The Kentucky Dental Health Coalition was formed in 1990 as an outgrowth of the public service plan, a collaborative effort between the University of Kentucky College of Dentistry and the University of Louisville School of Dentistry. In 1991, the Coalition expanded to include other oral health advocacy groups. KDHC has incorporated as a non-profit organization and is functioning at a grass roots level to improve oral health in Kentucky. The four main goals of the KDHC are to:

- Advocate for improved dental health throughout the communities in the Commonwealth of Kentucky
- Advocate for improved access to dental care
- Promote interaction between those providing and those needing dental health education
- Establish model projects for incorporating dental health programs, education and awareness in the communities of Kentucky

As a non-profit organization, the KDHC is sustained only by the continued support of its members and corporate sponsors. The Dental Access Summit would not have been possible without the generous support of our sponsors, and we acknowledge them on the facing page. We invite you to join our organization as a member, either individually, or as an organization, agency or corporation, to continue the mission of “improving the dental health in Kentucky”. For information regarding membership, or to obtain copies of this publication, please contact the KDHC at the following address:

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Please see our web site at: WWW.KDHC.ORG for upcoming activities or sponsored events.

The “proceedings” report was prepared by Robert G. Henry, DMD, MPH and was edited by the Kentucky Dental Access Summit Planning Committee.
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Kentucky’s Dental Access Summit
May 24-25, 2001
Lexington, Kentucky

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The Kentucky Dental Health Coalition extends its sincere appreciation and thanks to all the above organizations and companies who co-sponsored the Kentucky Dental Access Summit. In addition, KDHC thanks the many partners, companies, agencies and ongoing members who continue to support the Kentucky Dental Health Coalition’s mission which is: “To improve dental health in Kentucky”
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Chapter 1: Introduction

Background

In May 2000, the U.S. Surgeon General’s office released a report on oral health in America referring to oral disease as a “silent epidemic.” In Kentucky, tooth decay is the single most common chronic childhood disease affecting 20 percent of preschoolers, 50 percent of second graders and nearly 75 percent of 15 year olds. Total tooth loss, or edentulism, is extremely prevalent in adults over 65 in Kentucky, making it rank the second highest (over 44% are edentulous) nationally.

These statistics, and others like it (see Table 1), gave State dental leaders, legislators, state and local policy makers, community clinic directors, and educators the impetus to meet together to increase the dental awareness and develop strategies to deal with the widespread dental problems in Kentucky. The Summit created a forum for a diverse group of concerned people to hear and offer solutions to improve the oral health of Kentucky children and adults. Held on Thursday, May 24, and Friday morning, May 25 at the Embassy Suites of Lexington, over 100 people attended to hear presentations and participate in workshop discussions.

Sponsored by the Kentucky Dental Health Coalition, the summit included an opening address by Lt. Gov. Steve Henry and a keynote address on national trends in oral health and the U.S. Surgeon General’s Report by Burton Edelstein, D.D.S., director of the Children’s Dental Health Project. A state of the state address was presented by Jim Cecil, D.M.D., state administrator of oral health programs, Sharon Stumbo, deputy commissioner for public health, and Raynor Mullins, D.M.D., chief of the division of public dental health at the University of Kentucky College of Dentistry. Other presentations highlighted problems of access faced by those who seek dental care as well as from those dental professionals who attempt to provide dental care.

“Kentucky already has done a lot of work by getting the right people together for this Summit,” Edelstein said. “However, oral health in Kentucky remains a problem that is consequential for our children and adults.”

This proceedings booklet highlights several presentations occurring at the Summit. It also provides a summary of the recommendations which came from the task groups convening at the Summit. The hope of the KDHC is that this document will be used to remind participants of their commitment to the ideals and to encourage them to take action in implementing these recommendations over the next few years. It is the belief of the KDHC that the only way significant, long-lasting oral health changes will be implemented in Kentucky, will be if the solutions regarding access are approached from a multi-disciplinary perspective. However, with dedicated and committed people working together to improve the oral health status for Kentuckians, dramatic changes can not only be accomplished, but will be expected in the years to come.
**Table 1.**

**Selected Oral Health Problems Unique to Kentucky**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Source/Details</th>
</tr>
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<tbody>
<tr>
<td>Appalachian children in Kentucky are the least likely youngsters in America to see a dentist. (Source: 2000, Surgeon's Generals' Report on Oral Health)</td>
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<tr>
<td>Only 9.4% of children eligible for Medicaid in Kentucky received required (by law) early, periodicroll screening, diagnosis and follow-up treatment (EPSDT)—the lowest rate in the nation. (Source: 1996 Federal Inspector General's Report on Medicaid)</td>
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<td>Only 7.6% of Kentucky children have received dental sealants. (Source: 1987 Kentucky Oral Health Survey)</td>
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<tr>
<td>51% of 1,523 children in 14 elementary schools seen in 10 Appalachian counties in eastern Kentucky had visible, untreated tooth decay. (Source: 1998 U.K. Mobile dental sealant program)</td>
<td></td>
</tr>
<tr>
<td>57% of 1,386 children in 7 schools in western Kentucky had visible, untreated tooth decay. (Source: 1998 University of Kentucky Mobile dental sealant program)</td>
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<tr>
<td>Kentucky has the second highest rate (44%) of complete tooth loss in the nation among citizens over 65 years of age. The Appalachian region of the U.S. has the highest regional rate and West Virginia reported the highest rate of edentulism at 47.9% of any state. (Source: 1995-1997 Center for Disease Control's national phone survey).</td>
<td></td>
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<tr>
<td>Kentucky’s high rate of poverty among children speaks to a probable high rate of early childhood caries (ECC). The range of ECC is estimated to be 5-10%, but may be higher in Kentucky. (Source: JADA, 1998).</td>
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</tr>
<tr>
<td>66% of Kentucky’s population live over 200% below the poverty level. Statewide reimbursement for a dental sealant is $11, while the national mean has reached $28. (Am. Dental Association News, Aug. 6, 2001).</td>
<td></td>
</tr>
<tr>
<td>Rates of tooth loss are associated with not only low education (less than high school) and economics (lower income) but regular tobacco users. Kentucky has the highest proportion of smokers and smokeless tobacco usage than any other state. (Source: American Cancer Society).</td>
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<tr>
<td>Access to health care services for migrant workers in Kentucky is scarce and that these farm-workers have increased levels of oral health problems (more than other segments of Kentucky citizens). (Source: 1998, University of Kentucky migrant worker study).</td>
<td></td>
</tr>
<tr>
<td>Oral health related infections (gum diseases) appear to be linked to diabetes, coronary heart disease, and premature low birth weight babies. Parts of Appalachian Kentucky are termed the “coronary valley” due to the elevated prevalence and incidence of cardiovascular disease in the population. Currently there are no state specific data that make these links, but it is likely that an association is present. (Source: 1999, National Institute of Dental and Craniofacial Research).</td>
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</tr>
<tr>
<td>Over 600,000 people in Kentucky are Medicaid eligible. Of these, 300,000 are children and 65,000 are eligible for the Ky. Children’s Insurance Program (KCHIP). Only 300 dentists in Kentucky are active participants in Medicaid (although 800 dentists in Kentucky are enrolled. (Source: 2001, Jim Cecil, DMD, Director, Kentucky’s Oral Health Program, Frankfort, Ky.).</td>
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GOALS and OBJECTIVES for SUMMIT

On May 24 and 25, 2001 the Kentucky Dental Association co-sponsored the first ever Kentucky Dental Access Summit. Held at the Embassy Suites Hotel in Lexington, Kentucky, the purpose of the Summit was to increase the awareness of the scope of oral health problems in Kentucky and the related barriers to access for Kentucky’s most vulnerable populations. The summit sought to provide a forum for Kentucky’s health officers, legislators, health policy makers, state dental leaders and educators, advocates and consumers of oral health to develop strategies and offer solutions to improve the oral health of Kentucky residents.

There were five specific objectives developed for the summit, and can be seen in Table 2.

Table 2.

<table>
<thead>
<tr>
<th>Specific Objectives for the Summit</th>
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<tbody>
<tr>
<td>1. Increase awareness of the scope of oral health problems in Kentucky.</td>
</tr>
<tr>
<td>2. Identify the barriers to access to dental care and propose solutions for the state.</td>
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</table>
| 3. Discuss and develop prevention and access strategies for Kentucky’s most vulnerable populations, including but not limited to:  
  -children and adults who live in poverty or are disabled  
  -older patients who are dependent on others for oral care (institutionalized or homebound)  
  -people with cultural, behavioral, or other factors which prohibit them from receiving optimal oral health care |
| 4. Broaden the ownership for improving dental access beyond the Dental profession. |
| 5. Discuss and develop strategies that enhance the coordination, distribution or replication of successful efforts, which improve Prevention and/or access to dental care services. |

SUMMIT AGENDA

Over 100 participants attended the Summit. Individuals who attended included public health officials, state legislators, health policy makers, state dental leaders, dental educators, private dental practitioners and community advocates and consumers of oral health services.

The format and agenda for the Summit included welcoming remarks from Ms. Lois Reynolds, Director of Coalition Development for Oral Health America, past president of the KDHC and facilitator and moderator for the Summit, Dr. Fred Howard, President of the KDHC, Dr. Frank Metzmeir, President of the Kentucky Dental Association, Dr. Robert Klaus, President and CEO of Oral Health America, a major sponsor of the Summit, and Roberta Kelly, Regional Director of the Health Care Financing Administration and another major sponsor for the Access Summit.

Dr. Steve Henry, an orthopedic surgeon and the Lt. Governor of Kentucky, made opening remarks including his commitment that the “government has to do
more to encourage better oral care through prevention and better access”. He also stated that “dentists need to educate our leaders in government” about the relationship between oral health and systemic disease, citing the example of periodontal disease and low-birth weight/ premature babies.

Dr. Burton Edelstein, the Director of the Children’s Dental Health Project and former chair of the U.S. Surgeon General’s Workshop on Children’s and Oral Health, gave the keynote address. Dr. Edelstein articulated the problems that lack of oral health care can mean for children and adults, alike.

The morning session ended with a panel discussion of what the current state of Oral Health in Kentucky is like. Presentations from Loretta Maldaner, Director of the Purchase Area Health Education Center (AHEC) and Tammy Gay, President of the Richmond Family Resource Center, focused on what access problems are like from the patients’ perspective. Dr. Beverly Largent, pediatric dentist from Paducah, Kentucky and President-elect of the KDA, and Dr. Bob Henry, hospital and geriatric dentist from the V.A. Medical Center in Lexington, Kentucky spoke about the problems in providing care to pediatric, hospital, and geriatric patients. Sharon Stumbo, MA, Deputy Commissioner, Public Health Dept. State of Kentucky, Dr. Jim Cecil, Administrator, Oral Health Programs, and Dr. Raynor Mullins, Chief, Division of Dental Public Health, University of Kentucky presented statistics regarding the state of oral health in Kentucky and offered proposals and recommendations for implementation on a state wide basis.

Drs. Nancy Schoenberg, PhD, and Tim Smith, PhD gave the luncheon presentation: “Determinants of Oral Health Behavior in Kentucky”, which focused on the cultural and behavioral factors which are so influential in determining whether people will seek dental care or not.

All participants were asked to select one of four workgroups to participate in for the afternoon session. The workgroups and workgroup leaders were:
  - Ken Rich, DMD – Legislative Issues
  - Lois Reynolds, LLC – Public Awareness and Education
  - Jim Cecil, DMD – Dental Service Delivery Models
  - Rowland Hutchinson, DDS, MS – Dental Education Initiatives

Recommendations resulted from the four-workgroup sessions that were held the afternoon of May 24, and the following morning on Friday, May 25. Recommendations from the Summit workgroups are found in Chapter 3 of this proceedings publication.

