History of 'Mid-levels' in Dentistry and AAPD's Position

James J. Crall, DDS, ScD
AAPD Child Advocate

Chicago, IL
September 24, 2010

Presentation Overview

- History and description of various types of ‘mid-level’ providers in dentistry
- Context and drivers of recent initiatives
  - What’s similar this time around?
  - What’s different from previous efforts?
    - Foundations’ involvement
      - PEW, Kellogg, others
    - Involvement by various groups
- Summary of AAPD’s Position on ‘Mid-levels’
- Considerations going ‘forward’
- Conclusions / Q&A

‘Mid-level Providers’

Existing models:

- Dental Therapists (Dental Nurses)
- Expanded Function Dental Assistants (EFDAs)

  Work as part of dental teams and provide limited scope of restorative and surgical services under varying levels of dentist supervision.

Proposed models:

- Advanced Dental Hygiene Practitioners

  May work without dentist supervision or standing orders
- Community Dental Health Coordinators

  Provide preventive services, organize community services, link patients to dental care providers

‘Mid-level Providers’

Existing models:

- Dental Therapists (Dental Nurses)
  - NZ (1921), AU (1970s), UK, Canada (1972)
  - AK (2005), MN (2009)
- Expanded Function Dental Assistants (EFDAs) (1970s)

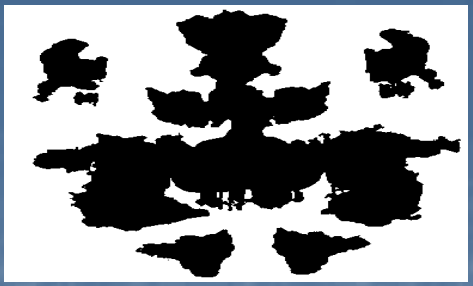
Proposed models:

- Advanced Dental Hygiene Practitioners
- Community Dental Health Coordinators

Dental Therapists

- New Zealand Dental Therapists (Dental Nurses)
  - Started in 1921 when 30 ‘dental nurses’ began a two-year training program sponsored by NZ federal government to address high levels of dental disease in children
  - Trained to perform oral examinations, develop treatment plans, provide preventive services, administer local anesthesia, prepare and restore primary and young permanent teeth, and extract primary teeth
  - Operate under the supervision of a principal dental officer of the district health board and provide dental services for a high percentage of New Zealand children
  - Use of NZ therapists is being restructured with greater emphasis on working in community settings as part of dental teams that include dentists

What Do We Really Know about the NZ and Other International Experiences?



The New Zealand oral health therapist program is touted by some as the model for this country's foray into a mid-level provider system; yet in 2004, a DHBNZ report declared the School Dental Service to be "in strategic crisis" and noted that inequities continue to exist, notably with low-income, minorities and rural populations. The report further concluded that many facilities were run down, not suited to modern practice and non-compliant with health and safety standards.

Impact / Cost / Sustainability of School-based Programs?

***Improving Child Oral Health and Reducing Child Oral Health Disparities. NZ National Health Committee*, May, 2003.**

Summary of main points – Chapter 2

A range of child oral health services are provided for New Zealand children, including care provided by school and community dental therapists, private dental practitioners (under the Special or General Dental Benefit schemes), or specialist hospital departments. The utilisation of the school dental services by school-age children is very high, but it is of concern that preschool uptake is variable, and considerably lower among Maori, Pacific people and those from groups of lower SES. The uptake of dental services by adolescents is considerably less than optimal.

Recent routinely collected school dental service data indicate that, nationally, 53 percent of five-year-olds are caries-free, with a mean mft of 1.8. At Year 8 (12–13 years), 42 percent are caries-free, with a mean MFT of 1.6. The prevalence and severity of dental caries vary considerably by region. Overall, regions with the highest percentage of children receiving fluoridated water have the lowest overall caries rates as well as lower socioeconomic and ethnic differentials in dental health. Caries rates in New Zealand children decreased steadily from 1980 to the early 1990s, but have either remained static or increased slightly since that time.

Comparison of US and NZ Kids at Age 12

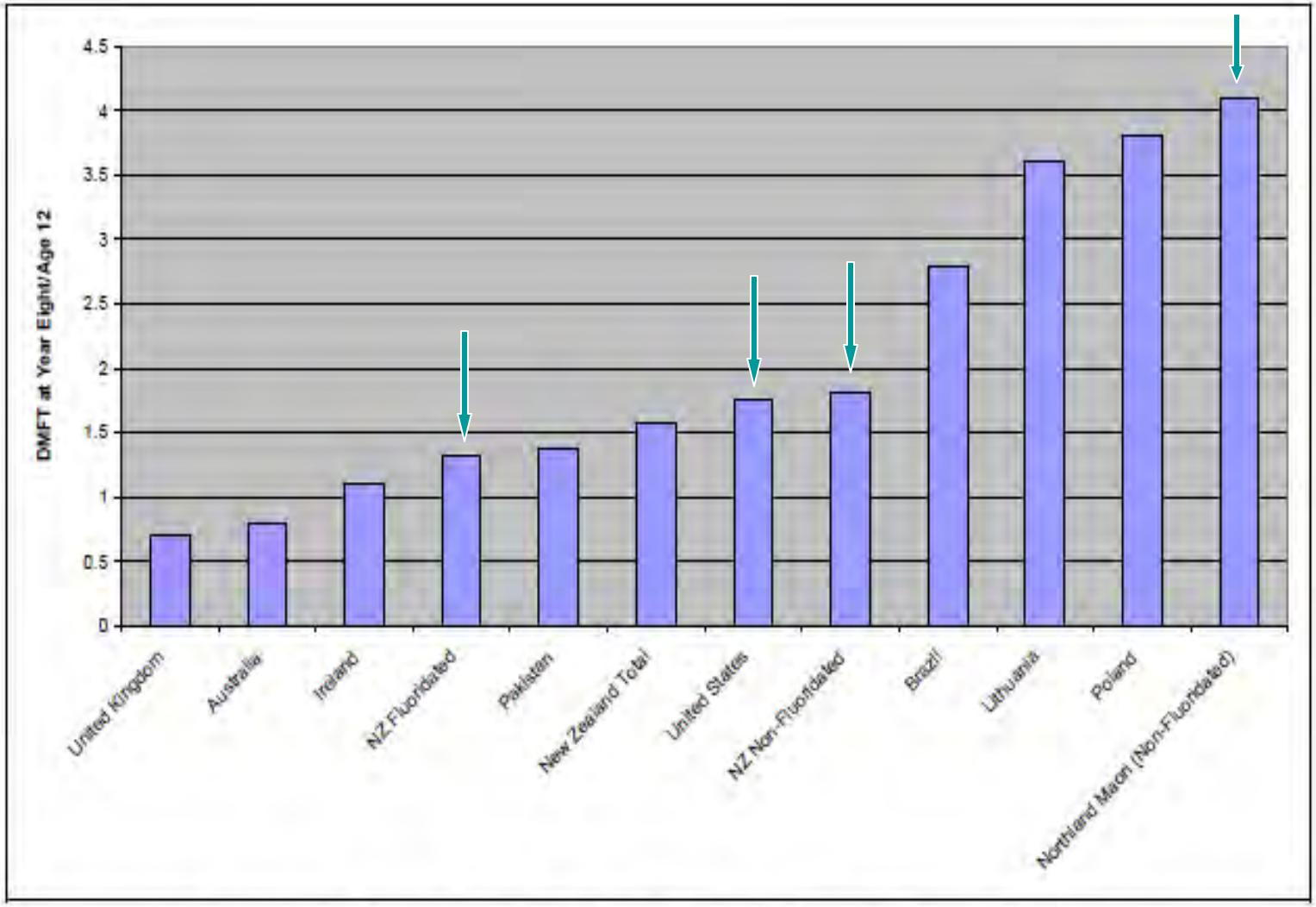


Figure 2: DMFT at Year 8/Age 12 by Country (WHO, 2004)

Intent ←→ Future?

