

Office of Disease Prevention and Health Promotion

Healthy People 2020: Who's Leading the Leading Health Indicators?

Oral Health Webinar, August 20, 2012 12:00 pm ET

DR. DON WRIGHT: Welcome to the eighth installment of the monthly series Who's Leading the Leading Health Indicators? Each month, this series will highlight an organization, state or community addressing one of the Healthy People 2020 leading health indicators. This series includes a monthly webinar, email bulletin and active conversation via Twitter and LinkedIn.

During today's webinar you'll hear from distinguished speakers. First of all, Assistant Secretary for Health, Dr. Howard Koh will introduce this month's LHI topic, oral health. From the Maryland Department of Health and Mental Hygiene, Office of Oral Health, Dr. Harry Goodman will discuss the state's experience with leveraging partnerships to bring about statewide changes in oral health.

We are also joined by Rear Admiral William Bailey, Jane Casper, Daphene Altema-Johnson who will participate in today's discussion and the question and answer portion of the webinar. Before we hear from the other speakers, let me give you a brief background on Healthy People and the Leading Health Indicators. For four decades Healthy People has provided a comprehensive set of national 10 year objectives that has served as a framework for public health activities at all levels and across the public health community.

Healthy People is about understanding where we are now and taking informed action to get where we want to go over the next 10 years. The Leading Health Indicators, the focus for this series, represent critical health issues that if addressed appropriately will dramatically reduce the leading causes of preventable death and illnesses. These indicators are linked to specific Healthy People objectives. They've been selected to communicate high priority health issues to the public along with actions that can be taken to address them with the overall goal of improving the health of the entire population. There are 12 Leading Health Indicator topics, and this month we are focusing on oral health. For the complete list of the Leading Health Indicators and to view our past webinar presentations, visit <http://www.HealthyPeople.gov>.

At this point, I'd like to turn the podium over to Dr. Howard Koh.

DR. HOWARD KOH: Thank you, Dr. Wright for your leadership and many thanks to my colleagues at the Offices of Disease Prevention and Health Promotion for sponsoring yet another webinar and we want to thank the many across the country who are a part of this webinar to address the issues around oral health. Let me talk a little bit about the impact and context of this topic with respect to access and prevention, tooth decay and health disparities.

And when we talk about oral diseases, that encompasses a wide range of conditions ranging from cavities to cancer which cause pain and disability for millions. Yet we know that oral disease are largely preventable, and we are concerned that nationally, even though annual dental visits help combat oral disease, about 108 million people have no dental insurance.

And then furthermore when you see the overall impact of these conditions on society, particularly kids, we know that tooth decay affects more than one quarter of young U.S. kids age two to five and half of

adolescents age 12 to 15. And then in addition, there are very disturbing disparities according to educational attainment, family income, race, ethnicity and other dimensions. So this is a critical public health issue and we're very pleased to address it on this webinar.

The next slide shows the indicator for oral health, which is persons aged 2 years and older who used the oral health care system in the past 12 months and the next slide shows the trend or lack of trend over the last 10 years with respect to dental visits in the past year for those aged 2 years and over.

In short, you see an absolutely flat line with no increase in the percent of people who have dental visits in the past year from the baseline of about 43 percent. You can see from this slide that the Healthy People 2020 target is 49 percent or greater, so that's where we're aiming for the future.

The next several slides show the same data broken down by various dimensions that highlight the very critical theme of disparities.

This one shows dental visits in the past year for those aged 2 years and over by education and income according to year 2007 in green and 2009 in blue. On the left you see the trends by educational status. For persons aged 25 years and over, those who attended at least some college had the highest percentage of dental visits. That's about 58 percent, but, of course, with less educational attainment, that percentage is much, much less. And then on the right hand side you see the same trends by family income, and again, those with higher income over 400 percent of poverty have a much higher percentage of dental visits in the last year compared to those with much lower family income.

The next slide shows the same trends by race and ethnicity. White non-Hispanic populations have the highest percentage of dental visits in the past year, about 49 percent, but much lower rates for those of various racial ethnic backgrounds. And you can see the lowest rate for Hispanic-Americans which is about 28 percent. And then the last slide before I turn it over shows a new outcome here that we are reporting to you, untreated dental decay for kids and teens for children age three to five years in blue, children age six to nine years in green and adolescents 13 to 15 in red. For each of those you see startling rates of untreated dental decay for these three categories, ranging from 14 to ... rather from 11 to 17 percent and then great disparities according to race ethnicity or according to income for each of these three conditions.