The Summit Agenda and biographies on the presenters can be found in Appendices A and B, respectively.
Chapter 2: Selected Presentations

Keynote Address

Burton Edelstein, DDS, MPH
Director, Children’s Dental Health Project

Dr. Edelstein began by giving credit to the work already done by the KDHC, KDA and now the participants at the Dental Access Summit. He reviewed the stakeholders who are addressing the oral and dental health inequities in Kentucky, and who needs to be concerned. The stakeholders include:

- the frail elderly, our adult handicapped, the new immigrant, the migrant laborer, the homeless, and all the others who are vulnerable and who are part of us, living in our communities, and our society, who need us to work on their behalf. We must remember that this group is not politically active, few seldom vote, and many don’t even speak English. Among children alone there is one in four who lives in poverty and is therefore at higher risk for dental and oral disease.
- parents of every kind who want for their children’s health as much as you want for your children, and your parents did for you.
- our health professionals-dentists, hygienists, physicians, nurses who realize they are healers above all else with the privilege, the ability and responsibility to prevent and relieve pain and suffering.
- state officials including the governor and lieutenant governor, legislators and health officers and politicians who must address as many of our common concerns as possible by developing priorities, policies, and programs that meet our common needs and interests. In other words to do the greatest good for the greatest numbers with limited resources.
- philanthropic communities such as federal grant makers who fund dental projects designed to improve dental access.
- the education community including: Women in Children (WIC) educators, Area Health Education Centers (AHECs), dental and dental hygiene schools, medical schools, social work programs, public health academics, grammar schools, high schools, Head Start, early childhood education and special education teachers.
- the advocacy community who include people who have the passion to move issues, build political will and drive public agendas.
- the faith community who help us set priorities and give us social conscience to help us meet the needs of vulnerable people.
- the business community who recognize that healthy workers are the best and most productive workers and that a healthy smile means a positive contact between a customer and service provider. The business community also knows that productive workers are the ones who don’t need to leave work to take care of a hurting child or parent.
• the press who may be the best and most influential ally in righting the wrongs of oral health inequities by building political will.

Dr. Edelstein stated that the time to fix the problem of oral health reform is right now. He suggested that unlike health reform, oral health reform is discrete and doable. He suggested that we need what has always been needed to tackle a messy problem: leadership, focus, a clear goal, a plan, and determination to see the plan through. He then reviewed each of these areas to suggest where each may come from in the case of Kentucky.

- **Leadership:** may come from any of dozens of attendees at the Summit.
- **Focus:** Dental and oral health is more doable since it is not as large or complex as medical care. Unfortunately, because dental issues are a smaller component of healthcare policymakers write off dental as unimportant or too small to deal with.
- **Goal:** This was articulated by Kentucky’s representatives to the recent National Governors Association Health Policy Academy on children and oral health. The goal as stated then was to assure that “All KY children have optimal oral health as part of being healthy, safe, and possessing the foundation that will enable school and personal success, and living in strong families and communities that foster social and economic development.” In addition, goals have been set for Kentucky in Healthy People 2010, which lays out ten year health objectives for Kentucky’s population including dozens of objectives related to oral health.
- **Plan:** Help awaits our state by reviewing the HRSA and CDHP websites and descriptions in our notebooks of other states’ approaches. Many states have faced similar issues and have worked out many of the problems.

Dr. Edelstein then reviewed two of the most common myths that policymakers believe: that dental disease is unimportant, or that oral health care policies are too small to deal with (not enough bang for the bucks).

The “unimportant myth” is addressed by clarifying the consequences of the diseases and conditions that we deal with—from dental caries to cleft palates, from periodontal disease to oral cancer, from trauma to developmental disturbances, infections, and dysfunction of speaking and chewing. Policymakers need to know that:

- More parents report unmet dental need than any other health care need for their children. 73% of all unmet health care need reported by parents is for dental. This is three times greater than medical, 4 times greater than vision, 5 times greater than prescriptions.
- Tooth decay remains the single most common disease of children – 5 times greater than asthma.
- For every child without medical coverage there are 2.6 children without dental coverage.
- Medicaid fails to deliver dental services to children and adults. Only 18% of children nationally are reported by the federal government to receive any dental service in a year. It is bad when you think of one-in-five children in the U.S. being denied dental care, but much worse
when you realize how concentrated dental disease is in low income children.

- Preschoolers who are from low income families have twice the likelihood of having tooth decay; twice the extent of decay if they have any cavities; twice the use of dental care for relief of pain; twice the coverage but half as many visits!
- In Kentucky, 50% of third graders have untreated visibly evident cavities (as reported by the Commonwealth of Kentucky).
- In Kentucky, one-in-four children under 18 live in poverty (poverty defined as a family of four with incomes of less than $18,000 per year). And 22% of the mothers of Kentucky have less than a complete high school education. This is important because low-income and limited-parental education are two of the most important predictors of poor oral health and low use of dental services.
- Ongoing health issues as children in Kentucky contribute to the oral health problems seen as adults. Especially the use of tobacco with its hazards to oral tissues and the systemic hazards to the body. The percent of edentulism in Kentucky at 44% is just a pediatric issue grown up. Nothing better predicts tooth decay in adults more than prior decay in these same individuals as children.
- Periodontal disease is rampant in Kentucky and may be part of the explanation for Kentucky’s reported high rates of pre-term and low-birth-weight deliveries.

Dr. Edelstein stressed the importance of Kentucky to improve access by raising reimbursement fees for children on Medicaid. “Nationally, dental spending in Medicaid represents about one-half of one percent. This is both a blessing and a curse. It could be doubled, tripled, and more without showing a real budget impact”. He added, “Actuarial studies show time and again that the cost of dental care for Medicaid and SCHIP kids is in the range of $17 – 18 per child per month. Compare that with the pittance paid by health plans to their dental vendors to manage our Medicaid dental program. Kentuckians are simply not in the same ballpark or even in the game. In fact, we in dentistry haven’t even been on the field for many a year.”

Dr. Edelstein presented convincing evidence that showed the majority of states that have raised dental fees in order to improve access have seen little change simply because these increases have failed to reflect the reality of dental costs and all-too-often fail to even cover the underlying costs of delivering care. He emphasized that while money alone will not fix the dental access problem, you cannot fix the problem without money. Whether you believe that private dental practitioners or a “safety net” of community health centers and clinics around the state will solve the access problem, you cannot escape the folly of paying less than the actual cost for care. You should be aware that many of these community clinics are threatened with closing due to grossly inadequate funding. Too many of these facilities are financial losers for their managers. Unfortunately, the greater the volume, the greater the loss.

For the 96% of dentists who practice in the private sector, you should know that grossly inadequate funding cuts short dentists ability to participate in Medicaid.
As illustrations to his presentation, Dr. Edelstein showed slides comparing what Medicaid reform accomplished in other states as well as a comparison of Medicaid rates in Kentucky with national means (See Table 3, and Figures 1 and 2). In general, Edelstein stated, when states begin to purchase at market rates children who are already getting care get more care. Secondly, those dentists who are already participating in Medicaid begin to see more children. Thirdly, more dentists begin to participate. He sited specific examples of states who had increased their Medicaid reimbursements to market rates to make his point:

- South Carolina saw an increase from 49% participating dentists to 68% participating dentists- a 40% increase.
- Indiana has experienced a 20% increase in enrolled dentists, a 28% increase in participating dentists, and a 136% increase in number of children with a dental visit.
- Delaware pays 85% of what dentists normally charge. This state had the worst Medicaid program in the country (they had only one provider at one time), and have rebuilt their infrastructure that can now meet the demand for care.
- Michigan realized the greatest success of any state, with increasing their rates that were full fee for 80% of all dentists. This state chose to give SCHIP and Medicaid Kids Delta Dental cards that were identical to commercial beneficiaries. They used the private delivery system and as a result dentists saw an incredible 85% of all enrolled children in its first year and Medicaid utilization jumped from 18% utilization to 34% in just the first 8 months of operation.
- In Western Pennsylvania, a CHIP experiment used the same approach as in Michigan. After one year the majority of Medicaid eligible kids had a dental visit, and a dental home, and the unmet need reported by parents fell precipitously down to 10%.

Table 3.- (Not Available)
Figure 1.
Figure 2.
Dr. Edelstein reminded the audience about the equal access provision of the federal law which states that states Medicaid EPSDT providers (which includes all dentists) must be paid at rates such that children covered by Medicaid have the same access to dental care as those children in the same geographic area who are not covered by Medicaid. He closed this section by saying that “our mothers were correct, we do get what we pay for and can’t have what we won’t pay for.”

Dr. Edelstein concluded with this opinion: “No matter how you slice it, there are four fundamental issues that must be addressed by any plan that will improve oral health and dental care for vulnerable populations. These are:

1. Financing, primarily through Medicaid and SCHIP.
2. Workforce – numbers, distribution, diversity, competency, and integration with primary care medical providers;
3. Infrastructure - including safety net facilities where the private sector is unavailable, information systems to track and monitor and evaluate performance, dental public health efforts like fluoridation and surveillance and public education, and capacity to link patients with providers through transportation, translation, and understanding of the system.
4. Reducing disease burden – using the best science to rationalize, not ration health care. Using techniques to pick out the highest risk kids early and periodically. Using science based interventions to limit disease progression, to stop the caries process, to prepare the child for definitive dental repair that will not need to be repeated again and again because the underlying problem was never solved.”

Overview of Kentucky's Oral Health

Loretta Maldaner, Director Purchase AHEC

The Patient Perspective

Ms. Maldaner began by reiterating the fact that tooth decay is the number one most chronic disease in children; 5 times more common than asthma. She pointed out that 89% of the problem with decay is caused by 30% of the children. Her presentation focused on the perspective that what is needed is a well-developed public awareness campaign to let local and state policymakers know about oral health issues that were stated in the keynote address by Dr. Edelstein.

She encouraged all the participants to include oral and dental health education and prevention strategies in all outreach activities that are already going on with families and children. In addition, oral health education needs to include parents on their role in dental health of their children including keeping their appointments, or if not parents, finding the case manager who should ensure the kids get to their destinations.

In regards to reimbursement, Ms. Maldaner said that dentists should receive a fair rate and furthermore should not have to go through unnecessary red tape and hassles to receive it. Instead of either private practitioners or public service clinics being mainly responsible for treating indigent children and adults, Ms. Maldaner suggested that there should be an integrated system of care using
both public and private systems for those who fall through the cracks. In addition, she felt that there should be an expansion of “free” preventive services such as school based dental sealant programs, designed for all children who may need them.

Ms. Maldaner’s concluding remarks called for greater participation in the State’s oral health program to be developed at the summit. Her five points to remember were:

1. Make oral health a priority. Include it in all health related programs.
2. Prevention is essential. Offer preventive programs to schools.
3. School based programs should be models for prevention as well as for delivery of services.
4. Policymakers should be flooded with information regarding the importance of oral health.
5. Each participant at the summit should encourage their local primary care provider (physician) to include dental health screening and education into routine check ups.

Beverly Largent, DMD, Pediatric Dentist, Paducah, Ky.

The Provider Perspective

Dr. Largent began her presentation by stating that she had been in the private practice of Pediatric Dentistry for 16 years, and had participated in the Kentucky Medicaid Program for all but nine months of those 16 years. She has been a Headstart provider for 15 of those 16 years, and has held contracts with as many as three area programs. Her discussion focused on her experiences as a pediatric dentist with access programs in Kentucky, specifically focusing on reimbursement issues with Kentucky’s Medicaid program over her 16 years.