Ayers KM et al. The working practices and career satisfaction of dental therapists in New Zealand. *Comm Dent Heal* 2007;24:257-63.

- High career satisfaction but much less satisfied with remuneration
- Done in 10 years with dental therapy
- Younger DTs were more interested in moving to private practice (also seen in UK & Australia)
- A mean of 6.5 years in career breaks for therapists

Dental Therapists

- Canadian Dental Therapists (+UK & Australia)
  - Modeled on NZ Program and begun in 1970s
  - Introduced to address the shortage of dentists in remote regions
    - Canada: Territories with 330,000 inhabitants, mainly indigenous people such as First Nations and Inuit
  - Now allowed to work in various practice settings and all jurisdictions
  - Work in conjunction with licensed dentists under general supervision
  - Provide services to any age group (not just children)

Dental Therapists

- Canadian Dental Therapists (+UK & Australia)
  - Dental therapists employed by the First Nations and Inuit Health Branch fall under the professional and general supervision of the Regional Dental Officer position.
  - Professional supervision provides a formal relationship that is the vehicle for liability coverage by the federal government

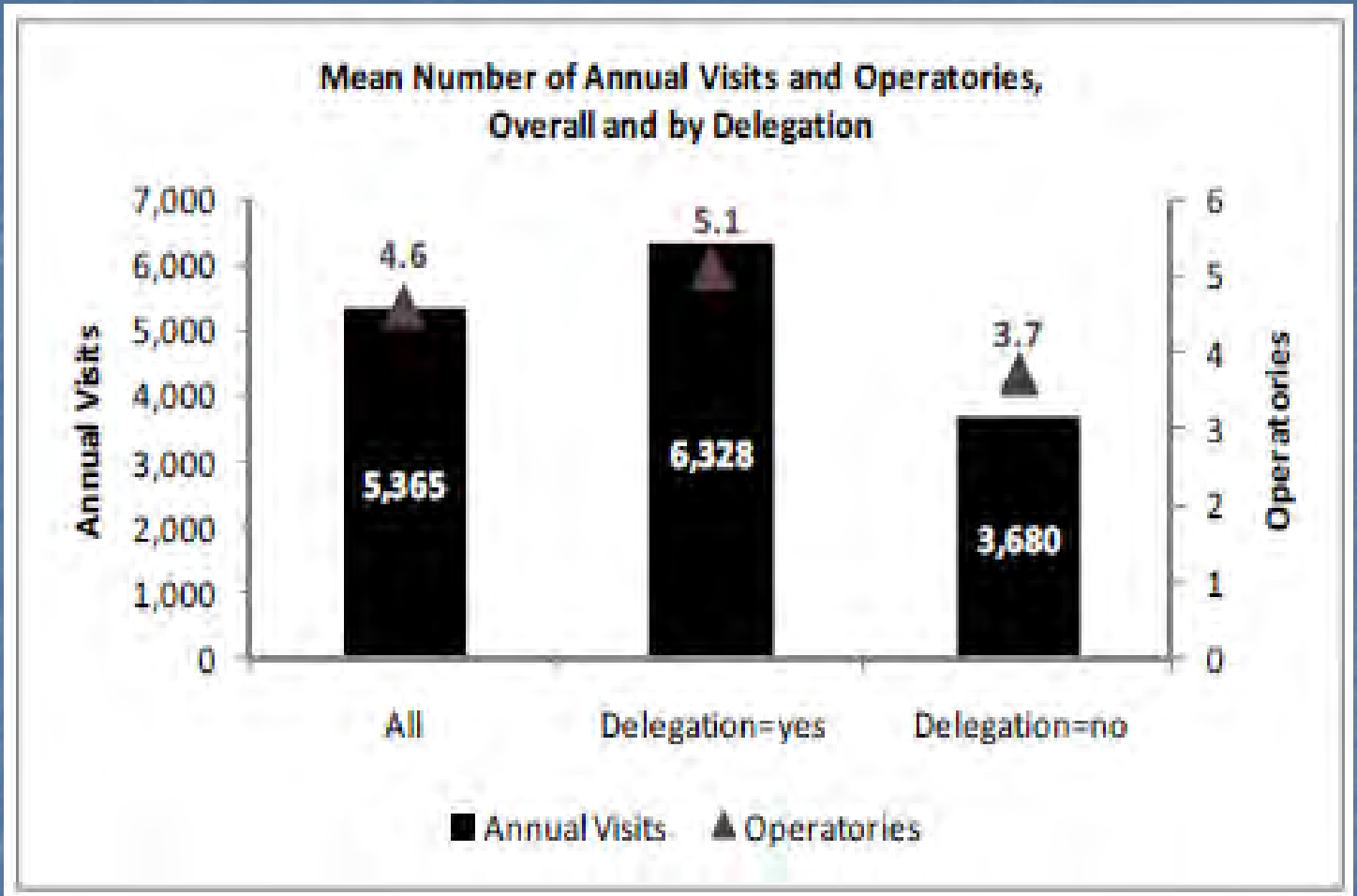
Dental Therapists

- Alaska Dental Health Aide Therapists (DHATs)
  - Model similar to NZ and Canada
  - Attempt to improve access to dental care in remote outlying areas within tribal lands
  - Provide basic oral health care in the context of the Community Health Aide (CHA) program, authorized by federal statute, in which tribes provide primary health care throughout Alaska
  - Meet specified training requirements, undergo a protracted preceptorship, work under general supervision, and have skills reevaluated biannually

