, fears and expectations. • the patient's influence on the cause, meaning and the course of the disease.
- Cure: an externally applied medical intervention that removes all evidence of the diagnosed disease.
- Healing: an internal process of recovery experienced on physical, emotional, mental & spiritual levels. • people heal when it is possible and proper to be well, and they feel worthy of being well.

Pain, be it emotional or physical, is a sensation caused by injury, disease or functional disorder transmitted through the nervous system.

Suffering is the personal experience of pain and affliction.

Pain in our lives is inevitable.
Suffering is optional.

Definitions
- Lerner

Suffering is optional.
Evolution of Health Care

Past assumptions:
- the disease explains the illness
- the same disease produces the same illness in everyone
- to know the science of medicine is to know diagnosis and treatment

Result: the clinician’s focus was on acute care, and the goal of cure.

Current state:
- chronic disease is the major disease burden:
  - the prevention and management of disability is a dominant goal.
- the patient is the primary focus, not the disease:
  - care is determined by personal, cultural, social, economic and political factors.
- the roles of practitioner and patient are altered.

Evolution of Health Care

It is more important what patient has the disease, than what disease the patient has.

William Osler, MD

Care provided and its outcomes =
- clinicians
- other care providers
- venue of care
- patient and family
- community
- society
- employers and payers

The Health Care Equation

If it were not for the great variability among individuals, medicine might be a science and not an art.

William Osler, MD [1892]
**Providers**

Variable factors in quality of care:
- provider prejudices, biases, personal beliefs
- provider's current level of training and experience
- provider's attention to patient's values, needs, preferences, expectations, desires
- patient autonomy in decision making
- provider beneficence toward patient

**Patients [people]**

Variable factors in seeking care:
- age, race, gender, ethnicity, religion
- well, worried well, acutely ill, chronically ill
- marginalized, vulnerable and underserved
- significant others, family, community
- cultural, economical, educational, linguistic
- personal meanings of illness, sickness, disease, wellness, cure, healing
- trust of modern biomedicine and/or non-western health care system

**Society**

Variable factors in access to care:
- health care as a right vs a privilege
- fragmented health care system
- inadequate support of public health
- non-equitable health plans and insurance
- variable definition of basic health care package
- availability of health care professionals
- focus on cure vs prevention and caring
- disparities secondary to geography, ethnicity, education, income, age, gender

**Payers**

Variable factors in paying for care:
- health care cost as major part of budgets
- 47+ million uninsured
- prevalence of under-insured
- increasing health care charges
- increasing health insurance premiums
- juggling of government funding
- oral health illiteracy
- THE RECESSION

**The Therapeutic Alliance**

Clinician  Patient

**Professional Ethical Duties**

- Provide an adequate diagnosis
- Explain treatment options
- Obtain patient informed consent
- Monitor efficacy of treatment
- Refer to appropriate professionals
- Maintain a complete record
- Subject treatment to scientific scrutiny
Clinician–Clinician Relationships

- Knowledgeable, skilled, caring providers who consistently evidence:
  - respect for colleagues’ skills
  - honest communication
  - commitment to person-centered care
  - integrated plan of patient care
  - participatory teamwork
  - appropriate referral
  - treatment of whole person

Clinician’s Healing Intention

- A conscious/mindful determination to improve the health of another person:
  - expectation of improvement in health and well-being
  - belief that a desired health goal can be achieved
  - understanding the meaning of illness

Clinician–Patient Covenants

- Compassion
  - trust
  - integrity
  - empathy
- Concern
  - active listening
  - caring
- Competence
  - skill
  - intellect
  - common sense
- Communication
  - availability
  - follow through

Truism

When people are stressed and upset, they want to know that you care before they care about what you know.

