The Hilltop Institute

analysis to advance the health of vulnerable populations

Developing Comprehensive Oral Health Policy: Challenges and Opportunities for State Health Policy Makers

Symposium Proceedings Summary

June 17, 2008

Introduction

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research, analysis, and evaluation on behalf government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

As a means of enhancing this mission, Hilltop hosts annual symposia that contribute to the national dialogue on timely and salient health policy issues that affect vulnerable populations. Hilltop is pleased to announce the success of its fifth symposium, *Developing Comprehensive Oral Health Policy: Challenges and Opportunities for State Health Policy Makers*, convened on June 17, 2008.

The symposium brought together over 130 policy makers, health services researchers, and health care practitioners, including the nation's leading oral health policy experts, from across the country to explore three major areas of policy innovation to improve access to and utilization of oral health care: integration of dental and medical service delivery; dental workforce issues; and health education and outreach strategies. The day was divided into four sessions and highlighted by a keynote address, a luncheon address, and concluding reflections.

In the following pages:

Symposium materials, including the day's agenda, speaker biographies, and PowerPoint presentations from the distinguished presenters, may be found at http://www.hilltopinstitute.org/Symposium/2008Symposium.cfm.

Summary of the Proceedings

The day began with welcoming and introductory remarks from **Chuck Milligan**, Hilltop's executive director, and **Arthur Johnson**, UMBC's provost.

Keynote Address: The Bridge from Oral Health to Total Health: Building a Policy Framework

While there is growing recognition of the importance of integrating oral health with "total" health, there is currently no roadmap for this integration. The keynote speaker, **Burton Edelstein**, D.D.S., M.P.H., professor of clinical dentistry at the Columbia University College of Dental Medicine, framed the day with a provocative assessment of this issue and challenged the underlying conceptions of dentistry. He began his presentation by challenging the audience to rid themselves of the pre-designation of dentistry as primary care.

Dr. Edelstein followed these remarks with his thesis that the disconnect between oral health and total health began in 1840 with the creation of the first medical school in the country, the Baltimore College of Medicine. He stated, "If dentistry had been parked in the Baltimore College of Medicine where it belonged, we wouldn't now have to imagine some kind of retro-fit of two disparate systems." Noting that medicine has both a medical side and a surgical side, he argued that if dentistry had been included in medical schools, it would have been placed in the surgical side. Thus, he argued that we should conceptualize dentistry as a surgical sub-specialty rather than primary care. He also compared medicine and dentistry to mammals and marsupials, respectively, to illustrate the challenge we face today in trying to re-integrate these two very different systems. He pointed out that this legacy of separation has affected public policy. The effect of this division was so profound that, in 1997, when the State Children's Health Insurance Program (SCHIP) was designed, the dental benefit was optional and no constituent or interest group requested its inclusion.

Using well-known school ground rules, Dr. Edelstein called for a "do-over." Noting that change will be difficult, he described two ways to re-integrate oral health and systemic health: either by pulling oral health into medical care or by pulling systemic health issues into dental care. He continued by contrasting pediatric and family medicine disciplines with dentistry. Whereas pediatricians and family physicians deal with determinants of health, health promotion and wellness, risk assessment, anticipatory guidance, and care coordination, dentists perform surgery. Because of this, Dr. Edelstein believes that re-integration is more likely to occur in the primary care physician's office than in the dentist's office:

> ***The placement of dental into the medical…is not just taking something that dentists already do and giving it to primary medical care providers to do. It's giving them the seed of what we do and having them grow it into something much more substantial.***

Following this discussion, Dr. Edelstein established the focus of the day: health policy. Acknowledging the responsibility of policy makers to serve the entire population, he described four levers that policy makers can pull toward re-integration. These levers—financing, work

force, safety net, and disease management—can be pulled to "change the content of dental services in ways that expand dental primary care on the medical side."

Following the keynote presentation, **Cindy Mann**, J.D., executive director and research professor of the Georgetown University Health Policy Institute, provided comments on Dr. Edelstein's address through her lens as a Medicaid expert. Noting that policy is stimulated by occurrences, she pointed out that "you never know what will rise up". These occurrences do not come along every day, every year, or even every four years. With the upcoming presidential election, SCHIP re-authorization, and health care reform on the table, opportunities for change will arise and we must take advantage of those opportunities.

