



2011

Regional Oral Health Summit Final Report

The Role of Public-Private Partnerships in Improving Oral Health

**Tuesday, September 13, 2011
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Beller Conference Center
Kansas City, Kansas**

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HRSA Regional Oral Health Summit Final Report

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Executive Summary

The Health Resources and Services Administration (HRSA) Regional Oral Health Summit was held on September 13, 2011 at the University of Kansas Medical Center, Beller Conference Center in Kansas City, KS. Co-sponsors included the DentaQuest Foundation, The Health Care Foundation of Greater Kansas City, the Missouri Foundation for Health, and the U.S. Department of Health and Human Services' (HHS) Office of Minority Health. There were approximately 130 participants at the summit, with 52 attendees from Missouri, 17 from Iowa, 10 from Nebraska, and 30 from Kansas. In addition, staff attended from several Federal agencies and the University of Kansas Medical Center.

The overall goal of the Oral Health Summit was to facilitate a regional discussion on oral health, and to leverage resources to optimally support HHS and regional oral health priorities to advance public-private partnerships. Outcomes included the introduction of regional partners and stake holders that are working on oral health access and prevention strategies, and to allow stake holders to meet and interact with each other. The agenda included welcoming remarks from Judy Baker, the HHS Regional Director in Region VII, followed by a session on the new landscape that addressed new developments in oral health. Remarks were given by CAPT Debra Scott, HRSA Regional Administrator; Ralph Fuccillo, President of the DentaQuest Foundation and a founding board member of the U.S. National Oral Health Alliance (The Alliance); and Dr. Peter Damiano, Director of the Public Policy Center and Professor of Dentistry at the University of Iowa. Dr. Damiano and Mr. Fuccillo served as co-lead facilitators for the day.

A panel of Federal representatives from five agencies next spoke on their oral health programs including, the Administration on Aging (AoA), the Administration for Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA). Each of the panelists presented an agency overview and discussed their role in improving oral health access.

After this session, participants from each of the four States met in groups to answer questions about oral health issues and potential actions. Facilitators led a discussion about how to strengthen public-private partnerships in oral health within their respective states. A normative group process was used to determine the key oral health challenge, followed by a facilitated discussion on significant populations that were affected, individual roles in addressing the issue, additional resources that may be needed, and actions that the group could take to ensure that the effort continues for at least the next year.

The Iowa breakout group agreed that community water fluoridation should be highlighted during the upcoming year. In the Kansas breakout, the lack of oral health providers in rural communities was selected, while the Missouri breakout selected access to care as a key challenge, with the understanding that many identified issues could be included in actions to address the main issue of access. The Nebraska participants concurred that their challenge is insufficient data collection, with the need for greater surveillance and an evaluation component to provide a baseline of oral health outcomes in the State.

Dr. Howard Koh, the HHS Assistant Secretary for Health gave the key note address, elaborating on HHS oral health initiatives, with a focus on addressing oral health disparities, then representatives from each state reported out on the results of their group discussions. The summit closed with a 'Requests and Offers' session and a discussion of next steps.

The goals and objectives of bringing together federal agencies, state health officials, providers, academia, and advocacy groups into one common meeting place to not only discuss, but also address oral health as a public health issue was achieved. The HRSA staff and Planning Committee members received positive feedback on the success of the summit, with requests to make it an annual event. However, it is too early to say whether the event will have a sustained impact or lead to significant improvement in oral health outcomes in the region. Success can only be determined by the progress that is achieved from the actual implementation of the action plans developed at the conference.

The real work is still to come and HRSA staff must be ready to assist or provide leadership if necessary. The Oral Health Summit was a first step in garnering a framework of collective impact for social progress. With this understanding, HRSA and HHS partners will continue to foster the public private collaboration with the U.S. National Oral Health Alliance, state leadership, philanthropic organizations, and other partners, to continue to address oral health disparities and access issues. If successful, we hope in the coming years to report significant improvements for those most in need of oral health care. If so, we will have been successful in improving the oral health and quality of life for members of the communities in our region.

I. Introduction

The Health Resources and Services Administration, Regional Oral Health Summit was held on September 13, 2011 at the University of Kansas Medical Center, Beller Conference Center in Kansas City, KS. Co-sponsors included the DentaQuest Foundation, the Health Care Foundation of Greater Kansas City, the Missouri Foundation for Health, and the U.S. Department of Health and Human Services (HHS), Office of Minority Health. There were approximately 130 participants at the Summit with 52 attendees from Missouri, 17 from Iowa, 10 from Nebraska, and 30 from Kansas. In addition about 15 staff from Federal Programs participated, and five students and faculty from the University of Kansas Medical Center.

A. Background

The Health Resources and Services Administration (HRSA) recently asked the Institute of Medicine (IOM) to provide advice on where to focus its efforts in oral health. The IOM was charged with assessing the current oral health care system, reviewing the elements of a HHS Oral Health Initiative, and exploring ways to promote the use of preventive oral health interventions and improve oral health literacy. A parallel study focused on issues of access to oral health care for underserved and vulnerable populations. In support of the IOM Report on Oral Health, and the HHS Oral Health Initiative 2010, the HRSA Office of Regional Operations in Kansas City, began to reach out to a broad spectrum of regional and Federal oral health stakeholders. As a result of these meetings, HRSA Region VII staff formed an Oral Health Summit Planning Committee comprised of key oral health leaders. Subsequently, the State Dental Health Directors were engaged to determine the two or three key principles that would be most relevant to focus on in their states, based on the Organizing Principles recommended in the first IOM Report. The role of public and private partnerships emerged as the common denominator in Iowa, Kansas, Missouri and Nebraska. The summit provided a venue for each state to conduct a facilitated analysis of this focus area, along with a panel of Federal leadership to discuss public-private partnerships and their role in improving oral health.

In addition to the increased Federal focus on oral health, new national dental initiatives are emerging, such as the U.S. National Oral Health Alliance that endeavors to forge common ground among both public and private partners for the promotion of optimal oral health, especially as it relates to services for underserved communities. The summit presented an opportunity for ground breaking discussions with colleagues from many sectors, including professional associations, academia, State health leaders, the safety net community, healthcare foundations, and representatives from Federal programs that support oral health, with a focus on how we can strengthen public-private partnerships. The summit provided an opportunity to align regional oral health interests and priorities to meet the coming changes in oral health care delivery, and the future challenges of oral health care in America.

B. Summit Goal and Outcomes

The overall goal of the Oral Health Summit was to facilitate a regional discussion on oral health, and to leverage resources to optimally support HHS and regional oral health priorities to advance public-private partnerships.

Outcomes included the introduction of regional partners and stakeholders that are working on oral health access and prevention strategies, and to allow stake holders to meet and interact with each other. Additional goals included:

- Promote awareness of oral health activities in the region, and identify opportunities for networking and possible collaborations.
- Review of each State’s oral health programs and initiatives, on order to identify best practices, and opportunities.
- Facilitate a panel of Federal partners to review current federal support in the region for oral health access and prevention.
- Facilitate a capstone session with requests and offers to help indentify coalitions and natural partnerships, and identify next steps to advance public–private partnerships in the region.

C. Agenda

The following were the agenda items for the Oral Health Summit:

7:30 to 8:00 **Registration and Continental Breakfast**

8:00 to 8:15 **Opening Session**

CAPT Debra Scott
Judy Baker

8:15 - 8:30 **Welcome, Ground Rules, Review of Agenda**

CAPT Debra Scott
Dr. Peter Damiano

8:30 - 9:00 **New Landscape in Oral Health**

CAPT Debra Scott
Ralph Fuccillo
Dr. Peter Damiano

9:00 – 10:00 **Panel of Federal Partners: Oral Health Access and Prevention**

- Administration on Aging – Sam Gabuzzi, Aging Services Program Specialist
- Administration for Children and Families (ACF) - Elizabeth Cox, Infant/Toddler Program Specialist
- Centers for Disease Control and Prevention (CDC) – LT Sheila Weagle, M.P.H, R.D.H., Public Health Advisor, Division of Oral Health
- Centers for Medicare and Medicaid Services (CMS) - Gail Brown-Stevenson, Oral Health Coordinator
- Health Resources and Services Administration (HRSA) - CAPT Julie Sadovich R.N., Ph.D., Deputy Director, Office of Special Health Affairs

10:00-10:30 **Break and Networking**

10:30-12:00 **State Breakout Groups**

Lead Facilitator: Dr. Peter Damiano

- 12:00-1:00 **Lunch**
- Speaker: H. William Barkman, M.D., M.P.H. Chief of Medical Staff, Kansas University Hospital
- 1:00-2:00 **Keynote Address**
- Dr. Howard Koh, HHS Assistant Secretary for Health, Office of the Secretary
- 2:00- 3:00 **State Report Out**
- Dr. Peter Damiano
- 3:00-3:30 **Break (Healthy Snacks)**
- 3:30-4:30 **Requests and Offers**
- Dr. Peter Damiano and Ralph Fuccillo
- 4:30-5:00 **Summary of Day/ Next Steps**
- Dr. Peter Damiano and CAPT Debra Scott

II. Welcoming Remarks: Judy Baker, HHS Regional Director

Ms. Baker represented Secretary Kathleen Sebelius as the HHS administrative and political authority for Region VII (Iowa, Kansas, Missouri, and Nebraska). She began her remarks with greetings from Secretary Sebelius as well as the Regional Director's office in Kansas City. Ms. Baker further stated that it was a pleasure to see so many different groups represented at the summit She additionally commented that;

“We at the U.S. Department of Health and Human Services and the Health Resources and Services Administration have brought you together because our nation and our region face real challenges in oral health. I know that the people in this room understand that oral health is essential to overall health, but that is not true for many decision makers, much of the public, and even to many health professionals. Unfortunately, this lack of knowledge can have tragic consequences. Just two weeks ago, a twenty-four year-old man died in a suburb of Cincinnati after an infection in his tooth spread to his brain. Kyle Willis knew he had a problem, and he did what many people without insurance do, he ignored it up and tried to put it out of his mind. When the pain became unbearable, he went to a hospital emergency room. There, he got prescriptions for a \$3.00 pain medication and a \$27.00 antibiotic, but Willis was an unemployed single dad, and he could not afford the \$27.00, so he tried to make do with the pain killer. It cost him his life. Dr. Lawrence Hill, former Director of the Cincinnati Health Department, spoke for everyone in this room when he told the Cincinnati Enquirer, ‘We simply don't have the resources in this community to address the problem. This was a disaster waiting to happen, and there are still thousands of other similar cases.’

This preventable death came eleven years after the surgeon general's report that described a ‘silent epidemic’ of oral disease in America, and the lack of access to oral health care is the

nation's greatest unmet health care need. Millions of adults and children are living with untreated oral health problems, which can lead to chronic, low-grade infection that gradually eats away the bone that holds teeth in place, or it can cause acute, painful infections that can cause permanent damage and even death”.

Ms Baker further commented that here in the heartland, those sorts of problems are not rare. In Missouri, for example, the CDC found that more than half the population age 65 and older had lost six or more of their teeth, and more than one in four seniors has lost all their teeth. She commented that this is simply not acceptable. Approximately 39% of Missourians had not visited a dentist in the past year, and in Kansas and Missouri, more than 27% of third graders have some degree of tooth decay. These statistics are truly heartbreaking, because there are proven preventive strategies that are underutilized. The knowledge of oral health practices is low, and profound disparities exist among people at different income levels, so people are not receiving the oral health care they need.

In addition she commented that it is known that communities with fluoridated water have about 25% less tooth decay than communities without fluoridated water, yet more than 80 million Americans live in communities without this benefit. Only 40% of children who are eligible for Medicaid or CHIP receive any dental treatment in a given year, and only about 20% of children, aged 6–11, from low-income families have received dental sealants, compared with 40% of children from higher-income families. Because dental care is not covered by Medicare, over 70% of people aged 65 and up have no dental coverage.

Ms. Baker stated that by some measures, our task is growing more difficult. The Kaiser Family Foundation found that the number of Americans who lack dental insurance is nearly three times as large as lack general health insurance, yet employers are reducing coverage of dental care to hold down the rising costs of employee benefits. However, the outlook isn't all bleak, and sometimes, real progress can grow from tragic circumstances. In 2007, a 12-year-old Maryland boy, Deamonte Driver, died from a tooth infection after his family lost its Medicaid coverage. Driver's story led to the creation of the Deamonte Driver Dental Project, which provides dental services to uninsured children in Maryland.