Expanded Function Dental Assistants

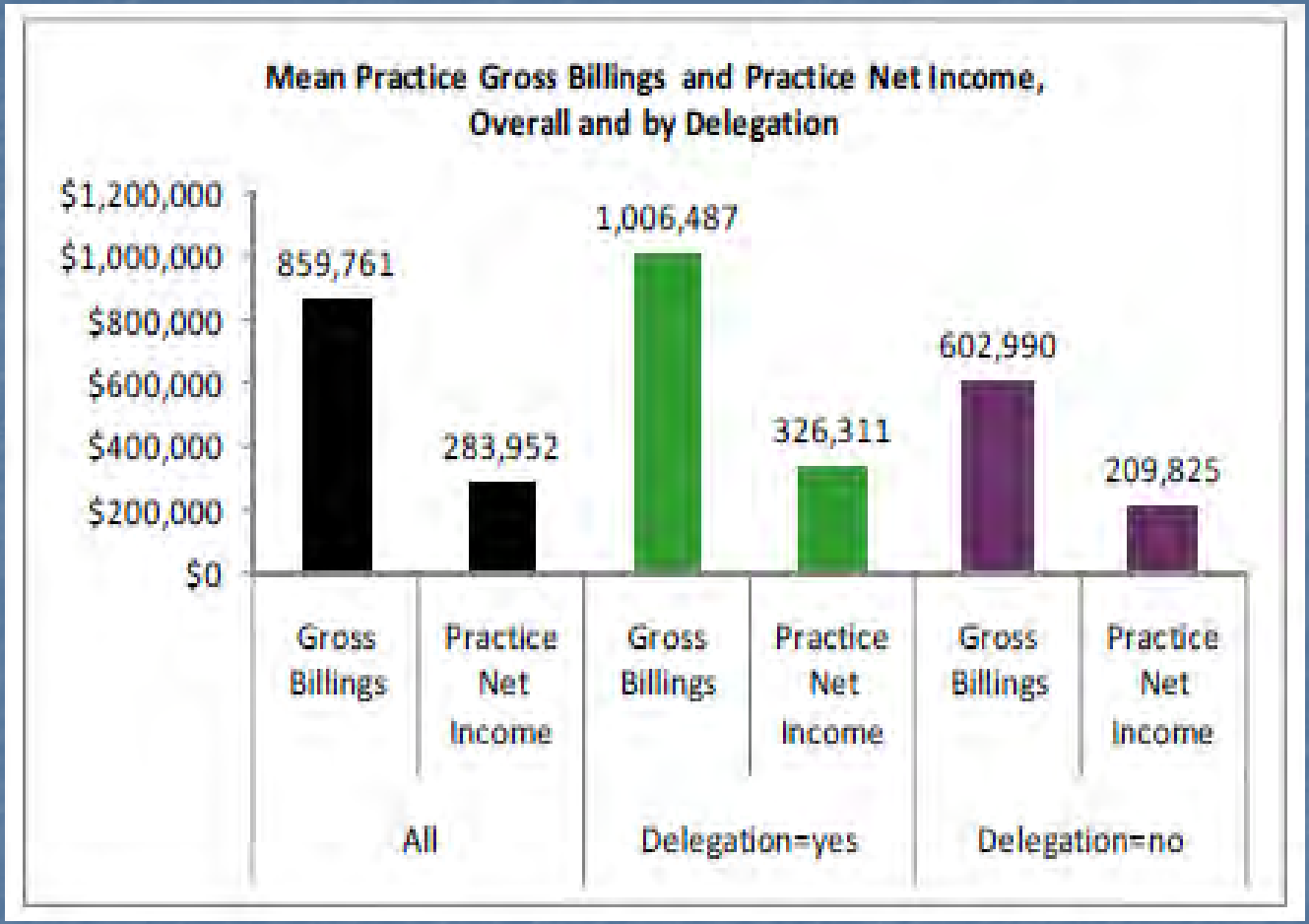
- EFDAs
  - Permitted under numerous state dental practice acts since the 1970's.
  - Allied health professionals who, under the direct supervision of a licensed dentist, can perform various reversible restorative procedures and other specified services (vary by State)
  - Generally include those who were previously trained and have experience as dental assistants, certified dental assistants or dental hygienists
  - Used by the Armed Forces and programs sponsored by several other federal agencies

EFDAs and Productivity



American Dental Association: An economic study of expanded duties of dental auxiliaries in Colorado, 2010

EFDAs and Productivity



American Dental Association: An economic study of expanded duties of dental auxiliaries in Colorado, 2010

EFDA Advantages:

- Permits wider range of ‘one-stop services’
- Dental home advantage
- Case management advantages
- Special needs advantages
- Increased capacity and cost-effective

‘Mid-level Providers’: Proposed Models

- Minnesota Dental Therapist Model
  - In 2009, Minnesota adopted legislation to begin training two proposed types of mid-level providers
  - Resemble existing dental therapist models noted above in terms of scope of services and requirements to function as part of dental teams under the supervision of dentists
  - DTs will require on-site supervision by licensed dentists and won’t be able to extract permanent teeth
  - Advanced dental therapists will need at least 2,000 hours of practice as a dental therapist and additional education, testing and certification beyond that of a dental therapist in order to treat patients without a dentist onsite

‘Mid-level Providers’: Proposed Models

- Community Dental Health Coordinators
  - Provide education and preventive services, organize community services, and link patients to dental care providers
- Advanced Dental Hygiene Practitioners
  - Proposed authority to practice without dentist supervision
  - Would mirror many services performed by dentists, including rendering diagnoses and providing irreversible procedures
    - e.g., restorations & extractions

Context and 'Drivers': What's it all about ? Where's the evidence?

- Access? Availability?
- Disparities?
- System redesign?
- Competition? Lower cost?
- Increased awareness?
- Increased commitment to oral health?
- ????

http://www3.interscience.wiley.com/journal/118502703/home

JOURNAL OF
Public Health Dentistry

Improving Oral Health Care Delivery Systems through Workforce Innovations

JPHD Special Issue
Release June 2010

JPHD Special Issue: Purpose

"The purpose of the special issue is to further develop ideas presented at the 2009 Institute of Medicine (IOM) workshop, *The Sufficiency of the Oral Health Care Workforce in the Coming Decade*. Using the IOM discussions as their starting point, the authors evaluate oral health care delivery system performance for specific populations' needs and explore the roles that the workforce can play in improving the care delivery model. The contributing articles provide a broad framework for stimulating and evaluating innovation and change in the oral health care delivery system. The articles in this special issue point to many deficits in the current oral health care delivery system and provide compelling arguments and proposals for improvements." – *Elizabeth A. Mertz and Len Finocchio*

Contributors

Funders

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Editor in Chief

Dr. Robert Weyant, DMD, DrPH

Guest Editor

Elizabeth Mertz, PhD, MA

Authors

- Elizabeth Mertz and Len Finocchio
- Scott Tomar and Lois Cohen
- Irene Hilton and Arlene Lester
- Wayne Wendling (ADA)
- Burton Edelstein
- Paul Glassman and Paul Subar
- Susan Skillman, Mark Doescher, Wendy Mouradian, Diane Brunson
- Raul Garcia, Ronald Inge, Linda Niessen, Dominick DePaola (Santa Fe Group)

JPHD Special Issue: Introduction

- *"The articles in this special issue point to serious deficits in the current oral health delivery system, and provide compelling arguments and proposals for improvements. Several of the oral health provisions in healthcare reform will provide the financing and policy framework to implement innovations proposed by authors in this issue. The new requirements and incentives of healthcare reform will begin to reshape our oral health system of care, long isolated from the forces of change."*