Session 1: The Bridge from Oral Health to Total Health: Policy Implications

The structural disconnect between oral health and total health spans delivery and benefits across public and private insurance markets and creates the greatest challenge to integrating dental and medical services. Presenters in this session summarized the latest findings on the links between women's oral health, adverse pregnancy outcomes, and infant oral health; the link between oral health and chronic disease; and policy implications that stem from this research. **Anna Sommers**, Ph.D., senior research analyst at The Hilltop Institute, moderated this first session.

David Albert, D.D.S., M.P.H., associate professor of clinical dentistry at the Columbia University College of Dental Medicine, started the session with a discussion of the research linking periodontal and chronic disease. His presentation, *Periodontal Disease and Chronic Medical Conditions: Implications for Policy and Practice*, began with an illustration of reattaching the head to the body. Stating that "the mouth is a harbinger for systematic conditions," Dr. Albert continued with statistics on the prevalence of periodontal disease in the adult population, noting that 50 percent of adults have gingivitis, 35 percent have some sort of periodontitis, and 40 percent have lost all their teeth.

Following this introduction, Dr. Albert discussed associations between oral health and cardiovascular disease and diabetes. Reporting evidence from a number of studies performed in the past 20 years, he explained the leading hypothesis of the inflammatory impact of periodontal disease on the cardiovascular system. He noted, however, the lack of evidence verifying whether the association between these two conditions is causal. He continued by describing the research associating periodontal disease and diabetes, reporting that periodontal disease is the sixth complication associated with diabetes. He also presented findings from a two-year, retrospective study using medical and dental claims data from Aetna, which revealed a possible association between periodontal treatment and per member per month medical costs.

Dr. Albert concluded his presentation with future directions on these issues, such as expanding scientific knowledge and research, identifying knowledge gaps, and developing clinical practice parameters. He then noted several deficiencies in practice and program administration. For instance, the lack of diagnoses codes for dentists inhibits the integration of dental services into chronic disease management. This, in turn, complicates reimbursement for people with chronic conditions, such as diabetes,

who require more extensive follow-up. In addition, the profession has not developed practice guidelines or parameters for the delivery of dental services to people with chronic disease.

Kim Boggess, **M.D.**, associate professor of obstetrics and gynecology at the University of North Carolina, Chapel Hill, presented her research on *Maternal Oral Health and Pregnancy Outcomes*. She opened her presentation with general statistics on the prevalence of oral disease and disparities, noting that 40 percent of all women of reproductive age have periodontal infection. Dr. Boggess continued by listing some of the biological effects of oral disease, including inflammation, immune response, and oxidative stress. She reported that oxidative stress in particular can have significant impact on pregnancy because of its effects on the function of the placenta.

The core of Dr. Boggess's presentation described her research involving maternal oral disease and adverse pregnancy outcomes, including associations between periodontal infection and preeclampsia, pre-term births, and fetal growth restriction. Her research indicates that the association between periodontal disease and preeclampsia is significantly higher than the association with other risk factors, including smoking. Women with severe periodontal infection are more likely to experience adverse pregnancy outcomes, and women with a worsening of periodontal disease during pregnancy are more likely to have adverse outcomes than women with stable or no periodontal disease.

Dr. Boggess presented research related to the treatment of periodontal disease during pregnancy, noting the potential of treatment to improve maternal oral health and reduce the occurrence of pre-term birth. She concluded her presentation by commenting, "It is typically difficult to get high-risk women into prenatal care, and dental is even more challenging." Part of this challenge is rooted in misconceptions by dentists and pregnant women alike about the appropriateness of dental treatment during pregnancy.

Norman Tinanoff, D.D.S., chair of health promotion and policy at the University of Maryland Dental School, concluded the first session with his presentation, *Ties Between Maternal and Infant Oral Health: Implications for Policy Makers*. This presentation focused on the issue of early childhood caries from four perspectives: epidemiology, etiology, the mother-child relationship, and policy implications.

Regarding epidemiology, Dr. Tinanoff presented findings from several studies indicating the prevalence of early childhood caries. A 1997 Arizona study of pre-school children found that while oral disease may start in the first 12 months of life, the disease is typically not treated until 36 months. More current data on U.S. children with family incomes below the federal poverty level show that disease prevalence has increased in recent years, yet treatment has not. Similarly, a 2000 study of Head Start children in Maryland reveals a high prevalence of early childhood caries, low amounts of restorative care, and significant amounts of pain.