She stated that here in Region VII, progress is also being made. A survey found that nearly half of Nebraska third-graders had received dental sealants, and not surprisingly, 83% of those third-graders had no untreated tooth decay. In Iowa, 92% of the population is served by fluoridated water, and looking forward, she felt that there are some signs of hope. There has been progress in some areas, such as improved access to care for children, and beginning in 2014, the Affordable Care Act (ACA) requires that all new insurance policies cover basic dental and vision needs for children. She continued to observe that one of the most important signs of progress was the participant's presence at this conference, and that by recognizing the challenges, together we can seek solutions. Nevertheless, this “silent epidemic” continues, and she asked what can we do to build on this progress?

“We can be strong advocates for this cause; we can raise the visibility of oral health; we can identify opportunities to work together, and we must realize that none of us can solve these problems alone. Each of the groups we represent deals with a particular aspect of oral health. Finding a solution for one part of the problem represents progress. But it won't be a breakthrough unless solutions are found along the entire range of challenges that face us. That is why collaboration is so important. Relationships we form at meetings like this one, and the ideas and perspectives we exchange with professionals in other disciplines will play vital roles in any effort to have an impact on major social problems like poor oral health”.

Director Baker quoted a recent article, by scholars John Kania and Mark Kramer (2011) who concluded that large-scale social change is more likely to come from better coordination across disciplines, rather than through intervention by individual organizations. “Substantially greater progress could be made in alleviating many of our most serious and complex social problems, if nonprofits, governments, businesses and the public were brought together around a common agenda to create collective impact. It doesn’t happen often, not because it is impossible, but because it is so rarely attempted.” She closed with the request “Today, let’s be different. Let us agree to come together around a common agenda to improve oral health. Let us proclaim that it is not impossible. Let us endeavor to make the attempt”.

III. The New Landscape in Oral Health

The following section contains summaries of the talking points provided by the three speakers addressing the topic of new developments in oral health care. Remarks were given by CAPT Debra Scott, Ralph Fuccillo, and Dr. Peter Damiano.

A. CAPT Debra Scott, HRSA Regional Administrator.

CAPT Scott opened her remarks with a welcome and stated that her task was to discuss how “we got here”, and why the participants should engage in the effort to improve oral health services for the underserved, along with “what is new” in the oral health landscape. She stated that oral health care has been a personal priority for a number of years, and that when she arrived in Region VII a year ago, along with the HRSA Deputy Regional Administrator, began to reach out to a number of key oral health stakeholders. She was impressed with at all that was going on in oral health in the region, and felt that it would be wonderful to get everyone in a room to learn about each other’s activities, and see if there were areas that we could work together or collaborate, and so they began planning a meeting that had that single focus.

In February, 2011 a project from the HHS Oral Health Initiative was released that included a compilation of activities that captured the breadth and diversity of efforts within HHS to support oral health. The new effort sought to improve coordination and integration among HHS programs to maximize their effectiveness, and Dr. Koh called for HHS agencies to collaborate to increase the efficacy across programs. As a result of this report, and on the advice of the planning committee, CAPT Scott then began to reach out to a number of HHS partners who provide oral health resources in the region, and invited them to participate in the summit. The leadership in all of the agencies that she contacted responded positively to her request and provided staff to participate in the Federal panel session.

The next major influence on the development of the summit occurred in April, 2011, with the release of the first IOM Report on Oral Health Prevention. The report was commissioned by HRSA, and the purpose was to do an assessment of oral health in the U.S., and then make recommendations to HRSA and HHS for strategic actions to address the need to improve oral health. Key points included the connection between oral health and systemic health, along with seven recommendations and ten guiding principles to improve oral health prevention. On the advice of the planning committee, CAPT Scott began to engage the oral health leaders in each state, in a discussion of which of the IOM guiding principles would be most relevant in their states, and the role of public private partnership emerged as the common theme. In these discussions, she also became better informed about oral health activities in each state and in her speech provided key examples of oral health initiatives from Kansas, Iowa, Nebraska, and Missouri, and commented on the impressive amount of oral health activities and initiatives in all four states.

The next influence included discussions with Dr. Burton Edelstein at Columbia University, where she learned about the U.S. National Oral Health Alliance. CAPT received an introduction to Mr. Ralph Fuccillo, the founding board member, who was asked to be a facilitator for the summit. In July, 2011 the second IOM Report on Oral Health Access was released, which focused on access for underserved populations, and studied the disparities in oral health outcomes, along with the role of safety net providers. HRSA is currently actively engaged in implementing the IOM recommendations with a national work group, of which CAPTs Sadovich and Scott are both members, and the former talked more about HRSA efforts during the Federal panel presentation. Soon after that, the planning committee became aware of a whole new set of oral health activities, including:

- The Centers for Disease Control (CDC) provides numerous resources to States to support the oral health infrastructure, and is developing a national oral health surveillance plan.
- The Center for Medicare and Medicaid Services (CMS) has a new national oral health strategy, and is addressing improved reimbursement, especially for prevention and children's services.
- The Agency for Children and Family Services (ACF) has a new Head Start dental home initiative involving a public private partnership with the American Academy of Pediatric dentistry.
- Indian Health Services (IHS) has started an early childhood carries initiative.
- In 2009, the American Dental Association (ADA) hosted a summit to create a common vision among diverse stakeholders to improve oral health access for the nation's vulnerable populations; as an outcome of the summit, the U.S. National Oral Health Alliance was created to provide the platform on which a diverse network of stakeholders in oral health could come together to build trust and forge common ground to harness opportunities and viable solutions for improved oral health through prevention and treatment for vulnerable populations across the U.S.
- The Ad Council will be initiating a three year campaign focusing on oral health literacy.
- Oral health will be one of the leading indicators in Healthy People 2020.

In addition to these many new opportunities in oral health, the Affordable Care Act (ACA) will also have an impact on oral health, and has resulted in greater collaboration and innovation across HHS programs. Dr. Damiano later discussed the implications of ACA on oral health coverage in the region. She went on to say that there is more going on now to support oral health than she has ever seen in her career, and the summit presented an opportunity for those who were in the room to learn about what is going on, and talk about ways that we can bring it all home to where we live and work. All of the new attention and programs will only matter if they make a difference in the lives of people in our communities and neighborhoods.

"We have the expertise the vision and will in this room to make a difference, but it cannot happen by magic; we have to talk to each other, find out what each of us are doing, discover common ground, versus being to converted to each other's point of view, especially on the heated topics like mid level dental providers and water fluoridation. We can then find ways to move forward that actually helps the people in our rural communities in Kansas, and in the small towns in Iowa and Nebraska, and in the inner cities and poorer areas of Missouri".

She stated that each of the participants has a role in finding solutions, and the planning committee understood that whatever outcomes were arrived at during the summit, that the next steps will not fall on just one organization or group. They agreed that HHS and HRSA, the Alliance and philanthropic

foundations, the state's leadership, and other partners, will share a role in the follow up, and that there is need to look for as many partners as possible, including new non-traditional ones such as the state library associations, and the community sports leagues.

She concluded her remarks by stating; "We are making progress...but we remain under resourced, and in this funding environment and with the budget debates in the Congress, we know that the times ahead will be challenging. We need to work smarter and more strategically with increased collaboration, and a common determination. That is the opportunity for us in the room today; it is our job to learn about these opportunities, find common ground in our wide scope of perspectives, and learn about the oral health landscape in our states, share our own wealth of knowledge and experience, find common links that we can work with to strengthen public and private partnerships, and to find meaningful solutions for our neighbors and the people living in our communities. She quoted RADM William Bailey from the CDC, 'When people ask why we are so enthusiastic about oral health...our answer should be that we are enthusiastic about people living optimal lives...pursuing their goals and doing the things they love doing... and the only way to lead an optimal life is by being healthy...and you just cannot be healthy without oral health' "

B. Ralph Fuccillo, President of the DentaQuest Foundation and Founding Board Member of the U.S. National Oral Health Alliance.

Mr. Fuccillo introduced participants to the U.S. National Oral Health Alliance with the Alliance's background and history. He began his remarks with mention of another summit, the 2009 "Access to Dental Care Summit" hosted by the American Dental Association, where leaders in dentistry, dental education, and the dental industry, medical professionals, health advocates, opinion leaders, and policymakers gathered. During the three-day meeting, the 2009 Summit participants reached concurrence on a shared vision: To assure optimal oral health through prevention and treatment for the nation's most vulnerable children and adults by 2014.

To continue the work and produce tangible outcomes of the 2009 Summit, participants supported the formation of a workgroup made up of the leaders of each stakeholder group. The workgroup met over the past two years to determine how to best continue the spirit of collaboration and trust-building that came out of the Summit. They agreed that an alliance was the best platform for forging common ground. The workgroup gave careful consideration to a name: An alliance describes a set of relationships across diverse partners who lend expertise, experience, and shared commitment to common goals. The workgroup agreed upon the creation of the U.S. National Oral Health Alliance (The Alliance).

The Alliance provides a new national platform for individuals and groups with multiple interests to come together, exchange ideas, and collaboratively forge common ground for improved oral health through prevention and treatment for the nation's vulnerable populations. It engages a diverse network of individuals and organizations spanning care, policy, financing, and community interests, who are striving for common ground in an atmosphere of trust and openness. The Alliance facilitates open discussion to clarify and understand each partner's point of view, and promote mutually reinforcing collaboration and collective impact by focusing on six priority areas:

1. Prevention and public health infrastructure.
2. Oral health literacy.
3. Medical and dental collaboration.
4. Metrics for improving oral health.
5. Financing models.

6. Strengthening the dental care delivery system.

The Alliance's stated mission is to provide the platform for a diverse network of stakeholders to forge common ground in order to harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations across our country.

The Alliance will host Leadership Colloquia across the country. The first Leadership Colloquium will be held on November 7–8, 2011 in Washington, DC and focus on medical and dental collaboration, one of the Alliance's priority areas. Leadership Colloquia will engage national, state, and community leaders from a broad range of backgrounds to come together, build trust, and forge common ground around a national commitment to improving oral health in the U.S.

Mr. Fuccillo mentioned some of the DentaQuest Foundation's other national initiatives that foster collaboration:

- National Interprofessional Initiative on Oral Health
- Funders Group for Oral Health
- Strengthening the Oral Health Safety Net
- Oral Health 2014

Mr. Fuccillo closed by commenting that the Alliance, the DentaQuest Foundation, and the HRSA Regional Oral Health Summit share many common goals, and there will be ample opportunities to collaborate on future actions steps that result from the summit.

C. Dr. Peter Damiano, University of Iowa, Director, Public Policy Center; Director, Health Policy Research Program; Professor, Preventive / Community Dentistry

According to the Centers for Disease Control and Prevention (CDC), there are 50 million uninsured people in the U.S., with a marked increase related to job loss during the recession. Employer costs are going up unpredictably, and according to the Commonwealth Fund, they have gone up 41% from 2003-2009. This has led to decline in employer based coverage, while at the same time that rising cost of health care is becoming unsustainable. Another significant factor in the current health care landscape is the Affordable Care Act (ACA) that was signed into law on March, 2010. There is confusion about what is included in the ACA, but the initial emphasis is on the individual insurance market, and the small business insurance market. There are few implications for large employer-based insurance, or for those who are already self-insured. There were 25 ACA reforms enacted in 2010, and 18 of 21 enacted in 2011, while the remaining proposed reforms for 2011 have not yet been funded. In 2014, the full ACA becomes law, and will include the coverage under the individual mandate and large employer mandate (over 50 employees only), along with Medicaid expansion. The Health Benefits Exchanges will also begin to operate for individuals and small businesses.

Under the ACA, there are provisions for dentistry that include additional coverage for expanded services under Medicaid for children, and expanded adult services in states that provide Medicaid benefits for adults. There will also be additional coverage provided under insurance policies that are bought from Insurance Exchanges, in which dental services are required. The ACA also expands coverage for dental prevention services, and for a five year national public education campaign for prevention of oral diseases. In addition there is an expansion of school based dental sealant program to all states and territories, and additional provisions for infrastructure and workforce. These programs include training grants in general, pediatric and public health dentistry, cooperative agreements between CDC and all states and territories to improve states' oral health infrastructure, and a demonstration project for

alternative dental health care provider (not funded under the current budget). The ACA also focuses on improved surveillance in which all 50 states and territories will participate in CDC National Oral Health Surveillance System (NOHSS), with oral health components integrated into national surveillance systems and surveys. Oral health research is also addressed, with a dental caries disease management demonstration grants to community based dental providers.

The impact of the ACA for oral health providers and the State oral health infrastructure will include the fact that all children will have dental coverage, and many more adults will have limited dental benefits through Medicaid or private insurance. Oral health education programs will result in improved awareness about oral health prevention, and will require states' to address the oral health infrastructure, and provide increased support for dental workforce. Additional services that will be needed include, primary care providers, and comprehensive and integrated oral health surveillance, along with practices that are evidence based.