–Elizabeth A. Mertz and Len Finocchio

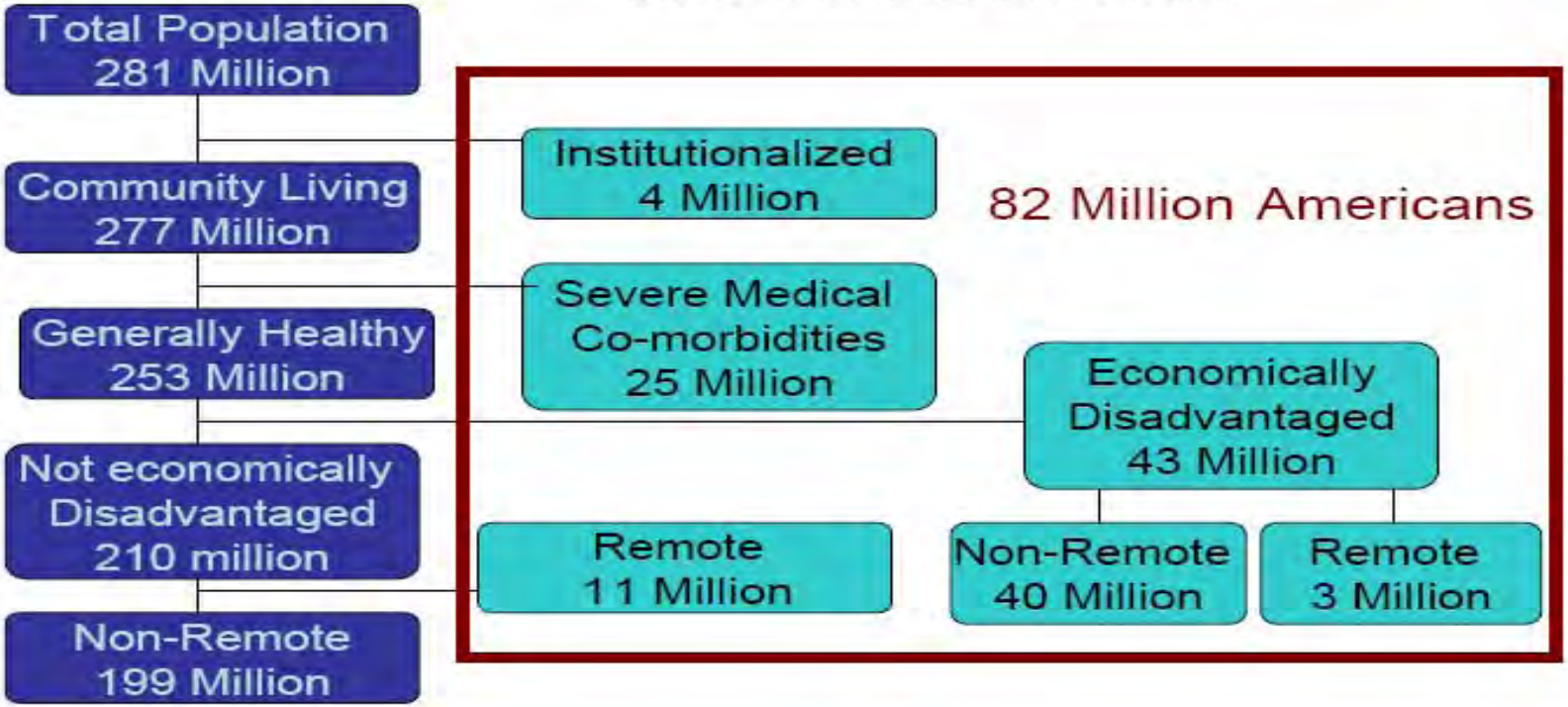
Conflict of interest: None.

Current Concern: Access to Care for 1/3 of US population

Affordable, Accessible, Culturally Appropriate.

Access to Dental Care – US Population

Source: American Dental Association



The Dental Safety Net

- Serves underserved populations, essentially the 1/3 who cannot get care in private market
- Comprised of a large set of uncoordinated programs and policies
  - Systems: FQHCs, VA, IHS
  - Policies: Medicaid and CHIP
  - Other: Corporate Medicaid practices, Dental Schools, Volunteer Free Care, Hospital ERs, large scatting of community based and public health programs
- Limited capacity and overall insufficency to meet need in population

JPHD Special Issue – 'Safety Net'

- *"The dental safety net includes facilities, providers, and payment programs that support dental care for underserved populations including those individuals disadvantaged by a variety of social, economic, and health conditions. Its components - health centers, dental schools, clinics, Medicaid-oriented dental practices, free-care programs, hospital emergency rooms, and others - vary in availability, comprehensiveness, continuity, and quality."*
- *"In short, the dental safety net is the composite of all places, providers, and programs that deliver dental services to people disenfranchised from the predominant private dental delivery system."*

  -- Burton Edelstein

Health Centers – 3.1 M Dental Patients

Oral Health Activities

- In FY 2009, HRSA awarded $8.7M to support expanded oral health services at 40 health centers
- Since 2001, a total of $55M has been awarded to support 312 oral health service expansion grants in health centers
- Health Centers (in CY 2008):
  - 86% of health centers provided preventive oral health care services on site or by paid referral
  - Provided care to 3.1M dental patients; 131% increase since 2001
  - Employed:
    - 2,299 dentists; 119% increase since 2001
    - 892 dental hygienists; 183% increase since 2001
    - 4,329 other dental staff; 122% increase since 2001

Source: Uniform Data System, 2008

Health Centers – ~2,300 Dentists

Health Center Program Workforce (2008)

HRSA

Total Staff		113,059
Physicians		8,441
Family/General P.	4,342	
Internal Med	1,453	
Pediatrics	1,577	
Ob/Gyn	798	
Other MD/DO	271	
Nurse Practitioners		2,978
Physician Assistants		1,706
Certified Nurse Midwives		454
Nurses		9,806
Other Med		13,782
Lab/X-ray		2,540
Dental		7,520
Dentists	2,299	
Hygienists	892	
Assistants	4,329	

Mental Health		3,189
Psychiatrists	299	
Clinical Psychologists	280	
Clinical Social Workers	887	
Other Licensed MH	785	
Other MH	938	
Substance Abuse		770
Pharmacy		2,310
Other Professional		868
Program Enabling Services (Case Managers, Education, Outreach, Transport, etc.)		10,995
Other Program/Services		3,344
Patient Support Staff		20,335
Management and Support Staff		11,513
Fiscal and Billing Staff		8,085
IT Staff		1,519
Facility Staff		2,904

Source: Uniform Data System, 2008 Data

Change Payments / Providers / Policies ?

