Public Forum on Dental Care Coverage and Access
June 19, 2012

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DIANE ROWLAND: I want to welcome you today to the Kaiser Family Foundation and to this public forum on dental care coverage and access. I'm Diane Rowland, the executive vice president of the foundation, and it's my real pleasure today to have you join us for a discussion that I think is long overdue. As anyone in this room will know by the end of this session, oral health is an often overlooked part of individual health and wellness and too often under the radar screen in efforts to improve health care coverage and access in this nation. Today we hope to shine a light - a spotlight - on the critical issues underlying oral health to raise awareness of these issues and hopefully stimulate some action to improve access to oral health services.

As background on the need for action we've assembled some key facts that are in your packet today and that I'd like to just very briefly

highlight for you so that we have some context for what will follow in terms of the film we're previewing today as well as our panel discussion. I think it is very important to recall that as we talk about the uninsured we often don't talk about them in terms of what their uninsured for. We talk about mostly uninsurance as an issue of medical care; oral health is indeed outside of that scope all too often.

While Medicaid and CHIP cover comprehensive dental benefits for children, 30-percent of children who have private insurance are actually uninsured for dental care. The number of adults without dental care is actually three times larger than the number of adults without health insurance, and we know how large that component is, and one in four Medicare beneficiaries today have no natural teeth. 44-percent of Medicare beneficiaries report no dentist visit in the past year, and Medicare itself does not cover primary

dental services, so it's not a covered benefit under the Medicare program.

The consequences of these gaps are immense. They lead to complications of major chronic illnesses. They impact children's growth and development and also their social development. They lead to nutrition problems, pain, late detection of oral cancer, as I indicated with the Medicare population, loss of teeth, missed school days for children, missed work days for adults, and in the end often expensive ERUs for preventable dental conditions.

Part of the problem, of course, relates not just to coverage and cost but also to availability, and as we look at this map we can see in many areas of the country there are further complications due to shortages of dental providers. In addition, when we look at the issues for children where we know early prevention and treatment can be so important, we see that

even among insured children there's a high rate of untreated carries, and we also see that for people with low incomes the problem is much, much higher.

We also know that even among adults many never see a dentist. 22-percent of those individuals who are low income with incomes under $21,000 a year have never seen a dentist or have not seen a dentist in the last five years, in contrast to eight-percent of those with higher incomes. So it's cost, it's availability, and it's coverage that matter in looking at how our population accesses oral health.

Today we're going to be spotlighting some of these issues by previewing a PBS Frontline documentary film called "Dollars and Dentists," which was produced and reported by Jill Rosenbaum, who's going to be with us today to open the discussion and to highlight some clips from the film that will be shown shortly, and then we're going to turn to a very distinguished panel to

really react not only to the film but especially to the issues challenging us in oral health, and after the film preview, Jackie Judd of Kaiser is going to come up and introduce the panel and provide us with a stimulating discussion to stimulate some action on oral health.

So without further ado, Jill Rosenbaum, please join us at the podium. [Applause].

JILL ROSENBAUM: Thanks, Diane, and thank you, Kaiser Foundation for having us. This is an issue that I knew very little about before I started working on this project, and given that I'd covered health care off and on for 15 years I'm kind of embarrassed now when I realize how little I knew about it. I'm just looking around to see if David Heath is here from the Center For Public Integrity because he's my reporting partner on this project, but I guess he's not.

So the film was an eye opener. I had no idea that dental disease, periodontal disease,

cavities, infection could affect the rest of your body. I had no idea how many people in this country went without care, how many people in this country were suffering. You know, the majority of people, as Diane pointed out, who are more affluent get care in a system, a private system that works very well for them, and it works pretty well for their dentists, too, but for the rest of those who are not in that system, it's a really catch as catch can kind of situation. Some people don't have the money. Some people don't live near a dentist. Some people may have Medicaid or CHIP insurance that dentists don't want to accept. There are a variety of reasons why people don't have care, but I think what you're going to see in the clips of our film are some of the consequences that they face.

People that we met along the way made a huge impression ranging from the volunteer dentists at the Missions of Mercy who come and

donate their time to try to help people in pain, to two individuals who—one in Minnesota and the other in Florida, they don't even appear in the film. Each told us how they tried to pull out their own teeth because they were in such pain, and they couldn't find a dentist who would do it for them.

In terms of Medicaid you're going to see the coverage that we have of our visit to Florida, and it's pretty shocking, and I just really wanted to point out that Florida is one of the worst states in terms of Medicaid coverage. So what you see is not the same in every state. I assume most of you know Medicaid is a state program as well as a federal program, so the range of coverage that kids get is pretty broad. So I just didn't want you to think that what you're seeing from Florida is the same for kids in every single place. And lastly, I was asked to explain how I got started on this project, and ironically I was having a

conversation with David Fanning, Frontline's executive producer, a year or so ago, and he said he was interested in something on dentists, and I thought, "Really?" But as I think you'll see, he was right. So anyway, thank you, all, very much.

The film, you know, when it airs in its entirety on Tuesday, has some additional segments looking at how the marketplace, for good or bad, is helping to fill the gaps, and, you know, if you want to see that, you'll have to watch on Tuesday, but thank you, all, so much for being here. [Applause].

[Clip from video played]

JACKIE JUDD: Nice job. Good afternoon, everyone, and thank you for joining us. Thanks to Jill for sharing this with us, and thanks also to Frontline and CPI for giving us a preview of an important subject. I'd like to ask the panelists to come up to the stage and join us now, and just to let the audience know the format will be that

I'll make introductions, we'll hear a few comments, I'll ask a few questions, and then I'm going to turn it over to you to lead the conversation. From my left is Marcia Brand, the deputy administrator at HHS of the Health Resources and Services Administration, Debony Hughes, a dentist herself, but she's here because she's the chief of the Dental Health Program in nearby Prince George's County Maryland, and Debony has overseen some of the initiatives that have taken place in PG County and, in fact, all of Maryland since the untimely death of a young boy, Diamonte Driver, who died after he had a tooth abscess. It was not properly treated. The infection moved to his brain, and he passed away.

Next is someone you're going to recognize from the documentary, and that's Dr. Terry Dickinson, also a dentist of course. In addition to his Missions of Mercy, which by the end of this year will be in 30 states, he is also the

executive director in his spare time of the Virginia Dental Association. (You're a busy guy.) And finally we have Greg Nycz, who is the executive director of the Family Health Center of Marshfield, Inc., which is based in Wisconsin, one of the largest, if not the largest provider in the state for care across a number of venues.

So thank you all for joining us. Just a few opening comments about the issue that Diane laid out for us, and then we'll start the Q and A. Marcia?

MARCIA BRAND: Thank you very much. It's great to be here today. Perhaps I should share with you that I'm a dental hygienist and haven't practiced for quite some time, but certainly this is an issue that is very important to me personally. It's very important to my agency, the Health Resources and Services Administration. We provide patient services, dental services, for about 3.8 million people each year through our

health centers versus the part of HHS that supports the workforce training programs and maternal and child health and other programs that were trying to increase access to oral health care services, so it's great to be here today. It's an extraordinarily powerful message that we just saw, and I think now that there will be a number of people who will compete with me to be the chair person of Dr. Dickinson's fan club [laughter] for all the good work you've done for the folks in southwestern Virginia, so it's very, very nice to be here today.