Challenges that we need to address today are numerous, and include an inadequate workforce to provide care to the newly covered population, and the fact that, dental professionals have had minimal involvement in healthcare reform discussions, and the dental community's role in implementation is not clear. The end result is that there will be a much greater demand for oral health services than most state infrastructures are currently prepared to handle. In Iowa there are 312,600 uninsured individuals, including 44, 500 children who will have dental coverage in just a few years. In Kansas there are 347, 400 uninsured people, including 74, 800 children; in Missouri there are 826, 600 uninsured, including 697, 900 children; and in Nebraska there are 208,300 uninsured with 168,000 uninsured children. These numbers present both an opportunity and a challenge to our States, and today we can begin the dialogue of the role of both public and private stakeholders in meeting this new landscape in oral health.

IV. Panel of Federal Partners: Oral Health Access and Prevention

Federal representatives from five agencies spoke on their oral health programs. Each of the panelists was given ten minutes to present an agency overview, and discuss their role in improving oral health access. This discussion included real examples of public-private partnerships and program implementation strategies. The presenters were asked not to deliver a routine presentation that had a "one fits all message" about their agencies, but to ensure that the presentation was unique, and provided examples of successes, and "how to" stories where public- private partnerships are working in their agencies.

A. Administration on Aging (AoA): Sam Gabuzzi, Aging Services Program Specialist

Mr. Gabuzzi noted that oral health is important for people of all ages. Specifically, he stated that the AoA is the agency responsible for the Americans on Aging Act, Meals Program, Caregiving/Caregivers Program, Elder Rights, and Community Based Services Work programs. The AoA programs are based on current aging research, and evidence-base with proven outcomes, and its oral health funding goes directly to States to distribute to agencies on aging. Such funding provides resources for elderly health care, daily living transportation issues, health multi-visit issues, building capacity to address elder need in communities, and training to caregivers on how to give assistance and/or where to go for assistance.

AoA staff work in conjunction with other Federal and State programs to leverage resources and improve outreach and impact for the elderly. AoA has oral health data available for summit participants from multi-year longitudinal studies on aging oral health outcomes and resources for access to service. State Offices on Aging can be contacted to find resources for transportation services to oral health appointments for the elderly.

B. Administration for Children and Families (ACF): Elizabeth Cox, Infant/Toddler Program Specialist

ACF provides funding for the Early Head Start (0-3 years) and Head Start (3-5 years) programs. As such, Head Start data shows that there are many counties in our region that have no dental services for underserved children. In addition, there is a need for improved oral health literacy as parents and health care staff are unaware of the need for oral health. The ACF goal is to bring parents on as Head Start teachers with a dental curriculum provided by Delta Dental, and the Delta Dental Foundation. Topics include prevention that starts at birth and the need to disseminate key information and education for oral health literacy to a broader population, particularly those with few health care resources. Key challenges include a lack of service providers and pediatric dentists with a focus on children three years and under, the lack of resources to provide transportation to those who cannot travel to oral health resources, Medicaid reimbursement is low for dental visits, and missed appointments often make dentists hesitant to reschedule appointments with Medicaid patients. ACF is actively seeking partners that they can work with to address these critical issues.

C. Centers for Disease Control and Prevention (CDC): LT Sheila Weagle, MPH, RDH, CHES, USPHS, Public Health Advisor, CDC Division of Oral Health.

LT Weagle noted that the core functions of the CDC Division of Dentistry include monitoring and surveillance of oral health, research, public health communications. The focus for States is on preventive strategies, State infrastructure, evaluation, investigation and diagnosis, building partnerships, and support for policy development. CDC provides funding to selected states through Cooperative Agreement Funds that includes direct technical assistance, project officer consultation, meeting support for state epidemiologist, evaluation assistance, and workshops.

Resources for all states include the opportunity to work with national oral health partners, web conferences, orientations for new State dental directors, and other meetings for dental directors, and oral health tools and resources. In terms of additional resources, there are three State-based CDC Oral Disease Prevention Programs to be implemented from 2008-2013, including:

- CDC Program Announcement DP08-802 in 16 States;
- CDC Program Announcement DP10-1012 in three States; and
 - State-based Oral Disease Prevention Program includes core and additional activities. The average award is approximately \$350,000 for previously funded and nearly \$270,000 for newly funded efforts.

LT Weagle shared that 18 States are the recipients of Infrastructure Building grants (CA 802/1012). Furthermore, there are short and long term process objective that are covered under these grants:

- Short Term - by the end of the funding period
 - Increase policies and programs supporting oral disease prevention
 - Increase community-based public health prevention services for prioritized populations based on disease burden
 - Community water fluoridation
 - School-based/linked sealant programs
- Long Term – beyond period of funding
 - Reduce prevalence of caries among prioritized populations

- Reduce disparities in oral health
- Core activities related to building the infrastructure necessary to allow implementation of community-based prevention programs

Additional activities undertaken once the core performance measures have been met according to CDC evaluation measures include: Infrastructure; Data Collection and Surveillance; Strategic Planning – The State Oral Health Plan; Partnerships and Coalitions; Access to and Utilization of Preventive Interventions; Policy Development; Evaluation; and Collaborations.

D. Centers for Medicare and Medicaid Services (CMS): Gail Brown-Stevenson, Oral Health Coordinator

CMS Oral Health Strategy/Initiative was launched in 1998 at a Lake Tahoe, NV event. Currently, CMS is taking steps to reinvigorate the initiative and are focusing outreach efforts on partners that have dropped out and maintaining those who have remained. CMS conducted statewide oral health reviews in 2008, where CMS staff talked to states, dental offices, and practitioners to get a clear picture of the issues with CMS reimbursement for oral health services. The survey results showed that there was a high degree of provider confusion on what data should be submitted and a high incidence of inaccurate data. The survey noted further oral health care barriers including transportation, low reimbursement rates, cultural issues, and missed appointments.

As such, a dental action plan is being developed which will address areas, including:

- Existing barriers;
- Data rates;
- Programs that are working/not working;
- Reimbursement rates;
- Sealant placement and outcome results;
- Dental Associations;
- Electronic dental records; and
- Innovative practices.

E. Health Resources and Services Administration (HRSA): CAPT Julie Sadovich RN, PhD, Deputy Director, Office of Special Health Affairs

CAPT Sadovich explained that HRSA commissioned the IOM to conduct two studies on oral health prevention and access with recommendations for areas that HHS could focus its efforts to address oral health services. HRSA is actively responding to the IOM recommendations, and taking steps to implement them nationally. This summit is one of these efforts.

HRSA has numerous established programs that provide or support health services for the underserved. HRSA supports about 16,750 safety net providers participate in the 340B drug discount program. Its efforts reach over 500,000 people living with HIV/AIDS receive Ryan White services and two-thirds are identified as racial or ethnic minorities. There approximately 34 million women, infants, children, and adolescents who benefit from HRSA maternal and child health programs. Additionally, there are more than 8,650 National Health Service Corps clinicians are working in underserved areas. HRSA proudly serves over 19.5 million patients through community health centers.

The HRSA Administrator’s key priorities include:

- Strengthen the Primary Care Workforce
- Improve Access to High Quality Primary Care Services
- Strengthen HRSA's organizational and technology infrastructure, workforce, and workplace climate

This specifically relates to oral health strategies, in that the HRSA Strategic Priority includes the expansion of oral health services and its integration into primary care settings. HRSA has directed oral health care through Health Center Programs with 3.7 million patients through 8.4 million dental visits (FY 2010); through the efforts of the Ryan White HIV/AIDS programs, HRSA has provided oral health care to more than 125,000 individuals living with HIV/AIDS; with the Title V Maternal and Child Health Program, HRSA continues to provide oral health care services for children through the states; and HRSA works to identify the Dental Health Professional Shortage Area (HPSA).

HRSA's Oral Health Workforce Development has awarded \$31.3 million in new grants in FY 2010 to train general, pediatric, and public health dentists and hygienists; supported over 2,400 disadvantaged dental and dental hygiene students through loans and scholarship; trained more than 12,000 in the dental workforce to provide oral health services to more than 40,000 individuals living with HIV; and through the National Health Service Corps, HRSA has supported more than 1,200 dental providers serve vulnerable communities (as of Aug, 2011).

In the areas of policy and research, the HRSA Administrator, Dr. Wakefield has jointly launched the HHS Oral Health Initiative in April 2010 with Dr. Koh, and HRSA has contributed to the Oral Health Initiative Study in April 2011 and Oral Health Access Study in July 2011. HRSA has also reviewed oral health status and care system. Vital to HRSA's efforts are the key oral health partnerships. HRSA partnerships focus on service, workforce, and policy and research:

- Service – Through partnerships, HRSA has developed a vision for how to improve oral health care especially for vulnerable and underserved populations.
 - *HRSA–American Academy Pediatrics*: working to develop a Oral Health Quality Module for primary care health professionals who provide oral health services to children;
 - *HRSA–ADA and ACOG*: collaborating with the Perinatal Oral Health Expert Workgroup (2008, 2011);
 - *HRSA- Local projects*: supporting demonstration projects to provide oral health services to people living with HIV;
 - *HRSA-National Migrant and Seasonal Head Start Collaboration*: improving oral health service delivery for migrant and seasonal children populations; and
 - *HRSA–States*: developing statewide action plans (ORO) and strengthening oral health infrastructure for women and children through Targeted MCH Oral Health Service System.
- Workforce
 - *HRSA – Teaching Health Centers*: supporting the general practice dental residency program to serve vulnerable populations;
 - *HRSA – Association of American Medical Colleges*: educating primary care providers in oral health through the development of CE courses and an oral health curriculum in medical colleges;
 - *HRSA - Morehouse School of Medicine's National Center for Primary Care*: developed a website for NHSC clinicians who provide care in rural/underserved areas; and

- *HRSA– State*: providing \$17 million for State Oral Health Workforce Program to improve oral health access through various workforce programs, including scholarships, loan repayment programs, and faculty development programs.
- **Policy & Research**
 - *HRSA - National Network for Oral Health Access*: providing technical assistance to Health Centers to expand and improve oral health services and supporting the National Primary Oral Health Conference annually;
 - *HRSA/ASPE – National Quality Forum*: advancing oral health performance measure development;
 - *HRSA – Medicaid/CHIP Dental Association*: improving oral health service infrastructure for women and children;
 - *HRSA - National Opinion Research Center*: developing a Pediatric Oral Health IT Toolkit and an Oral Health IT Toolbox;
 - *HRSA - American Academy of Pediatrics*: developed and disseminated Bright Future Oral Health Guidelines; and
 - *HRSA - National Maternal and Child Oral Health Resource Center*: serving as a resource for oral health information.

HRSA seeks to expand, innovate, and integrate through its partnerships. Such efforts will support the:

- Expansion of oral health services through Federally Qualified Health Centers and School Based Health Centers;
- Innovative workforce training models;
- Integration of Oral Health into Primary Care through an Interdisciplinary health team & health home approach; and
- Private-Public Partnerships to collaborate outward and coordinate inward.

V. State Break Out Groups

State facilitators were charged with moving participants into a discussion about how to strengthen public–private partnerships in oral health within the respective states, with 90 minutes to facilitate the dialogue and to develop content to present a summary of the discussion. Each breakout group had a lead facilitator (dental background) and a co-facilitator (federal government representative), and a HRSA staff representative. The co-facilitator captured the highlights of the discussion, and developed a slide state presentation that was presented at the State Report-Out Session, while the HRSA staff identified areas for possible future collaboration with each State.

A. Guidelines for State Sessions.

1. Do an introductory session to explain the context and format for the 90 minutes, in the context of public private partnerships for improving oral health.
 - a) Focus on guidelines for MAP-IT from HP2020 (see Section B) as a road map, and acknowledge that we are in the “Mobilize” phase but the goal of the session is to agree on ways to move to the action phase as quickly as possible.
2. Do an exercise (20 minutes) to determine the most important oral health-related challenges facing each State. This process will determine the focus and topic of discussion for the session.

- a) A normative group process was used. The moderator went around the group and asked each member of the group to identify one important challenge (or important focus area) affecting the oral health of people in their state. "Challenges" continued to be identified until all responses were complete. These challenges were recorded on large paper and posted before the group.
 - b) Then each member of the group was given a colored sticker to place, on what they thought, was the single most important challenge/issue /area for focus that faces oral health in their state, and that can be addressed by partnering resources between the public and private sectors.
 - c) The topic that received the most stickers was the oral health challenge/focus area that was discussed.
3. Questions for the facilitated discussion the group was guided to consider included the following areas:
1. What are the populations being affected by this challenge/issue /area for focus?
 2. What is “my” role in moving stakeholders to the next stage? (i.e., every group represented in the discussion). What are two action steps that every group can do to help improve this issue and address the challenge?
 3. What additional resources, assistance or leadership will be necessary to ensure that these roles can be fulfilled?
 4. What actions can this group take to ensure that this discussion continues for at least the next year?