So these trends you see over and over again for this very important public health topic and the question is how do we address this and build better systems to promote oral health and oral care and that's why we asked the State of Maryland and Dr. Goodman to come onto this webinar and discuss how Maryland has improved access to dental care by leveraging partnerships. So I'd like to turn the webinar now over to him.

DR. HARRY GOODMAN: Thank you, Dr. Koh. We are very honored to have been selected as the success story for this momentous occasion of oral health being highlighted as a Leading Health Indicator. We hope our story demonstrates how important oral health is to overall health and well-being and the role of partnerships and engaging stakeholders to recognize a sense of urgency and to act decisively once a tragedy strikes. Next slide.

This slide says so much, but drilled down it really shows that dental caries is the four most chronic disease in children and far more prevalent than other more well known diseases and maladies of childhood. Next slide, please. It's often easier to describe oral disease by seeing it. A picture tells a

thousand stories. Next slide. Given the fact that oral disease can have such an impact on a child's overall development potential, it is still alarming about how many children we find in Maryland, one of the wealthiest states in the country, with dental caries and that a relatively small proportion of them are receiving a proven oral disease prevention strategy in dental sealants.

And as is often the case with oral health, low income Maryland populations are disproportionately affected with a maldistribution of dental practitioners to provide services to them. Maryland has geographic and population-based dental health profession shortage areas statewide. Next slide, please. Of course the tragic event was the death of a 12 year old child Maryland Child, Deamonte Driver, due to an untreated dental infection.

Although we know there's deaths of a similar nature elsewhere, this story resonated because of its proximity to Washington, D.C. and our state's federal legislators. It has been widely reported that Deamonte lacked access to dental treatment services, but equally important is the fact that this child due to his low income situation also lacked access to needed education and prevention services that might have helped divert his need for treatment in the first place. Next slide, please. John Colmers, our Maryland Health Secretary at that time responded almost immediately and within months convened a Dental Action Committee to develop a series of recommendations to improve oral health access in Maryland. The DAC consisted of about 26 organizations representing government professional medical dental organizations, advocacy groups, insurance companies and family support groups. A report was developed within three months resulting in seven main recommendations spanning many significant reforms.

And as you can see, all were approved and many of them enacted within less than a year, receiving state funding through Governor Martin O'Malley's budget and receiving federal and state legislative support was key. But what's most important here was that many of the partners who participated on the DAC had already been working together for years prior to Deamonte's death on plans and activities to improve the oral health access situation in Maryland. When the DAC eventually met and deliberated, the plans flowed out and passage of all the recommendations occurred with minor opposition. Next slide, please. Probably the most significant of the reforms dealt with changes in our Medicaid dental program which previously was part of a system that contracted with multiple managed care organizations. The new dental Medicaid program now renamed Maryland Healthy Smiles was carved as a system and contracted with a single Medicaid dental vendor.

Another obviously important Medicaid reform was increasing many procedures to the median fee charged by local dentists as established by the American Dental Association. Other initiatives included expanding the dental public health safety net system, creating a new workforce category and utilizing public health dental hygienists and piloting a dental screening program in schools and entails case management and care coordination. Next slide, please.

Other initiatives including partnership with our state oral health coalition, developing an oral health literacy campaign called Healthy Teeth, Healthy Kids which targeted low income families of children ages 0 to 6 and pregnant women. The purpose of this media campaign was to inform this population about the importance of oral health and to empower behavior change with regard to home prevention activities and the need to seek professional oral health services. A website, <http://www.healthyteethhealthykids.org> and a hotline were also developed. Also, in partnership with our Medicaid program we instituted a statewide program, Maryland Mouths Matter that provide Medicaid reimbursement for fluoride varnish application by medical providers during well child visits for

young children so long as they completed our own training program which gives them guidance in risk assessment, anticipatory guidance, prevention and referral to dentists.

And finally, we partnered with the University of Maryland dental school to provide training in pediatric dentistry to general dentists in order that they feel more compelled to treat very young children. Next slide, please. You can see the outcomes from these reforms; considerably higher access for Medicaid children, greater participation by dentists in Medicaid dental program and a higher number of fluoride varnish applications to Medicaid kids from trained medical providers.