Dr. Largent pointed out that children from affluent families do not present with the problems of children from poor families. She said the concept of preventive dentistry has reached one set of parents and not the other. Affluent parents are seeking improvement, and perceive the dentist as an authority and resource to help them make life better for their children. The parents on Medical Cards are struggling day to day to survive. Because of these differences, the message regarding preventive dentistry (ie; toothbrushing, flossing, and limiting the amount of sugar in the diet to prevent tooth decay), is not being heard by the parents who need it most. An example of this failure to communicate to poor families is “that no matter what my approach, I am likely to see a younger sibling (from that family) in the same situation.” Therefore, she recommends that preventive dental education should not be limited to the dental office but included into Women and Child Care (WIC) programs, first-steps programs, school nursing programs and family resource centers. Physicians and pediatric nurse practitioners must be able to refer children to the dentist for the first visit before there are visible problems.

Dr. Largent continued by stating that typically those persons with the greatest dental need do not understand their need to see the dentist. “I believe that a mandated dental exam before entering school, or at least while in the first grade would relieve anxiety about the dental office, give the dentist opportunity to find small problems before they cause lost school days, and create an
awareness that dental care is an important part of health care.” Although the legislature did not pass this legislation this year, this should be reintroduced. She stated her understanding on why the legislation failed was “that it was improper to mandate a dental exam, when the number of Medicaid providers was so low that many would not be able to fulfill their obligation of the exam.” She expressed her displeasure with that reasoning, providing examples of alternate methods of funding for initial exams including:

- funding schools for those who qualify for school lunches (to fund children who receive them to pay for the initial dental exam)
- give vouchers for a dental exam to the children. Dentists would not be required to join the Medicaid program in order to provide the exam.

“The worst scenario is that the dentist may feel obligated to treat some of these children once they examined them.” By providing an exam to children upon entry to school, at least dentists have the opportunity to discuss what the problems are in the children’s mouth before pain occurs and parents will hear that dental disease is “not inherited” from the absent parent.

Dr. Largent expressed her views that the access to care problem in Kentucky is really two-fold. She said there is an access problem, which can be relieved by having more providers who take the Medicaid card in this state. The care problem is much more difficult to deal with and includes:

- the low value that Medicaid recipients place on preventive dental care
- the low perceived value of Medicaid recipients on overall dental care
- the very high no show rate among those patients with a medical card
- the difficulty with Medicaid administrators to confirm patients coverage and eligibility to the program (data entry was never accurate)
- difficulty in filing forms and administrative hassles
- limitations in treatment choices in the Kentucky Medicaid handbook (Ex: I cannot perform a pulpotomy on a child as the same day as the dental exam which means the child may remain in pain until the treatment can occur at the next visit)
- the feeling that “Big Brother” is watching you, with a legal audit if every rule is not followed in the Medicaid handbook

Dr. Largent summarized her presentation by saying that the problems of access to care is primarily one of education. The patient must view dental care given by the dentist is important, or nothing else will work. The results are failed appointments, inadequate utilization of preventive dentistry, and failed relationships between the provider and the patient. Coupled with this is that reimbursement rates for dental services provided, although better (I am at least no longer losing money treating these patients), is still lower than usual and customary fees. The management of the “system” falls short, but the real problem is that she feels she is not making a difference.

Robert G. Henry, DMD Geriatric Dentistry, VAMC, UK
The Provider Perspective

Dr. Henry introduced himself as a hospital dentist who has served as the dental director of the largest community based nursing home in Lexington for over 13 years. He told the audience that not only do children have particular problems accessing dental services, but people who are homebound or living in
institutions (nursing homes) or other assisted living facilities. This problem is especially severe for those older adults who suffer from dementia, mental illness and other disabilities.

Dr. Henry pointed out that the demand for dental care in older adults is increasing as people are living longer and due to water fluoridation and other dental advances, and are more likely to have kept their teeth throughout their lifetime. Importantly, Henry said, “older adults are the fastest growing segment of our population, and by the year 2030 will be 20% (70 million) of the U.S. population.”

Dr. Henry pointed out the differences between older adults and younger adults and children regarding dental needs. These differences included:
- tooth decay, periodontal diseases and tooth loss more prevalent
- dental problems tend to be more complex over time as a result
- dental problems are often compounded by chronic, systemic illnesses
- oral diseases are cumulative and can impact on general health, for example:
  - associations have been reported between chronic oral infections and diabetes, heart disease, and stroke
  - the oral cavity is a portal of entry for pathogens which can be blood borne or aspirated into the lungs
  - oral problems can have a negative effect on quality of life
  - diet(ability to eat certain foods)
  - functional-speaking and communicating
  - psychological-loss of self-esteem, anxiety, depression and social stigma
- Medicare does not reimburse for routine dental services
- Medicaid has limited coverage for older adults in Kentucky

Dr. Henry defined who the “vulnerable” elderly are in Kentucky. He said, vulnerable elderly are those elderly who fit one of the following descriptions: dependent in physical function, cognitively impaired, incontinent, economically disadvantaged, users of home services, homebound with caregiver or living in a nursing facility. The group of vulnerable elderly needs special consideration for dental services because:
- most have extensive oral disease
- most have one or more chronic diseases complicating their oral care
- most have psychosocial problems (competency, financial, transportation) which makes treatment planning longer and more complex

The barriers to access for vulnerable elderly were reviewed and included the following 5 main areas:
1. Lack of understanding or appreciation for good oral health (patients, caregivers, nursing staff)
2. Lack of properly trained/motivated oral health providers
3. Lack of effective dental care delivery system in Kentucky (inadequate dental facilities and equipment in Nursing Homes and for homebound)
4. Lack of enforcement of oral care standards in Nursing Facilities
5. Lack of dental insurance or financial concerns

Recommendations for actions for improving access, particularly for the
vulnerable older adults were given. These included financial, sustainability, capacity, and infrastructure and are summarized in table 4.

**Table 4.**

<table>
<thead>
<tr>
<th>Recommendations for Improving Access to Vulnerable Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial:</strong> most often cited as the barrier preventing or discouraging access to dental services</td>
</tr>
<tr>
<td>• consider inclusion of dental benefits under Medicare (HR 1288) at least for conditions considered “medically necessary”</td>
</tr>
<tr>
<td>• Medicaid: do NOT reduce already limited adult services (Benefits should not discriminate on basis of the age of a recipient, but provide benefits that are “appropriate and necessary to maintain the health of recipients”)</td>
</tr>
<tr>
<td>• Raise Medicaid rates to ADA’s recommended rate of 75% UCR</td>
</tr>
<tr>
<td>• Develop policy of cost-reimbursement for providers who are already providing services to elderly</td>
</tr>
<tr>
<td>• Pattern Medicaid program more like private insurance</td>
</tr>
<tr>
<td>• Simplify Medicaid administration to eliminate disincentives</td>
</tr>
<tr>
<td>• Extend dental insurance coverage past retirement into old age (Dental insurance should address the fact that dental diseases increase as patients progress from independence to being frail or dependent (vulnerable))</td>
</tr>
<tr>
<td>• Medicare should expand the services to provide for dental services for home health agencies to serve as part of the interdisciplinary team</td>
</tr>
<tr>
<td>• For vulnerable elderly, Medicaid should expand dental services to include house call fees, behavior management, etc.</td>
</tr>
<tr>
<td><strong>Sustainability:</strong> the ability to integrate oral health services fully and permanently into health delivery systems</td>
</tr>
<tr>
<td>• Enforce HCFA/OBRA 1987 regulations for nursing homes This includes the following current regulations;</td>
</tr>
<tr>
<td>• Assist residents to obtain routine/emergency dental care</td>
</tr>
<tr>
<td>• Provide/obtain dental services by hiring on staff or contracting with a dentist</td>
</tr>
<tr>
<td>• Assist/arrange for appointments and transportation to a dental office</td>
</tr>
<tr>
<td>• Refer a resident with lost or damaged dentures to a dentist promptly</td>
</tr>
<tr>
<td>• Develop on-site delivery systems such as:</td>
</tr>
<tr>
<td>• Apple Tree Dental (Minnesota)</td>
</tr>
<tr>
<td>• Dental Access (North Carolina)</td>
</tr>
<tr>
<td>• Determine best programs for communities of interest: Mobile (on-site) systems typically better than vans used for children because; more treatment room, better climate control, no waiting outside, better communication with staff, nursing help usually available, lower cost per unit, and able to offer bedside care</td>
</tr>
<tr>
<td><strong>Capacity:</strong> Refers to the number of oral health providers needed</td>
</tr>
<tr>
<td>• Survey nursing homes and community-at-large to determine how many and what type of oral health care providers are needed to treat vulnerable elderly</td>
</tr>
<tr>
<td>• Recruit dentists/oral health providers who may be interested</td>
</tr>
<tr>
<td>• Set up network (such as KDHC) so providers can communicate</td>
</tr>
<tr>
<td>• Enlist hygienists, assistants, and lab technicians as part of team</td>
</tr>
<tr>
<td>• Support general supervision for dental hygienists</td>
</tr>
<tr>
<td>• Develop a new “oral health nurse” role in nursing facilities, with a nurse having similar responsibilities of a teaching hygienist. This person may be a Nurse, RN/LPN or NA.</td>
</tr>
<tr>
<td><strong>Cultural competency:</strong></td>
</tr>
<tr>
<td>• Use public-private partnerships to improve the oral health of the vulnerable elderly from oral disease by:</td>
</tr>
<tr>
<td>• Developing innovative programs such as fluoride varnish for NH...</td>
</tr>
</tbody>
</table>
Ability of oral health providers to meet the needs in terms of their cultural beliefs, values, language, practice and health behaviors

- Seeking support for “start up”, operations for dental equipment
- Involving the community/administrator/politicians in oral health activities: such as, Senior Smile Week
  - Solicit input from Community decision makers in NH oral matters
  - Provide regular evaluation of your program and share it with community partners

Infrastructure:
Relates to the education and training as well as professional practice requirements

- Training at all levels. It (the training) must be long enough and of enough depth to ensure competency in oral health knowledge and in clinical practice regarding vulnerable older adults
- Training should include but not be limited to:
  - Caregivers (home health aides, nurses aides, family members)
  - Primary care providers (nurses and physicians)
  - Undergraduate and graduate training of nurses and physicians
  - Continuing education courses (professional meetings)
- Oral health care providers: dentists:
  - Undergraduates (mandatory training: 16 hours=1 credit)
  - Graduate and dental residency training (GPR mandatory rotation)
  - Continuing education offered (at least 1 time yearly)
  - National and regional continuing education
- Hygiene and assistant training: ensure education includes geriatric dentistry courses
- Join the Am. Society of Geriatric Dentistry (National Organization devoted to issues dealing with Oral Services to older adults)

Jim Cecil, DMD, MPH, Administrator, Oral Health Program
State of Kentucky Perspective

Dr. Cecil began by reviewing the history of public dental health programs in Kentucky. This review included the beginning of the public dental health program in Kentucky with the appointment of Dr. JF Owens in 1928, extending to preventive dental education programs from 1937 to the 1980s, to fluoridation of public water supplies beginning in 1974 and expanding to 90% of water fluoridated by 1977. In 1978 Kentucky’s General Assembly funded the sealant program, and in 1979 the state of Kentucky was awarded the American Community Dental Prevention Award.

The current Oral Health Program in Kentucky was reviewed and consists of the following components:

- Fluoridation:
  - currently 90% of Kentucky’s population receive fluoride in water
  - 23 schools have fluoride programs
  - supplemental fluoride program at the Louisville Health Department
- Sealant programs: 2,000 children treated last year
- Health Education and Promotion: 20,000 people reached
- Assessment: KY Oral Health Survey
  - Over 2,000 children screened over last year
  - Speakers bureau formed in 2000 to spread message of oral health

Dr. Cecil reviewed the statistics and status of Kentucky’s Oral Health. These are listed in Table 1 (selected oral health problems unique to Kentucky). He reiterated the following statistics: 44% of those over 65 years old are...
toothless, 50% of our children have untreated tooth decay, only 7.6% of children have sealants, 40% of adults use tobacco, and oral cancer rates are high in Kentucky and are probably under-reported. He also reviewed the fact that oral health has linkages with systemic disease including: cardiovascular disease, cancers relating to the use of tobacco, diabetes, pre-term, low birth weight babies, stroke, COPD relating to tobacco use. In addition, 26% of children in Kentucky live in poverty, and echoed Dr. Edelstein’s concern regarding those who are in poverty have poorer oral health.