Co-facilitators made one or two slides to report out at the General Session, and the recorder captured the rest of the content for future use and for the final summit report.

B. MAP-IT

In the introduction to the State breakout groups, the lead facilitator emphasized that this was the first step in a process based on the *CDC MAP-IT (Mobilize, Assess, Plan, Implement, and Track) Framework for Implementation: A Guide to Using Healthy People 2020 in Your Community* (CDC, 2009). No two health interventions are exactly alike, but most interventions share a similar path to success. MAP-IT is a framework that can be used to plan and evaluate health interventions to achieve Healthy People 2020 objectives.

Whether you are a seasoned health professional or new to the field, the MAP-IT framework can help create a path to a healthy community and a healthier Nation. The Oral Health Summit Planning Committee recommended that State participants consider this model, or a similar phased process when planning and evaluating the actions in their States, and stressed that this summit represented the Mobilize Phase. There will need to be follow-on activities after the meeting to move the initiatives through the progressive steps, and to accomplish the intended outcomes.

VI. Outcomes of State Break Out Groups

A. Iowa : Lead Facilitator, Pete Damiano; Co-Facilitator, Judy Jensen

This session was attended by 17 participants from the State, and five Federal staff. Dr. Bob Russell, the state Dental Director, and Tracy Rodgers participated on behalf of the Iowa Department of Public Health, and were joined by representatives of the Iowa Medicaid Enterprise, Iowa Dental Association, Iowa Head Start Association, Iowa Primary Care Association, Delta Dental of Iowa, the University of Iowa, College of Dentistry, and community health center dental clinics.

1. Key Oral Health Challenge

The Iowa workgroup identified several areas of potential focus, and then agreed that community water fluoridation should be highlighted during the upcoming year. The group felt that the current trend of some rural and municipal water systems discontinuing fluoridation will begin to erode some of the improvements already achieved. According to the CDC, water fluoridation has a cost-effective population-based benefit, and has been important in reducing dental disease rates since the mid-twentieth century. Several group members also felt that the need for a concentrated effort on education of early childhood visits could be a second key challenge. Iowa has seen several improvements in oral health and preventive care, particularly for children, through the I-Smile™ dental home initiative, and the progress needs to be sustained. The additional potential challenges that were identified before the group chose the key focus area included:

- Language barriers.
- Funding for oral health, and the cost of delivering care through public health programs.
- Apathy of the general public: suggest an oral health “Focus Month” and target general health care practitioners.
- High percentage of uninsured creates a need additional funding to cover more patients. There is an increasing demand for care for uninsured adults causing a strain on the community health centers (CHC).
- Lack of education and health literacy from infancy to adulthood, and the general lack of understanding of proper oral health.
- There tends to be not enough generational and cultural exposure among families, especially for those families who do not know how to access proper oral health services. There is a need multi-level health literacy programs.
- There is a lack of pediatric dentist and providers to take care of children ages 3-4 yrs old. We need to get all kids into dental care before age of 3.
- Need for coordination and open communication between everyone that is involved with public education and early childhood programs.
- Lack of resources across the life span, including access to care for elders and seniors who are institutionalized.
- Immigration populations create access issues, and they tend to not have coverage.
- Providers do not focus enough on public health and early childhood issues, and there is a need for them to understand the need of oral health, and the impact when there is inadequate care. The primary health care work force needs to focus on the integration of oral health into the spectrum of health care provision.
- Iowans are moving away from fluoridation, public education, and awareness of the importance of fluoridation.
- The media tend to promote cosmetic oral health and promotion of products, versus the need for good oral health
- Need for better coordination of the funding that is available, to both private and public agencies, and need to find new funding.

- The state government has restricted funding streams, so we need to focus on how we can be effective and efficient with what we have.

2. Populations

The participants felt that the general population of Iowa is in need of additional capacity for oral health services and water fluoridation.

3. Roles

There are a number of roles that are necessary to achieve well-coordinated oral health services. Iowa's workgroup felt that each organization represented had a responsibility to educate and promote the importance of water fluoridation. The Iowa Department of Public Health (IDPH) will continue to share information on fluoridation activities within the state. Planned contributions by the other workgroup members include identifying consistent and accurate facts on fluoridation to provide to advocates, offering education and advocacy tips, grant-writing as necessary and disseminating information. The roles include partnerships and collaboration, evaluation for building and sustaining oral health initiatives, and strategy and operations activities. The group identified the following partnerships and potential areas for collaboration;

- Iowa Department of Human Services (IDHS), Medicaid Division; Alert providers of fluoridation issues through a notice or communication to dentists in communities that have lost their fluoridated water.
- CHCs: Advocate for school based programs.
- Primary Care Association (PCA): Will provide support for advocacy for fluoridation, and grant writing for members, and messaging for dentist and legislators.
- IDPH: Conduit of information to stakeholders on trending issues, and national changes in statutory alerts. The messages will support private/public partners advocating for water fluoridation
- Delta Dental: Provide grants to rural water plants to support the equipment in the water treatment plants. Offer education and advocacy to member dentist and partners at the rural health associations, and to legislators.
- Dental Association: Positive messaging and advocacy on how the dentists have helped the community, and promote fluoridation in general and in targeted communities.

4. Resources

The Iowa participants identified the key resource that are needed include, consistent messaging from all Federal government agencies about water fluoridation, and more flexibility in the way that grant opportunities can be utilized by the states. In some cases Federal agencies fund projects that are not in alignment with state needs or priorities, but grant funds still have to be utilized in the proscribed areas, even if there is greater need elsewhere.

5. Actions

Iowa stakeholders will continue to work diligently to make differences in the oral health infrastructure to meet the needs of their communities. The following specific roles in promoting were identified by the group members:

- The IDHS will send an alert about Medicaid coverage to selected dentists in target communities.
- The Community Health Centers (CHC) will educate primary care providers and keep them informed with a consistent oral health message.
- The PCA will work with the State legislature’s Advocacy Committee to develop legislative activities to support oral health and water fluoridation. They will also disseminate information to CHCs in communities that are at risk of losing fluoridation.
- The IDPH will regularly disseminate information to stakeholders on activities and progress.
- Delta Dental will host and convene a “next steps meeting” with the partners in conjunction with the Iowa PCA.
- The University of Iowa will collaborate with Steve Levy to promote advocacy support

Feedback from the Iowa participants on the group discussion was positive and included comments that they felt that discussion had been worthwhile, with a unique opportunity to engage and give suggestions to representatives from Federal programs.

B. Kansas: Lead Facilitator, Dr. Steve Geiermann; Co-Facilitator, Dr. Jackie Counts

There were 34 participants in the Kansas session, and the facilitator did a commendable job of engaging diverse stakeholders with varying opinions, particularly on the topics of mid-level dental providers and water fluoridation. A large list of issues resulted from the normative group process, and it was suggested that the group take the time to consolidate the list of focus area and issues, but that did not occur. As a result, by a vote tally, the lack of oral health providers in rural Kansas was selected. A consolidation effort may have resulted in a selection of a different focus area, but a strong discussion point was made about focusing on the demand side of the oral health equation.

1. Key Oral Health Challenge

The Kansas workgroup identified several areas of potential focus, and then agreed that the lack of oral health dental providers in Kansas, in both rural areas and inner cities was the key challenge, and that requires a focus on recruitment and retention strategies.

2. Populations Affected

The participants outlined the following key populations that are in need of additional capacity for oral health services:

- The poor and economic disadvantaged.
- Isolated and geographically remote communities.
- Children, including infants & toddlers.
- Special needs, such as the disabled or those with chronic mental illness.
- Residents in special care facilities.
- Seniors in their own home.
- Pregnant women.
- Undocumented workers.
- There is a lack of coverage for adults.
- Uninformed patients who are unaware of the need for oral health care.

- Chronic disease and co-morbidity patients (HIV+, AIDS, Diabetes, etc.).

3. Roles (Opportunities and Strategies)

The Kansas group expressed the roles in terms of strategies that would address the workforce issue, and possible opportunities that potential stakeholders could pursue to further the strategy of improving the Kansas oral health work force. For recruitment and retention strategies they felt that there was potentially a role for establishing a dental school in Kansas, and to consider potential new members of the dental team. They also felt there is an opportunity to address oral health delivery systems and the seamless delivery of care across the life course, including in medical settings, preschools, and enabling services. All members had a possible role in these strategies.

Retention strategies included further developing incentives for new oral health providers, such as state and Federal scholarship and loan repayment programs, and fostering increased community-based experiences for dental students and residents. It was also suggested there is a role for economic support for incentives by local governments and Kansas foundations, and to consider personal incentives, such as higher reimbursement rates for services, and housing opportunities, mentoring for dentists in remote areas, and to provide term limited assignments.

4. Actions and Resources

The group members offered the following actions items; the Kansas Dental Association and the Kansas Association for the Medically Underserved will add workforce recruitment and retention to the agendas of their regularly scheduled meetings, and consider incorporating the topic into their initiatives. All stakeholders will look for collaborative opportunities to build a statewide workforce for the oral health system, and they will ask Oral Health Kansas to continue a dialogue about workforce strategies.

When Kansas reported out to the General Session in the afternoon, the Directors of the Kansas Primary Care Association and the Kansas Dental Association each came from the opposite ends of the room to the podium to report out together. Even though they both said that this was a coincidence, it created a positive image for the Kansas participants.

C. Missouri: Lead Facilitator, Ralph Fuccillo; Co-Facilitator, Kit Wagar

There were 56 participants in the Missouri session, including Federal partners, and the group seemed engaged and very interactive, and had more of a philosophical or contemplative discussion about oral health services in their State. The recurring issues that resulted from the discussion were sustainability, education, costs, and early intervention for oral health. Missouri currently has an Oral Health Coalition, with multiple stakeholders, but it has not been active recently. As a result of discussions at the summit, the members agreed to begin meeting again, and to engage in some of the outcomes activities proposed by the break-out group.

1. Key Oral Health Challenge

The issue that the group chose as the key challenge was access to care, with the understanding that many of the other issues that were identified could be combined, or included in actions to address the main issue of access.

2. Populations Affected

Following a lengthy discussion of all of the population groups that may be affected by lack to oral health care access, the group selected seniors, children and infants, low income, minorities, and especially those in rural communities, as the priority populations that suffered disproportionately from the lack of access to oral health care.

3. Roles and Resources

This discussion focused more on the potential roles that are needed to address access issues, than on the roles of representative groups or individuals participants at the summit. They identified the need for the following roles or activities and resources:

- Greater coalition and support building.
- Identify partners and other needed resources.
- Find legislative champions.
- Work with dental schools to increase access.
- Work to increase diversity in the oral health workforce.
- Work on health literacy and education in communities, and encourage volunteerism.
- Facilitate and monitor state programs to address access strategies.
- Address resource and funding issues at the State and Federal levels, including assessment of funding issues, and the need for sustainable funding for all potential actions.
- There is a need for greater educational resources, funding for innovations, and increased use of technology, as well as an increased provider pool.

4. Actions

The facilitator began the discussion of roles by asking the group what actions they would commit to promote oral health access. Participants put much thought into the question and appeared willing to make commitments to support the action plan.

- Advocate for a State Dental Director.
- Recruitment and engagement at the community level.
- Encourage community volunteerism.
- Ombudsman services for access.
- Find legislative champions.
- Expand number of health professionals.

In the report out session, a participant from each representative group spoke. This gave the impression there had been a collaborative process in developing the responses to the questions, and the audience appeared attentive and interested. However, the outcomes that were reported on were more subjective, with no definite actions or timelines.

D. Nebraska: Lead Facilitator, Nathan Ho; Co-Facilitator, Cindy Cento

This session was attended by ten participants from the State, and three Federal Staff. Two weeks prior to the summit, the Dental Division of the Nebraska Department of Health had invited 50

stakeholders to attend the Nebraska Oral Health Advisory Panel, and so many of the attendees had recently met to discuss oral health issues in their state. The Nebraska oral health partners are working on three priorities including, social marketing, workforce development, and policy and environmental changes. The group also began efforts to develop a state oral health plan. During the facilitated discussion at the summit, the group came to consensus on the following concepts.

1. Key Oral Health Challenge

The Nebraska participants concurred that the key oral health challenge is insufficient data collection, and the need for surveillance and an evaluation component to assess the need, and provide a baseline of oral health outcomes in the State. The challenge is to develop a statewide oral health surveillance system to produce data and evaluation that will support the development and sustainability of effective oral health initiatives.