JACKIE JUDD: Thank you.

DEBONY HUGHES: Good afternoon. I would like to first thank the Kaiser Family Foundation for the invitation to participate in this most important and timely discussion on oral health access for children and adults. As the results of Diamonte Driver's death in 2007, Maryland's oral health agenda was elevated to the highest level.

Before I go on I must tell you to watch that film, as a mother and as a practitioner, it almost brought me to tears. It is shameful that individuals have to exist with that type of pain. It's really unbearable. But after five years of effort and commitment by many in the public and private sectors, including the leadership of Governor Martin O'Malley and Maryland's Congressional leadership, notably Senator Ben Cardin, Senator Barbara Mikulski, Congressman Elijah Cummings, and Congressman John Sarbanes, Maryland is now in the forefront in efforts to make sure that the underserved children of this state have access to dental prevention and treatment services.

Even with all the work that has been done we still have approximately 40-percent of the children enrolled in Medicaid that do not access dental care and an even larger percentage of adults who do not have any access to care. The

data regarding adults who are enrolled in Medicaid indicate that of their 195,000 enrollees in 2010 there was only 14.9-percent utilization. The 2008 behavioral risk factor surveillance system self-reported data reveals that 19-percent of Prince George's County population is uninsured. Estimates from various sources indicate the number of uninsured to range from 80,000 to 120,000. This is the highest percentage of uninsured in the state of Maryland.

As the significant disparities have been recognized in the receipt of and delivery of oral health services to children and adults, the many stakeholders around the state have established recommendations and policies to address and mitigate these issues of disparity, and I look forward to our discussion this afternoon.

JACKIE JUDD: Thank you. Terry?

TERRY DICKINSON: Well, first of all, let me dispel the myth of any hero, you know. The

people that care about this issue are the heroes, and so I'm assuming that's all of you. You know, in July of 2000 we'd completed our first day of our first project in Wise, Virginia. It had been a long hot day in an airport hangar, and on the way out my wife requested that we stop at the airport building there for a real restroom because the porta potties by late afternoon are probably not a favorable place to go. So while she went inside I sat in the car and waited for her, and shortly thereafter this old beat up Chevrolet drove up next to me, and there was a young lady in there, looked like she was about 21 and had a little girl with her, eight or nine years old, and she rolled down the window and said is this where the dental project is, and I said yes, it is, but I said we're closed for the day, and she said—just really got this sad look on her face and said—you know, I said but it's okay. If you'll come in the morning, I'm sure we could see your daughter. She

said well, I've driven four hours to get here, and this was about seven o'clock at night, and she said I don't have the money for gas to come back. So at that point I knew what I was supposed to be doing. I was determined that I would not hear that story again, and so that set me on a mission to do something to address this, and I guess the—one of the big things that I've really come out of is how important collaborative—collaborations are to this issue, and I think we must stop talking past each other. I'm a dentist. I belong to the American Dental Association. We must work together if we're going to make change in this, but what I've found in Virginia is this power of collaborative agreements.

I would question whether any other state has to the degree that we have in Virginia been able to work with a broad group of stakeholders. We have this great oral health coalition that puts everybody at the table, but we must stop talking

past each other. We must talk to each other. So I look forward to the conversation today as all of us, and thank you for being here.

JACKIE JUDD: Thank you. Greg?

GREG NYCZ: Yes, we all have our personal stories, but mine I'll give you first, and that was a call that I received from a patient, a young woman. She had an eight-year old son in the background who was alternately screaming in pain and sobbing, and she was crying. She had called 40 dentists in an increasing circle more and more distant from her, couldn't get care. This was before we had our own dentist, and, you know, you can distinguish when kids cry when it's like real pain or they're being petulant or something, and what got me was not just the child's pain and how awful that was but was that this woman, this mother, was feeling like she was not a good mother because unlike so many other mothers when their child was in pain, they simply called, took their

kid to a dentist, had the pain resolved. She felt a failure as a mother, and I thought not in Wisconsin. You know, not in our state. We're not going to do this, and my board, I work for a community health center, and I want to tell you what I'm going to briefly say we could not do without the Health Resources and Services Administration.

We would not be doing without our nation's investment and the NIH and science that teaches us how the mouth is related to the body, and what we decided to do is there are a lot of good efforts out there, lots of things that are incremental. We focus on kids. We focus on people in the nursing home. We said, What should it be? What should it be? What's our preferred future? What's our vision? And for those of you who might have got—I have 50 copies of something. I use this Lewis Carroll quote, "If you don't know your destination, any road will do - will take you

there." And so we developed, kind of, a preferred future, and in that preferred future there would be equitable access to care throughout our region. Physicians would work virtually together. We'd have a rapid expansion. We would have if you took your child in to a dentist in the future and they might say good, great checkup, but did you know your child is missing a vaccination? We can help you get that. If you took your child to a pediatrician, the pediatrician may say great checkup, but I see your child hasn't been in to see a dentist.

So we want to put the mouth back in the body, and we want our folks to work together, and we set off on that path, which I say is we're trying to protrude the present for a preferred future, and we now have eight dental centers with 45 dentists and 45 hygienists. We served over 40,000 people last year. We've got the capacity

to serve nearly 50,000 with the addition of our ninth center. Again, thank you, HRSA.

MARCIA BRAND: You're welcome.

GREG NYCZ: Which is going to be working with the Ho-Chunk Nation tribal center, and you cannot do this alone. The USDA Rural Development fund has helped finance many of our dental centers. We've had support from Delta Dental. We've had even support recently from Walmart providing us resources to go into the nursing homes to provide care. So no one organization can do this. We have partnered with Marshfield Clinic, which is a terrific organization, but they never did dental before, but they consider themselves a leader in health care, and within one hour of talking to me back in 2001, I said my board set me on a path to solve this oral health problem. I would like to do it with you. We can go further faster together than we could on our own, and we had an hour discussion with their

leadership. I left them with the question this is a huge public health problem. You're a leader in health care. What would a leader do? And it was unanimous we'll work together to solve this problem.

So I'm looking forward to the rest of this, and the Surgeon General didn't call this a silent epidemic for nothing, and I really want to thank Kaiser for helping to shed more light on this.

JACKIE JUDD: Thank you. I should have said in my opening remarks, and it's clear from your comments, that Greg is a real pioneer in figuring out ways to extend access to the underserved, a pioneer not only his state but nationally recognized.

The Oral Health Initiative was enacted in 2010. I think it was through that program that you got over a million dollars for one of your

projects. Can you give us an overview and an update of where in 2012 things stand?