Dr. Tinanoff continued by describing the etiology of the disease and implications for the mother-child relationship. He noted that the etiology of the disease is multifactorial, associated with tooth characteristics, diet, and bacteria. He further reported that the disease process is simple, occurring when bacteria attaches to the teeth to form an acid, which can be transmitted from mother to child. Findings from seventeen studies performed over the past thirty years indicate

that oral bacteria may be transferred from mother to child. However, studies on mother-child interventions to decrease bacteria and caries in children have produced limited results.

Dr. Tinanoff closed his presentation with several suggestions for policy making. He called for more research on the etiology, transmission, prevalence, societal impact, and prevention of maternal and infant oral health disease. He also called for more provider education on the issue and for the training of more pediatric dentists. He noted the need for more partnerships between physicians and dentists. Finally, Dr. Tinanoff challenged the audience to "re-think" conventional wisdom in dental education.

Session 2: Approaches to Integrating Dental and Medical Services Delivery for Children

This session explored evolving paradigms to integrate dental and medical service delivery through expanding the role of primary care practitioners. The session explored this role through the perspectives of two state demonstrations. **Cynthia H. Woodcock**, M.B.A., director of long-term supports and services for The Hilltop Institute, moderated this session.

Rebecca King, D.D.S., M.P.H., the dental director of the North Carolina Division of Public Health, gave an overview of *North Carolina's Into the Mouths of Babes (IMB) Program*, including its history and evolution, evaluation issues and findings, and lessons learned. The program began in 1996 as a demonstration funded by the Appalachian Regional Commission for the purpose of utilizing the primary care setting to provide early prevention of oral health disease. Pediatricians were involved in the process from the very beginning, and stakeholders agreed that early childhood caries are a public health issue that can be addressed through early intervention. The demonstration caught the eye of policy makers, resulting in statewide expansion and Medicaid reimbursement for oral services delivered by primary care providers for up to six visits for children up to age three. Medicaid reimbursable services in the IMB program include anticipatory guidance, oral screening and referral, and fluoride varnish application. These services are paid out of the budget allocation for physician services, not the allocation for dental services.

Program evaluation is currently underway. Since 2000, the state has seen a thirty-fold increase in oral health services for children under age 3 and no reduction in the use of dentists' preventive services. The state is currently measuring cost-effectiveness of the program.

Dr. King concluded her presentation with key lessons learned from the program's implementation. Program challenges include nursing licensure, referral problems stemming from a low dentist-to-population ratio, and physician training. She reported that the partnership of key stakeholders has been the best lesson and the key element for success of the project.

Russell Maier, M.D., residency director of the Central Washington Family Medicine Program, gave an overview of innovative programs to integrate *Oral Health and Primary Care* in Washington State. First, he presented his argument for the use of the primary care setting for preventive oral health services. He noted that there is a shrinking supply of dentists and a growing population, so looking solely at the dental community to solve this problem is not very

realistic. Further, by age 2, children have typically seen a primary care provider 7 times, so this would be a natural setting for intervention.

> ***We can't drill and fill our way out of this crisis.***

Dr. Maier then described five key activities underway in the state. He began with the *Smiles for Life* curriculum, which is used to train medical residents in oral health. Training modules address children, adults, emergencies, pregnancy, and fluoride varnish, thus training family physicians to treat patients of all ages and conditions. The state has also embarked on public service campaigns to raise awareness on the importance of oral health and baby teeth. At the same time, the state secured Medicaid reimbursement for physician application of fluoride varnishes. The Washington Dental Services Foundation and Delta Dental have recently partnered with GroupHealth, a vertically integrated health care system, to pilot a demonstration that combines well-child care with oral health care throughout the system, from electronic health records to payment mechanisms. The fifth and final activity he described was the well-known *ABCD Program* (Access to Baby and Child Dentistry), which trains general dentists to treat young children.

Dr. Maier closed his presentation with a discussion of "roadblocks and throughways," as well as future directions for the field. He listed national and local politics over turf, scope of practice, dental coding, and financial and insurance silos as major issues. He noted that dental insurance providers often only reimburse dentists but instead need to recognize mid-level providers and reimburse dental hygienists and others. Dr. Maier also pointed out the need for "medical-dental experts." He concluded by calling for continued integration of oral health into overall health and the realignment of financial incentives in the health care system to focus on prevention.