2. Populations

The participants outlined the following key populations that are in need of additional capacity for oral health services:

- Low-income.
- High risk populations.
- Rural communities.
- New citizens.
- Elderly.
- Special needs populations.
- Perinatal/ Early childhood groups.

These groups have presented challenges in service delivery, either in practice or policy.

3. Roles

There are a number of roles that are necessary to achieve well-coordinated oral health services. The roles include partnerships and collaboration, evaluation for building and sustaining oral health initiatives, and strategy and operations. The group identified the following partnerships and potential areas for collaboration:

- Build relationships with partners who have current oral health data sources (U of N).
- Work with health centers to maximize safety net resources.
- Engage practicing dentists and encourage colleagues to participate in data collection.
- Add important partners who are not currently involved, and propose forming a broader collaborative coalition.
- Identify staff for coordination and leadership roles.
- Engage dental students & dental schools to support data collection and evaluation

There is also a need to broaden stakeholder's thinking on how evaluation can be used. The Nebraska Department of Health & Human Services (NDHHS) will identify sources to guide data collection, evaluation, and data sharing with groups. This will involve determining what data is available, and accessing existing national resources such as CDC and NIH.

4. Resources

Examples of available resources the group identified include:

- National Oral Health Surveillance System (CDC).
- Upcoming leadership colloquium on metrics for improving oral health (U.S. National Oral Health Alliance).
- Centralizing HRSA oral health activities (HRSA-Office of Regional Operations).

5. Actions

Nebraska will continue to work diligently to make differences in the oral health infrastructure to meet the needs of their communities. The Nebraska Oral Health Advisory Panel has begun an initiative to develop a Nebraska Oral Health Coalition, and this group can assist with developing additional data, surveillance, evaluation, and reporting mechanisms for the State.

Summary of State Breakout Sessions

Each state had rich discussions on opportunities, challenges, and resources, and could have focused on a number of oral health issues, including:

- Access-Transportation.
- Reimbursement Rates.
- Medicaid patient no-shows.
- Expansion of Medicaid to address adult needs.
- Insufficient training for parents and parental involvement.
- Patient self-responsibility.
- Oral health literacy and cultural health understanding.
- Community and parental educational partnership.
- Dental lab costs.
- General public education regarding the importance of oral health.
- Access for poverty children and low number of Medicaid providers.
- Fluoride in all communities.
- Right mix of oral health providers.
- Elderly healthcare givers education regarding oral health.
- Integrating oral health with general health care.
- Seamless delivery system.
- Evidence based courses of action and research for oral health.

During the summation of the presentations, it was stressed that the outcomes of the state groups was the first step, and that the Federal partners will be there to support the state and regional efforts, but not to enforce any of these proposals for action. The representatives from the Federal government are the state's partners, with resources and information to share, but will not provide oversight for the action plans. Follow up actions will be up to the initiative of the individual stakeholders in the states, along with the support of Federal partners. The sessions were very productive, with opportunities for stakeholders from across the state to meet and discuss important topics and issues about oral health for their communities.

VII. Dr. Howard Koh- Key Note Address

Dr. Koh is the HHS Assistant Secretary for Health (ASH), and began his remarks by commending the wide range of colleagues gathered at the summit and who were partnering across sectors.

“People say there are three types of leaders: proactive, reactive & inactive. You're definitely in the first category, proactive! I heard that, throughout the planning of the summit, many partners said they didn't want the information in this meeting to be “status quo”, with discussions of routine oral health issues, but with no action or meaningful follow-up. It's wonderful to be joining such an inspiring group focused on producing solutions and real change to align resources, and move partnerships forward, and improve partnerships with Federal agencies and other stakeholders, all with goal of taking us all to the next level of enhancing public/private partnerships to improve the oral health infrastructure and to increase prevention and access to services”.

He expressed that he understood that many of the participants felt that, while there was a great deal of engagement around oral health from the previous Administration, very little actually came out of the various discussions and initiatives, as we still have the same poor outcomes and issues that are driving this “silent epidemic”. He commented that everyone at the summit was aware that 53 million U.S. children and adults have untreated tooth decay in their permanent teeth. Tooth decay continues to be the single most common chronic disease among children, mostly due to access problems involving poverty or geography, as well as language or cultural barriers, and fear of dental care. Oral health problems are highly preventable through better health literacy; more attention among primary care providers, and increasing provider coverage, along with patient access to care.

He further stated that public/private partnerships can address the following issues:

- Strengthen prevention and public health infrastructure.
- Expand medical and dental collaboration.
- Implement metrics for improving oral health.
- Design and evaluate public-private financing models.

Dr. Koh also offered a bit of his personal story. He is a physician who has treated patients for 30 years or more, a former Massachusetts Health Commissioner, and he spent six years working with state and local government to create prevention programs aimed at reducing health disparities. As ASH, he stated that it is an honor to continue in public service, to create better systems for prevention and care that will help all people reach their full potential for health, and achieve true health: “A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (World Health Organization, 2010). By working together, we can reaffirm our commitment to this important goal and to creating a society where, each person enjoys the beauty and gift of health, and we celebrate a health system that delivers prevention early, instead of treatment too late.

He went on to describe the many activities that HHS is engaged in to promote the oral health infrastructure nationally and in the individual States, and discussed HHS efforts to address the significant disparities in oral health outcomes. As with many diseases, there are major disparities in oral health for both children and adults along racial and ethnic lines (e.g. 40% of Mexican American children aged six to eight years old, have untreated decay, compared to 25% of white children). Twice as many black and Mexican American adults have untreated decay, compared to their white peers, and people with less than a high school education are about three times more likely to have periodontal disease.

Twice as many men, as women are diagnosed with oral cancer each year, and the mortality is nearly twice as high in some minorities, especially black males, as it is in whites.

HHS recently released HHS Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy to Achieve Health Equity, which outline goals, including oral health actions, (public and private) to help racial and ethnic minorities reach their full health potential. Oral health is a key component for HHS, with a focus on investing in our primary care workforce, with a special focus on physicians, nurses and dentists from under-represented communities, who we know are more likely to return to those same communities to practice. HHS is training more medical interpreters to serve patients with limited English skills, and training more community workers (promotoras) to help people navigate the system. HHS is also enhancing data collection on health of minority populations (if you can't count it, it doesn't count), and are using the health reform law to expand coverage and to increase the quality of care for minority populations.

As a physician, Dr. Koh cannot emphasize enough the need for medical and dental collaboration in promoting optimal oral health, and for HHS to be a visible, public example of cross-disciplinary collaboration. The Alliance and HHS can serve as the model for public-private partnerships, ensuring sustainability for oral health education and advocacy, and enabling longitudinal strategic planning. The public-private partnership encompasses oral health as a key component of HHS' National Plan for Action to End Health Disparities, and the Alliance is a response to and natural outcome of the HHS Oral Health Initiative.

In his closing remarks, Dr. Koh said that there is an opportunity for renewed public leadership within the government and HHS around national oral health. Our job as Federal leaders is to assist those with varying interests and agendas to find common ground that will lead to meaningful collaboration.

“I am thrilled to be here today. This is a wonderful opportunity to align regional and Federal oral health interests and priorities to meet the coming changes in oral health care delivery, and the future challenges of oral health care in America. Thank you for your efforts to make a difference in the lives of the people we serve, especially the underserved. I look forward to continuing to partner with you, so that together we can do everything possible to help all people reach their highest attainable standard of health”.

VIII. Requests and Offers

A. Requests:

- Dr. Russell from Iowa requests that HHS create a national message on oral health that has strong brand recognition, such as the slogan, “Only you can prevent forest fires”, which makes people think of Smokey the Bear. An example could be “Ignore your teeth – and they will go away”. He also requests more Federal support for messaging for the efficacy of water fluoridation. It is often difficult to get some rural or isolated communities to understand the value. A suggestion was offered that participants can work with the Ad Council to draft such messaging, or collaborate with the state library association or sports leagues for distribution.
- There was a request from an ADA representative to ensure longitudinal funding in the planning phases for programs that have proven outcomes. Numerous dentists have engaged in initiatives, and invested a great deal of time and gotten impressive results, but then the funding goes away (under a new administration), and the programs are discontinued. At that point everyone, including foundations, communities, patients, doctors, etc, are all frustrated and reluctant to

reengage. Most dentists want to help solve the problems, but want to be sure they are investing in long term, effective solutions. For example the HOPE Medical Outreach initiative, which allowed specialists to come into communities and provide patients at FQHCs with free services, was a fantastic program, but was defunded and the progress was lost.

- Although there are many good federal initiatives, historically the programs do not reach the level of “boots on the ground”. There is a request that during the planning process to consider that sustainability is needed, especially with a focus on how the programs can be realistically implemented at the community level, and on how outcomes can be continued once the funding goes away, or the grant expires.
- There are many good programs and initiatives, but organizations generally do not get the word out about what’s going on, and the request is that they do more marketing and outreach. For example, there is a great agreement between with University of Missouri at Kansas City (UMKC) and Olathe School District that is funded through the REACH Foundation, but is not widely known.
- Request that key agencies; (i.e. CDC, ADA) collaborate to developed accepted quality and safety standards for dentistry, to increase the validity of surveillance and outcomes reports. This is especially pertinent in the consideration of the need for evidence base for dental mid-level providers.
- There were several requests related to CMS reimbursement.
 - More assistance is needed with Medicaid funding to deal with the lack of transportation (in rural areas), and no-show rates with dental patients.
 - Medicaid forms (State 116 forms) are too complicated for patients and private providers. There is a request to simplify the process at both entry points. The CMS representative explained that some states have changed their forms already, to streamline the effort required to enroll or apply for reimbursement however, state agencies largely direct how they want to internally operate. CMS has an initiative to work with states to simplify their forms and processes, but only a few states have elected to participate.
 - There was request for Medicaid provisions for reimbursement for adult dental services. This effort could lead to significant cost-saving measures, as the evidence connects improved oral health to better outcomes for CAD, diabetes, and other chronic diseases, which are high cost conditions for CMS. Reimbursement should be structured around the evidence base for oral health and primary care integration.
- With oral health grants program, there should be an evaluation plan incorporated into each grant that requires grantees to develop solutions that can be done cheaper, faster, and quicker.
- Request for accurate data to share with others agencies, and on which to base funding decisions. It’s important to have an easy way to collect data, and to do an accurate assessment of the true need for services, and documentation of oral health outcomes. We could then put limited efforts and resources into programs that are most effective, in terms of outcomes and costs. Suggestion that Feds, states, and universities collaborate on data systems and processes. (Note that CDC and NIH have new national oral health surveillance initiatives).
- Discussion on the need for compatible electronic health records and data warehousing for integrated oral and primary health care, and to enhance data fidelity, surveillance, reporting, and to improve outcomes.

B. Offers

- CAPT Scott offered to share the above requests with CMS and other pertinent Federal partners, and to communicate them to key HHS leadership.

- Dr. Michael McCunniff of UMKC, offered to partner on Missouri efforts to improve data and reporting on oral health, especially as it relates to emergency room visits for oral health services. The hope is that documentation of the cost that is incurred for emergency services for untreated dental diseases will provide a business case for additional reimbursement for oral health prevention and treatment services.
- Ralph Fuccillo, invited participants to join the Alliance in the spirit of collaboration and participate in the Alliance's leadership colloquia held throughout the year. Alliance partners interested in leading the way in oral health can come together at the leadership colloquia to listen to, and learn from one another, while also honoring each individual's dedication to innovative oral health improvement. Through the leadership colloquia, the Alliance engages a broad group of partners who are committed to building common ground and focusing efforts among national, state, and community leaders. He reminded summit participants that the Alliance provides the platform for a diverse network of stakeholders in oral health to come together, build trust, and forge common ground in order to harness opportunities for strengthening oral health efforts in the U.S.
- HRSA Region VII staff can serve as a resource to convene summit follow up meetings, or serve as a source for an information exchange. HRSA State Leads are interested in participating in State oral health collaborative efforts and initiatives.