Envisioning Success

- Three key themes:
  1. the foundational issues of "who pays" together with "who is paid" and "exactly what are they paid to do";
  2. the evident gaps in the US dental educational system with the resulting failure to educate enough of the 'right' types of providers; and
  3. the overriding need for significant policy changes, at both the Federal and state levels, in regards to matters such as licensure, scope of practice, and related concerns.
- Framework for evaluation of success must include assessment within each domain

ADHA Perspective on Workforce Changes

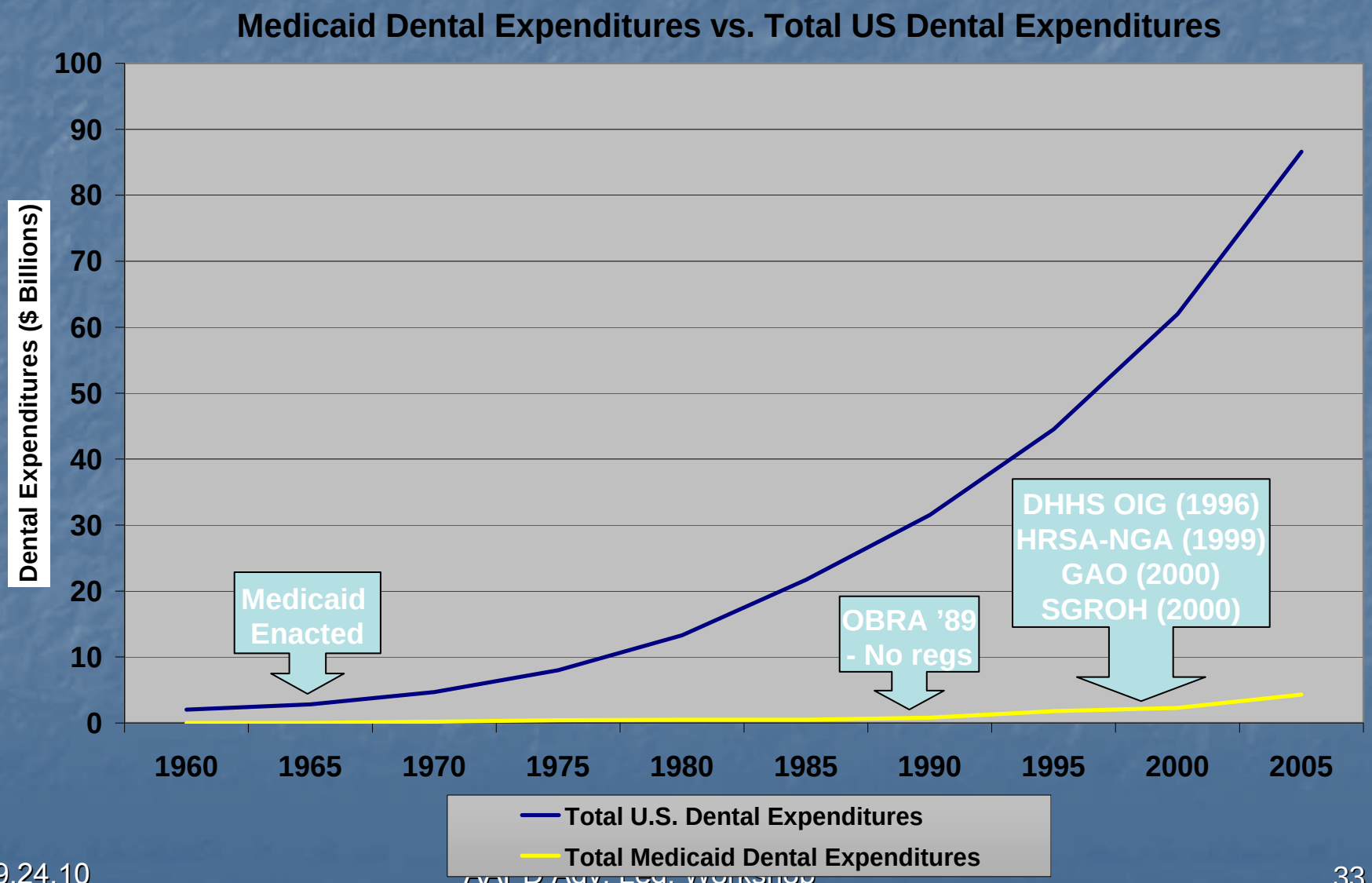
Positive Trends in Dental Delivery

- Policies that make dental hygiene services more accessible:
  - Direct access
  - Medicaid reimbursement
  - Shift from direct supervision to collaboration
- Recognition of need for new providers
  - Advanced Dental Hygiene Practitioner
  - Minnesota dental therapist legislation 2009
  - Emerging dental therapy models
- Health reform legislation