MARCIA BRAND: So in 2010 Howard Koh, he's the secretary for health, and Dr. Mary Wakefield, who is the agency administrator at HRSA, announced an Oral Health Initiative for the department, and historically the department had the Surgeon General's report, and it was nearly ten, 12 years old, and we were benchmarking off a very old document about what the status of oral health in the nation was, and so Dr. Koh and Dr. Wakefield kicked off sort of a refresh of the department's work around access to oral health care, and so they announced initiatives that HRSA would be engaged in, and we funded two Institute of Medicine studies to look at how the department can improve its oral health efforts and how we'd also— the second one, how we could also better serve vulnerable populations, and CDC, IHS, and others

within the department had specific projects that they too were going to engage in.

We are two years into this. We've done, I think, a really good job of completing those activities, and we're getting ready to refresh again and see how we might as a department work together more collaboratively across the department as well as in our respective operating divisions to address these issues.

We're very pleased to see that one of the leading health indicators for the first time is an oral health indicator, and that is one we would have seen a dentist in the past year. So we continue to make progress. There's always more that we could do.

JACKIE JUDD: How much in federal grants have you distributed?

MARCIA BRAND: You mean HRSA?

JACKIE JUDD: Yes.

MARCIA BRAND: Well, I think that's a difficult question to answer. I'd say that because of the ACA we significantly increased the resources available for the health centers to 11 billion dollars, and our health centers provide either onsite or through contracts oral health care. We were also because the ACA was able to spend 2.5 billion dollars more on the National Health Service Corps, and dentists and dental hygienists can be in the corps. They get their loans repaid for serving in those areas that are hardest to serve, and so we've been able to increase the National Health Service Corps to 10,000. It's about the highest level it's ever been, and about several thousand of those folks are dentists or dental hygienists, and so in those two programs we've been able to make significant investments.

And I'll just highlight a third program, school-based health clinics. We need to treat

folks where we are, and kids are in school, and so we were very fortunate through the ACA to have additional resources to fund school-based health clinics, and a significant proportion of those school-based clinics do provide oral health care services.

JACKIE JUDD: Greg, one of the things you touched on in your opening comments is not something we often hear about, when you talked about putting the mouth back in the body. Is one of the obstacles to expanding care the notion that dental care is secondary to everything else-physical care? Do you have to make that argument even now?

GREG NYCZ: Yes. I just find it odd that people would say you think about Medicaid policy, and Medicaid policy is most of the states have we provide dental care—dental coverage for children, but most of the states don't have dental coverage for adults. And if you asked yourself just as a

consumer why do they provide adult dermatology coverage, but they don't provide adult dental coverage? Why is that? I mean, is the skin more important than the oral cavity? You know, it's really bizarre, and so there's a way that we have been thinking. We have separate medical records. We have separate insurances. We look at this differently, and we ought not to. Science is telling us we ought not to. I think it was Dr. Ipping Hanz at Case Western's team that discovered the—or documented the first case of a still birth that was caused by the migration of oral bacteria through the placenta wall, and it ended up killing the baby. Should we not act on this? There's a debate about whether there's lower birth weight babies. You know, periodontal disease is a risk factor for lower birth weight babies. I don't want to be ten years down the road when science finally discovers, you know, that it's true or false and have not taken care of those pregnant

women with periodontal disease. We ought to be acting on this now because there's not a problem associated with providing quality dental treatment for pregnant women. So it's not like we're trying to compare a drug that says do the good aspects of the drug outweigh the bad? Dental care should be available for everyone, and it's just a shame that we've been patterned to think differently about dental care.

JACKIE JUDD: Terry?

TERRY DICKINSON: It reminds me of a story. You know, some do get it. Some of the physicians do get it. I got a call, gosh, it's been five, six years ago, from a pediatric anesthesiologist at University of Virginia, and she said, listen, I've got this three-year old girl here I'm getting ready to put to sleep and take all her teeth out, and I stopped and thought, and she said there's something wrong with this. This shouldn't happen. I said if you really think

it shouldn't happen and you want to have a conversation about it, I would be happy to come drive over to Charlottesville and have a conversation with you, which I did, and we ended up—the end result was this great program for physicians to do fluoride born issues and bring them into the care system that—including the dental care system at an earlier age, but, you know, let me give another kudos to HRSA and Marcia because one of the things that we—there are kids out there that need to go into the OR and have GA, and through a HRSA grant we've been able to do that. I don't know if any other states currently do it, but we have a program that we've made an arrangement with a hospital for a set amount, $1500, and I challenge any other hospital to match that as a benchmark, but that's the total cost for each case no matter how much dentistry is done.

The pediatric dentist volunteers his time to do that, and the word is out to every free

clinic, community health center, any kind of clinic in the state if they have a child that needs to go and have general anesthesia that we'll get them to Richmond. We'll provide transportation. We'll put em up. We'll do whatever it takes to make sure that child gets the care that they need. So again, Marcia, thank you and HRSA for allowing us that opportunity.

JACKIE JUDD: Debony, share with us some, if you would, call them success stories in PG County, the kind of innovative programs that have begun to occur since 2007. You talked about the gaps earlier. Where are some of them being filled in and how?

DEBONY HUGHES: I think—excuse me. The most notable would be the Diamonte Driver Dental Project. It was a project that started from grassroots dentists who said, after the death of Diamonte, this cannot occur and especially in our county, and we have tremendous support from our

legislators and our governor, who has provided funding through the Department of Mental Health and Hygiene, Office of Oral Health. So as a result we have a mobile unit, a three-chair mobile unit that services Title 1 schools in Prince George's County. The program has been in existence for four years now, and we have treated more than 5,000 children.

The children are, after they are seen—what really makes this project wonderful is the volunteer dentists. The dentists—the unit is staffed by dentists who are volunteers who work in the communities where the schools are. So the idea is the dentist that see these children, these children will be placed in their offices as dental homes, so they're already familiar with the dentist and are comfortable with them treating them. So it's a wonderful project.

JACKIE JUDD: And do these kids get seen regularly, or is it episodic?

DEBONY HUGHES: Well, the mobile unit visits the schools once a year, but the idea is once they are seen, they are placed in the dentist office for a permanent dental home. That is our goal. So the program is to identify immediate problems, so we won't have another Diamonte Driver.

JACKIE JUDD: And if you had unlimited funds, how many more of these mobile units would be needed to reach all the children in PG County who need this kind of help?

DEBONY HUGHES: If we have unlimited funds? [Laughter]. Don't ask me a question like that. You know, right now we're working—we're collaborating with Federally Qualified Health Center and with Children's National Hospital and the Colgate van. They are coming into the county to provide services as well. So in the fall we are happy to announce that we will have five mobile services in the county that will cover the

majority of the schools, but we could always use funding for more.

JACKIE JUDD: It's clear from our discussion so far that workforce issues are tremendous when you talk about the dental care gaps. Terry, you heard in the documentary dental therapists. The parallel was made to nurse practitioners versus doctors and the AMA. What is your view of dental therapists? Should there be more? What services do you think they can and should be providing?