IX. Wrap-up Session and Next Steps

Dr. Damiano and CAPT Scott facilitated a discussion with participants, summarizing the day's events and outcomes, and then led a discussion on the formulation of next steps

A. Next Steps:

- Recommend that the participants each have regional oral health conference calls or meetings with partners or participants from the Summit, to stay abreast, excited, and motivated on oral health activities and accomplishments
- Suggestion to educate and share knowledge gained from the summit with other HHS Regions and HRSA Headquarters, to share lessons learned so others can benefit from the positive experience in Region VII, and expand the awareness and level of effort for oral health in other parts of the country.
- Participants suggest that HRSA staff maintain a database of oral health contacts established from the summit, and share or e-mail pertinent oral health information and developments to mail list from the database.
- State's participants will follow up on the action steps that they discussed in their respective break out groups. Since one summit has been completed, a suggestion was made that it would be great to have some follow-up on the agreed upon activities, and come back each year to share the progress.
- Several participants from across the represented states expressed that they would like to come back in a year to discuss their progress, and oral health updates. It is beneficial to have such dialogue with state participants and across the region, so an annual oral health event would be most beneficial, so that the diversity of stakeholders can stay connected.
- Consider ways to get State legislators involved in the summit and outcome activities. We will need legislative and funding support for many of the proposed action steps and initiatives from the State breakout groups.

B. Action Steps from HRSA:

- Host an annual regional oral health meeting in Kansas City, inviting State Dental Directors, and key oral health leaders in each state for updates, and to address key action items related to the summit.
- HRSA State Leads will send the presentations from the summit to the state’s participants, and offer supportive follow up as the States move into action.
- Follow up with federal partners to explore HHS Regions Together activities in support of the oral health call to action.

C. Closing Remarks

CAPT Scott closed the summit by thanking the facilitators and Federal panelists for their significant contributions, as well as Dr. Dale Grube, the KUMC Associate Dean for Continuing Education, and her staff for their outstanding support with facilities and logistics. She also thanked the HRSA Regional staff for their superlative effort, hard work, and attention to detail that contributed to making the day a success, and particularly thanked Sharon Turner and Michelle McCord for going far above and beyond the call of duty. She went on to thank all of the participants for taking the time from their extremely busy schedules to attend the summit, and for their contributions to achieving the common vision of ensuring access to care and prevention, that supports optimal oral health for the region’s most vulnerable children and adults. She further said that because they took the time to participate and contribute their knowledge and expertise to the summit, we now have a successful regional platform to find ways that we can continue to forge common ground as the basis for finding real solutions.

The goal of the Oral Health Summit was to facilitate a regional discussion on oral health, and to leverage resources to optimally support U.S. Department of Health and Human Services and regional oral health priorities to advance public-private partnerships, and CAPT Scott stressed that we took important steps toward achieving that goal. “HRSA values partnerships on every level and we appreciate their support in contributing to the success of our 2011 Oral Health Summit. The hope is that the sessions empowered participants to move forward to the next level of enhancing public private partnerships to improve oral health”.

X. Summit Evaluation

A. Results of Participant Evaluation Forms

The Oral Health Summit Evaluation form was completed by 39 out of 130 participants, for a 30 % response rate. The overall rating of the nine elements that were assessed, added up to a 93 % combined rating of “agree” or “strongly agree” scores, resulting in a cumulative positive evaluation of the effectiveness of the sessions. Sessions that received a few scores (less than 5%) in the “disagree” (less effective) category, included the information provided in the Federal Panel, the State break out groups, and the Requests and Offers sessions. Several comments were provided by participants that will be valuable in planning future oral health meetings.

The following is summary of the compiled data for the participant’s responses on the summit evaluations form.

1. Opening Session: Judy Baker, HHS Regional Director
 - The session was effectively presented. Results:
 - Strongly Agree 54%

- Agree 46%
2. New Landscapes in Oral Health
 - The session was effectively presented.
 - Strongly Agree 49%
 - Agree 51%
 3. Panel of Federal Partners: Oral Health Access and Prevention
 - The session was effectively presented
 - Strongly Agree- 33%
 - Agree – 62%
 - Disagree-5%
 4. State Breakout Groups
 - Strongly Agree- 49%
 - Agree – 43%
 - Disagree-5%
 - Strongly Disagree-3%
 5. State Report out Session
 - The session was effectively presented
 - Strongly Agree- 45%
 - Agree – 55%
 6. Requests and Offers
 - The session was effectively presented
 - Strongly Agree- 34%
 - Agree – 63%
 - Disagree-3%
 7. Over All Effectiveness of the Summit
 - The session was effectively presented
 - Strongly Agree- 50%
 - Agree – 50%

B. Participant Recommendations or Suggestions for Improvement:

- May just be my perspective but Pete focused on the negative and controversy as a motivator. Found it challenging, not uplifting. Wanted more positive in the beginning.
- CDC gave good information but get to outcomes/possibilities sooner. Too much government speech. Recommend a more easy approach to bring it home. Too much reading of the slides in a mad rush.
- Need to invite legislative representation/staffers to the table.
- Sustainability discussion sounded like “whining” after awhile. The Requests & Offers Session was tedious and laborious, though Ralph’s comments were encouraging.

- Not convinced that Dr. Damiano was the right person to facilitate this summit.
- Good meeting-Thank you!
- Great meeting! Thank you for your work on this.
- Introductions around the room would be worthwhile.
- It was great to hear from federal representatives.
- The State breakout sessions felt too compressed. It was a great process, but a lot of information in a very short period of time, and the final result felt overly simplified.
- I really enjoyed the initiative and format of this event.
- I am so happy to see the excitement of oral health expanding to the federal levels.
- A bit cold in the afternoon.
- Great Summit.
- Parking directions and directions to the building were difficult to follow.
- Location for the meeting was a long way from parking, and hard to find even with the guides.
- This should be an annual event during which states report on progress and devise strategies to further statewide goals.
- The federal partners panel was overwhelming, too much information for such a short time.
- State Breakout Group was organized, but not helpful.

C. Post Summit Comments from the States Dental Directors

In addition to the feedback gained from the participant's evaluation responses, HRSA staff received congratulatory e-mails from the State Dental Directors from Iowa, Kansas, and Missouri. Karen Bassford, R.D.H, Oral Health Program Consultant of the Missouri Department of Health and Senior Services wrote:

“CAPT Scott, I want to personally thank you for your work in getting the Regional Oral Health Summit together. It speaks volumes to what one person can do with a great idea. I have been a dental hygienist for 24 years and I am so encouraged with the growing interest in oral health. I had worked in the private office setting most of my career until the last eighteen months when I took a position with the State of Missouri as an Oral Health Consultant. Being relatively new to the public health arena I am learning so much. The Summit was wonderful for me to hear about other organizations and what everyone is doing in their region. Thank you again for your vision....

Bob Russell, DDS, MPH, State Dental Director, Chief of the Oral Health Bureau in the Iowa Department Public Health wrote, “I appreciate your encouragement and helping us identify the common issues we can work to address in our state. The summit was a success in many ways. HRSA, through this summit has shown great leadership in the oral health of our region!” Dr. Kathy Weno, the State Dental Director from Kansas wrote, “I appreciate your interest and support of oral health, and thank you for the opportunity for Kansans to get together to discuss our state’s most pressing issues. I think we had a great group there and an excellent discussion”.

D. Summary of Planning Committee Post Summit Comments

The Planning Committee met for about 45 minutes at the end of the summit, and in a round robin style discussion, members made the following observations or suggestions:

- There is genuine hope that we will have the resources to have follow on meetings, and not just have this session as a “one and done” effort. There is real need to continue with more summits.
- Regarding the state breakout facilitators, it was noted that the role of a co-facilitator was not really needed. In future planning, recommend that there is only a lead facilitator and recorder, and HRSA representative in the State sessions.
- In future meetings, ensure that the steps for the break out groups are clearer and less vague, and define the expectations for concrete outcomes: Missouri’s actions steps were a bit vague.
- Look at partnering with other state meetings for future summits, and coordinate similar agendas, so there is less redundancy in our efforts i.e., PCAs, Oral Health Coalitions).
- Strive for better outreach to private dentists, and recruit more private practitioners early on for next year’s summit.
- As a planning committee, establish a clearer goal of what is expected with tangible goals and outcomes for the individual sessions. “We also need to assess what happened? What came out of this summit, and what did we learn? How can we use this knowledge to inform future actions”?
- There is a genuine need for individuals (practitioners) to know what is expected from them, and what they can contribute. “What can I do?” should be more tangible and have more of a focus in future agendas.
- Set the ground work for “Federal Policy 101” to clarify the relevance of the Federal role in the regions and states.
- Invite key staffers from State legislators and State Departments of Health, as many of the resources and actions steps will need to be authorized by them. The summit can assist with getting their buy-in.
- Share the outcomes of the summit with attendees in order to hold the participants accountable
- Look at National Oral Health Measures, and Healthy People 2020, and tie them into the summit action steps and subsequent outcomes.
- HRSA and CDC should provide regional trend and surveillance data on oral health outcomes prior to the summit, so participants have more information, and background on which to make their choices for action.
- In future summits, it would be good to design the agenda with more regional cross-pollination, and sharing of issues and best practices among the states, instead of just facilitating an isolated discussion within the states.
- Recommend that CAPT Scott call the key players in each of the States at intervals to ask “How is it going”. This will give the group members an idea of what has worked well, and what has not, and where we should focus our efforts in the future. We need to continue the engagement after the summit in order to keep the momentum going.

- Secure more community engagement in future summits, and focus presentations on community models that work.
- Consciously think about evidence based action steps that foster relevant social change and try to incorporate these concepts into the summit leadership process.
- We should assess who was there, and who was not, and who we still need to reach out to.
- Assess the level of detail that participants need about oral health. For example, if foundation staff is present, then a great deal of clinical information about dentistry is not relevant to them. Think beforehand about what level of knowledge that the participants need, and tailor the information more to the audience.

XI. Conclusion

The social sector is filled with examples of partnerships, networks, and other types of joint efforts, but collective impact initiatives are distinctly different. Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants (Kania & Kramer, 2011). The Oral Health Summit was a success in that a coalition was initiated that can work together on collective impact. There was a genuine feeling of excitement, anticipation and curiosity by participants, and HRSA staff and Planning Committee members received many positive comments from a wide range of stakeholders throughout the day. It was consistently expressed that the summit was a beneficial and positive experience, and that they appreciated the opportunity to engage with oral health partners throughout the region to share, brainstorm, and discuss issues. Many participants also expressed that they would like to continue the interactions, and asked if we would consider making the summit an annual event. Overall, the summit was a resounding success and exceeded expectations in almost every way. The planning and organization that went into the pre-planning, logistics, and preparation were exceptional, with a fine attention to detail. The organization and teamwork by the HRSA staff, the Federal partners, and the Planning Committee was inspirational, and we now have experience in the actual level of effort that a meeting of this scope requires. Dr. Koh, Judy Baker, and Dr. Barkman's participation gave the summit credibility, and in many ways the speaker's presentations were the best aspect of the event, and clearly demonstrated transformational leadership in action.

The goals and objectives of bringing together federal agencies, state officials, providers, and academia into one common meeting place to not only discuss, but also address oral health as a public health issue was achieved. At this point it is difficult to say whether or not the event will have a sustained impact, or lead to significant improved outcomes in oral health in the region. Success can only be determined by the progress that is achieved from the actual implementation of the action plans developed at the conference. This progress will not be immediately apparent; it will take time to measure, and we may not know for a year or more whether the event had a lasting impact. The HRSA role will be to keep the topic at the forefront, keep it fresh, and not let it recede once we have accomplished the first objective of holding the conference and mobilizing a wide range of stakeholders. The real work is still to come, and the HRSA staff must be ready to assist or take the lead wherever possible.

Lessons learned include, the need to look at common themes from all of the states, and focus efforts on the common threads, instead of trying to cover everything in one day. It was apparent from the feedback that there needs to be a clearer role for dentists in the summit, and to assess the quality of the facilitation for an oral health professional. How can they best contribute to the solutions, and how can they be engaged more in the dialogue with policy makers and government leadership? We also need to provide more state specific data prior to a summit, as well as engage state legislators in the discussions and in the

sessions. Policy that supports the oral health infrastructure, funding, and sustainability emerged as the some of the key issues to improving oral health services.

HRSA staff also observed that the State breakout groups were not facilitated in a consistent manner, even though the facilitators were provided with a handbook for the summit, with preparation conference calls, and a two hour session with facilitators two days prior to the event. Even though the expectations were clarified in a variety of venues, there was a wide difference in the format of the group facilitation, and the outcomes that they achieved. In future sessions, we could focus on more specific roles of individuals and groups, and concrete outcomes that they will commit to achieving.