Luncheon Address: Achieving Access and Quality in Dental Care

The luncheon address reflected on the evolution of pediatric health policy over the past 32 years and its implications for dental access and quality. **Sara Rosenbaum**, J.D., Hirsh professor and chair of the Department of Health Policy at the George Washington University Medical Center, provided a passionate overview of her experiences with Medicaid and children's oral health policy. She opened her presentation with an anecdote from the beginning of her career as a lawyer:

> ***One of the great shocks of my life … was the first time a family with children with no teeth in their mouth came into my office.***

Dr. Rosenbaum noted that dental access and pain were the earliest topic of litigation in the early days of implementation of Medicaid programs for children. To the best of her knowledge, dental cases brought by beneficiaries had never been lost.

After these introductory remarks, Dr. Rosenbaum discussed the course of dental care in child public policy from the late 1960's to the present, noting four distinct historical events. The first, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), was intended by Congress in the late 1960s to cover any condition that could affect a child's health, including dental services.

During the Nixon administration, many childhood services were made optional, but dental, vision, and hearing services were singled out as basic requirements for all children. In 1981, the obligation for all state Medicaid programs to provide EPSDT services was written into statute. Congress strengthened EPSDT again in 1984 by entitling children to go directly to a dentist without a prior screening. Finally, in 1989, Congress made dental benefits a statutory obligation for all state Medicaid program enrollees under age 21.

The second major event was the enactment of SCHIP in 1997, which Dr. Rosenbaum believes was a major setback for oral health. This legislation made dental services an optional benefit for SCHIP programs administered separately from Medicaid programs. She noted that this legislation was a great step away from the public health model of child health policy developed through Medicaid. In 2007, when SCHIP was debated, stakeholders understood how critical it was to reiterate the public health model, and dental care was reaffirmed as a required benefit. The third historical event was the Deficit Reduction Act of 2005 (DRA). In the spirit of benchmarking benefits and granting states flexibility in coverage, Congress came extraordinarily close to making EPSDT an optional benefit.

Finally, Dr. Rosenbaum discussed Medicaid oral health coverage for pregnant women. In the mid 1980s, Medicaid extended coverage to pregnant women. This legislation allowed states to cover any health condition (including oral) that could affect pregnant women, even if those services are not covered for other adults.

Dr. Rosenbaum commented that although these events have articulated the standard of oral health during pregnancy and childhood, coverage in the commercial market is shrinking badly. She concluded her presentation with the following:

> ***In public finance, we hold on to a vision of child health and health during pregnancy that is remarkably different from where the market is … and it is the professions who will be particularly influential over the definition of coverage, as coverage is a stopping point on the way to care.***

Session 3: Increasing the Dental Workforce and Program Participation of Dental Providers

This session explored dental workforce issues and the challenge of increasing the supply of dental practitioners who participate in public programs. Leaders from the field reviewed national workforce trends; novel incentive structures; innovative models to expand scope of practice; and lessons from state Medicaid fee reimbursement reforms. **Mike Nolin**, M.A, deputy director of The Hilltop Institute, moderated the session.

Allen Finkelstein, D.D.S., national dental director for United Health Care, started the session from the perspective of a large insurer. In his presentation, *Increasing the Dental Workforce and Program Participation,* he described the issues his organization faces regarding access and utilization of dental services by children enrolled in Medicaid. He began with some general statistics, noting that 100 million Americans do not have dental insurance. His organization, in particular, insures 2.1 million Medicaid beneficiaries.

Following this introduction, Dr. Finkelstein stated that workforce is one of the biggest obstacles to delivery of care. He reported that broken appointment rates are the single largest factor in dentists not joining his company's Medicaid managed care programs. Similarly, treatment compliance, below market payment rates, slow claims processing, and the administrative burden associated with Medicaid licensure all affect the dental workforce. In addition to access and workforce, Dr. Finkelstein reported that dental service utilization in public insurance programs is a major problem for his organization, as it is difficult to engage high-risk populations.

He concluded his presentation by offering remedies to increase the dental workforce. Dr. Finkelstein advocated for quality-based reimbursement and differential reimbursement for general and specialty dentistry. He commented on the fact that there is no preventive model in dental insurance. He also suggested an integrated dental-medical model for reimbursement and believes that primary care should play a role in dentistry.

David Nash, D.M.D., M.S., Ed.D., professor at the University of Kentucky College of Dentistry, advocated for the adoption of a new paraprofessional in the U.S. oral health care system as a means of reducing disparities and increasing pediatric access to oral health care. His presentation, *A New Paradigm to Address the Dental Workforce Crisis*, explained that this new professional designation, which he refers to as a pediatric oral health therapist, was first developed in New Zealand in 1921 and has since spread to 52 other countries. In the New Zealand model, pediatric oral health therapists are assigned to each school to provide preventive and basic restorative oral health care services. He noted that 610 therapists treat nearly 98 percent of the country's school children in a given year, while seven pediatric dentists provide complex tertiary care.