TERRY DICKINSON: Well, you know, I think that's, you know, something that I've certainly kept a close eye on. You know, I do have some concerns about the supervision issue, and that's simply from my experience in seeing thousands of patients and the complexities of their medical conditions. This last weekend we actually had a project—I mean, the blood pressure was 190 over 120. I had been waiting to transport that person

to the hospital. I mean, it's—the populations that I personally see are medically compromised and of a very complex nature. So, you know, I do have some concerns about that.

JACKIE JUDD: But in a clinical setting where a child needs a cavity filled, a tooth pulled, his or her teeth cleaned?

TERRY DICKINSON: Well, certainly –

JACKIE JUDD: A hygienist could do that last –

TERRY DICKINSON: A hygienist could do that, but, you know, from a personal standpoint that's an area that I'm very interested in seeing what happens in Minnesota. I followed the Alaska situation. You know, for a long time, and, you know, I guess the question we're all trying to answer is how do we get care, you know, to the populations that really need it, and so I think it's one of many parts, and certainly that's a part that Minnesota has chosen to do, and I'm not

going to say that it's something that's not going to do good. You know, I don't know that, but certainly the data is going to be important to look at to see if that's something that might be appropriate, but, you know, at this time I'm just not—I don't feel comfortable enough to answer that definitively.

JACKIE JUDD: Marcia?

MARCIA BRAND: Well, certainly those issues, a scope of practice issues, are state issues, and we watch them with interest, as you do. One of the things that HRSA has just been working on, however, is—and certainly in addition to taking a look at the providers that are part of the oral health provider community, who else can we engage in this work? And so we've been working on a project that tries to create interprofessional core competencies for non-dental providers so that physicians, nurse practitioners, nurses, physician assistants, others engaged in

primary care could do some basic services, that they think to look in the patient's mouth. You know, asking the question have you seen the dentist does not allow you to check the column.

You know, you need to look. They need to be able to do some basic risk assessment. They need to be able to provide some basic services, depending on what the state would permit, and certainly oral health education is important, too, and so we've been working and piggybacking on some work that some other groups have been doing around how to expand the workforce that thinks about access to oral health care. You know, in my own mind there are three million nurses. If you get each of them to take that moment to take a look in someone's mouth, you know, and understand what they're seeing and then be able to make the appropriate referrals, we'll go a long way to ensuring that the three-year old doesn't end up in

a situation where he or she has to have his teeth extracted.

JACKIE JUDD: Greg, workforce issues are something you've spent a lot of time thinking about. I think in the state of Wisconsin I read there's one dental school that turns out 80 dentists a year?

GREG NYCZ: They are expanding now, but we-

JACKIE JUDD: You've been pushing for a second dental school?

GREG NYCZ: Yes, we plan on working with Marshfield Clinic to stand up a second dental school in the state, and there's a whole raft of reasons why we want to do that. One is as we try to get to our preferred future, our vision of health care homes for everyone and equitable treatment, we do not want to be stopped by workforce issues. We recognize since the cutbacks and loss of dental schools in the 80s that's coming home to roost now. So we're going to have

literally 30-percent of our workforce disappear at current replacement rates over the next 20 years. That's unacceptable.

Rural areas suffer more because dentists have preference for urban areas. So that's why we put ourselves on the path of a dental school. That's one of the reasons. The other reasons are a little bit what we were getting into here. My job as a health center director is try to match the resources to the population needs, and I can tell you that we hire dentists that come right out of school. There's no residency requirements in 48 of the states. So they come right out of school. They come into our clinics. What they see in our clinics is frightening. It is what the doctor is talking about, people with lots of complex medical issues on top of other issues.

We've had at least one dentist who said I'm not trying to do this. This is too intensive. I got to leave. We didn't want him to leave. We

felt we could bring him along. So to throw a dental therapist in that mix is tough to do. Do I think there's a role for dental therapists? Yes. Ironically I think a dental therapist would work best in the private practices that are treating less oral disease, and that will be our practice someday if our goal comes true and we raise the oral health profile.

We have a tough time right now because we're engaged in what Dr. McGinnis wrote many years ago called the Primacy of the Rescue. We open our doors. People come from all over the state, and I don't know if there are any advocates for the disabled population in the room, but I can tell you they have the toughest time of anybody, and we haven't—we signed a memorandum of agreement with the state of Wisconsin that we would take care of any of our disabled population that wants to seek care with us. We have large treatment

rooms, wheelchair lifts, and we build that in all our facilities.

The fact that a lot of dentist don't get enough training time with disabled populations is problematic. If we have a school, we can train them to serve the disabled population. It's also interesting to know that you have a profession the Institute of Medicine publication, Dental Education at the Crossroads, 1995/96 called for change, but change was too slow in coming. If we can build something from the ground up, we can put that change in. Consider that we have this epidemic of early childhood carries all over the country.

What is about a profession that trains dentists who feel uncomfortable taking care of one, two, and three year olds? I mean, isn't that a little weird when you figure out that most of the disease starts very early on? We train pediatric dentists to help in that regard, but if

you're in rural areas or frontier areas, you're not going to find pediatric dentists. So if we're going to train, we want to have a school for many reasons. One of those is to train general dentists who are going to go out in rural areas and be comfortable serving kids and avoiding those early childhood carries before they start, working collaboratively with medicine.

JACKIE JUDD: Debony, can you speak to how the state of Maryland is trying to grow the workforce?

DEBONY HUGHES: Oh, absolutely. One of the recommendations from the Dental Action Coalition Committee that was formed after the death of Diamonte Driver was to educate general practitioners in pediatric dentistry, and the University of Maryland has done a wonderful job in holding many residency seminars for general dentists to teach them how to treat young very young, and also the Office of Oral Health has a

program to train physicians, nurses, and nurse practitioners on the use of fluoride varnish in their offices. The program has been very successful. I think it was initiated two years ago, and there are more than 600 practitioners participating in the program.

JACKIE JUDD: We've spent a lot of time this morning talking about pediatric dental issues, but of course as Diane pointed out earlier the issue extends through all of our lives for many, many people out there. So, Marcia, talk for a moment or two about programs that specifically are targeted for people, let's say, 65 and older.

MARCIA BRAND: Sure. So one of my ongoing concerns has been the fact that Medicare does not pay for much in the way of oral health care, very limited range of services, and there are not a lot of programs that provide access for seniors if you don't have private coverage, and so I've been looking at what our health centers do in terms of

how many seniors they see, and only six-percent of the folks who come into health centers are seniors, and so I don't know, Greg, if your population is different from that, too.

GREG NYCZ: So –

MARCIA BRAND: But I'm thinking that as the population ages more folks may seek access to oral health care services through health centers because we see them regardless of their ability to pay. We also support other training programs that help individuals be more comfortable in caring for older patients. Just as some folks don't want to care for a child who's less than three years old, other folks don't have experience with working with older Americans, and so they are less likely to be comfortable and provide those services. So we provide geriatric training programs for dentists as well.

JACKIE JUDD: Terry, what is the breakdown in the events that you have in terms of older

Americans versus younger people like some people we saw in the documentary?