In the effort to improve the oral health infrastructure, and ensure access for all, and not just those who can afford the high cost of a dentist, no single organization is responsible for solving this major social problem, nor can any single organization cure it. Social problems arise from the interplay of governmental and commercial activities, not only from the behavior of social sector organizations. As a result, complex problems can be solved only by cross-sector coalitions that engage those from a variety of sectors. Shifting from isolated impact to collective impact is not merely a matter of encouraging more collaboration or public-private partnerships. It requires a systemic approach to social impact that focuses on the relationships between organizations and the progress toward shared objectives (Kania & Kramer, 2011). The Oral Health Summit was the first step in the framework of garnering collective impact for social progress. With this understanding, HRSA and our HHS partners can continue to foster the public-private collaboration with the U.S. National Oral Health Alliance, the state leadership, the safety net, and other partners, to continue to address oral health disparities and issues. If we are successful, in the coming years we hope to report significant improvements for those most in need of oral health care, and that we have been successful in improving the quality of life for members of the communities in our region.

“What might social change look like if funders, nonprofits, government officials, civic leaders, and business executives embraced collective impact? This exciting evolution of collective impact initiatives is far removed from the isolated impact approach that now dominates the social sector and that inhibits any major effort at comprehensive, large-scale change. If successful, it presages the spread of a new approach that will enable us to solve today’s most serious social problems with the resources we already have at our disposal.” (Kania & Kramer, 2011, p.48).

Appendix A

Final Oral Health Summit Packet

2011 Regional Oral Health

*The Role of Public-Private
Partnerships in Improving Oral
Health*

Tuesday, September 13, 2011

University of Kansas Medical
Center
Beller Conference Center
Kansas City, Kansas



U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Regional Operations



Welcome



On behalf of HRSA Office of Regional Operations in Kansas City, I want to personally thank you for your participation in the 2011 Regional Oral Health Summit. Your contributions will play a critical role in the success of the oral health discussion, and provide valuable resources and insights to your regional colleagues. The Summit represents a wide range of oral health stakeholders, from public health and private practice dentists, academia, State administration, regional health leaders, Federal partners, and foundations. However, we all share the common vision of ensuring access to care and prevention that supports optimal oral health for the region's most vulnerable children and adults. The summit will provide a platform to find ways that we can continue to forge common ground as the basis for finding real solutions.

The charge for the planning committee was to develop an action oriented day with the focus on aligning resources and moving partnerships forward. The hope is that the sessions will empower participants to move forward to the next level of enhancing public private partnerships to improve oral health.

I look forward to a very rich day of discussion and planning, and again thank you for partnering with HRSA as we advance oral health to improve the lives of the people in our communities.

Sincerely,

CAPT Debra Scott

Debra Scott, R.N., M.S.
Captain, U.S. Public Health Service
Regional Administrator
HRSA Office of Regional Operations, Region VII

Summit Information

Background

The Health Resources and Services Administration (HRSA) recently asked the Institute of Medicine (IOM) to provide advice on where to focus its efforts in oral health. The IOM was charged with assessing the current oral health care system, reviewing the elements of a Health and Human Services (HHS) Oral Health Initiative, and exploring ways to promote the use of preventive oral health interventions and improve oral health literacy. A parallel study focused on issues of access to oral health care for underserved and vulnerable populations.

In support of the IOM Report on Oral Health, and the HHS Oral Health Initiative 2010, the HRSA Office of Regional Operations in Kansas City, began to reach out to a broad spectrum of regional and Federal oral health stakeholders. As a result of these meetings, HRSA Region VII staff formed an Oral Health Summit Planning Committee comprised of key oral health leaders. Subsequently, the State Directors of Dental Health were engaged to determine the two or three key principles that would be most relevant to focus on in their states, based on the Organizing Principles recommended in the IOM Report. The role of public and private partnerships emerged as the common denominator in Iowa, Kansas, Missouri and Nebraska. The Summit will provide a venue for each state to conduct a facilitated analysis of this focus area, along with a panel of Federal leadership to discuss public-private partnerships and their role in improving oral health.

In addition to the increased Federal focus on oral health, new national dental initiatives are emerging, such as the U.S. National Oral Health Alliance, that endeavor to forge common ground among both public and private partners for the promotion of optimal oral health, especially as it relates to services for underserved communities. The Summit presents an opportunity for ground breaking discussions with colleagues from many sectors, including professional associations, academia, State health leaders, the safety net community, healthcare foundations, and representatives from Federal programs that support oral health, with a focus on how we can strengthen public-private partnerships. The Summit is an opportunity to align regional oral health interests and priorities to meet the coming changes in oral health care delivery, and the future challenges of oral health care in America.

Summit Goal

The overall goal of the Oral Health Summit is to facilitate a regional discussion on oral health, and to leverage resources to optimally support U.S. Department of Health and Human Services and regional oral health priorities to advance public-private partnerships.

Outcomes

- Introduction of regional partners and stake holders that are working on oral health access and prevention strategies, and allow stake holders to meet each other.
- Promote awareness of the many oral health activities in the region, and identify opportunities for

networking and possible collaborations.

- Review of each State’s oral health programs and initiatives, and identify best practices, and opportunities.
- Facilitate a panel of Federal partners to review current federal support in the region for oral health access and prevention.
- Facilitate a capstone session with requests and offers to help identify coalitions and natural partnerships, and identify next steps to advance public–private partnerships in the region.

University of Kansas Medical Center Welcomes HRSA Regional 2011 Oral Health Summit



H. William Barkman, MD, MSPH
Chief of Medical Staff
University of Kansas Hospital

H. William Barkman, MD, MSPH, has served as Chief of the Medical Staff at KU Hospital Since 1998.

Dr. Barkman is board certified in Internal Medicine and Pulmonary Diseases. He is a graduate of Creighton University School of Medicine and did his residency work at the University of Utah and the University of Oklahoma as well as a fellowship at the University of Utah. Dr. Barkman also holds a Master of Science in Public Health.

Dr. Barkman's clinical practice is focused on Occupational Lung Disease, Chronic Obstructive Pulmonary Diseases, Asthma, General Pulmonary and Sleep Apnea. His specialties include Pulmonary and Critical Care Medicine, Diagnostic Pulmonary Medicine, Environmental Medicine, General Pulmonary and Occupational Pulmonary Medicine.

Oral Health Summit Presenters

Keynote Speaker



Dr. Howard Koh
HHS, Assistant Secretary for Health
Office of the Secretary
Office of the Assistant Secretary for Health

Dr. Howard K. Koh serves as the 14th Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS), after being nominated by President Barack Obama and confirmed by the U.S. Senate in 2009. As the Assistant Secretary for Health, Dr. Koh oversees the HHS Office of the Assistant Secretary for Health, the Commissioned Corps of the U.S. Public Health Service, and the Office of the Surgeon General. He also serves as senior public health advisor to the Secretary. Dr. Koh previously served as the Harvey V. Fineberg Professor of the Practice of Public Health, Associate Dean for Public Health Practice, and Director of the Division of Public Health Practice at the Harvard School of Public Health. At Harvard, he also served as the principal investigator of multiple research grants related to community-based participatory research, cancer disparities affecting underserved and minority populations, tobacco control and emergency preparedness. He was also Director of the Harvard School of Public Health Center for Public Health Preparedness.

Dr. Koh served as Commissioner of Public Health for the Commonwealth of Massachusetts (1997-2003) after being appointed by Governor William Weld. As Commissioner, Dr. Koh led the Massachusetts Department of Public Health, which included a wide range of health services, four hospitals, and a staff of more than 3,000 professionals. In this capacity, he emphasized the power of prevention and strengthened the state's commitment to eliminating health disparities.

Dr. Koh graduated from Yale College and the Yale University School of Medicine. He completed postgraduate training at Boston City Hospital and Massachusetts General Hospital, serving as chief resident in both hospitals. He has earned board certification in four medical fields: internal medicine, hematology, medical oncology, and dermatology, as well as a Master of Public Health degree from Boston University. In recognition of his national contributions to the field of early detection and prevention of melanoma, the Boston Red Sox designated him a "Medical All Star" (2003) which included the ceremonial first pitch at Fenway Park. Dr. Koh and his wife, Dr. Claudia Arrigg, are the proud parents of three children.

Opening Remarks



Judy Baker
Regional Director,
Region VII

Judy Baker, Regional Director for Health and Human Services in Region VII, has served in the health services arena for thirty years in both the private and public sectors. Before being appointed by Secretary Kathleen Sebelius to the regional post, she completed two terms as State Representative for the State of Missouri. While in the legislature, she worked on several key health care related initiatives and contributed to policymaking on the health care committees. These accomplishments helped earn her the recognition of Emerging Health Care Leader from the National Conference of State Legislatures.

Baker's educational background includes a bachelor's degree in educational studies, a master's in divinity, and a master's in health care administration and informatics from the University of Missouri.

Before entering public service, Judy served in administrative roles in the private sector in single and multi-specialty clinics, an academic medical center and in consulting roles in a variety of health care settings. She was Interim Executive Director of University Physicians at the University of Missouri Health System and director of operations at Capital Region Medical Group in Jefferson City. She has served as part-time administrative director for ACTS International, a not-for-profit, humanitarian organization dedicated to building partnerships that benefit the country of Georgia. She has also worked as an adjunct professor teaching managerial economics at Columbia College and Health Care Policy and Politics at University of Missouri. She formerly served as vice chairman of the Missouri Petroleum Storage Tank Insurance Fund.

She and her husband, Dr. John D. Baker, are the parents of Sarah, 23, a graduate from the School of Business at Mizzou, Lauren, 21, a junior at Mizzou; and David, 17, a senior at Rock Bridge High School.

HRSA Office of Regional Operations-Region VII Regional Administrator



Debra Scott, R.N., M.S.
Captain, U.S. Public Health Service

Captain (CAPT) Debra Scott was appointed Regional Administrator in Region VII, for the Health Resources and Services Administration (HRSA), Office Of Regional Operations, in the Department in the Department of Health and Human Services, on October 1, 2010. As Regional Administrator in Kansas City, CAPT Scott is responsible for supervising a team of dedicated Public Health Analysts and health care professionals in providing oversight and consultation for HRSA's established Federal healthcare safety-net programs in Kansas, Nebraska, Iowa, and Missouri. CAPT Scott and the HRSA regional team also provide consultation for the implementation of the HRSA provisions of the Affordable Care Act in these four states.

Prior to her appointment with HRSA, CAPT Scott served as the Director of Business Development at Federal Occupational Health, in the Program Support Center, Office of the Assistant Secretary for Administration, in Washington D.C. CAPT Scott received her commission as an officer in the United States Public Health Service (PHS) in 1997, and began her career as the first Quality and Accreditation Manager for Immigration Health Services (DIHS). She was promoted to Associate Director of Policy and Planning, and her time at DIHS included a detail as Special Assistant to the Chief of Staff in the Office of The Surgeon General. CAPT Scott has also served as National Nurse Consultant at the National Health Service Corps (NHSC) where she worked to place NHSC clinicians in underserved communities, and also served as a NHSC Ready Responder in rural Hawaii working with the Native Hawaiian Health Care Systems.

CAPT Scott has a Bachelor of Science Degree in Nursing from Loyola University of Chicago, and a Master of Science Degree in Healthcare Administration from Alameda University. She is a member of Sigma Theta Tau, the National Honor Society for Nursing. In addition to numerous PHS Awards, CAPT Scott has received the FOH and NHSC Director's Award for Excellence; The Secretary's Award for Heroism and Exceptional Volunteer Service for 9/11 Response; The Secretary's Award for Distinguished Service on two separate occasions; and most recently the PHS Chief Nurse Award.

Lead Facilitators



Peter C. Damiano
Director, Public Policy Center
Director, Health Policy Research Program
Professor, Preventive and Community Dentistry

Dr. Peter Damiano is the Director of the Public Policy Center (PPC) and Professor, Department of Preventive and Community Dentistry at the University of Iowa. He started the health policy research program at the PPC in 1990 and has been Director of the Center since July 2007. He is a health services researcher who investigates issues relating to access to care, quality, cost and outcomes of care. Dr. Damiano has authored over 100 peer-reviewed journal articles and research monographs and has been the principal investigator on over 50 research studies funded by federal, state and Foundation sources. He is a former staff intern in the US Senate, a Robert Wood Johnson Dental Health Services Research Scholar and HRSA Primary Care Policy Fellow. He is a graduate of the University of Iowa College of Dentistry (DDS) and UCLA School of Public Health (MPH).



Ralph Fuccillo, M.A.
President of the DentaQuest
Foundation and
Founding Board member of the
U.S. National Oral Health Alliance

Mr. Fuccillo is a seasoned leader in the non-profit sector with a lifelong career that has included professional and volunteer experiences in education, health and human services, and organizational development. As an advocate for disease prevention and health promotion, his work has focused on the social determinants of health, policy development, and behavior change to reduce injury and violence, HIV/AIDS, substance abuse, other preventable illnesses, and now oral health.