Will Rogers

Patient Self–Interests

- Social role:
  - external perspective
  - place in society
- Subjective interest:
  - internal perspective
  - unreflective personal values & beliefs
- Deliberative interest:
  - internal perspective
  - application of intellectual discipline

Ethical Principle of Autonomy

- Definition: respect for the concrete values and beliefs of the individual.
- Implementation:
  - identify the patient’s self-interests as they relate to decision making and expected outcomes
  - interpret the patient’s self-interests into action guides for clinical practice
  - promote and protect the patient’s appropriate behaviors and actions
**Ethical Principle of Autonomy**

Patient’s perspective:
- “Are my needs being met?”
- right to be fully informed about treatment goals, limits, time course
- right to choose between options
- right to be the final decision maker

Clinician’s perspective:
- “Am I meeting my patient’s needs?”
- promoting dialogue and partnership
- promoting patient’s well-being and care
- honoring her values and decision making
- facilitating informed choice
- seeking appropriate consultation

**Ethical Principle of Beneficence**

Definition: clinician acting in a way that is reliably expected to produce a greater balance of goods over harms for the patient.

Implementation:
- protection and promotion of patient's self-interests
- negotiation of differences

Clinician’s perspective and role:
- serves as patient advocate
- evaluates value for patient
- applies evidence-based practices
- avoids harmful or useless practices
- seeks consultation
- refers appropriately

**Patient’s Reality Testing/Barriers**

- Degree of oral health related literacy
- Confusing sources of information
- Cultural beliefs and backgrounds related to personal health and its priority
- Level of commitment to personal health
- Access to affordable dental care
- Habit of getting a ‘quick fix’ when sick
- Precontemplation stage of behavior change [Prochaska]

**Prochaska: Behavior Change Model**

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse
- Termination

[NIH]
Fiscal survival in current payer environment
Protection from medico-legal pressures
Providing care with minimal interference
Possessing knowledge and information pertinent to the patient’s needs
Easy access to unambiguous information
Minimizing wasting time
Avoiding conflict in the fiduciary therapeutic alliance role

Defined and limited fiscal resources
Economics of health-related issues:
- what care is basic?
- who can provide it?
- how much does it cost?
- who must pay for it?
Universal health care coverage:
- ebb and flow of federal legislative funding champions vs those who oppose and resist it

Health care inequality is a moral issue!

Move patient into preparation and action stages of behavior change:
- acquire knowledge of oral health and dental care with consistent messages
- practice continuous oral health care
- promote preventive oral health and dental care to family members
- accept responsibility for self-care
Action Steps: Clinician

- Provide care to the whole person:
  - Increase knowledge and apply evidence-based oral health care
  - Increase dental/medical coordination and integration
  - Identify and refer to practitioners and community resources

Action Steps: Educators

- Academic Centers curricula:
  - Whole person vs organ specific orientation
  - Interpersonal, communication skills
  - Faculty and private practice models
  - Underserved exposure, experience, advocacy

- Continuing Dental Education focus:
  - Whole person vs organ specific orientation
  - Liability and dental-legal
  - Pediatric and perinatal
  - Successful underserved business models

Action Steps: Society

- Define and guarantee essential core health benefits for all
- Acknowledge the value of oral health and dental care for all
- Decide on a hierarchy of health care funding priorities
- Invest in primary and preventive care
- Invest in expanding the evidence base to identify needs and treatments
- Enforce politicians' fiduciary responsibility

Truisms

There is no one way.
There is no one right way.
Truth is evanescent.
Oral Health Access to Care Summit
A Social Marketing Perspective

Bill Smith AED
Social Marketing Quarterly

Fluoridation Regular Cleaning

Effective Home Care

Less disease Less $ Costs

More Dental visits Reimbursement Costs

Shortage of Dentists

Underserved Primary Target

BEHAVIOR CHANGE

Non-Voluntary

Regulation

Education

Facilitation

Voluntary

Many people do essentially the same thing, “Brush regularly.”

Many people interact doing different things, “Water systems are fluoridated.”

SYSTEM CHANGE

Human Behavior

Educate

Regulate

Facilitate

Social Marketing

Why and how to do it.

Make it harder, or make it hurt, not to do it.