TERRY DICKINSON: We probably see about 20-percent of the population we see are probably in that older age group. They have different challenges because of medications they're on that may cause dry mouth and which gets into the root decay area that are very difficult technically to deal with in some instances, and a lot of these folks come in, and they basically have just given up, and that's why you heard the comment that they've got two teeth left, and they just want their dentures. And that's kind of been the culture in some areas is that they're parents and their grandparents, and so we need somehow to break that cycle and give them a different message that there is a different way, that they can keep their teeth for a lifetime, and so you have to kind of—how do you deal with each of these cohorts as they move through life, and so I think we're

looking at all that. I had the opportunity yesterday to meet with the nursing home folks, the state nursing home folks, and some of the directors of some of the nursing home areas because they face immense problems with their patient population. So we're trying to work with them to see what we can come up with in as far as training within their facility so that they can do some of the things that they're qualified to do to be able to help their residents.

So we continue to look for that. Again, HRSA gave us a grant on the special needs folks, so we've done training courses around the commonwealth to train our providers, and those have been sellouts. So it's not for a lack of interest or anything. We have dentist that are—they want to know how to do that, but it's a special talent in that same way with the very young.

JACKIE JUDD: Greg and then Marcia.

GREG NYCZ: And I want to add to that a little bit. We do see—because as a health center we can offer a sliding fee program, and a lot of the elderly are between 125, social security brings them right out of poverty, but they're not that high out of poverty. So, we—you know, those folks get a 75-percent discount, and they only pay nominally if they're in poverty, but one of the surprises that I had that I was unaware of until we entered into this dental provider world is that vets can't get—we talked about the elderly, and veterans of all wars have a great deal of difficulty getting dental care if they're unemployed or uninsured, don't have the money to pay for it, on Medicaid, on Medicare, and when we went into our Chippewa Falls, our second dental center, the veteran's affairs officer—I think his name is Mike Hatley told us that he gets ten calls a week from vets. This is in a county of 55,000,

and that was his number one health problem he had difficulty meeting for his vets.

Unless you're, I think, a hundred-percent service disabled you're not eligible for dental care. So, you know, I think this is really important, if you're advocates in the audience in that, because there is a strong sense in the country that we ought to do better by our vets, and that should include dental care as well, and I know that it's helped garner us broad bipartisan support in Wisconsin for expanding what we're doing because all you need to do is ask your ask your legislator to talk to their veterans affairs officer and say what are the problems. In our neck of the woods, you know, five out of six said number one was dental, and the sixth one said it was number two, and we put a dental clinic in there, and it disappears as a problem. It's no longer an issue.

JACKIE JUDD: Marcia?

MARCIA BRAND: So this kind of cross departmental collaboration is really important, and I think HRSA has engaged in a new area of work. The Administration on Aging, which now has a new name, it's Administration for Community Living, and HRSA are beginning to collaborate to see where the administrational aging has its services, delivery sites, or coordinative sites and how they might work with health centers so we can assist in getting those kinds of patients, those patients, into care in the health centers so they don't have to, you know, try to figure out that link themselves.

JACKIE JUDD: I want to open it up to the audience in just a moment. There will be three young women with microphones. If you could wait to have a mic, stand up, identify yourself if you're here representing an organization, and we'll do that in just a moment. I just had one final question I wanted to ask Greg and Debony,

and Terry mentioned communications and reaching vulnerable populations. I'm wondering at the state/local levels if either of you has seen a particularly effective campaign to reach out to these hard to reach communities about getting dental care? About what is good dental care?

DEBONY HUGHES: Yes.

JACKIE JUDD: I'm so glad that was your answer. [Laughter].

DEBONY HUGHES: The state of Maryland just launched a oral health literacy campaign in March targeting low income families with children that are on Medicaid. The campaign is statewide, and it provides a message to parents that they should take their children to the dentist at a very young age, and these mechanisms to reach the community has been through radio, through television, and also bus placards, and I also brought brochures if anyone would like one [laughter], and there is a call center associated with the campaign where

families can call in and get information about enrolling in Medicaid.

JACKIE JUDD: Greg?

GREG NYCZ: Second yes. We have a number of strategies to do this. One is that we've integrated the electronic record, so we have essentially a combined medical dental electronic record. Many people come in and see their physicians. In the future if their physician sees them, there will be a popup screen to say whether or not they've had dental care. So we can use our physician community to help remind those who haven't gotten it and to educate them on the importance. That's one strategy. The other strategy is in the communities, and what we tell them is when we start, we open up a dental clinic. It's like this rescue operation. We get people from 40 counties. We get people from our biggest cities traveling hundreds of miles to a little rural community to get dental care. Imagine that,

and so what we tell the local groups, the social service agencies, the public health, the area aging—we work with the aging groups—and all these folks is that there's a tremendous first mover advantage because once you're in as a registered patient of ours, we will give you access for as long as you want to stay with us, and so don't let the—we tell them don't let those folks from the other counties, you know, get their patients in first, and when started doing this, what it is, is we have something to offer them, and we don't want to wait until people—there are so many people in the rural areas that feel why would I go to a dentist? I don't need a dentist. Well, when do you need a dentist? Well, when I have oral pain.

Whoa, we don't want you to ever have oral pain, you know, and so it takes a village in a sense, and we work with all these groups, and one group that hasn't been mentioned that—I'm a slave essentially, you know, to my board and to my

patients in the community, but I'm also a slave to the taxpayer, and I have to find a way to do this as efficiently as possible so that I can get the taxpayer to continue invest in what we're doing, and part of the way that I can give back to the taxpayer — and I told the Medicaid folks this - the best thing I can do in helping you lower your costs is get somebody off Medicaid. So go talk to the job service agencies. A lot of those job service agencies have people in Clark County, right next to our headquarters, there's 33,000 people. It's a rural county. They tell us a hundred adults a year that they have that aren't really eligible for service sector jobs because of the condition of their mouth. Well, we're paying to provide them with training. So the taxpayers make an investment in training, and I say, well, you know, for a few bucks more we can actually help them get a job, which makes the job service agency and these placement agencies much more

efficient, provides a huge return for the state, and you now have somebody gainfully employed in a job that hopefully has private insurance.

So as a health center we got to be out in the communities.

GREG NYCZ: We got to work with everybody.

JACKIE JUDD: Okay, questions from you, this gentleman up here?

JOSEPH JANAHAN: Hi, Joseph Janahan, Americans for Tax Reform. Just wanted to gauge the panel's opinion on growing trend of private neighborhood dentist offices contracting with DSOs and DMOs, which are dental service or management organizations that very briefly handle the backend of, you know, all non-medical administrative work like accounting, things like that. It's a growing trend. The model is a growing trend- this model of contracting with third parties. Would you say that—I'm sorry to steer the conversation from what I perceive to be public health. Would you say

that this model of contracting increases the quality of dental services and the access to care for dental patients?

JACKIE JUDD: Terry? [Laughter].

TERRY DICKINSON: See that bulls eye, huh?

JACKIE JUDD: Thank you.