For this, we thank our Medicaid program for all their efforts. We also have now an expanded oral health safety net system and we recently completed our Healthy Teeth, Healthy Kids social marketing campaign. We are currently evaluating this campaign and hope to extend it. Next slide, please.

Partnerships were key to our success in Maryland. We value and have great partnerships with both our state dental and dental hygiene associations which is critical. But you cannot discount all the work done prior to the DAC to develop partnerships and spread the gospel of oral health when the state ranked among the lowest in access in the country. The partnerships started with the traditional dental circles but eventually spread to groups that we quite frankly didn't know existed and did not know had a vested interest in oral health. In time we found both federal and state legislative champions through countless visits with them. Everyone was primed and motivated to do something when this tragedy occurred and to do something more than had been previously done. The DAC did not spend very much time if at all in discussing the problems since everyone knew what they were. It immediately went into developing solutions. This was not about individual agendas, but rather the big picture of improving oral health. It was very important to have the dental and medical societies as well as government on board with these proposals, but I think it was equally important that they were exposed to some of the issues that the advocates and parent groups brought to the table. A real trust between everyone ensued and as the success of the DAC and its recommendations became known, the collective group developed a sense of pride about itself.

And with this trust and credibility and good tidings came all the benefits that come with it, pool political capital, partnership in developing new policies, access to new and expanded networks and a sense of urgency and empowerment to solve a common problem. This led to the metamorphosis of this committee into an independent statewide coalition. Next slide, please.

These strong successful partnerships allowed the old DAC to make a smooth transition into the independent Maryland Dental Action Coalition or MDAC. The MDAC developed early success by finding common ground and bringing stakeholders together to support cross cutting legislation and policies. In short time it became the main independent voice for Maryland stakeholders on oral health. And as you can see, the Office of Oral Health collaborated closely with the MDAC on the oral health literacy campaign, the co-sponsorship for a statewide oral health summit and in development of the Maryland State Oral Health Plan to bring DAC recommendations to fruition. While important that it established early success to gain credibility, hopefully when controversial issues emerge in the future, the MDAC will be better prepared and certainly have the confidence to deal with it. Jane Casper is here representing the MDAC and I'm sure can answer any questions regarding further details about it. Next slide, please.

Maryland did receive some national accolades and attention from our federal and national partners, which is always appreciated since it makes it easier to get support locally, but much more needs to be done. There are many great state oral health programs out there, and we know the state oral health

programs in every state can play an important role and need to be supported so they can in turn better support oral health as a Leading Health Indicator. Next slide, please. Here's just a short list of where we still need to go in the future. Primary is implementation of the state oral health plan, which encompasses many of the items that you see on the list. And next slide, please.

And finally, this slide kind of speaks for itself. This is what happens when I speak to my sons. So thanks for your attention and hopefully you didn't have the same reaction. Thank you.

DR. DON WRIGHT: Thank you, Dr. Koh and Dr. Goodman. I invite participants who have not already done so to send their questions through the WebEx Q&A feature or via Twitter using the #LHI. We're also joined by Rear Admiral William Bailey, Jane Casper and Daphene Altema-Johnson. These individuals can respond to your questions about this LHI topic and the presentations we've seen today. Rear Admiral Bailey is the acting Director of the Division of Oral Health in the Center for Disease Control and Prevention. Jane Casper is the Vice Chair of the Maryland Oral Health Plan and a board member of the Maryland Dental Action Coalition. Daphene Altema-Johnson is an epidemiologist and evaluator in the Office of Oral Health at the Maryland Department of Health and Mental Hygiene.

You'll be promoted to fill out a survey about your experience with this webinar during the Q&A session.

We encourage you to complete the survey so that we can improve future webinars in our series, and let me thank you in advance for your feedback. We already have a number of questions that have been submitted. The first question actually goes to you, Dr. Goodman. Is there a master evaluation program for the implementation of the DAC recommendations and are individuals' programs evaluated separately?

DR. HARRY GOODMAN: I'll answer the last question first that yes, the individual programs are evaluated separately. In terms of the bigger picture, we really are evaluating the overall reforms basically through our Medicaid data that continues to improve every year. I think the bottom line in terms of the reforms was to ... and similar to this Healthy People 2020 objective to increase access to care and so access will be evaluated in terms of the proportion of the population served obviously as well as the number of dental health practitioners that join the Medicaid program as well as now improving also the ... increasing the number of medical providers to provide new portals for access for the very, very young children who go to them, to well child visits.