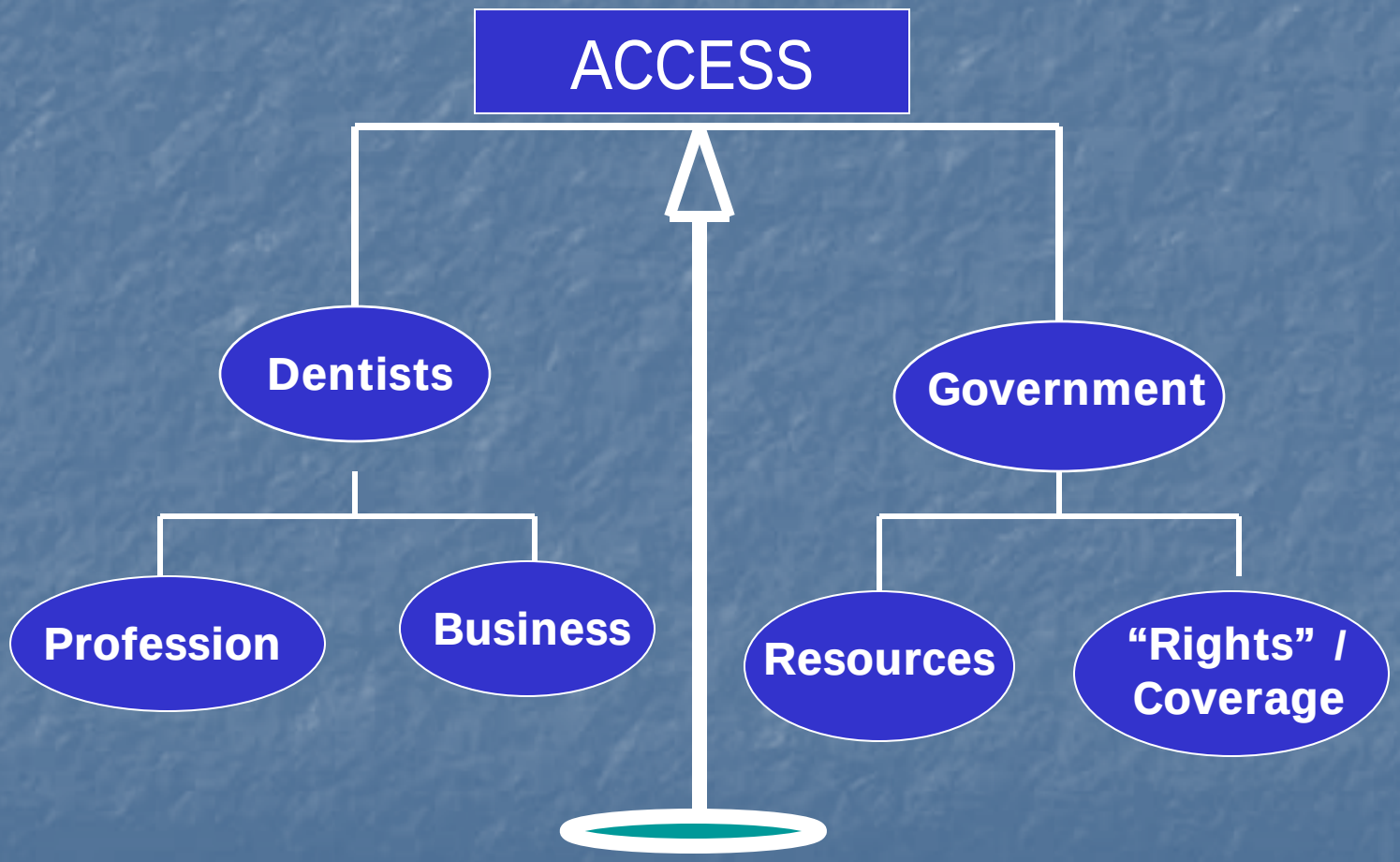
Federal Activities

- DHHS responses:
  - OIG Report on EPSDT Dental Service Utilization (1996) – *< 1-in-5 getting any dental services*
  - Lake Tahoe Conference (1998)
  - HCFA/HRSA Oral Health Initiative (1990s)
  - Surgeon General's Conference, Workshop and Report on Oral Health (1999-2000)
  - NGA Oral Health Policy Academies (2000-2001)
- Congressional responses:
  - GAO Reports
  - Legislation
  - Hearings (following death of Deamonte Driver)

Dental Care Financing Trends: Medicaid vs. Total US. Dental Expenditures



Access: A Question of Balancing Responsibilities



What's happened of late in the oral health policy/program environment?

- Alaska, Minnesota
- Renewed CMS attention / new administration
- Prominent foundation involvement:
  - PEW
  - Kellogg
  - DentaQuest
- HRSA / CA HealthCare Foundation-funded Institute of Medicine (IOM) studies

Change in Absence of Data ???

State has authorized a new primary care dental provider, 2009	Number of states
Yes	1
No	50

- PEW has advocated dental therapy in the absence of data with no therapists on the streets yet (other than AK) and no model duplicating the system characteristics of the US.

Basis for Policy Development:
Data? Anecdote? Urban/Rural Myth?

State of Iowa: Workforce:

Number of dentists in the state	1,446
Percentage of dentists enrolled in Medicaid	95%
# of dentists with > 1 paid Medicaid claim	1,137
# of dentists with paid Medicaid claims >= $10K	568
# of counties without a dentist	0
Total of county population without a dentist	0
Medicaid / CHIP utilization*	46% / 58%

Source: CDC Synopses by State: Iowa – 2005.
Available at http://apps.nccd.cdc.gov/synopses/StateDataV.asp?StateID=IA&Year=2005

W. K. Kellogg Foundation

- New Report Details Training of New Dental Professionals to Ease Dental Care Crisis - Dec 16, 2009 -- Battle Creek, Mich.
- Searching for ways to ensure dental care for millions living in dentist-shortage areas, the W.K. Kellogg Foundation today released a wide-ranging assessment of international and U.S. experience straining and deploying new types of dental health care providers who could be used to help fill gaps in care. In particular, the report suggests that dental therapists, who perform preventive and basic dental services, could provide sorely needed care to millions of underserved Americans, working in collaboration with dentists while expanding their reach. Similar to a nurse practitioner or physician assistant in the medical field, dental therapists are envisioned as members of the dental team that is led by the dentist or dental specialist.
- "Promotion of new mid-level providers working as part of dental teams under the supervision of dentists"

IOM Committee on Oral Health Access to Services

- An IOM committee will assess the current U.S. oral health system of care; explore its strengths, weaknesses and future challenges; describe a desired vision for the oral health care system; and recommend strategies to achieve that vision. The project will examine issues that affect underserved populations that are most vulnerable to oral disease and the role of safety net providers, both public and private, who serve them, with a specific focus on the provision of oral health services to women and children.

IOM Access Committee Members

- Frederick Rivara, Chair
- Paul Erwin, MD
- Caswell Evans, Jr., DDS
- Theodore Ganiats, MD
- Shelly Gehshan
- Kathy Geurink, RDH
- Paul Glassman, DDS
- David Krol, MD
- Jane Perkins
- Margaret Potter
- Renee Samuelson
- Phyllis Sharps
- Linda Southward
- Maria Rosa Watson
- Barbara Wolfe

IOM Oral Health Initiative Committee

- The committee will review current relevant oral health care actions, the barriers to progress, and ways in which policy can improve access to oral health care. In so doing, the committee will examine existing oral health activities and programs, existing regulations, statutes, and resources that affect efforts to support oral health care, and research, data, financing, and policy efforts that bear on oral health.

IOM Oral Health Initiative Cmte Members

- Richard D. Krugman, MD
- Claude Earl Fox, MD, MPH
- Terry Fulmer, PhD, RN, FAAN
- Vanessa Northington Gamble, MD, PhD
- Paul E. Gates, DDS, MBA
- Mary George, RDH, MEd
- Alice M. Horowitz, RDH, PhD
- Elizabeth Mertz, MA, PhD
- Matthew J. Neidell, PhD
- Sara Rosenbaum, JD
- Harold C. Slavkin, DDS
- Clemencia Vargas, DDS, PhD
- Robert Weyant, DMD, DrPH

Parallels in Medicine

Doctor Shortage Fuels Nurses' Push For Expanded Role

TOPICS: DELIVERY OF CARE

By Andrew Villegas
KHN Staff Writer
FEB 22, 2010

Nurse practitioners - like Irene Cavall in North Carolina - are gaining support in their drive to play a larger primary care role. But the powerful AMA is waving a yellow caution flag before state regulators and legislators. (Ron

There are no doctors in rural Tyrrell County, N.C. There is only Irene Cavall, a licensed nurse practitioner and the sole source of primary care for 4,000 residents spread out over 600 square miles.

It's been that way since the county's lone doctor moved away 2 ½ years ago. Cavall sees as many as 40 patients a day at the Columbia Medical Center. It's about 40 miles west of the Outer Banks; an ambulance ride to the nearest hospital takes 25 minutes.

There are limitations to her work – by state law, she works under the supervision of a doctor, albeit one many miles away, and calls him and specialists as needed. But for 15 years, Cavall has been helping patients with a range of routine problems, from colds to management of diabetes, that don't always require a doctor. As she says, doctors "don't need to give someone a Tylenol."