Federal Panelists

Administration on Aging - Sam Gabuzzi, Regional Aging Program Services Specialist

Mr. Gabuzzi is currently an Aging Program Services Specialist with the Administration on Aging and serves as the Native American Title VI Grants officer for a ten state region. Sam works with Tribes on their senior nutrition and family caregiver support programs in addition to assisting with the development and usage of Evidence Based Disease Prevention Programs.

Sam came to AoA from Federal Occupational Health where he was the National Director of

Wellness/Fitness Services. During Sam's tenure at FOH he was responsible for the development and management of 40 federal wellness/fitness centers and programs. Mr. Gabuzzi has an M.S. Degree in Human Performance with a concentration in Exercise Physiology from the University of Wisconsin La Crosse and is a certified Health Fitness Director from the American College of Sports Medicine.

Administration for Children and Families - Elizabeth Cox, Infant/Toddler Program Specialist

Elizabeth (Beth) Cox serves as the Infant/Toddler Program Specialist in Kansas City, Missouri for the Office of Head Start. She holds a Bachelor's degree in Elementary Education from the University of Missouri-Kansas City and a MS in Education Administration from Missouri State University. She has been with Head Start for 8 years, the last 3 ½ with the Office of Head Start. She serves as the Oral Health Liaison in this region which covers the states of Iowa, Kansas, Missouri and Nebraska.

Centers for Disease Control and Prevention - LT Sheila Weagle, MPH, RDH, CHES, Public Health Advisor, Division of Oral Health

LT Sheila Weagle is currently stationed with the Division of Oral Health at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia where she works as a Public Health Advisor providing support to state oral health programs in oral health infrastructure development and capacity building. She transferred to the CDC from the Indian Health Service where she provided oral health care to the Native American population as a community/clinical dental hygienist in Lawton, Oklahoma.

Prior to joining the US Public Health Service, LT Weagle served over 11 years in the US Air Force as a Preventive Dentistry Officer as well as providing direct patient care to service members as a Registered Dental Hygienist. In July 2007, LT Weagle earned a Bachelor of Applied Science in Dental Hygiene from St. Petersburg College. LT Weagle is a Certified Health Education Specialist with a Masters in Public Health from A.T. Still University (ATSU) and will be graduating in November 2011 with a Doctorate in Health Education.

Centers for Medicare and Medicaid Services - Gail Brown-Stevenson, Oral Health Coordinator

Gail Brown Stevenson is the Maternal & Child Health (MCH) Coordinator for the Centers for Medicare & Medicaid Services (CMS) Regional Office (Region VII). In this position she is responsible for the collaboration and oversight of and also provides policy federal guidance regarding children's Medicaid services that include oral health, immunizations, EPSDT, asthma, obesity, and other child-centered Medicaid services; as well as maternal issues that include pre & post-natal services, HIV/AIDS, smoking cessation, and maternal child safety training programs.

Gail has been with CMS for 17 years, with the last 13 being in the Division of Medicaid as the MCH coordinator. Prior to coming to CMS, she spent 18 years with the Social Security Administration's Kansas City Regional Payment Center. She attended the St Luke's School of Nursing (RN) Program, specializing in OB/GYN & Pediatrics; which she feels serves her well in her current role within CMS.

She has also spent 25 years involved in various community initiatives that focus on health prevention awareness, maternal nurturing outreach to young mothers, Parents as Teachers, childhood mentoring, and youth crime prevention programs.

Health Resources and Services Administration - CAPT Julie Sadovich RN, PhD, Deputy Director, Office of Special Health Affairs

CAPT Sadovich is a Nurse Officer in the United States Public Health Service (USPHS) and is currently assigned to the Department of Health and Human Services (HHS) in the Health Resources and Services Administration (HRSA). CAPT Sadovich is currently the Deputy Director for the Office of Special Health Affairs and the Director of the Office of Strategic Priorities. Previously, CAPT Sadovich was assigned to the Administration for Children and Families (ACF) as the Director of the Office Human Services Emergency Preparedness and Response and the Department of Homeland Security, Office of Health Affairs. During her career she has had extensive experiences clinical nursing, health care regulations, and disaster management. While assigned to the Department of Homeland Security, CAPT Sadovich served as the Associate Director for Global Health Security, Office of International Affairs and Global Health Security, Director of Emergency Management and Medical Response Integration, Office of Medical Readiness in the Office of Health Affairs and served as the Chief of Staff for the Office of WMD Operations and Incident Management in the Science and Technology Directorate. Other assignments include clinical nursing and research in oncology and critical care at the National Institutes of Health (NIH) and health care regulatory and policy design and enforcement at the Centers for Medicare and Medicaid Services (CMS). CAPT Sadovich has deployed for medical assistance in a variety of natural disasters, man-made incidents, and refugee movements into the US.

CAPT Sadovich holds a Doctorate in Human Services with a specialty in Health Care Administration from Capella University, a Masters degree in Nursing with an Education Certificate from George Mason University and a Bachelor Degree in Nursing from the University of Nevada Las Vegas. In addition, she has completed the Joint, Interagency, and Multinational Planner's course, the Joint Operations Medical Managers course, the Homeland Security Medical Executive program and has received the National Emergency Preparedness Award.

2011 HRSA Regional Oral Health Summit
“The Role of Public-Private Partnerships in Improving Oral Health”
Agenda

Tuesday, September 13, 2011	
7:30 am to 8:00 am	Registration and Continental Breakfast
8:00 am to 8:15 am	Opening Session CAPT Debra Scott, HRSA, Office of Regional Operations, Region VII, Regional Administrator Judy Baker, HHS Region VII, Regional Director
8:15 am to 8:30 am	Welcome, Ground Rules, Review of Agenda CAPT Debra Scott, HRSA Region VII, Regional Administrator Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa
8:30 am to 9:00 am	New Landscape in Oral Health CAPT Debra Scott, HRSA Region VII, Regional Administrator Ralph Fuccillo, President, DentaQuest Foundation Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa
9:00 am – 10:00 am	Panel of Federal Partners: Oral Health Access and Prevention Administration on Aging – Sam Gabuzzi, Aging Services Program Specialist Administration for Children and Families - Elizabeth Cox, Infant/Toddler Program Specialist Centers for Disease Control and Prevention – Sheila Weagle, MPH, RDH, CHES LT, USPHS, Public Health Advisor, Division of Oral Health Centers for Medicare and Medicaid Services - Gail Brown-Stevenson, Oral Health Coordinator Health Resources and Services Administration - CAPT Julie Sadovich RN, PhD, Deputy Director, Office of Special Health Affairs
10:00 am to 10:30 am	Break
10:30 am to 12:00 pm	State Breakout Groups Lead Facilitator: Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa
12:00 pm to 1:00 pm	Lunch is served: H. William Barkman, M.D., MPH Chief Medical Staff KU Hospital

1:00 pm to 2:00 pm	Keynote Address: Dr. Howard Koh, HHS, Assistant Secretary for Health, Office of the Secretary, Office of the Assistant Secretary for Health
2:00 pm – 3:00 pm	State Report Out Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa
3:00 pm – 3:30 pm	Break
3:30 pm – 4:30 pm	Requests and Offers Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa Ralph Fuccillo, President, DentaQuest Foundation
4:30 pm – 5:00 pm	Summary of Day/ Next Steps Dr. Peter Damiano, Director, Public Policy Center & Professor University of Iowa CAPT Debra Scott, HRSA Region VII, Regional Administrator



The HRSA Region VII staff would like to express their deep gratitude to the Oral Health Summit Planning Committee for the generous contribution of their time, expertise, and insight.

Pete Damiano, DDS, MPH

Director, Public Policy Center & Professor
University of Iowa

Steven P. Geiermann, DDS

Senior Manager, Community Oral Health Infrastructure and Capacity Council on Access
Prevention and Inter-professional Relations
American Dental Association, Chicago, IL

Jessica Hembree, MPA

Program and Policy Officer
Health Care Foundation of Greater Kansas City

Mike McCunniff, DDS, MPH

Director of Dental Outreach
Associate Professor, Department of Dental Public Health and Behavioral Sciences
University of Missouri at Kansas City

Bob Russell, DDS, MPH

Public Health Dental Director, Chief Oral & Health Delivery Systems,
Division of Health Promotion and Chronic Disease Prevention,
Iowa Department of Public Health,
Des Moines, Iowa

CAPT Jose H. Belardo, JD, MSW

Regional Health Administrator
HHS, Office of the Assistant Secretary for Health/ Region VII

Patricia Brown

Regional Administrator
HHS Agency for Children and Families/Region VII

Cindy Cento

Executive Officer
HHS Office of the Regional Director/Region VII

A special thank you to Dr. Burton Edelstein for advice and introductions.



2011 Regional HRSA Oral Health Summit Recognizes State Breakout Facilitators

Iowa

Lead Facilitator: Pete Damiano, PhD

Co-Facilitator: Judy Jensen, MPA

HRSA State Lead: Sharon Turner, MSW, MPA

Kansas:

Lead Facilitator: Steve Geiermann, DDS

Co-Facilitator: Jacqueline (Jackie) Counts, PhD

HRSA State Lead: CAPT Dave Ellison, R.Ph., MPA

Missouri

Lead Facilitator: Ralph Fuccillo

Co-Facilitator: Kit Wagar

HRSA Representative: Suzanne Richards-Eckart, LMSW

Nebraska

Lead Facilitator: Nathan Ho

Co-Facilitator: Cindy Cento

HRSA State Lead: LCDR Delia Jones-McHorgh

A Special Note of Thanks to Our Co-Sponsors



Health Care Foundation of Greater Kansas City is dedicated to our mission of providing leadership, advocacy, and resources to eliminate barriers and promote quality health for uninsured and underserved in our service area.

Steve Rolling | President | 877-241-2006 | www.hcfgkc.org



Our vision is to improve the health of the people in the communities we serve. We empower the people of the communities we serve to achieve equal access to quality health services that promote prevention and encourage healthy behaviors.

Dr. James Kimmey | President | 800-655-5560 | www.mffh.org



The DentaQuest Foundation supports and promotes optimal oral health. We are a partner and collaborator in communities across the United States. We connect key stakeholders, raise awareness, and support solutions.

Ralph Fucillio | President | 800-655-5560 | www.dentaquestfoundation.org



The Office of Minority Health is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities.

LCDR Tracy Branch | Minority Health Consultant | 816-426-

Regional Oral Health Summit Evaluation

PRELIMINARY RESULTS

39 Responses

We want to hear from you. Please place a circle around the number that best describes your response. Rating Key: SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree

Opening Session: Judy Baker, HHS Regional Director		Results	
The session was effectively presented.	Strongly	Agree	
The session stimulated further thought and I felt it was beneficial.	54%		
Overall Rating for the Presenter(s)	Agree		
	46%	Disagree	
		Strongly Disagree	
New Landscape in Oral Health: Ralph Fuccillo/ CAPT Debra Scott/Dr. Peter Damiano			
The session was effectively presented.	Strongly	Agree	
The speakers were well prepared.	49%		
The speakers were knowledgeable about the subject.	Agree		
The session helped me gain a better understanding of the topic	51%		
Overall Rating for the Presenter(s)	Disagree		
	Strongly Disagree		
Panel of Federal Partners: Oral Health Access and Prevention			
The session was effectively presented.	Strongly	Agree	
The speakers were well prepared.	33%		
The speakers were knowledgeable about the subject.	Agree		
The session helped me gain a better understanding of the topic	62%		
Overall Rating for the Presenter(s)	Disagree		
	5%	Strongly Disagree	
State Breakout Groups			
The session was well organized and useful.	Strongly	Agree	
The session helped me to understand my role in promoting public-private partnerships to improve oral health.	49%		
Overall Rating for the Presenter(s)	Agree		
	43%	Disagree	
	5%	Strongly Disagree	

	3%	
State Report Out		
The session was well organized and useful.	Strongly	Agree
The facilitator(s) were effective in leading the group to discuss important topics.	45%	
	Agree	
The session helped me gain a better understanding of the regional oral health landscape.	55%	
	Disagree	
Overall Rating for the Session	Strongly Disagree	
Requests and Offers		
The session was well organized and useful.	Strongly	Agree
The facilitators were effective in leading the group to discuss important topics.	34%	
	Agree	
The session was useful in identifying public –private-partnerships and next steps.	63%	
	Disagree	
Overall Rating for the Presenter(s)	3%	
	Strongly Disagree	
Overall Program Evaluation		
	Results	
Overall, I feel that this meeting furthered the goals of promoting Public-Private Partnership in addressing the oral health agenda.	Strongly	Agree
The meeting room was adequate and comfortable.	50%	
	Agree	
The meeting was well organized and ran smoothly.	50%	
	Disagree	
Overall rating for the Meeting	Strongly Disagree	