So there is indeed an evaluation plan and with Daphene Altema-Johnson who is also our evaluation specialist, we're currently looking at how we're doing.

DR. DON WRIGHT: Thank you, Dr. Goodman. Jane, it looks like we have a couple of questions lined up for MDAC. The first question, how did the MDAC engage their partners and ensure continued commitment from their coalition members?

JANE CASPER: Well, actually, it's a very diverse group of oral health champions in Maryland, including Medicaid and our state legislature. And while the original Dental Action Committee's focus was on access to care for children, the mission of the MDAC is expanded to include access for adults.

DR. DON WRIGHT: Thanks, Jane, and one additional question, an execution question. How did the MDAC identify priorities for the Maryland Oral Health Implementation Plan?

JANE CASPER: Okay, there were 80 different stakeholder groups involved with the design of the Maryland Oral Health Plan. The MDAC split into three different groups and we had co-leaders ... we have co-leaders for each of those groups. The work groups are access to care, oral disease and injury prevention and oral health literacy and education, and each of these groups was charged with coming up with the priorities and the activities to achieve the goals of the Maryland Oral Health Plan.

DR. DON WRIGHT: Thank you, Jane. Rear Admiral Bailey, it looks like the next question is for you. What is being done to address oral health among minority groups? Do you know of some successful community wide interventions?

REAR ADMIRAL WILLIAM BAILEY: Yeah, there are a number of things done at the HHS level to address oral health among minority groups. One of those is of course to monitor the Healthy People objectives that are focused on disparities. Examples of things being done at CDC, for the first time ever, CDC oral health will be included in the CDC health disparities and in a qualities report.

We're also developing fact sheets for communities on water fluoridation that will be targeted to ethnic and minority population groups. As far as NIH, NIDCR's funding the centers for research to reduce disparities in oral health. They have numerous and varied types of studies underway on understanding and eliminating inequalities. The Center for Medicaid and Medicare has a new oral health initiative and they have two performance objectives. One is to increase by 10 percentage points over the next five years the number of enrolled children aged 1 to 20 who receive a preventive dental service and the second is for children age 6 to 9 that are receiving sealants. Indian Health Services has a new early childhood caries collaborative that includes providers of many different types that are looking to decrease early childhood caries for children age 0 to 5 with a goal of decreasing this by 25 percent over the next five years. And HRSA has a number of activities that are scholarships, loan programs, providing oral health services to people living with HIV, outreach grant programs for the Office of Rural Health Policy. There are so many things being done across HHS to address disparities, and as far as community interventions, there are also many, many examples of those, school-based sealant programs, especially those targeted at schools that have high rates of free and reduced lunch programs, children on free and reduced lunches.

Of course community water fluoridation is an outstanding preventive intervention that communities are working on and many communities have also fluoride varnish programs that involve not only oral health professionals but other types of health professionals applying fluoride varnishes for children's teeth.

DR. DON WRIGHT: Thank you, Dr. Bailey. Dr. Koh, a question for you. Does HHS have resources to help states strengthen their infrastructure? Infrastructure is so critical in order to serve populations.

DR. HOWARD KOH: Well, we want to work closely with states and local leaders on this key public health issue, and in fact, we have an oral health cross department initiative that was launched in 2010 and Admiral Bailey reviewed many of the highlights from many of the agencies. In particular, I want to stress that we have great leadership at CMS and at Medicaid and there are some programs to focus in on particular eight state Medicaid programs that have really offered some new innovation here.

So we're trying to take our current resources and integrate them and coordinate them even better. I should also mention that there's a very active new national oral health alliance and the advocates here have worked very strongly and closely with us, so we hope to take all these efforts up to a higher level in the very, very near future and maximize all the resources that we have at our disposal.

DR. DON WRIGHT: Thank you, Dr. Koh. A question that perhaps Dr. Koh or Rear Admiral Bailey can answer, how do we build better systems to promote oral health care?

REAR ADMIRAL WILLIAM BAILEY: Well, this is Bill Bailey. One of the things we need to do is to better integrate oral health into overall health care and we're doing that by extending partnerships, some of the partnerships that Dr. Goodman talked about, those types of things, but systems have to look beyond what is just ... those that involve just oral health proponents and people that are working in oral health but they also have to involve the other health disciplines so that we can build systems that really focus on health and not just oral health and to integrate oral health into overall health.