Nursing leaders say large numbers of practitioners like Cavall will be needed to fill gaps in primary care left by an increasing shortage of doctors, a problem that would intensify if Congress extends health insurance to millions more Americans. Advocates say nurse practitioners have the extra education and training needed to perform a variety of services, including physical exams, diagnosis and treatment of common ailments and prescribing drugs.

But the American Medical Association and doctors' groups at the state level have been urging state legislators and licensing authorities to move cautiously, arguing that patient care could be compromised. This battle has been waged for years, even as nurse practitioners grew rapidly in

Parallels in Medicine

The New York Times

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February 15, 2010

Expecting a Surge in U.S. Medical Schools

By ANEMONA HARTOCOLLIS

Peter Allen applied to 30 medical schools after graduating from the University of Pittsburgh last year. Twenty-eight said no.

Of the two that said yes, one had something in common with Mr. Allen: It, too, was starting out in medicine. He enrolled in the inaugural class of The Commonwealth Medical College in Scranton, Pa.

"I was ecstatic that I had been accepted to a medical school," Mr. Allen said, adding that he would have gone for a master's in bioengineering if he had not been accepted. "It's a giant sigh of relief; it secures your plans for the rest of your life really."

The Commonwealth is one of nearly two dozen medical schools that have recently opened or might open across the country, the most at any time since the 1960s and '70s.

These new schools are seeking to address an imbalance in American medicine that has been growing for a quarter century. Many bright students were fleeing to offshore medical schools, or giving up hope entirely, when they could not get into domestic schools. Meanwhile, American hospitals were using foreign-trained and foreign-born physicians to fill medical residencies. During the 1980s and '90s only one new medical school was established.

"Huge numbers of qualified American kids were not getting into American medical schools or going abroad to study," Dr. Lawrence G. Smith, dean of the proposed Hofstra University School of Medicine, in Hempstead, N.Y., which is not yet recruiting students, said last week. "I think it was a kind of wake-up call."

The proliferation of new schools is also a market response to a rare convergence of forces: a growing population; the aging of the health-conscious baby-boom generation; the impending retirement of, by some counts, as many as a third of current doctors; and the expectation that, the present political climate notwithstanding, changes in health care

AAPD Position on Mid-level Providers

Position Paper

Available at: http://www.aapd.org/upload/news/2009/3648.pdf

American Academy of Pediatric Dentistry Analysis and Policy Recommendations Concerning Mid-level Dental Providers

- Review of existing mid-level models
  - NZ, AK & Canada Dental Therapists, EFDAs
- Review of proposed mid-level models
  - ADHP, CDHC, MN Dental Therapists
- Values & principles concerning oral health care for all children and the dental home
- Policy Recommendations

AAPD Key Principles

- Dental Home Concept (AAPD / ADA definition)
- Examinations and treatment plans performed by dentists
- Team-based systems of care headed by dentists
  - DHs, EFDAs, others may be part of primary care process as determined by State scope of practice laws/regulations
  - Details of 'affiliated practice' arrangements are key
- Adequate funding for Medicaid & CHIP
- Extension of services to underserved populations
  - E.g.. Head Start Dental Home Initiative

AAPD Policy Recommendations

AAPD supports the use of mid-level dental providers who perform or assist in the delivery of specified reversible procedures and certain surgical procedures under the general supervision of a dentist, provided that such arrangements have been thoroughly evaluated and demonstrated to be safe, effective, and efficient and to not compromise quality of care in similar settings.

AAPD Policy Recommendations:

AAPD supports greater use of EFDAs based on extensive evaluations of their effectiveness and efficiency in a wide range of private and public settings as part of dental teams.

AAPD Policy Recommendations

AAPD recommends further evaluation of Dental Therapist and CDHC (Community Dental Health Coordinator) models prior to policy decisions regarding their use.

AAPD Policy Recommendations

- AAPD joins others in rejecting the ADHP model on the basis of its incompatibility with the principle that dental care should be provided directly by or under the supervision of a dentist.

AAPD's Position:

- AAPD suggests that the burden of proof in evaluating such models is to first show they actually work, versus trying to implement nationwide programs based on "what harm can they do? / something is better than nothing"
- "Something" that drains away resources and promotes less comprehensive care for children could in fact be worse than doing nothing.

Considerations going ‘forward’ …

- Context
  - History (policies, delivery systems)
  - Culture
  - Infrastructure
  - Financing and reimbursement
  - Integration / disintegration

Dental Issues in Health Care Reform

- Medicaid Expansion
  - Beginning 2014, states required to provide Medicaid coverage. New category for childless adults and certain parents incomes below 133% FPL. Benefits differ from traditional Medicaid coverage to 'benchmark equivalent'
- CHIP
  - Extended reauthorization for two years, and increase of federal matching
- Premium subsidies are available to States on sliding scale
  - Up to 400% of poverty to assist coverage in Exchange