TERRY DICKINSON: You know, that's kind of a new hot item right now as these large groups that are forming, and I think part—you know, there are a number of reasons why they're forming, but, you know, the demand and the pressure from a third party payers and their looking at that as a way of perhaps dealing with the lowered reimbursement rates, but also the economy of scale, and that's being able to buy supplies and contract with dental labs and HR and all of these other things to be a more efficient operation, so I suspect, I think we're probably—I think over the last three to four years we've seen probably three percentage point increase in the number of these large group—

and you can segregate them into various how big the groups are, but I think that's part of the future is that we're going to be looking at these big organizations that are somehow linked but management company with the dental services, which will be the treatment side of it. So that's part of the future. Whether how much effect it's going to have? Certainly it creates a more efficient operation, so you would assume that it might increase the access, getting more people in for care.

JACKIE JUDD: A question over here?

FEMALE SPEAKER: Hi, I'm Videa. I'm a student at the University of Minnesota, and I'm interning at the Association of Maternal and Child Health Programs. So my question was—first let me congratulate Jill on a fantastic documentary and to all of you for the wonderful work you're doing. So with the documentary and with what you've spoken, we see a lot of problem with cost. So my

question is kind of on the other side on the workforce. Is there any shortage from there? Now, if it was affordable, are you able to have enough workforce to meet that demand because there is a demand at an emergency level, and at like what level are—I mean, is there a shortage of workforce at any particular level, pediatric, geriatric? So is there enough workforce to meet the demand?

JACKIE JUDD: Who wants to take it? Greg, why don't talk about—

GREG NYCZ: Well, I can speak in Wisconsin.

JACKIE JUDD: —in Wisconsin.

GREG NYCZ: From Wisconsin's perspective, if we are committed to provide equitable care to everybody in our population, we do not have anywhere near enough workforce today, and that's going to deteriorate over the next 20 years.

MARCIA BRAND: And there are issues, not just in terms of numbers, but distribution, you know, where folks practice. As I think Greg mentioned earlier there are a lot fewer providers in rural communities, but you could go to a block in Manhattan, and there would be a hundred dentists there and providing all different kinds of care, pediatric care, geriatric care. So there's a distribution as well a numbers concern around access.

DEBONY HUGHES: And in Maryland I don't think the numbers are there. It's the number of dentists who accept Medicaid. Only about ten-percent of the population participate in Medicaid, and of the 24 jurisdictions in Maryland, each jurisdiction has a public health dental clinic or a Federally Qualified Health Center. So I can't say that there's a shortage, but there's a shortage of those that treat the underserved.

JACKIE JUDD: And when you talk to the 90-percent of dentists who don't accept Medicaid patients, what's the refrain? I mean, how much would the reimbursement rates have to change in order for them to consider taking on those patients?

TERRY DICKINSON: Well, I think, you know, one of the things that happened in Virginia in 2005 is that out of many meetings with the Department of Medical Assistance Services with a gentleman named Pat Fenerty, who is executive director of that, we came out with what we think is one of the better Medicaid programs in the country, Smiles for Children, and even though we're probably between 25 and 30-percent number of providers, what we've been able to do more importantly I think is to take the number of kids that are being seen. We're up at like 56-percent of the kids that are eligible for care are being seen. And that's three to 21. So we're looking—

we keep looking at that. I just saw yesterday some gap analyses that are being done in some of the counties that we're looking at to make sure that we have the providers. If they showed that we need another provider or two providers in those counties, we go and get them. I mean, it's really simple. So even though the reimbursement rate went up in 2005, and I think most of the studies show that if you increase the reimbursement rates, you increase the number of providers, but, we have not had an increase in the reimbursement rates in seven years, but we're still maintaining that base.

JACKIE JUDD: Debony?

DEBONY HUGHES: Maryland has had an increase in the preventive services, and that has caused the number of dentists to increase that do participate. However, there are other issues in the billing process, broken and cancellation rates from patients that deter them from participating,

so it's not just alone the reimbursement rate itself that causes them not to participate.

JACKIE JUDD: Marcia?

MARCIA BRAND: And one of the things we want to make sure is that is not incumbent upon the parent to find a dentist who will accept the Medicaid and CHIP payments. And so the Insure Kids Now website has a button you can go to, and you can go to that site and find who in this community does provide care for Medicaid and CHIP kids so that the parent doesn't have to make 40 calls, you know, in the middle of the night to find someone who will see this child.

JACKIE JUDD: Are there questions over here? Yes?

BARBARA KORNBLAU: My name is Barbara Kornblau, and I'm with the Coalition for Disability Health Equity, and the disability section of the American Public Health Association, and thank you, Dr. Nycz, for bringing up the issue

of people with disabilities, and we know there are a lot of reasons why dentists don't want to see people with disabilities, the same reasons for Medicaid Plus. There are physical access issues. Some people don't want to deal with certain types of people with disabilities. They don't want them in their office. Now, my colleagues and friends at Special Olympics are doing training of dentists and how to address the needs of people with intellectual developmental disabilities. I'm wondering what HRSA's doing, what the state of Maryland's doing in training dentists to meet the needs of people with disabilities?

JACKIE JUDD: Marcia?

MARCIA BRAND: Certainly, so HRSA has the Maternal and Child Health Bureau and has a long history of providing assistance to dentists who are dealing with children with special health care needs. One of the challenges we're beginning to look at and I'd be interested in hearing other's

views on this is what do you do with the children as they age out of the Maternal and Child Health system that we've created and making sure that they have access to dentists after the pediatric dentist, you know, that's not the appropriate place for them to get their care anymore. So it is a significant challenge, and we acknowledge the concerns that you raise.

JACKIE JUDD: Debony?

DEBONY HUGHES: In Maryland it is a challenge for parents who have children with disabilities to find care. Most of the care is provided at the dental schools at either Howard University or University of Maryland. We don't have a specific training program for dentists in that care, but I'm sure that is something we would be willing to work with HRSA to provide for our dentists.

JACKIE JUDD: Terry, at the dental fairs that you help organize, are the dentists able to accommodate disabled people?

TERRY DICKINSON: Yes, we actually do see disabled, but we also work with Special Olympics. We actually provide dental care during the annual Special Olympics project. We actually provide care.

JACKIE JUDD: Okay.

TERRY DICKINSON: So I was a little apprehensive about it, you know, because we're just outside. It's not like we're in, you know, where we have a little office or anything, but I tell you those kids did great. The providers loved it. Everybody walked away feeling great about it, and I would, you know, certainly encourage more people to partner up with them. They're great.

GREG NYCZ: And, you know, we have a memorandum of understanding with the state to take

care of the disabled population. In our Chippewa Falls facility we have five to six hundred severely disabled folks that we care for as a health care home. They're always welcome, and they get continuity of care and regular treatment. The integration of medicine and dentistry is also important to bring up here because we've had patient—she's an adult now but when she was an adolescent, an example, she had all kinds of problems, medical problems, and was nonvocal and combative. So every time she went into medicine for all the different things she needed, it was a struggle, and they ended up, in many cases, not getting all the care in they wanted to get in, and once we had the dental capacity end, we had our folks coordinate because when she needed dental care, we had to take her in and put her under. So instead of just getting her dental care, she got everything else. She got her blood work done, her OB, just everything came in, and we brought in all

the medical specialists, and they were able to get everything done for them, and that, for the parents, is like, you know, wow.