DR. HOWARD KOH: And this is Howard Koh. I would back that and support that and also stress that Dr. Goodman's excellent presentation has many themes that we all can learn from as a nation to involve other types of providers to stress more communication with the public through an emphasis on health literacy, to bring in more kids through Medicaid particularly because that's where the disparities are very focused.

These are all very, very important themes and so I want to echo what both Admiral Bailey and Dr. Goodman said.

DR. DON WRIGHT: A follow up question from Twitter for you, Dr. Goodman. What are examples of what the state of Maryland has done in the past and is doing to build those better systems of prevention?

DR. HARRY GOODMAN: Well, we've actually come from far behind, but one of the big systems that we're truly working on is our school-based dental sealant programs. We really feel first of all dental sealants along with community water fluoridation are the two evidence-based prevention strategies that is obviously known. And while the state has done incredibly well in terms of our community water fluoridation, we really have been lax in our school sealant projects.

And that's because for many years we didn't have a state oral health program to sort of develop a focus for such a statewide initiative so they were done just on a local level. But now we're coordinating and coalescing all those activities and truly promoting the provision of sealants in schools. We also ... something kind of lost I guess in today's discussion is that we developed a public health hygienist category as a result of the Dental Action Committee recommendations.

And our health departments and federally qualified health centers and other public health entities are increasingly using this very critical workforce to provide preventive services in schools, in Head Start programs, WIC programs and the like. And we can only continue to increase those critical efforts, and that's what our plan is right now in terms of prevention.

DR. DON WRIGHT: Thank you, Dr. Goodman. Our next question was submitted from an employee at a community health center and I think Rear Admiral Bailey, you'd be appropriate for this question. I work in a community health center. Can you give me some direction on where we can find some oral health literacy materials to educate our patients many of whom come only for emergencies and not for preventive care?

REAR ADMIRAL WILLIAM BAILEY: Yes. A broad array of oral health literacy materials have been developed. CDC has resources, HRSA has resources, Indian Health Service has resources. Maybe we can make those available somehow, but there are a number of tools and resources related to health literacy.

You know, for the federal government there's something called the Plain Language Act that requires the federal government employees that are putting out any regulations and so forth to write in plain language.

Something that's encouraging is for the first time ever this year, the IOM round table on health literacy held the first ever day long workshop on oral health literacy, so there is greater emphasis on oral health literacy. There are lots and lots of resources. I'm not sure how we can make those available but we can certainly explore the avenues, but there are many, many out there and you can just look at some of the HHS websites, CDC, HRSA and so forth and you'll find lots of materials on health literacy.

DR. HOWARD KOH: This is Howard Koh. I can also add that Dr. Seiji Hayashi at HRSA has leadership in many of these oral health outreach and education and health literacy themes, so if you want a main contact person at HRSA, I'm going to put his name forward here.

DR. HARRY GOODMAN: This is Harry Goodman, and I want to reiterate driving people to our own website, which is <http://www.healthyteethhealthykids.org> and also we have in our own backyard one of the foremost experts in oral health literacy in Dr. Alice Horowitz who's now at the University of Maryland at College Park School of Public Health.

DR. DON WRIGHT: Thank you. Dr. Goodman, a very specific question from one of our listeners, where can we find the locations of the five public health clinics in Maryland?

DR. HARRY GOODMAN: The new public health clinics were in areas that were previously noted to have no public health facilities whatsoever, so they are really in five different counties. I can name them if you want, but those are counties that when we first started our reforms we basically did an environmental scan of all the jurisdictions in the state and these were found to have absolutely no public health resource, that being not a FQAC or a local health department.

And so we've been able now to basically fund through state funding and through other resources as well programs in those particular five jurisdictions. I will say that they are a combination of rural and suburban counties. Well, actually one is actually a rural county, but they really span the type of populations that live there.

DR. DON WRIGHT: Thank you, Dr. Goodman. Rear Admiral Bailey, I think the next question would be for you, and I think you touched on this in one of your previous answers. Why is it important for everyone in different areas of health care to be concerned about oral health such as medicine, dentistry and pharmacy?

REAR ADMIRAL WILLIAM BAILEY: Well, not everybody accesses care from their dentist and we heard on the call earlier that over 100 million people don't have dental insurance coverage, so people are going to other types of providers and those other types of providers can help to integrate oral health into primary health care. There are groups now that are teaching other types of providers to conduct an assessment and to alert patients of their oral health needs to try to refer them to the proper care that they need.