Dr. Nash argued that pediatric oral health therapists would be a cost-effective addition to the U.S. health care system. These professionals typically require two years of schooling and a salary of approximately $40,000 per year, compared to the eight to ten years of required training for dentists with average salaries ranging from $200,000 to $350,000 per year. He also noted that pediatric oral health therapists, despite objections made by the American Dental Association, receive more hours of clinical training specific to children than dentists.

Dr. Nash concluded his presentation by calling for leadership outside of professional dentistry. He challenged the audience to take action on the issue:

> ***The silent epidemic of dental disease is no longer silent. It is screaming at us to do something***.

James Crall, D.D.S., Sc.D., director of the Health Resources and Services Administration Maternal and Child Oral Health Bureau National Oral Health Policy Center and professor and chair of pediatric dentistry at the University of California, Los Angeles, concluded the session. His presentation, *Medicaid Dental Programs: Successful/ Unsuccessful Reforms*, reflected on actuarial research describing the challenges and promising practices associated with public programs.

Dr. Crall began by describing public payment rates, noting that most state Medicaid rates are substantially below market rates. This is due, in part, to the usual, customary, and reasonable (UCR) pricing methodology used by states. The

theory behind UCR is that, if dentists are paid what is usual and customary, they would not have any economic objection to providing services. In practice, due to the lag in data analysis and providers billing at the Medicaid rate, the payment becomes watered down. When the UCR is discounted by the typical 35 percent overhead rate, dentists end up being paid at the 10th percentile of fees, which is below the cost of providing the service. He also reported that it is not uncommon for Medicaid rates to be set and left in place for more than 15 years.

Dr. Crall followed this discussion by describing promising programs in other states. He cited research indicating that Medicaid dental rate increases in seven states led to increased dental provider participation in the program. Similarly, he provided evidence of increased service utilization associated with these rate increases. Dr. Crall concluded his presentation by listing four critical issues to address as part of reform efforts: financing and reimbursement, program administration, outreach and care coordination, and relationships with key stakeholders.

Session 4: Engaging Consumers and Providers: Education to Improve Access to Dental Services

The fourth session of the day addressed methods of engaging consumers to improve access and the resources providers need to deliver care to underserved and special needs populations. Topics included consumer outreach models in state Medicaid programs, provider strategies to encourage appropriate service use, and an innovative program to treat the oral health needs of individuals with severe disabilities. **David Idala**, M.A., research analyst for The Hilltop Institute, moderated this session.

Nicholas Mosca, D.D.S., dental director for the Mississippi State Department of Health, opened the fourth session with a discussion on engaging consumers. Dr. Mosca began his presentation by stating that "engaging consumers is about motivating consumers to purchase dental care." He noted that consumers want to know the cost of care before receiving dental services, which can be a problem in his state. He also suggested some novel methods to educate dental providers on engaging underserved consumers, such as using the expertise of health economists, accountants, and tax attorneys in developing curricula for dental students on managing the business side of dental practice. Dr. Mosca then challenged the audience to consider their own motivations for going to the dentist and stated that many times when there is a choice between purchasing dental care and purchasing food, things like dental care fall by the wayside.

He followed this discussion with an overview of the challenges Mississippi faces. He noted that Mississippi is labeled as poor, under-educated, and under-funded. One in five children in Mississippi is a Medicaid beneficiary. Forty percent of adults in the state do not receive a dental exam in a given year. Finally, he described the state's tragic case of Alexander Callender, who died from septic shock resulting from a tooth infection.

Dr. Mosca concluded his presentation by describing efforts the state has made to better engage consumers, noting that "if you can do it in Mississippi, you can do it just about everywhere." In 2007, the Mississippi Department of Health invested $50,000 in a local public radio broadcasting campaign to raise awareness of childhood oral health issues. Although the campaign was initially

scrutinized for not targeting the highest needs population, it drew the attention of policy makers in various agencies. In 2008, the state began reimbursing for fluoride varnish codes, and local health departments received billing numbers, allowing them to bill for oral health services for the first time ever.