MARCIA BRAND: Right.

GREG NYCZ: You know, it's so needed.

JACKIE JUDD: Question over here? Yes.

MICHAEL DEWANIS: Dr. Michael Dewanis with the American Optometric Association, and you're probably wondering why the American Optometric Association. [Laughter]. I want to talk about the collaboration and mention something that—so I have just a quick comment and then a question. So Marcia and Terry both mentioned interprofessional collaboration, and you just mentioned it as well. So at CDC they have a program called PPOD, and it's where optometrists and dentists work together on issues related to diabetes and complications in the eye and in the mouth. People with diabetes get periodontal disease, and once they have periodontal disease, it means they have diabetic

retinopathy, and the ones that have diabetic retinopathy, guess what? They have periodontal disease. So we have the dentists referring to optometrists, and the optometrists referring to the dentists. We work side by side in that respect. I went to school with a dentist, so optometry, dental, and medicine all took the same classes and were trained together. The dentists practiced on us. We practiced on the dentists. [Laughter]. But the medical students, I don't know where they went. We couldn't find them. So that's just my point here about the importance of interprofessional collaboration. I think that that's key.

The question I have for the group though is we know that from the Affordable Care Act that one of the provisions of the Affordable Care Act was in the essential benefits plan under children's pediatric services that one of the conditions in the plan was that it in order to be

a qualified plan, it had to include pediatric vision and oral care, and so I was just wondering if you could comment on what you think that that's going to do for this situation and then also how HRSA's preparing to meet the needs for that large group or contingency of people that will have now oral and vision care.

JACKIE JUDD: I guess I'd ask Marcia to answer that, and I would add one more question to that, and that is we all know the supreme court is about to rule on the ACA. So is HRSA gaming out what should happen if the law changes in some way as a result of the ruling?

MARCIA BRAND: So –

JACKIE JUDD: I had to ask. [Laughter].

MARCIA BRAND: Drawing on 21 years of government and bureaucracy experience let me frame a response here. Certainly on the positive side we are very excited about the opportunities that the ACA creates for increased access to care. We

are concerned about capacity. We've built out significantly in health centers, and we're doing the best we possibly can to expand our workforce programs. There will be challenges, and in regards to the supreme court decision, I just really would not want to speculate because there are—first of all, there are lots of folks with a lot more experience in constitutional law than I doing that work, but we're continuing to plan to provide that care for folks in 2014.

JACKIE JUDD: Anyone else? Greg?

GREG NYCZ: What it means for us is, again, we have limited money that we're trying to get the maximum benefit for, so if some of our patients who we're now providing sliding fee support for, for instance get access to coverage, that frees up that sliding fee resource for that patient, and we can give it to another patient. So I'm looking forward to any changes that would expand coverage.

JACKIE JUDD: I think I saw a raised hand in this area? Lady up here?

SARAH RADIS: Hi, I'm Sarah Radis with the University of Maryland's Horowitz Center for Health Literacy, and we've been talking a lot about treat, treat, treat, but where does prevention fall in breaking the cycle of extract, drill, and fill?

JACKIE JUDD: Good question, Greg?

GREG NYCZ: Yes, I mean, this is what I call our phase two. When you first set up a clinic, the demand among the poor population of the region is overwhelming, and we don't have to advertise. We don't have to do anything. People just come from everywhere. That's phase one. We got to keep more and more and more while we get enough so we can saturate that demand. Then we're into health literacy because we know that a lot of the people—if we had unlimited dental capacity, half the population that's low literacy is not

going to come in until it's too late. So, again, we're hoping that our pediatricians, our OB/GYNs and our specialists, everybody's going to try to do this anticipatory guidance and try to help. So starting from when someone's just thinking about having a family and letting them, you know, know that. So there's a tremendous effort. I did get a bit of bad news on my way out here. We had applied for a CMS initiatives grant that would essentially be focused on health literacy, helping physicians understand the oral health, helping oral health professionals better understand the medical, and then working with the population in itself. I mean, we've got in our electronic record we don't have even a patient portal, and our patients are very interested. Even our low income patients, 60 or 70-percent of them say they have access to this through libraries or to—you know, and they want information, and so we want to try to pattern information for them, make it

special for them so that they can work with us on their good daily oral hygiene.

We're sending our hygienists out to nursing homes to work with the staff in the nursing homes to help them train them on how to deal with their population's daily oral hygiene, and we have to keep sending them back because there's turnover in the population, but the nursing homes are always glad to have that. So I'm glad you brought up health literacy. I think it's like incredibly important for us to get to where we want to go.

JACKIE JUDD: A question back here? Tiffany?

MARY WORSTELL: Thank you all very much. I'm Mary Worstell, and I am with Department of Health and Human Services Office on Women's Health, and I'm focused on older women's health issues, and you just brought up the nursing homes. Very interested in your perspectives on how we

address the issue of poor oral health for institutionalized individuals, both in terms of the assessment when they enter that institution and then the ongoing care, and if we were to do one thing, what would that one thing be?

JACKIE JUDD: I think Greg just touched on that. Terry, do you want to pick up?

TERRY DICKINSON: One thing, you know, in the conversation that I had yesterday, that—you know, that's what they're looking for is how can we help each other because this is a population a lot of folks simply do not have the manual dexterity, you know, for whatever reason to be able to even get a toothbrush in their mouth, and so I think if I had to choose one thing, it would be to educate the staff. There's a lot of things they can do to increase the betterment of those folks. They really struggle, and I don't have all the answers. We're certainly looking forward to working within to try to help them in that most

difficult arena, but it's just—it is very difficult.

JACKIE JUDD: Debony?

DEBONY HUGHES: So Jackie asked what I would do with additional funding for a mobile unit?

JACKIE JUDD: We found it.

DEBONY HUGHES: There we go.

JACKIE JUDD: We found how to spend it, huh?

DEBONY HUGHES: Yes.

JACKIE JUDD: Okay, older people.

DEBONY HUGHES: Yes, yes, absolutely. We need to take the services to them.

JACKIE JUDD: Uh-huh [affirmative].

TERRY DICKINSON: Before I forget let me—I just wanted to, on the oral health literacy, if I could just—you know, it was a telling—as you can see I'm a story person. I tell stories because that, you know, really tells about something I

think in so much a better way, but last year at one of our projects in the southwest this young man who was in the line to get his teeth taken out goes up to the person that's one of our volunteers that's moving the patients around and says to her, How did you keep your teeth? How did you keep your teeth? How did you get to age 40 and have all your teeth? And I thought that was a very telling question. It's not that they don't want their teeth or that they don't care. They do care. They just don't know what to do, and that's where we need to really concentrate our efforts. I think, you know, that—I think you're going to see hopefully August this new ad campaign that the ad counsel's going to put out that the ADA is one of the many partners, and it's going to be about messaging. How do you get the message to folks? And so I think there are a number of ways we can do that, but again it's going to take a lot of resources.