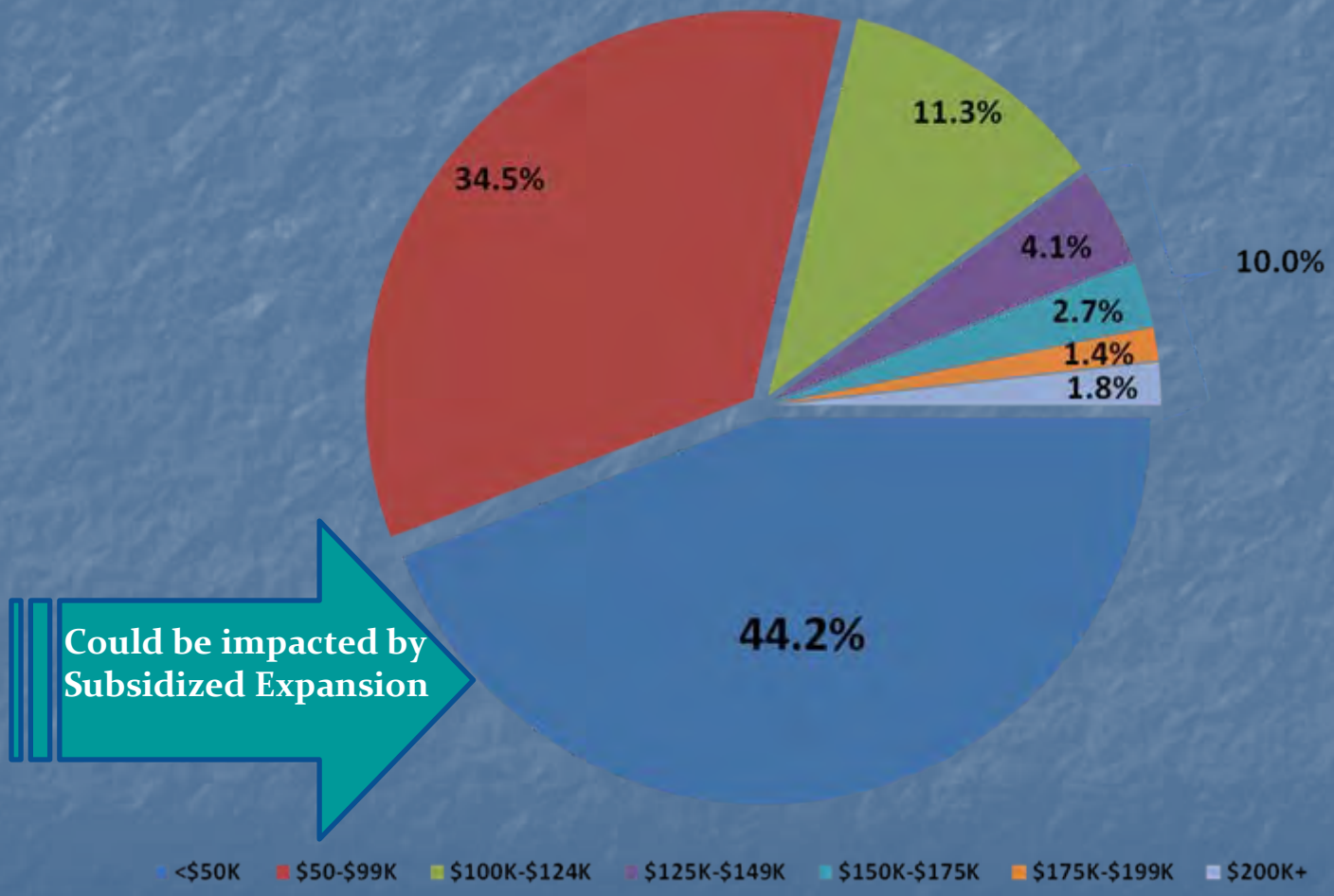
Dental Issues in Health Care Reform

- Prevention
- Training
- Workforce Demonstrations
  - Training programs for alternative dental providers to increase access in rural, tribal and underserved communities.

- Regulations unknown, could lead to further medical/dental integration and expansion of duties

Why should dentists care about HC reform proposals?

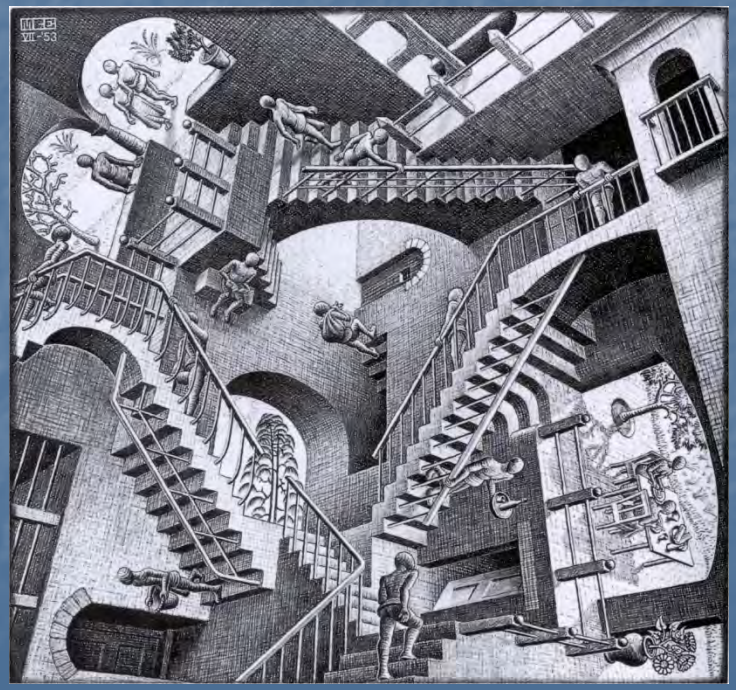
Household Incomes of Americans with Dental Benefits (NADP, 2010)



HCR Regulations and You… the Great Unknown [NADP, 2010]

- Workforce Demonstrations?
  - What type of reporting measures
  - Will reimbursement of new providers be required?
  - Accreditation?
  - Licensing?
  - Will additional dental coverage be allowed in State Exchanges?
  - Medical integration?

Law of Unintended Consequences ???



Health Care Reform: Authorization → Appropriations??

- New provisions have been authorized, but need appropriations in order to be implemented
- Upwards of $200 M required to implement all provisions
- Within the context of:
  - A federal 'discretionary budget freeze'
    - Funding of new programs requires reducing or eliminating funding of current programs
  - State budget woes
  - November, 2010 elections

Debates generally center on:

- Medicaid program funding, reimbursement and administration? OR providers' unwillingness to treat certain types of patients?
- Inadequate supply of services / not enough providers? OR not enough providers in certain places?
- Access to services? OR demand for services?
- Patient education? OR provider education?
- Lack of education? OR lack of motivation?

Model Programs: AAPD Dental Home Initiative

Head Start Dental Home Initiative

Program Information

AAPD and Head Start are partnering at the national, regional, state, and local level to develop a national network of dentists to link Head Start Children with dental homes.

A dental home means that each child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist.

A national network of pediatric dentists and general dentists will be created to provide quality dental homes for Head Start (HS) and Early Head Start (EHS) children; train teams of dentists and HS personnel in optimal oral health care practices; and assist HS programs in obtaining comprehensive services to meet the full range of HS children's oral health needs. This partnership will also provide parents, caregivers and HS staff with the latest evidence-based information on how they can help prevent tooth decay and establish a foundation for a lifetime of oral health.

Regional consultants will assist state leadership teams in development of collaborative networks throughout the state. Networks will consist of local dentists and HS personnel as well as other community leaders who work together to identify strategies to overcome any barriers to HS children's access to dental homes.

Lessons learned: >If you build it, . . . ‘Health Literacy’?

Change vs. Progress

The key to progress lies in:

- determining the real nature of the problem,
- rigorously examining the evidence for proposed changes,
- reasoned decision making with consideration of the potential ramifications of policy change,
- thorough evaluation that allows for assessment of the impact of different factors.

Top Ten Quotes Every Advocate Should Know*

10. "Being in politics is like coaching football. You have to be smart enough to understand the game and dumb enough to think it's important." – *Eugene J. McCarthy*

9. "Those are my principles. If you don't like them I have others." – *Groucho Marx*

8. "We are not retreating – we are advancing in another direction." – *General Douglass MacArthur*

7. "If stupidity got us into this mess, then why can't it get us out?" – *Will Rogers*

6. "If you are going through hell, keep going." – *Sir Winston Churchill*

Source: ADA Leadership Conference

Top Ten Quotes Every Advocate Should Know*

5. "Forgive your enemies, but never forget their names." – *John F. Kennedy*

4. "First they ignore you, then they laugh at you, then they fight you, then you win." – *Mahatma Gandhi*

3. "I have not failed. I've just found 10,000 ways that won't work." – Thomas Alva Edison

2. "I don't make jokes. I just watch the government and report the facts." – *Will Rogers*

1. "No man's life, liberty or fortune is safe … while our legislature is in session." – *Ben Franklin*

Source: ADA Leadership Conference