The positive news regarding oral health is that 90% of Kentuckians are exposed to fluoride. There is a long history of dental public health in Kentucky, and many programs are already in place. The Area and State Territorial Dental Directors (ASTDD) reviewed and created recommendations for Kentucky, which gives our state some guidance, and opportunities for improvement. There was a Medicaid increase for oral/dental treatment procedures in April 2000, and this has helped somewhat in recruiting dentists and in providing a greater incentive to treat children and adults who are eligible.

The opportunities and challenges for Kentucky as well as other states have been delineated in the Surgeon General’s report published in the summer 2000 and were reviewed by Dr. Cecil. These challenges state: disparities do exist in certain areas of our country, including Kentucky. One problem is that data on oral health (studies) are scarce. It is known that the burden of disease is borne primarily by the poor and sick. Preventive strategies do work but unfortunately prevention has not been used much in the past. In addition, there are limited state and national oral health programs. In fact, Oral Health America has developed a “report card” grading states on the quality of comprehensive statewide oral health programs and gives Kentucky an overall grade of D, and the U.S. as a whole, a C minus.

The ASTDD report recommends that Kentucky develop a strategic plan, (which may take place at this summit), provide for a dental director, build up a Dental Public Health (DHP) infrastructure, and develop an oral health surveillance system including developing policy, creating programs and evaluating those programs to determine success. A surveillance conference was held in January 2001, and in May 2001, immediately preceding this summit to address the plans for ongoing oral health surveillance. In addition, the University of Kentucky College of Dentistry recently completed Kentucky’s children oral health survey, and the University of Louisville School of Dentistry is scheduled to begin the adult oral health survey sometime in the fall of 2001, or in 2002.

Dr. Cecil reported that Kentucky has been selected as a participant of the National Governors’ Policy Academy that met for the first time in May 2001. During the Academy 14 strategies were developed to address children’s oral health. He added that short and long-range action plans would be developed.

Dr. Cecil reviewed what Kentucky’s population looks like in terms of demographics and is summarized in Table 5.
Table 5. Kentucky Demographic Information

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>120 counties, 92% Caucasian</td>
</tr>
<tr>
<td>Poverty</td>
<td>17.9% (1995)</td>
</tr>
<tr>
<td></td>
<td>- Medicaid eligible 13.6% (members, 600,00)</td>
</tr>
<tr>
<td></td>
<td>- 300,000 children</td>
</tr>
<tr>
<td></td>
<td>- 65,000 KCHIP</td>
</tr>
<tr>
<td></td>
<td>- Under 18 years old in poverty = 26%</td>
</tr>
<tr>
<td></td>
<td>- Mothers with less than high school education = 22%</td>
</tr>
<tr>
<td>Elderly (65+)</td>
<td>12.5% and growing</td>
</tr>
<tr>
<td>Licensed dentists</td>
<td>2,200</td>
</tr>
<tr>
<td>Dentists taking Medicaid</td>
<td>800 (only 300 are active claimers)</td>
</tr>
<tr>
<td>Dentists in KDA</td>
<td>Approximately 75%</td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>Poor penetration (those most needy not covered)</td>
</tr>
<tr>
<td>Shortage of Dentists</td>
<td>Looming national crisis</td>
</tr>
</tbody>
</table>

Dr. Cecil closed by giving his vision and plans for Kentucky’s future oral health program. He highlighted three components for a successful program: assessment, policy development, and assurance. Each of the essential parts of these components is listed here:

- **Assessments:** oral health surveys, surveillance system, and continued evaluation of programs for the effectiveness, efficiency, appropriateness, and scope
- **Policy:** partner with other public health programs; use an evidence based programmatic approach; rebuild the public health service infrastructure; look at legislation to increase access points
- **Assurance:**
  - **Prevention:**
    - Ensure fluoride in water for all Kentuckians
    - Fluoride varnish programs for at risk infants
    - Statewide sealant programs in schools
  - **Oral Health Education/Promotion**
    - Relate to other diseases and conditions: common risk factor approach
    - Promote the Kentucky Speakers Bureau
  - **Access for non-served and under-served**
    - Regional access points for referral, consultation, prevention, and treatment where little or no access is available in private or public venues

In conclusion, Dr. Cecil encouraged the participants to realize that Kentucky’s oral health problems are opportunities where all present can make a difference. The challenges are significant and include financial, the vision to make dramatic changes, and the need to partner with all stakeholders. “We must continue to keep our eyes on the prize if we are to develop an orally healthy new generation of Kentuckians.”
Raynor Mullins, Chief, Director Dental Public Health Division, 
University of Kentucky College of Dentistry
State of Kentucky Perspective

Dr. Mullins introduced himself as a dental public health dentist with over thirty years of experience with community dental programs and dental education in Kentucky. He submitted for the Summit a summary of existing data about oral health in Kentucky. He proclaimed, “The current dental access problems are the worst he has ever observed in Kentucky”. Dr. Mullins further reported on the many, many requests that are received by the University of Kentucky Public Service Program for help with dental access problems. All existing information indicates there are substantial problems statewide and these problems are not limited to one region of the Commonwealth.

Recent local dental screening results from the University of Kentucky indicate many Kentucky children have pain, infection, and untreated tooth decay and very limited access to proven dental preventive services such as dental sealants. This fall, for the first time in over a decade, statewide dental epidemiological information will be available from the 2000-2001 Kentucky Children’s Oral Health Survey. Dr. Mullins assessment was both oral health and general health disparities are enormous due to high numbers of patients with special needs and very high poverty levels and the associated low educational levels in Kentucky.

Dr. Mullins stated “If you keep going in the direction you’re going, you will end up where you are headed. I submit to this summit - - we are headed for disaster - - many of Kentucky’s children and adults have already been adversely affected and many more will be unless we change directions and take different steps to address access problems”.

Dr. Mullins then recommended highly collaborative approaches involving both dental and non-dental and private and public stakeholders. He also noted collaborative activities are not the norm for dentistry. The profession is used to working in a very independent manner. Dr. Mullins then challenged the Summit with five “Big Recommendations” that he believes should be part of a strategic plan to improve both oral health and general health in Kentucky. These findings link oral health and general health in Kentucky. He noted the emerging research findings linking oral infections and systemic diseases are very important. The current patterns of health care practice must be altered to include this new knowledge.

The Five Recommendations were:

1. Plan and implement a strong oral health component into Kentucky’s New Early Childhood Development Program (KIDS Now).
2. Develop a statewide collaborative private and public “Seal Kentucky” Program to insure that all of Kentucky’s high-risk school children receive the full benefits of preventive dental sealants.
3. Revise the Kentucky Dental Practice Act to permit general supervision of dental auxiliaries in both public programs and private dental practices.

   Dr. Mullins proposed a substantial new strategy, **Regional Critical Dental Access Support Programs (CDASP’s)**. These programs would be hospital-based with residency training programs linked to universities and affiliated public and private dental and health networks.


   Dr. Mullins challenged the State Oral Health Program to organize a new science-base campaign to get the messages to the various target groups. He stated “It is very important to educate not only the public about the important relationships between oral health and general health, but also state policy makers and other health care providers”.

### SUMMARY

Dr. Mullins concluded that implementing these recommendations and improving dental support systems for financially disadvantaged and special needs populations is a win-win situation for dentists in the private sector, for state government, and for universities. His presentation assumed that improving early childhood oral health and maternal oral health are not only an important health considerations for Kentucky - - but also involve important childhood development, education, and economic development considerations that can have substantial long term financial benefits for the Commonwealth. However, he cautioned “Highly collaborative approaches will be essential to achieve these benefits”.

### Luncheon Presentation

**Nancy Schoenberg, PhD**  
**Tim Smith, PhD**

*Determinants of Oral Health Behavior in Kentucky*

Drs. Schoenberg began the presentation by explaining that both she and Dr. Smith were both Behavioral Scientists at the University of Kentucky. Her and Dr. Smith’s presentation focused on all the components that determine the behavior people exhibit towards oral health including: structural or access to care aspects, psychological aspects, and cultural aspects including language.

Dr. Smith cited two studies done in Kentucky that focused on dental health behavior, dental fear, and dental economic factors. One study examined 104 patients who visited a dental emergency room at the University of Kentucky in 1990 and the other study cited reviewed a population of 5,303 from rural Menifee County of which 35% were below the poverty level and 66% were below 200% of poverty level. In Menifee County 23% of the population were Medicaid eligible. The reasons that kept the patient from going to the dentist can be seen in Table 6.
Table 6: Reasons keeping Patient from Going to the Dentist

<table>
<thead>
<tr>
<th>Reason</th>
<th>% of E.R. patients</th>
<th>% Menifee Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too expensive</td>
<td>53</td>
<td>59</td>
</tr>
<tr>
<td>Dentist scares me</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>Bad Experience</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>No Need</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>No close dentist</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Time</td>
<td>--</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

The three highest percentages (reasons) which kept patients from going to the dentist were: the dental fees were too expensive, there was no (perceived) need (by the patient) and dental fear (the dentist scares them).

In another study done by Ismail and Sohn on dental access and caries, published by the American Dental Association (ADA) in March 2001, 1,614 children in Nova Scotia, Canada were evaluated. All children were covered by one insurance program that provides basic preventive, restorative and surgical services. The socioeconomically disadvantaged children did not achieve the same low level of caries experience, as did the other children in Nova Scotia. This was similar to findings in studies done in the United Kingdom. Dr. Smith reported the authors’ findings, which were that “Oral health cannot be promoted solely via the provision of professional dental care.”

Dr. Smith reviewed a program designed to increase access to care started by Grembowski and Milgrom. Called “Access to Baby and Child Dentistry Program (ABCD), 465 parents of children ages 13-36 months were enrolled and compared to parents/children who were Medicaid recipients on dental access issues. The five components of the ABCD program were:

- OUTREACH – marketed through community organizations and events
- TRAINING – families were enrolled and oriented (not just children)
- CERTIFICATION OF DENTAL PROFESSIONALS – one-day program on child management and preventive procedures plus periodic newsletter.
- ENHANCED DENTAL BENEFITS – early and periodic screening, diagnosis and treatment plus 3 fluoride-varnish treatments per year, sealants, fillings in primary teeth and oral health instruction
- ENHANCED DENTAL FEES – paid to providers who participated in program

Dr. Smith reviewed the results of this study which is seen in Table 7.

Table 7. Results of ABCD Access Study

<table>
<thead>
<tr>
<th></th>
<th>% of Children Visiting the Dentist in a One-Year Follow-up Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCD</td>
<td>43%</td>
</tr>
<tr>
<td>Non-ABCD (Medicaid)</td>
<td>12%</td>
</tr>
</tbody>
</table>

The target group of ABCD participants = 100-12 = 88%

Additional motivated parents = 43-12 = 31%

Success rate = 31/88 = 35%
The conclusion reached is that families who enrolled had a greater understanding and motivation which translated to an increased follow-up visit rate.

Dr. Smith cited a number of studies done in Kentucky from 1989 through 1999 on dental fear. Three of the surveys were done State-wide (1989, 1992, 1997). The results revealed that the percent of respondents who reported “moderate or greater” dental fear ranged from 17 to 40%. He said this indicates that dental fear has not decreased in the last 3 decades and that the rates are similar in all regions of the U.S. A. and state of Kentucky. Dental fear obviously influences use of dental services in a negative way.