But by doing this they can also consider oral health conditions when they assess the patient's overall health. They can also assist in being willing to deliver oral health preventive interventions and, you

know, this increased partnering helps to integrate health across all disciplines. There are some medications that cause things such as gingival hyperplasia and xerostomia which is dry mouth.

Xerostomia puts people at a higher risk for tooth decay and there are a number of types of medicines such as antihypertensives and antidepressants and antihistamines and so forth that can cause a person to have dry mouth, so it's important for other types of professionals to know about oral health, and in fact, some initiatives have been launched by other types of professionals.

There's a national interprofessional initiative for oral health that is being driven by physicians and physician assistants and nurses and pharmacists about oral health to make sure people are more informed about oral health issues and they've developed a Smiles for Life curriculum which is a nice curriculum that can be accessed by the Internet.

DR. DON WRIGHT: Thank you...

REAR ADMIRAL WILLIAM BAILEY: So yeah, that's good.

DR. DON WRIGHT: Thank you, Dr. Bailey. Another question for you, Dr. Goodman. Has Maryland's Office on Oral Health worked with the Maryland Dental Action Coalition on any school-based intervention? If so, how were the schools and communities engaged?

DR. HARRY GOODMAN: Well, we're just getting going in that. Of course as part of our state oral health plan we work to basically include that as a very critical part of our work with MDAC but we did work with them to actually help co-write a proposal to the Kaiser Foundation. They received a pilot school screening grant which they're currently in the middle of right now to try to test efficiencies in terms of basically providing care coordination case management to kids who were screened in schools and then if needed referred to the dental home.

And they're sort of piloting that connection point between the screening and then the actual receipt of any needed follow up care, so we've been pretty active on that. As I said earlier, we're only going to continue to do more in this particular area. It's a really big emphasis for us.

DR. DON WRIGHT: There's two questions about what's happening nationwide, and I think Rear Admiral Bailey, you can help with this. First of all, are there any states on which states require dental exams prior to enrollment in daycare and secondly, Maryland is often used as a great example. Are there any other known success efforts in other states?

REAR ADMIRAL WILLIAM BAILEY: As far other states that have successes, there are a number of other states that have had considerable successes. Wisconsin comes to mind. The Wisconsin Seal-A-Smile program has worked to raise visibility of that essential preventive intervention, and just this year the state legislature in a time where the state is under some tough budget constraints, they appropriated 500,000 additional dollars for state sealant programs.

The state of Arkansas passed a statewide fluoridation legislation that will now provide benefits of fluoridated water to people living in communities of 5,000 persons or more. And what was the first question? I'm sorry.

DR. DON WRIGHT: Are there any states on which states require dental exams prior to enrollment in daycare?

REAR ADMIRAL WILLIAM BAILEY: Yes, and I don't have those in front of me, but if people on the call will go to the Children's Dental Health Project, they've looked at that and I believe that they're available on that website.

DR. DON WRIGHT: Thank you, Dr. Bailey. Another very broad question for Dr. Koh. What is the Department of Health and Human Services doing to address oral health?

DR. HOWARD KOH: So I think I alluded to this oral health initiative that we launched in 2010, and again, Admiral Bailey and others have commented on the contributions of various agencies. We've talked about the contributions from CMS and Medicaid in particular. Admiral Bailey talked about the Indian Health Service and their early childhood caries effort. I did want to thank the CDC. We have some CDC colleagues in the room because they have given grants to some 20 states for state-based oral disease prevention programs.

But this is an opportunity that I believe we can do more as a department and as a nation, and as I mentioned earlier, there is a new national oral health alliance and so we have been in discussions with them about whether we can take some of these efforts that were started in the department in 2010 and earlier and move them up a couple levels, so those conversations are occurring now and by including oral health as one of the Leading Health Indicators we want to show how important this is for our department and the country.

DR. DON WRIGHT: Thank you, Dr. Koh. We have another question for you, Jane Casper. Once priorities were identified for the plan, how did the MDAC and OOH determine where to focus implementation efforts?

JANE CASPER: Well, that was easy. There were already activities due to the continuation of the momentum from the DAC recommendations and we looked for what Dr. Goodman has already said, the low hanging fruit, things that were achievable considering our current economic atmosphere. And we are building on the resources we already have such as the oral health literacy campaign that was kicked off in Maryland in March of 2011.