Brooks Woodward, D.D.S., director of dental services for Chase Brexton Health Services, Inc., in Maryland, provided a firsthand safety net perspective on *Engaging Consumers and Providers: Education to Improve Access to Dental Service*. Dr. Woodward first provided a brief description of his health center and the patients they serve. Chase Brexton, as a federally qualified health center, receives significant federal and other grant funding. Providing a comprehensive array of health services, the center strives to be a "one stop shop" and health care provider of choice. Dr. Woodward provides comprehensive dental services to an increasing number of clients each year.

He continued by describing the challenges he faces on a day-to-day basis. One of his largest challenges in serving the uninsured and low-income populations is a high no-show rate for new patients. To address this issue, the health center double-books for new patients, performs aggressive outreach, and disengages clients with high no-show rates. He also allows his providers to erase appointments for clients with high no-show rates. These clients, however, are still served if they show up for the appointment. Provider turnover, specialty referrals, and funding are other significant issues. Dr. Woodward offers loan repayment options, incentive compensation, and externships with the dental school to address these issues, but it still takes four to six months to find replacement staff.

Dr. Woodward concluded his presentation with his recommendations for state policy solutions. His principle recommendation is to increase funding to community health centers, which would allow for, among other things, broader application of sliding fee schedules, service expansion, and competitive staff salaries. He also advocated for increased funding for loan repayment plans that provide incentives for new dental providers to enter into community health care.

Mark Goldstein, D.D.S., CEO of Special Smiles Ltd., and **Paul Westerberg**, D.D.S., M.B.A., chief dental officer of the Pennsylvania Department of Public Welfare, concluded the session with a description of their innovative program to provide oral health services to individuals with severe physical and mental disabilities, *Special Smiles in Pennsylvania*. Dr. Goldstein opened the presentation by describing his background and the history of the program. Identifying the need for this service, Dr. Goldstein and his colleagues sought experience in a hospital serving patients with severe disabilities to better understand their medical and dental needs. Then, in 2000, they made a proposal to the Commonwealth of Pennsylvania to create a dental facility designed to treat the needs of special needs patients. After a period of negotiations with the state's Medicaid managed care organizations (MCOs), they proposed a global budget to serve 1,000 cases per year. Each MCO agreed to fill their market share of the slots and the state negotiated a dental code providing higher reimbursement for this population.

Dr. Goldstein proceeded to describe the program and its patients in more detail. *Special Smiles* serves patients aged 12 and older who require full sedation to receive dental treatment. Patients include individuals with intellectual and physical

disabilities, behavioral problems, and those dually diagnosed with mental health and mental retardation disorders. Most patients cannot cooperate during an oral examination and many have never received dental care. Services are delivered in two appointments per patient per year, with the first appointment involving a screening and the second involving a full-mouth rehabilitation under sedation.

Dr. Goldstein closed the session by describing program milestones and lessons learned. Since its inception in 2001, *Special Smiles* has completed over 60,000 procedures. The program has reduced cancellation rates from 47 percent to 10 percent through innovative efforts, such as providing free lunches and transportation. Finally, he noted that contractual relationships with Medicaid MCOs, collaborative partnerships with over 100 advocacy organizations, and perseverance have contributed to the success of the program. He noted, however, that their program's intervention cannot serve as a substitute for good oral health behaviors, which is a significant challenge for populations with severe disabilities.

Reflections

In this final session, **Jack Dillenberg**, D.D.S., M.P.H., dean of the Arizona School of Dentistry and Oral Health, reflected on the day's proceedings and offered thoughts and inspiration on policy directions that hold promise. Introduced by Mike Nolin as the "wild man," Dr. Dillenberg provided a lively commentary on the issues discussed throughout the day. He began his presentation by sharing his view of dentistry, stating, "We're health care providers, not tooth technicians," and talking about the importance of collaboration, particularly at the local level, to bring about change.

Dr. Dillenberg also described the public health dental school he established in Arizona to train more dentists willing to care for underserved populations. The school selects students on the basis of community service experience because this is the best predictor of who will return to serve underserved communities. The school also provides all graduates with a certificate in public health. As evidence of the success of this model, he pointed out that in 2007, 30 percent of his graduating class went on to work in community health centers.

At the conclusion of his presentation, Dr. Dillenberg urged audience members to converse with each other on the issues and ideas discussed throughout the day. He challenged them to take these ideas back to their communities to bring about change, stating:

You're only limited by your initiative and your imagination.

For information on other events hosted by The Hilltop Institute, please visit http://www.hilltopinstitute.org.