The results of the dental access study done in Menifee County revealed several factors which influenced the use of dental services and both positive (encouraged use) and negative factors (discouraged use) are seen in Table 8.

Table 8. Factors Influencing Use of Dental Services: Menifee County

<table>
<thead>
<tr>
<th>Positive Factors</th>
<th>Negative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having check-up or cleaning on the last dental visit</td>
<td>Having False Teeth</td>
</tr>
<tr>
<td>Rating dental care as highly important</td>
<td>Being afraid of the dentist</td>
</tr>
<tr>
<td>Having dental insurance</td>
<td></td>
</tr>
<tr>
<td>Perceiving oneself to have good oral health</td>
<td></td>
</tr>
<tr>
<td>Having had parents teach you the importance of dental care</td>
<td></td>
</tr>
</tbody>
</table>

Dr. Schoenberg concluded the presentation by reviewing the many elements of culture and how culture affects health care in particular and oral health care behavior in specific. The conclusion of the presentation highlighted these important points:

• More than access needs to be addressed if Kentucky’s oral health is to improve substantially (ie, culture, behavior, education, etc, must all be considered)
• Kentuckian’s need to prioritize and choose a few promising things to work on first
• Kentucky needs to realize that it is not Sweden or Canada (with socialized medicine) and will need to develop our own answers
• As seen in studies mentioned and also in clinical trials in other health areas, many things won’t work and progress will be made only in small increments. (Example: cancer rates improve only very slowly).
Chapter 3: Workgroup Recommendations

The afternoon of Thursday, May 24, participants chose one of four workgroups to develop recommendations and strategies designed to improve access problems in Kentucky. What follows is a list of the work group leaders, co-leaders and recorders for this session along with a list of goals and recommendations that were developed.

**WORKGROUP LEADERS**

**LEGISLATIVE**  
**Leader:** Dr. Ken Rich  
**Co-leader:** Mike Porter  
**Recorder:** Dr. Sue Feeley

**PUBLIC AWARENESS & EDUCATION**  
**Leader:** Ms. Lois Reynolds  
**Co-leader:** Dr. Fred Howard  
**Recorder:** Ms. Judy White

**DENTAL SERVICE DELIVERY MODELS**  
**Leader:** Dr. Jim Cecil  
**Co-leader:** Dr. Steve Feldman  
**Recorder:** Dr. Bob Henry

**DENTAL EDUCATION INITIATIVES**  
**Leader:** Dr. Roland Hutchinson  
**Co-leaders:** Dr. Leon Assel, John Williams  
**Recorder:** Dr. Raynor Mullins

Legislative: Pertains to legislative actions that may be taken to improve Ky. Oral Health. Ex: Medicaid fees, Medicare issues. Mandatory dental exams prior to first grade.

Public awareness and education: Initiatives to educate the public and raise awareness of oral health throughout the state.

Dental Service Delivery Models: Innovative programs to deliver dental services, such as dental vans, teaching nursing homes, homeless center clinics, migrant worker clinics, sealant programs, denture access, etc.

Dental Education Initiatives: Dental School Programs pertaining to outreach to minority/disabled or disadvantaged.

**WORK GROUP #1: LEGISLATIVE**

Legislative Goal: Assure that eligibility for oral health care benefits translates (insures) access to care.

1. Reimburse Medicaid at not less than 100% of the 75 percentile of the SE Regional Fee schedule. This would ensure adequate participation and access for recipients.
3. Mandate dental exams for children initially entering school and for people entering Nursing Homes/Long-term care facilities.
4. Increase dentists support for denture access program for the indigent.
5. Manpower issues:
   - Legislate general (indirect) supervision for hygienists and expanded duties for auxiliaries. This would include coronal polishing by trained dental assistants.
   - Establish off site residency programs for post-doctoral dental residency training (increase providers into the community).
   - Provider incentives (financial) for serving target populations.
6. Remove carbonated sodas from public schools.
WORK GROUP #2: PUBLIC AWARENESS AND EDUCATION
GOAL: Increase awareness and education in oral health so the citizens of Kentucky value and demand good oral health.

1. Prioritize groups that we need to reach, based on who are most important initially and also where our resources can be used the best.
2. Who within these groups should we target and in what order?
3. What message should we deliver to each group?
4. How should we deliver the message-crafted in language that is most effective and understandable?
   • Delivery vehicle for each group.

Priority Groups Identified:
1. Policy Makers:
   • Governors Office
     i. Early Childhood Development Initiative
     ii. National Governor’s Association (NGA) Initiative
   • Lt. Governor
   • Legislators
   • Cabinet for Human Resources
     o Medicaid Steering Committee
     o Utilize interdepartmental newsletters, etc. that can be used in state government to communicate our message
2. Healthcare educators (outside of dentistry)
   • Physicians (Practitioners and students)
     i. Pediatricians
     ii. Family practice
     iii. Neonatologists
   • Nursing
     o R.N.s
     o Neonatal
     o Nursing schools
     o Health Departments
     o Home Health
     o Hospice
3. Educators
   • Family resource and youth service centers
   • Site based councils
   • Classroom teachers (Kentucky Smile Curriculum Update)
4. Community groups (Public at Large)
   • Extension agency
   • Senior citizens centers
   • Retirement centers
   • Individuals (families) in the community
WORK GROUP #3: DENTAL SERVICE DELIVERY MODELS

STRATEGY and OVERVIEW:

- Begin with oral health education and health promotion
- Partner with other agencies, groups, organizations
- Network with other organizations
- Remember dollars are scarce: leverage dollars from others
  - No new dollars in system for some programs

DELIVERY MODELS PROPOSED

1. Qualify local health department clinics for National Health Service Corps designation as underserved areas.
   - Couple with loan forgiveness as an incentive to attract providers
   - NHSC does not pay the salary of the provider (must be local)
   - Provide financial incentives for providers to practice in an area
   - Must be part of a business plan for carrier and provider
3. Universal statewide sealant program
   - Tied to education system
   - Public/private collaboration
4. “Networking”
   - Use existing coalitions
   - Education/health promotion focused
   - Primary prevention
   - Collect data
   - Least expensive
5. Well-baby checkups
   - Provide preventive care on a sliding scale
   - Non-dental providers involved (need training)
6. Incorporate oral health into public programs already in existence
   - Dental education/health promotion focused
7. Legislation to require dental exams for children before entering school.
   - Incentive to tie volunteer dental service provision to social credits as part of requirements for licensure.
   - Link with requirements for continuing education
8. Form regional dental resource centers throughout state
   - Education based GPR and pediatric Dentistry residency programs
   - Comprehensive care
   - University based
   - Includes RDH and other auxiliary programs
9. Expand Health Kentucky to 120 counties
   - Expand volunteer programs for dentists statewide
   - Hard to sustain
   - Dental versus medical model complicates participation
10. Reform Medicaid
    - Raise fees to market acceptable level
    - Add patient and provider incentives for participation
    - Consider use of “credit card” for eligibility, billing, etc
    - Do something about failures and administrative hassles
WORK GROUP #4: DENTAL EDUCATION INITIATIVES:

1. Educate non-oral health personnel to include but not limited to:
   - Physicians, nurses, nurse assistants, dieticians,
   - Parents (pre-natal education is critical)
   - Legislators, Medicaid personnel
   - Teachers and school personnel

2. Advocate for general supervision of oral health by allied personnel with protective caveats to discourage/prevent independent practice opportunities. Expand duties of selected allied personnel.

3. Due to the severe shortage of pediatric dentists – develop joint pediatric programs, made possible with multiple remote sites. Utilize distance education modalities.

4. Encourage, devise, support loan forgiveness, scholarship type programs for graduates willing to practice in underserved areas. Legislative changes to designate “underserved” areas.

5. Advocate and support pre-school oral health exams.

6. Incorporate smoking and smokeless tobacco cessation programs into all curricula and education programs.

7. Align the dental school’s curricula with the needs of Kentucky dentistry (oral health needs).

   Several recommendations from the four work groups overlap. An edited version (to remove the redundant topics) is included in the executive summary.
Chapter 4: Executive Summary

In conclusion of his presentation, Dr. Edelstein stated, “Good people can solve even the most difficult problems. You have much to do today and tomorrow. I look forward to hearing of your success, learning of your effectiveness, and pointing to you as the new best example of doing it right.”

The KDHC invited participants to spend Friday morning on May 25 to prioritize recommendations and determine who would be responsible for these particular areas. Dr. Bob Henry and Ms. Lois Reynolds served as moderators for this session that included about 50 participants in a lively discussion.

What follows is an edited version (eliminates redundant topics) of the workgroup recommendations along with an action list of individuals in attendance who agreed to take leadership roles in pursuing the development or resolution of the problem identified. Note: not every topic, which was listed on Thursday, was mentioned again on Friday. The Friday morning meeting was a group process meeting and included members from all 4 workgroups from the day before.

WORK GROUP #1: LEGISLATIVE
Legislative Goal: Assure that eligibility for oral health care benefits translates (insures) access to care.

1. Reimburse Medicaid at not less than 100% of the 75 percentile of the SE Regional Fee schedule. This would ensure adequate participation and access for recipients.
2. Reform Medicaid: In addition to raising fees to a market acceptable level, Medicaid reform to include:
   - Adding patient and provider incentives for participation
   - Consider use of “credit card” for eligibility, billing, etc
   - Do something about administrative “hassles” and failures
4. Mandate dental exams for children initially entering school and for people entering Nursing Homes/Long-term care facilities.
5. Increase dentists’ support for denture access program for the indigent.
6. Manpower issues:
   - Legislate general (indirect) supervision for hygienists and expanded duties for auxiliaries. This would include coronal polishing by trained dental assistants.
   - Establish off site residency programs for post-doctoral dental residency training (increase providers into the community).
   - Provider incentives (financial) for serving target populations.
7. Remove carbonated sodas from public schools.

INDIVIDUALS AGREEING TO PARTICIPATE IN LEGISLATIVE AREAS
*Indicates chair person or group leader for each
1., 2. Medicaid: Evaluate fees, seek increase and reform
   Gerry Ferretti*, Mike Porter, Ken Rich, Fred Howard, Dave Willis, Raynor Mullins, Billy Reynolds, Mike Johnson, Frank Metzmeir, Sue Feeley
INDIVIDUALS AGREEING TO PARTICIPATE IN LEGISLATIVE AREAS
(continued)
*Indicates chair person or group leader for each
LEGISLATIVE

3. Anesthesia benefits for children...
   Mike Porter*, Ken Rich, Frank Metzmeir, Guy Furnish, Mike Johnson

4. Pre-school dental exam...
   Ken Rich*, Sue Feeley, Frank Metzmeir, Darlene Goodrich, Dave Willis,
   Mike Porter, Guy Furnish, Lois Reynolds, Doug Schutte

6. Manpower issues: expand role of dental auxillaries...
   Connie Drisko*, Mike Porter, Ken Rich, Frank Metzmeir, Doug Schutte,
   John Tarrant

7. Remove carbonated sodas from schools...
   Sue Feeley*, Mike Johnson, Steve Feldman, Mike Porter, Frank
   Metzmeir, Ken Rich

   Note: Although no one signed up for issue #5 (dentists support for denture
   access programs), this will still be addressed by the KDHC.

WORK GROUP #2: PUBLIC AWARENESS AND EDUCATION
GOAL: Increase awareness and education in oral health so the citizens of
Kentucky value and demand good oral health.

1. Prioritize groups that we need to reach, based on who are most important
   initially and also where our resources can be used the best.
2. Who within these groups should we target and in what order
3. What message should we deliver to each group.
4. How should we deliver the message-crafted in language that is most
   effective and understandable.
   • Delivery vehicle for each group.