DR. DON WRIGHT: Thank you, Jane. Another question for you, Dr. Goodman. How are your various stakeholders and partners engaged in evaluation and planning?

DR. HARRY GOODMAN: Well that's going to definitely come through the Maryland Oral Health Plan essentially, because we really ... in that plan, it's a very comprehensive plan. It gets into areas where we have made, you know, maybe just medium progress such as oral health for adults as an example, which is something we're all striving for, but I think it's the implementation of that plan through the stakeholders which is through the Maryland Dental Action Coalition that's going to really help drive policy, help drive activities and certainly in and of itself serve as an ongoing evaluation of our progress.

We're placing a lot of stake in that plan and a lot of effort has gone into that plan and is still going into that plan as we speak.

DR. DON WRIGHT: Thank you, Dr. Goodman. A question for you, Rear Admiral Bailey. Can you speak about how a state would go about integrating dental care in medical homes which are currently being created under the Affordable Care Act?

REAR ADMIRAL WILLIAM BAILEY: Yeah, well first, you know, you had mentioned that CDC funds states to build infrastructure and capacity. One of the recipient activities for that is building collaboration, so first thing to do is to establish relationships and some kind of systems to integrate oral health into overall health. But once you start establishing those relationships and children are regularly being referred by other types of providers to dental homes, then it's a process of finding the people that will take those children into dental homes.

I know that one of the things of the HHS Oral Health Initiative is to find dental homes for children, and over the past several years over a thousand new dental homes have been established, and it's just a lot of hard work really. It's knowing the dental network, it's knowing the other provider's networks and it's trying to match these children with needs up to people who will do that.

One of the things that the CMS is doing currently is their new national oral health strategy is developing state plans in all 50 states to look at this to see how they can increase access to Medicaid children to increase the numbers of children receiving the necessary services, and so these state plans are being developed under CMS's leadership.

DR. DON WRIGHT: Thank you very much. I regret that we're not going to be able to get to all the questions that have been submitted today. Perhaps we have time for two more questions. Jane, the next question is for you. Regarding the educational component, how did you get your coalition funded? Is it a long-term resource? Are the messages potentially available for other states to use for their efforts at educating their residents?

JANE CASPER: Well, yeah, actually, they can go on the website of the Maryland Dental Action Coalition and it's <http://www.MDAC.us> that will have the plan and right now we are looking into funding from various sources, grants that are available because we will need resources, financial resources to continue.

DR. HARRY GOODMAN: This is Harry Goodman. You know, the coalition was originally seeded through our CDC cooperative agreement and then it led to funding by the DentaQuest Foundation and the MDAC now has actually applied for another grant, the Oral Health Alliance 2014 and has developed a very interesting Maryland Oral Health Learning Alliance, so they're going for that.

They're really going for multiple sources of funding and the fact that they have an executive director and a staff and the support of all the stakeholders in the state I think goes a long way to their sustainability, but it's always going to be a challenge.

DR. DON WRIGHT: Thank you, Jane, Dr. Goodman. Dr. Goodman, I'll give you the last question for the day. How do you plan to monitor policies and how will you identify if policies need to be changed or revised over time?

DR. HARRY GOODMAN: Well, we actually developed sort of a crosswalk. One of our staffers who works on policy has really basically cataloged all our policies and basically is tracking them in time and we basically look at that crosswalk from time to time and see whether they're effective, whether they're working, and again, those policies get almost woven into the state oral health plan itself basically, because the policies that have been established really have become in many ways the goals, the objectives of the state oral health plan.

We actually worked with the children's dental health project on developing a template to monitor policy and because of having that crosswalk template, it kind of keeps it on our radar, so policy has been very, very important to our state. We actually built our program off legislative and other kinds of regulatory initiatives, so it's something that comes pretty natural but it's something we're always going to have to kind of monitor.

DR. DON WRIGHT: Thank you, Dr. Goodman. Again, I regret that we're unable to answer all the questions that have been answered today but hopefully we addressed a representative number. Let me end by thanking you for joining today's webinar. This webinar is part of a series and we hope you'll continue to join us. Healthy People is looking for real stories from organizations that are working to make its goals a reality.

If your organization is doing great work on specific Leading Health Indicator topics, we want to hear about it. Go to <http://www.HealthyPeople.gov> to submit your story.

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