JACKIE JUDD: Marcia?

MARCIA BRAND: In response to your question about working with folks in nursing homes and other extended stay facilities, as a grad student that was my thesis was what could you do to improve health outcomes- oral health outcomes- and the thing that was most apparent to me then, even as a new practitioner, was that the staff needed a resource. They didn't know. There was no one for them to go to, to ask the question about how can I get into this individual's mouth safely, you know, for that individual, and how do I approach this patient, and how do I talk to the family? And so just having a resource available, someone who could answer questions about oral health, made a tremendous difference in their willingness to take a look into a patient's mouth and help them with their oral concerns.

JACKIE JUDD: Question here?

KELLY HUNT: Thank you all for sharing all of your great stories and all of the work that you're doing. I'm Kelly Hunt. I'm from the New York State Health Foundation, and I wanted to bring up a topic, community water fluoridation, find out what your thoughts are on that, if any of you have engaged in a debate in your respective states and whether you think it's worth it?

JACKIE JUDD: Okay, Greg?

GREG NYCZ: I've got a story there. [Laughter]. Chippewa Falls, second largest community in the state of Wisconsin without fluoridated water. I went there with the help from Lauren Lemayer, a public health dentist. We had a state grant, and they were—it was interesting - they were having this debate in the common counsel about whether they should fluoridate the water, and the last time they did this, their home of [inaudible] and it's fresh spring water, and you don't want to do anything to

adulterate the water, but since the first time public health failed, they had to put chlorine in the water because there were problems. So already the water's got chlorine in it, so figure let's take another run at this. My colleagues in public health were all saying it's a done deal. We've canvassed. A lot of people said I thought there was fluoride in our water. We thought it was a done deal. I went to a hearing and with—again like I said with help from Lauren. I didn't have in my hand, but I basically said, look, I understand money's tight. I understand you got five well heads. We're going to build a dental center in your community. Your kids have all kinds of problems. If you want to help us and they'd love to have that dental center there with 60 new jobs, and so they really wanted that, and I said we'll build it whether you fluoridate your water or not, but if you want to know how to help us, fluorinate your water. It will save the

taxpayers money in the end. We'll have less work to do, and I said I'm going to put my money where my mouth is. I have $50,000. I will help you train your folks and put it in. There were three physicians there from Marshfield Clinic. There's only one dentist, you know, advocating for this. We even had an anesthesiologist was there advocating for fluoride in the water, and they—you know, they felt that they couldn't do this on their own, so they had to have an advisory referendum. The anti-fluoridation people were all over the place. There was this wonderfully nice lady who could have been a perfect grandma for anybody, and she got up with a quavering voice, talked about how fluoride would crumble the bones, and we have to stop this, and I talked to her afterwards, and I said, you know, fluoride's been around 50, 60 years, and she said well, yes, but it might not affect you until you're in your 80s, and I said, well, you might be surprised to know

that there are parts in the state of Wisconsin where fluoride naturally occurs in the water at the right levels, and so they don't have to fluoride. It's in the water already, and I said there's no people crumbling bones in those communities. It's been there for all time. She said that's different. God put it there.

JACKIE JUDD: Terry, could you put your ADA hat on and speak to that issue for a moment or two?

TERRY DICKINSON: Well, we're seeing an upsurge in attempts at taking out fluoride in water systems either through because of cost concerns or because of all—like he said, Greg said, the crumbling bones and all this other stuff. You know, we were fortunate that we have 95-percent of our water supply fluoridated in Virginia, but they still keep coming, and we seen an upsurge in these folks that are very passionate in about what they believe, and so but what it

does as a public health measure I find it very difficult to deal with, with people that don't see the benefit of it and what it does for these kids that really struggle.

JACKIE JUDD: Debony?

DEBONY HUGHES: Yes, in Maryland I'm happy to say that 96-percent of the state is fluoridated. However, the problem we have with our patients is they don't trust drinking the water. [Laughter]. So they drink bottled water, and we try to tell them that the water is fine and you need to utilize the water because that's where your fluoride is coming from. So that's one of the problems we see with our patients. So that is an ongoing, talking and trying to get them to use the tap water.

JACKIE JUDD: Okay, question over there? Yes?

BOB HALL: I'm Bob Hall with the American Academy of Pediatrics, and I have two quick

questions. One, the ACA in addition to the great dental EHB component also includes access to Bright Futures, which is a HRSA product that we work with you all, and guidance was mentioned. Wanted to see if you think there might be any impact to people getting such preventive services and well child visits, and would they be visits for no co pay, whether that anticipatory guidance might have some impact on oral health incomes? And then additionally I'm an ADA representative. Interested in finding out your perspective. Is it only payment as the burden in regards to the Medicaid? We have a pediatrician who flies around the country trying to get fluoride varnish paid for under Medicaid programs, and additionally hear all the time about the paperwork burden that's associated with Medicaid. Are there some easier fixes than sort of the payment fight?

JACKIE JUDD: Marcia, you want to take the first and, Terry, the second?

MARCIA BRAND: Sure, I'm happy to take the question, but I'm not really prepared to respond to it today. Certainly the Bright Futures has been around for a long time, and we've been great partners in preparing these documents and sort of using those to lean forward and drive care, but I'm really not familiar with the direct sort of cause and effect that that might have, but I appreciate your question, and I'll go find out.

JACKIE JUDD: Terry?

TERRY DICKINSON: You know, Medicaid, the whole Medicaid system has been one that we've struggled with, you know, because of the administrative hurdles, the preauthorizations, the reimbursement rate, it was just became a model that was hard to sell until we made that conversion, and I tell you it's a model in my opinion that works if you get—make it easy. You can't have a stack of papers like that to fill out to become a Medicaid provider. It's nonsensical.

You've got to have an adequate reimbursement rate. I mean, you've got to pay the overhead, and you've got to have—make it easy for them in, you know, through a partnership with DentaQuest we've got that in Virginia. I mean, I used to get a call every two or three days from a provider that was unhappy about Medicaid, and you know what? It's probably been two years since we went to that new program. So it's possible. It can be done. It just takes a lot of work.

JACKIE JUDD: I would like to end this event where we began, and that is by asking Jill a question about two of the people we saw in the documentary. Tell us what happened to Vanessa and Trinity.

JILL ROSENBAUM: So I can't tell you about Vanessa. I can't tell you about Vanessa. You have to watch. [Laughter]. But Trinity went through her procedure successfully, and we actually didn't follow up on it in the film

because it's kind of anticlimactic. I mean, she came out, and she's fine, and I think, you know, she just represents thousands of children, and as a mother I was just, you know, so blown away is the only word I can use. It's not a very precise one, but she's fine.

JILL ROSENBAUM: Thank you for your concern.

JACKIE JUDD: Thank you all very much for joining us today. Thank you, panelists. I think that they will be able to stay for a couple of minutes if any of you want to come up and ask some additional questions, but thank you for attending something that we feel is a very, very important subject and for Jill kind of triggering the conversation. Thank you. [Applause].

[END RECORDING]