   Priority Groups Identified:

1. Policy Makers:
   • Governors Office
     i. Early Childhood Development Initiative
     ii. National Governor’s Association (NGA) Initiative
       • Lt. Governor
       • Legislators
       • Cabinet for Human Resources
         o Medicaid Steering Committee
         o Utilize interdepartmental newsletters, etc. that can be
           used in state government to communicate our message

2. Healthcare educators (outside of dentistry)
   • Physicians (Practitioners and students)
     i. Pediatricians
     ii. Family practice
     iii. Neonatologists

2. Healthcare educators (outside of dentistry) (Continued)
• Nurses
  o R.N.s
  o Neonatal
  o Nursing schools
  o Health Departments
  o Home Health
  o Hospice
  o Nursing homes
  o Licensed practical nurses (LPNs)
  o Nursing Assistant (NAs)

3. Educators
   • Family resource and youth service centers
   • Site based councils
   • Classroom teachers (Kentucky Smile Curriculum Update)

4. Community groups (Public at Large)
   a. Extension agency
   b. Senior citizens centers
   c. Retirement centers
      • Individuals (families) in the community

INDIVIDUALS AGREEING TO PARTICIPATE IN PUBLIC AWARENESS
and EDUCATION
*Indicates chair person or group leader for each

4. Examine other states to change attitudes toward oral health issues...
   **Guy Furnish**, Gerry Ferretti, Raynor Mullins, Leon Assael
   1., 2,3, **Increase education and public awareness**....
   **Fred Howard**, Steve Feldman, Dedra DeBerry, Marie Markesberry, Barry Ceridan, David Gardner

5. Networking with community groups and agencies (Ex: Speaking at AHEC Centers Directors Meeting)
   **Barry Ceridan**, Dedra De Berry, Steve Feldman, Doug Schutte

4. Corporate community prevention programs:
   Proctor and Gamble: Healthy Smiles-Contact David Gardner
   Colgate: Bright Smiles-Contact Marie Markesberry

WORK GROUP #3: DENTAL SERVICE DELIVERY MODELS
STRATEGY and OVERVIEW:
• Begin with oral health education and health promotion
• Partner with other agencies, groups, organizations
• Network with other organizations
• Remember dollars are scarce: leverage dollars from others
  o No new dollars in system for some programs

DELIVERY MODELS PROPOSED
1. Qualify local health department clinics for National Health Service Corps designation as underserved areas.
   • Couple with loan forgiveness as an incentive to attract providers
   • NHSC does not pay the salary of the provider (must be local)
• Provide financial incentives for providers to practice in an area
• Must be part of a business plan for carrier and provider

3. Universal statewide sealant program
• Tied to education system
• Public/private collaboration

4. “Networking”
• Use existing coalitions
• Education/health promotion focused
• Primary prevention
• Collect data
• Least expensive

5. Well-baby checkups
• Provide preventive care on a sliding scale
• Non-dental providers involved (need training)

6. Incorporate oral health into public programs already in existence
• Dental education/health promotion focused

7. Form regional dental resource centers throughout state
• Education based GPR and pediatric Dentistry residency programs
• Comprehensive care
• University based
• Includes RDH and other auxiliary programs

8. Expand Health Kentucky to 120 counties
• Expand volunteer programs for dentists statewide
• Hard to sustain
• Dental versus medical model complicates participation

INDIVIDUALS AGREEING TO PARTICIPATE IN DENTAL SERVICE DELIVERY MODELS

*Indicates chair person or group leader for each

3. Develop Early Childhood Caries Prevention Program Statewide…
   (Ex.: Sealant and/or fluoride varnish program)
   Raynor Mullins*, Steve Feldman, Darlene Goodrich, Fred Howard, Guy Furnish, Barry Ceridan

8. Develop private practice initiatives to increase access…
   (Ex.: Develop solutions/options for Medicaid participants)
   Frank Metzmeir*, Mike Porter, Ken Rich

Note: It is possible that more people did not sign up for these models because of the complexity and time commitment required to develop these. However, several of these may be undertaken jointly with the KDHC, Dental Schools, and Dept of Public Health Dentistry support.

WORK GROUP #4: DENTAL EDUCATION INITIATIVES:

1. Educate non-oral health personnel to include but not limited to:
   • Physicians, nurses, nurse assistants, dieticians,
   • Parents (pre-natal education is critical)
   • Legislators, Medicaid personnel
   • Teachers and school personnel (See #2 under public awareness and education)
2. Due to the severe shortage of pediatric dentists – develop joint pediatric programs, made possible with multiple remote sites. Utilize distance education modalities.
3. *Encourage, devise, support loan forgiveness, scholarship type programs for graduates willing to practice in underserved areas. Legislative changes to designate “underserved” areas. (see #1 under dental service delivery models).*
4. Incorporate smoking and smokeless tobacco cessation programs into all curricula and education programs.
5. Align the dental school’s curricula with the needs of Kentucky dentistry (oral health needs).

INDIVIDUALS AGREEING TO PARTICIPATE IN DENTAL EDUCATION INITIATIVES:

*Indicates chair person or group leader for each

2. Increase number of pediatric dentists and pediatric dental educators in Kentucky....
   Guy Furrnish*, Gerry Ferretti, Raynor Mullins, Leon Assael

Note: Although no one signed up for #5 (align the dental school curricula…), There was agreement from the group that dental schools need to improve/enhance Kentucky’s dental school curricula on: the state’s oral health needs, “general healthy lifestyles”, and relationships between dentistry and general health.
PLANS FOR FOLLOW-UP:

Before the group dismissed, it was agreed that the Dental Access Summit Planning Committee would remain an active group to coordinate assignments, write this proceedings notebook, and follow-up on any correspondence which may be necessary to implement the recommendations developed. Dr. Bob Henry was nominated and appointed chair of the newly named “Kentucky Summit Access Committee” under the jurisdiction of the KDHC. In addition, several new members were appointed due to their positions as dental leaders in the state or dental schools. The members of the committee (in alphabetical order) are: Leon Assael, James Cecil, Dedra DeBerry, Sue Feeley, Stephen Feldman, Gerry Ferretti, Bob Henry (chair), Fred Howard, Frank Metzmeir, Raynor Mullins, Beth Petersen, Mike Porter, Lois Reynolds, Ken Rich, and John Williams.

This Committee has met once since the summit and plans are to meet once a month to coordinate efforts with the KDHC, KDA, and the group leaders identified here. Currently the plan is to distribute the proceedings notebook to all participants as well as begin efforts to support the Legislative proposals outlined here. In addition, there may be a yearly meeting in conjunction with the KDHC annual meeting to review the progress on the plans and recommendations developed at the Summit.

The KDHC can use a lot more help to battle these issues over the next few years. If you can help, please do so. Choose a particular problem or area of interest to you and contact Beth Peterson, Executive Secretary of the KDHC, at KDHC1@aol.com, or TBLPETE@aol.com or phone KDHC: 859-339-5342. Let her know how you want to help, and make a commitment to improving the oral health of the children and adults in Kentucky.
# APPENDICES

## APPENDIX A: Summit Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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| 6:00-8:00 pm | Wednesday, May 23, 2001  
Welcoming Reception and Registration  
Meet the participants |
| 6:30-8:00 a.m. | Thursday, May 24, 2001  
Continental Breakfast and Registration |
| 8:00-8:30 | Welcoming Remarks – Steve Henry, LT. Governor, KY.  
Lois Reynolds, Moderator, Oral Health America  
Fred Howard, DMD, President, KY. Dental Health Coalition  
Frank Metzmeir, DMD, President, KY. Dental Association  
Roberta Kelly, Regional Director, Health Resources & Services Administration  
Robert Klaus, CEO, Oral Health America |
| 8:30-9:30 | Keynote: National Trends in Oral Health—Surgeons General Report  
Burton Edelstein, DDS, MPH Director, Children's Dental Health Project and Former Chair, U.S. Surgeon General's Workshop/Children's & Oral Health |
| 9:30-9:45 | Break |
| 9:45-10:15 | Overview of Kentucky's Oral Health—Panel Presentation  
The Patient Perspective  
Loretta Maldaner, Director, Purchase AHEC  
Tammy Gay, President, Richmond Family Resource Center |
| 10:15-10:45 | The Provider Perspective  
Beverly Largent, DMD, Pediatric Dentist, Paducah, Ky.  
Robert Henry, DMD, MPH, Geriatric Dentist, VA Medical Center, Lexington, Ky. |
| 10:45-11:45 | State of the State  
Sharon Stumbo, MPH, Vice-Commissioner Public Health, Kentucky  
Jim Cecil, DMD, MPH, Admin., Oral Health Programs, KY.  
Raynor Mullins, DMD, MPH, Chief, Division of Dental Public Health, University of Kentucky |
| 11:45-12:00 | Panel Discussion |
12:00-1:30 p.m.  **LUNCH / Luncheon Speakers: Determinants of Oral Health Behavior in Kentucky**
Nancy Schoenberg, PhD, Behavioral Scientist
Tim Smith, PhD, Behavioral Scientist

1:30-2:45  **Breakout Sessions: Workgroup leaders**
Ken Rich, DMD  Legislative Issues
Lois Reynolds, LLC  Public Awareness and Education
Jim Cecil, DMD, MPH  Dental Service Delivery Models
Rowland Hutchinson, DDS, MS  Dental Education Initiatives

2:45-3:00  **Break**

3:00-4:00  Small work groups continue
4:00-4:30  Plenary session: Share findings
4:30  First Day Summit Concludes

**Friday May 25, 2001**

As per recommendations, the specifics of “what to do next” was the focus of the second Summit day. This meeting was used to engage the people who have the responsibility for sorting out, implementing, monitoring, and advancing strategies. Approximately 50 people attended the Friday morning session.

6:30-8:00am  Breakfast buffet

8:00-9:00  **Plenary Session: Overview of where we are and where we want to go:**
Moderator: Lois Brown and Bob Henry

9:00-11:00  **Small Work Groups Continue**
(develop strategies and responsibilities for follow-up)
(ie. Who is responsible for carrying out the plan)

11:00-12:00  **Plenary Session: Share findings and recommendations with conference participants**

12:00  Second Day Summit Concludes
APPENDIX B: Presenters’ Biographies

James C. Cecil, DMD, MPH, is the newly appointed (October 2000) Administrator of Oral Health Programs for the Commonwealth of Kentucky. Prior to his appointment, Dr. Cecil was a faculty member in the Division of Dental Public Health, Department of Oral Health Science in the College of Dentistry at the University of Kentucky. He has been a faculty member since his return to Kentucky in 1996, where he completed a distinguished career with the United States Navy Dental Corps. His research and service projects relate to access to oral health care where he is actively involved with the development of preventive dental outreach programs that serve Appalachia, Central, and Western Kentucky.

Burton L. Edelstein, DDS, MPH is a pediatric dentist and Chair of the Division of Community Health at Columbia University School of Dental and Oral Surgery. He is the founding director of the Children’s Dental Health Project which is a non-profit organization established as a strategic alliance of the American Academy of Pediatric Dentistry, American Academy of Pediatrics, and American Dental Education Association. With primary support from the WK Kellogg Foundation, the Project promotes children’s oral health and access to dental care through advancements in public policy and clinical practice. Dr. Edelstein serves as a consultant to the federal government’s HRSA-HCFA Oral Health Initiative and manages the public-private partnership on children and oral health for the Department of Health and Human Services. He was a Congressional fellow in the office of US Senate Democratic leader Tom Daschle during SCHIP enactment, chaired the US Surgeon General’s Workshop on Children and Oral Health, and authored the child section of the Surgeon General’s Report “Oral Health in America”.