Make it easier and/or more rewarding to do it.
Heidi Joyce
Social Marketing

“I don’t need a lipstick that is kissable, I need one that will get me equal pay for equal work.”

Social Advertising

“I don’t need a message that makes me feel guilty, I need a program that will help me solve my problem.”

Social marketing is an organizational process for creating . . . programs that are easy to say yes to. . .

Obesity, Traffic Safety, Smoking, Heart Disease, Infant Mortality/Family Planning/HIV/AIDS/Malaria

Diarrhea mortality Honduras
57%
All infant mortality
13%
Heart Disease
(National High Blood Pressure Education Program NHBPEP)

18% 41%
1973-74 1980-82

% of 25-59 Male hypertensive's under treatment

New Product plus a Pervasive Message

300 million dollars later...

300 million dollars later...

Why?

You’re not just educating- you’re competing.

Annual adult per capita cigarette consumption and major smoking and health events—United States, 1900-1998

Re-Framing

It’s about Your Health
Environmental Smoke
Corporate Crooks

Education Facilitation Regulation

Multiple Interventions
No one thing was magic.

Tobacco WARS

40 years
The Saint Paul Police Canine Unit is in desperate need of German Shepherds.

Seat Belt Usage

85-90%  50%  30%

Fear appeals  Passive SS Laws  Click it or Ticket it

Resisters – Death and Cost

We need to address people’s perceptions as well as policy.

Have a priest bless car seats.

Reyes Syndrome

Use of aspirin in small children Soumerai et al 1992

Not a campaign- but press coverage.
Exercising your mind is important too.

Health is rarely the first priority in people’s mind.

RESULTS:
34% increase in free time physical activity in 8.6 million children ages 9-10
We Can! NIH Helps Children and Families Maintain a Healthy Weight!

NIH Science working through Communities, Partnerships, and Media...

Communities
- Local Partnerships
- Outreach Events
- Media

Partnerships
- Federal
- Clinical
- Outreach
- Media
- Corporate
- Web
- Print
- Television

...to help Children and Families maintain a healthy weight.

A Growing National Movement from 14 sites to 1000

Over 1000 community sites in all 50 states and 11 countries

We Can! Resources to Mobilize Communities

Easily downloadable resources in English and Spanish

From a National Web Platform
http://wecan.nhlbi.nih.gov
1-866-35-WECAN

Partnership with SUBWAY®

Program Plus Messages

Funding for We Can! trainings around the country

Reframing Oral Health

System Change
**Oral health in America: A Report of the Surgeon General**

"Oral health is general health."

The word oral refers to the mouth.

**Mouth Disease**

Mouth disease is painful.
Mouth disease is transmissible, infectious, and preventable.
Mouth disease is the most common chronic disease of US childhood.
Mouth disease is associated with diabetes, heart disease, stroke, and adverse pregnancy.

**Fight “Mouth Disease”**

You can fight mouth disease

- daily mouth care,
- fluoridation,
- tobacco cessation,
- Using dental services such as
  - sealants and
  - oral cancer examination.

**Profound disparities in mouth disease exist as the result of disparities in:**

- fluoridation,
- access to care,
- disability,
- lack of adequate dental insurance,
- poor understanding of the importance of mouth disease.

**ORAL HEALTH**

Mouth Disease

Lack of medical insurance coverage for mouth disease is a national disgrace.
Many people do essentially the same thing. “Floss regularly.”

Non-Voluntary

Regulation

Facilitation

Voluntary

Innovations

System Change

Benefits to Barriers Ratio

# of Chauffeurs

Causal Loops

Assumptions:

All transportation requires chauffeurs

Limited Access

Benefits to Barriers Ratio

Number of Dentists

Demand for Dentists

Assumptions:

All patients need qualified dentists

• Avoid expensive and ineffective message campaigns in favor of programs that ... are easy to say yes to.

• Reframe the concept of oral health/more competitive.

• Address systems issues by examining the assumptions underlying our definition of benefits and barriers in causal loops.
Policy makers loved it.