Tammy S. Gay, is a veteran coordinator currently serving in her ninth year at the Richmond Family Resource Center, Madison County. She serves the students and families of Mayfield Elementary (Preschool – grade 5), of which 94% are eligible for free/reduced meals. Tammy was appointed by the Secretary for the Cabinet for Families and Children to serve on the state’s Task Force for Welfare Reform. A member of the Family Resource Youth Services Coalition of Kentucky, Inc., she served as President from 1998-2000 and is currently Chairman of Public Policy. Tammy serves on the Board of Director’s for the Kentucky Dental Health Coalition (KDHC).

Robert G. Henry, DMD, MPH is director for Geriatric Dental Services and Assistant Chief of Dental Services at the Dept. of Veteran’s Affairs Medical Center, Lexington, Kentucky. He is also a Clinical Associate Professor at the University of Kentucky College of Dentistry, and an Associate, Sanders-Brown Research Center on Aging. In 1986, he established a dental clinic at the Lexington Center for Health and Rehabilitation, Lexington’s largest community based nursing home and served as the dental director until 1999. Dr. Henry is the immediate past chairman of the Board of the Federation of Special Care Organizations in Dentistry, a national organization whose mission is to improve the oral health of all Americans who have disabilities, who are hospitalized or who are elderly and may be unable to access needed dental services.

Beverly A. Largent, DMD is a pediatric dentist in private practice since 1984 in Paducah, Kentucky. She is a Fellow and Diplomate in the American Academy of Pediatric Dentistry. Dr. Largent has participated in the Kentucky Medicaid Program since beginning practice. She has participated in the Headstart programs in her area, and has served on the Headstart board as dental director, as well as participating in the Free Dental Clinic in her community. Dr. Largent has been an active member of the Kentucky Dental Association (KDA), and is presently serving on the Executive Board of the KDA, and the Council on Constitution and Bylaws and Judicial Affairs. She is a trustee elect for the Board of Trustees of the American Academy of Pediatric Dentistry. Currently, she is serving as the President of the Board of Directors of Child Watch, a children’s advocacy program in her community. Dr. Largent is the President-elect of the Kentucky Dental Association.
APPENDIX B: Presenters’ Biographies (continued)

Loretta Maldaner, is Director of the Purchase Area Health Education Center in Murray, Kentucky. Loretta has worked for the AHEC for nine years. For the past five years, the Purchase AHEC, University of Louisville School of Dentistry, West KY. Technical College Dental Assisting program and a local community dentist have sponsored a free dental clinic for children who have no insurance or ability to pay. In addition, Loretta has been active in developing the West KY Children’s Dental Health Coalition, which currently has 40 members.

M. Raynor Mullins, DMD, MPH, is currently Chief, Division of Dental Public Health at the University of Kentucky College of Dentistry. Since 1995 he has led the education, service and research initiatives for the Division of Dental Public Health. He is a past President of the American Association of Public Health Dentistry. Dr. Mullins research and service interests include oral epidemiology and dental promotion and prevention programs for mothers and children. He is also actively studying access to care issues for the dental Medicaid and KCHIP programs in Kentucky and is a member of the Governor’s recently appointed Kentucky Medicaid Quality Oversight Committee. Dr. Mullins is actively engaged in public health practice, directing mobile dental programs in Eastern and Western Kentucky and providing dental consultation and technical assistance to the Kentucky Department of Public Health. Dr. Mullins currently is the secretary-treasurer of the K.D.H.C.

Nancy E. Schoenberg, Ph.D., is an Assistant Professor in the Departments of Behavioral Science, Anthropology, and Internal Medicine (Cardiology) and a faculty member in the Sanders-Brown Center on Aging and associate at the Center for Health Services Management and Research at the University of Kentucky. Dr. Schoenberg is a medical anthropologist who has research interests in self-care decisions of older adults toward chronic diseases (especially heart disease, hypertension, and diabetes), qualitative methodology, and culturally appropriate long-term care options for elders.

Timothy A. Smith, Ph.D., is a Professor of Behavioral Science in the College of Medicine at the University of Kentucky. Since 1969 he has been a member of the faculty of the College of Dentistry in Lexington teaching patient relations and communication and of the College of Education teaching statistics and testing. He has published numerous papers on dental fear and presently is Co-Investigator on a HRSA grant to develop rural sites for general practice residents using distance learning methods. Dr. Smith has been a visiting Professor at Harvard University, the University of Washington, and the Royal Dental College in Aarhus, Denmark.

Sharon L. Stumbo, MA, is Deputy Commissioner for the Department of Health Services, and Acting Division Director/Health Systems Development for the State of Kentucky. Sharon graduated from Berea College in 1966 and completed a Masters degree in Guidance and Counseling from Western Kentucky Univ in 1972. She received her second Masters Degree in Health Care Administration in 1992 from the University of Kentucky. In her current position, Sharon assists with managing the Dept. of Health Services which includes 7 divisions including the maternal and child health systems development. Among her many accomplishments include creating a statewide public health practice committee that redesigned a patient services manual which changed the financial and coding systems, created an evaluation instrument, and reduced forms.
# APPENDIX C: Dental Access Summit Planning Committee

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Cecil, DMD, MPH</td>
<td>Administrator, Oral Health Programs</td>
<td>Commonwealth of Kentucky</td>
</tr>
<tr>
<td>Sue Feeley, DMD</td>
<td>Private Practitioner and Board of Director</td>
<td>Kentucky Dental Health Coalition</td>
</tr>
<tr>
<td>Stephen Feldman, DDS, MS Ed.</td>
<td>Director, Community Services</td>
<td>University of Louisville School of Dentistry</td>
</tr>
<tr>
<td>Robert Henry, DMD, MPH</td>
<td>Director, Geriatric Dental Services</td>
<td>Dept. of Veterans Affairs Lexington, Kentucky</td>
</tr>
<tr>
<td>H. Fred Howard, DMD, PSC</td>
<td>Private Practitioner and President,</td>
<td>Kentucky Dental Health Coalition</td>
</tr>
<tr>
<td>Rowland Hutchinson, DDS, MS</td>
<td>Immediate Past President and Former Dean, UL School Dentistry</td>
<td>American Dental Education Association</td>
</tr>
<tr>
<td>M. Raynor Mullins, DMD, MPH</td>
<td>Chief, Division of Dental Public Health</td>
<td>University of Kentucky College of Dentistry</td>
</tr>
<tr>
<td>Beth Petersen</td>
<td>Executive Secretary and Conference Planner</td>
<td>Kentucky Dental Health Coalition</td>
</tr>
<tr>
<td>Mike Porter</td>
<td>Executive Director</td>
<td>Kentucky Dental Association</td>
</tr>
<tr>
<td>Lois Reynolds</td>
<td>Director, Coalition Development</td>
<td>Oral Health America</td>
</tr>
<tr>
<td>William (Ken) Rich, DMD, FACD</td>
<td>Private Practitioner and Chairman,</td>
<td>Kentucky Dental Association Legislative Committee</td>
</tr>
<tr>
<td>Judy White, RDH, MPH</td>
<td>Associate Administrator, Oral Health Programs</td>
<td>Commonwealth of Kentucky</td>
</tr>
</tbody>
</table>
APPENDIX D: Pre-summit questionnaire

PRE-SUMMIT INTERVIEW

Please complete the following questions regarding your perceptions of oral health problems and issues in Kentucky:

1. From your perspective, what do you feel are the critical issues involving access to oral and dental health in Kentucky?

________________________________________________________________________
________________________________________________________________________

2. In regards to access to dental health services, rank the groups below in order of who you feel should be entitled to free or low-cost dental services:
   (1=highest priority)
   _____disabled (physically and/or mentally disabled children and adults)
   _____children (low income, geographically isolated)
   _____nursing home, homebound, and dependent elderly
   _____low income adults (so they can afford the cost required to visit the dentist)
   _____other group?

________________________________________________________________________

3. Is the Kentucky Medicaid program (KMAP) for low-income and disadvantaged people effective in this state? _____Yes _____No. If not why?

________________________________________________________________________

4. Is the Ky. Child Health Insurance Program (KCHIP) in Kentucky effective in regards to providing dental programs/services to children? _____Yes _____No. If not, why?

________________________________________________________________________

5. My suggestion(s) for improving the state Dental Insurance program (KMAP) or KCHIP program for low-income children (and eligible adults) would be to:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. Do you believe there is a shortage of dentists or dental help (hygienists, assistants, lab techs) in the state? _____yes _____no
   Explain:_________________________________________________________________

7. Do you believe there is a distribution problem of dentists in the state?  _____yes  _____no
   Explain:_________________________________________________________________
8. What is your advice for solutions, or what knowledge do you have of programs and strategies in place to address challenges to access?

___________________________________________________________

9. Are there any legislative proposals you would like to see developed?  
   _____yes  _____no

   Explain:____________________________________________________

10. Are there any dental service delivery models (innovative programs to meet oral health access need), you are aware of or would like to propose?  
    _____yes  _____no

   Explain:____________________________________________________

11. Are you aware of any public oral/dental health educational campaigns in any community in Kentucky which has been successful, or which you would like to propose?  _____yes  _____no

   Explain:____________________________________________________

12. What would make the Kentucky Dental Summit worth your time (whether you can attend or not)?

   _____________________________________________________________

   _____________________________________________________________

13. What are some outcomes from this meeting that you think would be relevant at this time?

   _____________________________________________________________

   _____________________________________________________________

   Thank you for answering this questionnaire as part of the registration!
APPENDIX E: Responses to Pre-summit Questionnaire

1. **What do you feel is the biggest problem regarding oral health access in the state?**
   Providers willing to participate in rural areas & volunteer time to clinics which provide care. Lack of incentives for practitioners to locate in underserved areas. Maternal-prenatal oral health care. Dental health not having the same importance as medical care. Welfare to work parents- work jobs that they can't leave for appointments. That all children have access to dentists, hygienists and dental floss, toothbrushes, etc. Dentist who will accept a Medical card. The restrictive nature of practice for dentists and dental hygienists and the ability to work in various practice settings. Time and location. Inadequate programs that result from a lack of perceived value. Access for low-income children and adults. Medicaid funding. Restructuring the Medicaid program so it's sensible, i.e. No coverage for orthodontics. Include funding for promoting the program to people who need care. Manpower. Trained auxiliaries to assist with outreach, not considered to be a high priority by state politicians, residents, etc. Getting parents to take dental health seriously. They don’t view it as a health issue. Most critical-out of pocket expense. Culture.

2. **In regards to access to dental health services, prioritize the following in order of what you would like to see done first (1=done first, 2=second, etc):**
   - Ensure disabled are able to be treated by dentist
   - Ensure children are able to be treated by dentist
   - Ensure nursing home elderly are able to be treated by dentist
   - Ensure low income people can afford the cost required to visit the dentist
   - Other- I have great difficulty assigning a priority to 1-4 Oral Health is very important for all, in regard to general health & well-being. Working poor. Children entering school for the first time. College Students. Difficult to rank, all are equally important.

3. **Is the Kentucky Medicaid program (KMAP) for low-income and disadvantaged people effective?** Yes _________ No __________ If not, why?
   Somewhat-low SES populations have priority problems & usually seek ER care-prevention is low on the list. Under funded. Lack of effective benefit management. Lack of access-dentist participation. Overall shortages of general dentists and pediatric dentist given the population to be served (scope & location). I think the program works for the people it is designed for, however there is a substantial gap between those who are eligible and those who can afford care. The efficiency of the program is so poor that the dollars being expended are not being utilized efficiently. Not enough doctors willing to participate due to poor reimbursement and patient compliance. Scope of the program is limited. 20% Utilization. No educational component to educate parents of the benefit. Does not develop appreciation and desire for dental care. Don’t think they are aware they have dental insurance included. Due to post-war fee’s (until lately August 2000) very limited in providers-especially specialists. Poor utilization review, unfriendly filing
system and delay in reimbursement. It is too cumbersome for most dentists to use; must be simplified. People who would qualify are not using it. Pulling decayed teeth is what is covered by KMAP; that’s one of the reasons that Kentucky has a high rate of toothlessness. Dental Health extremely low priority in minds of politicians.

4. Is the Kentucky Child Health Insurance Program (KCHIP) effective in regards to proving dental programs, services to children? Yes No If not, why?

No, same as Medicaid, benefit package is good. With KCHIP added on to an already failing Medicaid program and no additional state commitment to funding it will eventually cause failure of both programs. Prevention is the key. Not enough dentists willing to see these patients. Access problem perhaps do we have the dentists to know? Received a lot of information and attention at the beginning of the movement, but have not received any for the attention as of late. Provider network. Are “selling” services to parents, but still does not raise the dental IQ. It depends on where you are in the state. Yes- but people need to be more informed about the program. Somewhat delivers money for care, does not address prevention or compliance. The percentage of children with access is critically low. Again, not enough children who are qualified are using it. Maybe-too soon to tell.

5. My suggestion(s) for improving the state Dental Insurance program (KMAP) or KCHIP program for low-income children (and eligible adults) would be:
   - Increase providers, Increase rates.
   - Simplify paperwork/administrative support. Provide case management.
   - Make services more accessible for children-provide them at school.
   - If patient fails appt. and it is documented, lose services in the future.
   - If an adult or are referred to social services for neglect in cases of children. I know many dentists I have talked said high insurance fees will not get them back in, that the headache on dealing with the agency and for the most part the clientele is more than it is worth. Assuring care.
   - Re-evaluate services provided and funding for the same. More incentives to participate.
   - Diagnosis the problem, test hypothesis of problems with access, cost of care etc. and then design programs to improve program.
   - Provide services at schools. Train high school students to floss by posters, etc. on preventing Bad Breath. State must commit to funding both programs properly either by additional dollars or decrease in benefits. Continue to review. School based prevention programs for children-statewide. School based dental treatment programs (mobile and fixed) in communities where access is insufficient. Regional safety net programs linked to regional medical complexes. Should have a co-pay—at least for adults-you appreciate what you pay for. Education-that dental/oral care is available. A more aggressive public education/relations on the programs and its services.
   - A yearly cost of living raise-say 2% so we know what is coming in the future. Allow separation of KCHIP from Medicaid. Publicize where patients can go for treatment. Help with transportation. Adequate funding and reimbursement, proper utilization review. Support alternative service sites. Enforce preventive recall visits. To make red tape involved with reimbursement non-existent. Publicize the program to enroll more eligible children. Clinics run by the state dental schools and or make it advantageous for providers to see these patients, consider using trained auxiliaries to help. Make sure parents who are in the program take full advantage of it, which includes regular check-ups for their children. Awareness/Education for clients-develop comprehensive dental preventive health package for children, with recommended service intervals, i.e. 9 months, 12 months, 18 months, etc. Educate politicians-program low on list of Health Issues- “It is only a tooth”.

6. Do you believe there is a shortage of dentists or dental help (hygienists, assistants, lab techs) in the state? Yes No Depends on goal—to substantially improve access for Medicaid, KCHIP and Nursing Homes/elderly—Definitely. I for see a shortage in the near future that will potentially get worse due to decrease in enrollments and increase in aging populations. No-two dental schools at half capacity due to a oversupply of practicing dentists. Distribution problem.
Yes—tends to be lack of qualified and educated assistants due to lack of programs throughout the state. No—Dentists and Hygienists tend not to locate in the low income areas due to reimbursement and commitment. No—if answer is based on current demand. More of a distribution problem than a shortage. Can’t get good help nowadays (assistants/hygienists) There will be a shortage of Dentists within 5-10 years, also we need more hygienists in rural areas. Hygienists—especially. A maldistribution of dentists. Difficult to get and keep good assistants and hygienists. A regional problem. Too many in Louisville and Lexington, not enough in rural.

7. **Do you believe there is a distribution problem of dentists in the state?**

- **Yes**
- **No**

Not enough in rural and inner city areas. Not as much as in the past. Dentists tend to locate in geographic areas of higher education and income. Yes, but it is not totally the dentists fault-poor compliance and reimbursement. In our twelve county area there are only 2 Pediatric Dentists. 79% of all dentists in Kentucky are located in 20 counties. Just look at Eastern Kentucky. Dentists go where they can make a living.

8. **What is your advice for solutions, or what knowledge do you have of programs and strategies in place to address challenges to access?**

Free clinic settings care for low income working families. Federal Loan Repayment program—should make arrangements with the IRS for direct loan repayment and not give as much tax money out. School based prevention and treatment programs, regional dental access safety net programs. Programs already begun, i.e. mobile programs, school based programs need to be expanded. Dental professionals need to make more aware of access issues and involved in their local problems. Recruit dental students from rural areas. Require student aid recipients to intern in rural areas. Use local community leaders—Extension, EPNET to reach low income families. Sealant programs in schools. Increase the reimbursement sent to providers but limit the individual to a certain cap per year if the government does not want to pay out all the money. Scholarship programs requiring placement in underserved areas and provide adequate funding for practitioners who locate there. Put dental care on the same status as medical. Require screenings before entry into school. Increase campaign for Dental Education Awareness. Cross—train and educate other health care providers on what to look for—education, etc. Fixed site incentives—loan forgiveness repayment. Increase Medicaid rates. Low cost office building and leasehold improvement programs in isolated areas for dental start ups. See California Report. National Health Service Corporations. Expand duties for allied personnel. Possibly a scholarship program; education reimbursement program. The UK mobile dental unit is a wonderful program for the student in Eastern Kentucky. My knowledge is limited. I refer families to UK’s dental programs. Find out who the dentists are and where the clinics are and publicize it. Adequate funding (5% Total Medicaid Budget) The KDA has a program that provides access—The Kentucky Dentists Care Program. Dental college and schools training hygienists and assistants volunteer time. Mobile unit at Western Kentucky University—South Central Kentucky. High cost of dental care is always a hindrance. Lobby any and everyone on need for Dental Health.

9. **Are there any legislative issues you would like to see developed?**

- **Yes**
- **No**

Support for dental programs offered by charitable organizations. General supervision of dental auxiliary. School based prevention and safety net. Regional dental access safety net. Better support for dental Medicaid program. Creation of dental access “safety net” using PGY1 dental graduates in community based settings. Health Insurance coverage to hospital dental treatments (medically comprised patients). Place medical assistance programs on better funded basis and not allow bureaucratic shortchanges of the programs. Any company that provides health care must also provide dental. Expand practice of Dental Hygienist with direct supervision of dentist. Make lack of dental care an abuse issue. Early childhood exams mandatory for entry into elementary school.
year entry into school exam – modeled on Head Start dental exam. Dental laws need to be updated. Denturty issue needs to be solved. Change in practice act to allow general supervision of hygienists. Dental health regulation of middle school, high school and college.

Mandatory funding at a reasonable level. Medicaid to pay for adult dental services. Mandatory insurance coverage for general anesthesia- not brought for a vote in the 2001 session. Reinststate money for the fluoride mouth rinse programs, fund sealant programs. Expanded licensure by credentials. If a dental exam is mandatory for school entry (not just first grade) give the schools the power to exclude until parents comply. We are not trying to hinder their entry to school, however, what good is a mandate if schools can not enforce it. Also have funding/solutions for parents to comply—especially for those without dental insurance/ or under insured,

10. **Are there any dental service delivery models (innovative programs to meet oral health access need), you are aware of or would like to propose? Yes_____ No_____**

Free dental clinics, sealant programs in schools. Not at present, University of Kentucky is planning such a model. School based or mobile clinics. Regional dental health clinics to fill access gaps. Dental advisor to school systems similar to KMA’s program. Mobile van-2-3 days.


11. **Are you aware of any public oral/health educational campaigns in any community in Kentucky which has been successful, or which you would like to propose? Yes_____ No_____**

Local coalition model for county/regional consideration. Would like to have more psa’s on TV and radio that work. No-old system of placement of trailers on school property and providing professionals to man them seemed to work well. Tooth Fairy-Dental hygiene education program provided by South-East Kentucky AHEC/HETC. Community Clinics with student rotations.

Colgate Kids-Colgate funding to the University of Louisville to treat lower income children. Water Company Partnership in Louisville to promote Louisville water, sealant program in Louisville.

12. **What would make the Kentucky Dental Access Summit worth your time (whether you can attend or not)?**

Learning more about national trends and other delivery models. Legislative and Cabinet for Health Service follow up and program initiatives. Work with attendees from outside of dentistry to develop an understanding of the problems we have but also to develop solutions and strategies for solving these problems. Establish the facts, then find root cause(s), then brainstorm solutions, then make an implantation plan for the best solutions. If we can make the public more aware of necessary oral health habits- we can solve many dental problems. Topics look good. Review of access issues, look at data, draw conclusions develop action agenda. To begin addressing the issue of poor reimbursement and why it is important to provide care in all aspects with demographics included. Develop programs that will be implemented rather than talked about. Concrete plan to improve access. A good result! To learn the current information re: dental education to pass on to the 3-4000 children I reach. Would like to learn more. To gather information about what services are needed in Kentucky related to dental health. Real solutions discussed, not ruling anything out or focusing on “professional issues” only! Answers to the KMAP program. Inform me on how I can find better services for families in my community.

To gain some ideas to help resolve some problems, don’t want information and figures only. Collaboration with other educators/private practitioners to discuss access issues. As much media as possible-letting the public know that access is in their hands- keep
appointments, etc. I.D. ways to solve and I.D. access and educational challenge. Helping Legislature, Community leaders to understand implications of Surgeon Generals Report. Working toward a common goal—improve and maintain oral health in Kentucky. To find out what is going on in Kentucky as far as dental health issues are concerned (Who is doing what, etc.). Already worth my time... hope to come away with seeds for an oral health program. Start actions. Actual long term changes. Keep the oral health channels open. Involve Kentucky School Nurse’s Association for input.

13. **What are some outcomes from this meeting that you think would be relevant at this time?**

Some successful models and people present who have the authority to make the changes, not just talking about the problems. Development of statewide support for action to improve dental access. Education of non-dental groups/individuals and policy makers. Engagement of dental industry and foundations in trying to be part of dental access solution. Legislative proposals.

Greater communication-outreach to groups interested in this problem-poor dental health-poor nutritional intake in elderly adults. Case studies, set priorities, develop action agenda. Hopefully programs and commitments will be made that will positively effect dental health care delivery to the underserved areas of the commonwealth. Increased access to care, increased participation by dentists in Medicaid program. A written report. Commitment to improve oral health from a wide variety of sources. Who to send kids to for dental problems. Referral system for children who have dental problems. New community service programs. Legislative initiatives to change KMAP, allow general supervision and increased duties for hygienists, etc. Groups of people coming together from different areas with ideas for solutions, support from ASDA on these issues and maybe ADA, awareness. Put information into legislation/programs from research. To educate public that dental health is quality of life equal to television, Nintendo, etc. Address issues pertaining to Kentucky and Utah among other states. Network of dentists to address and follow thru with programs. Seek ways all Kentuckians can have good oral health. Development of a foundation for a strategic plan to address access in the state. Funding proposals. Increased awareness of the crisis in dental care for the poor and near poor. Legislation- Task force to promote better dental care. Recommendation to legislature regarding dental issues. To develop a networking system from education to access to good dental care that would make dental care a # 1 priority with Kentuckians. A total children’s oral health program. More dentists participating in KMAP and KCHIP.
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